GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 15, 2023

Tracey Hamlet
MOKA Non-Profit Services Corp
Suite 201
715 Terrace St.
Muskegon, MI 49440

RE: License #: AS410294135
Investigation #: 2023A0357017
68th Street

Dear Ms. Hamlet:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPOR

I. IDENTIFYING INFORMATION

License #:	AS410294135
Investigation #:	2023A0357017
Complaint Receipt Date:	04/25/2023
Investigation Initiation Date:	04/25/2023
Report Due Date:	06/24/2023
Licensee Name:	MOKA Non-Profit Services Corp
Licensee Address:	Suite 201 715 Terrace St. Muskegon, MI 49440
Licensee Telephone #:	(616) 719-4263
Administrator:	Tom Zvirgzds
Licensee Designee:	Tracey Hamlet
Name of Facility:	68th Street
Facility Address:	1777 68th Street Caledonia, MI 49316
Facility Telephone #:	(616) 554-3091
Original Issuance Date:	02/28/2008
License Status:	REGULAR
Effective Date:	08/09/2022
Expiration Date:	08/08/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The medicine cabinet was left unlocked all day and Resident A's Vicodin pills were missing.	Yes

III. METHODOLOGY

04/25/2023	Special Investigation Intake 2023A0357017
04/25/2023	Special Investigation Initiated - Telephone Recipient Rights, network 180.
04/26/2023	Contact - Telephone call made. With Jessica Hanselman, Recipient Rights, network 180.
04/26/2023	Contact - Document Received Received and reviewed an Incident Report concerning Resident A.
04/27/2023	Inspection Completed On-site Unannounced inspection Rights.
04/27/2023	Contact - Face to Face Interview with Home Manager Wilford Mkandawire, Direct Care Staff, Queen Muhinpunbu and Sidney See.
04/27/2023	Contact - Face to Face Met Resident A.
05/11/2023	Contact - Telephone call made. To Agency Staff, Kiaura Garner. No answer and no way to leave a message.
06/14/2023	Contact - Telephone call made: Telephone interviews with Sheryl Williams, Supervisor, Tom Zvirgzds, Administrator and Jessica Hanselman, Recipient Rights, network 180. I interviewed by telephone Direct Care Staff Kiaura Garner.
06/15/2023	Telephone exit conference was conducted with the Licensee Designee, Tracey Hamlet.
06/15/2023	APS referral.

ALLEGATION: The medicine cabinet was left unlocked all day and Resident A's Vicodin pills were missing.

INVESTIGATION: On 04/25/2023 our Online BCAL received a complaint that read as follows: *'On 03/20/2023, multiple employees were working at the AFC home on the day of this incident. One of the employees left the medicine cabinet unlocked all day leaving the medications inside accessible by all employees and all the residents. At some point throughout the nigh approximatively 90 tablets of Hydrocodone had gone missing from the cabinet, but it is unknown who took them.'*

On 04/26/2023, I spoke by telephone with Jessica Hanselman, Recipient Rights Advocate, from network 180.

On 04/27/2023, Ms. Hanselman and I met at the facility. This was an unannounced inspection. We met with the House Manager, Wilford Mkandawire. He stated that Resident A is on the medication Hydrocodone for pain as a PRN (as needed) medication. He went on to explain that this was a Sunday, March 19, 2023 and stated, "I went to pass the medication on second shift and the meds were missing. I double checked them, and the medications were missing." He went on to explain that the staff relieving him came late about 9:00 am. He stated that the two direct care staff who were working the first shift on Sunday were not trained to pass medications. I asked him for the names of the two staff and he reported that one is named Kiaura Garner (goes by Ki Ki) and the other is Queen Muhimpudie. He stated further that he had to go to church, but he also had to return to the home to administer resident's medications. He said he left between 9:00am and 9:20am to go to church and he said he returned to the AFC home at 2:00 pm. This was when he discovered that all of the medication cards for Resident A's Hydrocodone were missing. He said you cannot misplace these medication cards. He reported that he searched everywhere including the medication cabinet, but he did not find the medications. He said he called the Kent County Sheriff's Office and they came but did not leave a card for their name and phone number. He also explained that Ms. Muhimpudie was new at that time. He said she never left the home while she was working her shift. He went onto say that he called his Supervisor, Sheryl Williams and reported to her what had happened but was uncertain as to the date and time. I asked him if the medication cupboard was locked. He said it was a mistake, but he left the key to the med cupboard in the drawer.

I asked him about the number of pills since the complaint identified 90 tablets were missing and he said that was not true, but in fact there were 50 or 52 pills missing because they counted the control substances at the end of each shift and the start of the next shift. He stated that MOKA corporation replaced Resident A's pills and the pharmacy brought them to the home. He said that he could not count the pills with the staff that did not pass resident's medications, so he was waiting for the staff who passed residents' medications to come and count the pills with him. I asked if he could copy Resident A's Medication Administration Records (MARs) for me and he reported that he is too new and has not learned how to do that yet.

On 04/27/2023 I reviewed the Incident Accident Report, which was dated 03/19/2023 by Mr. Mkandawire. The report read as follows: *'I was counting medication around 10:30pm to prepare for shift change at 11:00pm then I found out that (Resident A's) Hydrocodone APA 7.5 controlled medication is missing. Last time checked was at 8:00 am of the passing morning med. I left the home at 9:20am leaving Queen and Ki Ki. I came back at 11:45am and left after an hour and came back for 2nd. shift. At 2:30pm. At 4pm I didn't do the count because I was waiting for shift change with the 3rd shift with someone who would sign as witness. I didn't report some time at night because the staff asked me to give them time to check all over but when I came back this afternoon we have concluded that the medication is missing. I have reported the incident to the police and opened up the case 23-114900 and have reported the incident to network 180 and my second manager. I will buy lock for medication closet and everyone who is entitled to pass med will have his or her own key. This will give more security as well as make everyone accountable if the med closet is found open.*

The home was searched along with the trash cans. All medications were double checked and no other medications were found missing. We will work with the HS Wiliford to make sure that there is only one key available and this key is passed from one medication passer to the next in a secure location where only trained MOKA employee has access. We will move things that are general use like surgical masks to another location other than the med closet and make sure all the staff are assuring that the closet kept locked. Police were notified and talked with two employees on duty. Please note that Ki Ki was a temp agency employee. This medication was a PRN medication for (Resident A).'

On 04/27/2023, Ms. Hanselman and I conducted an interview of direct care staff, Queen Mkandawire. She reported that this was her second month working in the home. She said she works all shifts and she picks up extra shifts when she can. She stated that she has not been trained in medication administration yet, but she plans to take the class soon. She stated she worked on 03/19/2023, third shift into first shift, which was a double shift. She stated she worked the first shift with Ms. Garner and reported Mr. Mkandawire passed the morning medications then went to church and then came back to pass the residents' medications on first shift on 03/19/2023, for the afternoon meds. She did not know if the medication cupboard was locked or not because she does not pass medications. She said the next day she was asked by Mr. Zvirgzds about the missing medications. She said she denied taking the medications and did not know who would have taken the medications. She said she prepared the meals for the residents while the second staff watched Resident B. I asked her when they administered Resident A her Hydrocodone medication and she stated staff administer the medication when she has anxiety, exhibits problem behaviors or when they think she is in pain.

On 04/27/2023, I met Resident A. She is unable to speak and therefore could not contribute to the investigation.

On 04/27/2023, Ms. Hanselman and I conducted a face-to-face interview with direct care staff, Sidney See. She stated that she does not pass medications. She also stated that she worked second shift on Sunday March 19, 2023. She said she did not count any resident medications. She denied taking any of Resident A's medications.

On 06/14/2023, I conducted a telephone interview with Ms. Sheryl Williams, Supervisor. She confirmed that Mr. Mkandawire had notified her on Monday, 03/20/2023 of Resident A's missing medications and was aware that the police had been notified. She confirmed that Ms. Garner and Ms. Muhandawire worked the first shift on Sunday and that neither of them was trained in medication administration. She was unsure of the exact number of tablets that were missing but we spoke about 50 or 52 pills. She reported that they narrowed the missing pills to Sunday, 03/19/2023. She reported that Ms. Garner had refused to talk to her or anyone. She stated that the police tried to interview her, and she refused to talk to them. She reported that she called the temp agency that Ms. Garner was employed by and told them they never wanted Ms. Garner to work in any of their homes again. She stated that Ms. Garner had worked in the home for about two months, and she knew where the med keys were kept. She stated that at any time a staff may be in the bedroom of a resident or in the bathroom providing personal care to a resident so they would not be able to see all that is going on in the main parts of the home.

Ms. Williams stated that they had the staff check the entire house and they did not find anything. She said she believes that Mr. Mkandawire hooked the lock on the med cupboard but failed to close it completely which would allow anyone to open it. In addition, he left the med keys in the drawer. She reported that they went through all the resident's medications and no other medications were missing other than Resident A's medication of Hydrocodone. She stated that the medications were replaced. She also stated that they had made immediate changes with their procedures. She said now, the med passer has the key on their person along with other procedural changes to ensure that no one has access to the resident medications except the med passer. She said the locks have also been replaced. She stated that the police reported to them that they were suspicious of Ms. Garner, but she refused to talk with them. She also reported that there were issues that they had learned about with the pharmacy and their system. She explained that at the end of the month the pharmacy had to catch up and recalibrate and that was why the count of the missing medications was not correct at first. She said it was not 90 pills missing but more like 50 or 52 and the pharmacy confirmed the count also.

On 06/14/2023 I conducted a telephone interview with direct care staff Kiaura (Ki Ki) Garber. She confirmed that she worked at the 68th Street home on 03/19/2023. She stated that she had worked at this home about three months. I asked her about the medication cup board, and she said she did not go by it because she did not give any medications to the residents. She said she did not know about it being locked or unlocked because she did not have access. She was aware that Resident A's medications were missing, and she denied taking them.

On 06/14/2023, I conducted a telephone interview with Mr. Sergeis Toms Zvirgzds, administrator. He acknowledged that the medication cupboard was not locked, and that Resident A's medication pills were missing. He said that he conducted interviews with the staff and they all denied taking the medication. He stated Ms. Garner would not talk to him. He explained that the staff leaving the shift and the staff starting the shift counted the control substances together and they had the documentation for this. He reported that they made immediate changes, and the med passer now has the key on their person. He also stated that Resident A's medications were replaced by the pharmacy.

On 06/15/2023, I conduced an exit conference with the Licensee Designee, Tracey Hamlet and she agreed with my findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was alleged that the medication cupboard/cabinet was not locked on Sunday 03/19/2023. The Home Manager, Wilford Mkandawire, acknowledged that he left the key to the medication cabinet in the drawer while he was gone from the facility on 03/19/2023. During this investigation it was confirmed that the key was left available and the med cabinet was not locked and therefore there is a violation to the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the Licensee provide an acceptable plan of correction and the license remain the same.

Arlene B. Smith 06/15/2023

Arlene B. Smith Date
Licensing Consultant

Approved By:

06/15/2023

Jerry Hendrick Date
Area Manager