GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 7, 2020

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

RE: License #: AS410278077
Investigation #: 2020A0357017
Mullins AFC Home

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 REPORT

I. IDENTIFYING INFORMATION

License #:	AS410278077
Investigation #:	2020A0357017
Complaint Receipt Date:	06/01/2020
Investigation Initiation Date:	06/01/2020
Report Due Date:	07/01/2020
Licensee Name:	MOKA Non-Profit Services Corp
Licensee Address:	Suite 201, 715 Terrace St. Muskegon, MI 49440
Licensee Telephone #:	(231) 830-9376
Administrator:	Beth Ann Hoffer
Licensee Designee:	Tracey Hamlet
Name of Facility:	Mullins AFC Home
Facility Address:	1630 Mullins Avenue, NW Grand Rapids, MI 49534-2435
Facility Telephone #:	(616) 735-2327
Original Issuance Date:	09/28/2005
License Status:	REGULAR
Effective Date:	03/27/2020
Expiration Date:	03/26/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The staff were not able to administer Resident A's prescribed Carbamazepine (Tegretol) because the medication was not in the medication cupboard.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/01/2020	Special Investigation Intake 2020A0357017
06/01/2020	APS Referral The referral was denied.
06/01/2020	Special Investigation Initiated - Telephone Telephoned the Home Manager, Beth Hoffer and conducted an interview with her by telephone.
06/01/2020	Contact - Document Received Received documentations from Beth Hoffer.
06/17/2020	Contact - Telephone call made Conducted telephone interviews with Direct Care Staff, Angeline Henderson and Michael White.
06/22/2020	Contact - Telephone call made Conducted a telephone with Direct Care Staff, Tisheila Smith.
07/07/2020	Conducted an exit conference with the Licensee Designee, Tracey Hamlet.

ALLEGATION: The staff were not able to administer Resident A's prescribed Carbamazepine (Tegretol) because the medication was not in the medication cupboard.

INVESTIGATION: On 06/01/2020, I received a call from Beth Hoffer, the Administrator of the home. She stated that she had received a text message from Direct Care Staff, Angeline Henderson who was working in the home on 05/31/2020, that they did not have any prescribed Tegretol to administer to Resident A. The medication is to be administered three times per day at 08:00,14:00 and 20:00. Ms. Hoffer stated that Resident A requires the medication to control his seizures and his Self-Injurious behaviors. She stated Ms. Tisheila Smith was the assistant and she would have been the one that received the cycle medications into the home when

the pharmacy delivered the home's medications. She also reported that the medications for the residents had arrived at the home but was uncertain of the date they arrived, but she could tell by the computer that the medications had been checked in. Ms. Hoffer stated that she went to the home and looked everywhere and eventually found the medications in a tub in the basement and the tub did not have a lock on it. She explained that they do not store any residents' medications in the basement and that this did not make any sense to her. She acknowledged that Resident A had not received his medication Tegretol for several days. She was certain that Ms. Smith would have administered Resident A's medications on Friday May 29th, and she would have known that his medication was either out or would be out for the weekend. She said the medication card would have been empty. Ms. Hoffer stated that she had called Centralized Intake, Licensing and had reported the incident to Recipient Rights of network 180. She also reported that she had contacted the hierarchy of the agency of MOKA.

On 06/01/2020 Ms. Hoffer sent me by e-mail the Incident Accident Report (IR) she had completed which I reviewed. The IR indicated the Ms. Henderson was working and she had explained to Ms. Hoffer the following: "*Upon passing morning mediation, I noticed that there was no Carbamazepine for (Resident A). I began looking for the cycle (medications) because I knew they were here and I could not locate them. I called the assistant (Tisheila Smith) who had the MOKA on-call phone because I was concerned because this particular medication is a seizure med. The first call there was no response. About two hours later I called again and she (Ms. Smith) called me back. I told her I did not have this med for (Resident A) and she told me she would take care of it tomorrow. I then called the supervisor who came to the home to look for the med. The cycle meds were found and he (Resident A) was given the 2pm dose. Upon giving this dose I noticed the computer history and he was not given the medication on May 29, at 8pm. Also, on May 30th at 2pm and 4pm (SIC) (should list 8:00 PM, because he does not have this med at 4pm) and this morning on May 31st at 8am and that is at least 4 missed doses."* Ms. Hoffer's name was typed on the IR and she typed in that the staff had been instructed to monitor for any signs or symptoms of seizure as well as SIB and the staff, Ms. Smith, had been suspended pending the outcome of the investigation.

On 06/01/2020 Ms. Hoffer sent me Resident A's Physician's Orders for his prescribed medications. I reviewed the documents. Resident A was prescribed Carbamazepine (Tegretol) 200 mgs. "Take 1 tablet by mouth three times daily. Scheduled Daily at 08:00, Daily at 14:00, Daily at 20:00."

On 06/17/2020, I conducted a telephone interview with Direct Care Staff, Angeline Henderson. She reported that she did not pass residents' medications on Friday May 29, because she had been assigned to the kitchen to prepare the meals. She stated that she worked a double shift on Saturday May 30/2020, working first and second shifts. She also reported that she was assigned to kitchen duty on Saturday in the AM so she did not administer residents' medications but in the afternoon she was assigned to administer resident medications. She stated that she went to look

for Resident A's medications and his Tegretol was unavailable. Therefore, Resident A missed his 2:00pm and 8:00pm does of Tegretol. Ms. Henderson stated that she worked on Sunday May 31/2020 and she could not find Resident A's, Tegretol for his 8:00 AM dose, so she called Ms. Smith and left a message and she did not call back. She said she called her again and she left another message. She said Ms. Smith called her back and she told her, 'I will take care of it on Monday.' She said she could see that the medication had been checked in, but they were not in the locked cupboard. She reported she could not find them anywhere. She reported that she sent a text message to Ms. Hoffer, the home's Supervisor to find out what was going on. She stated that Ms. Hoffer came into the home and found Resident A's medication in the basement of the home. Ms. Henderson confirmed by checking the computerized medication documentation that Resident A had not received his prescribed Tegretol on 05/29/2020 at 8:00 PM., He also did not receive he prescribed dose on 05/30/2020 at 8:00 AM, 2:00 PM and 8:00 PM or his 8:00 AM medication on 05/31/2020. This is a total of 5 missed pills, each 200 mgs, of Tegretol. I asked Ms. Henderson if Resident A had had any seizures or SIB's and she stated: "not to my knowledge."

On 06/17/2020 I conducted an interview with the Direct Care Staff, Michael White who had worked on the weekend Friday and Saturday on first and second shift. I asked him when Resident A was to receive his prescribed Tegretol, and he stated 8:00 AM, 2:00 PM and 8:00 PM. He stated that he had not seen the new medications come to the home and he said if they had "I would have checked them in." He stated that on 05/29/2020 he was not able to administer Resident A's 8:00 PM dose of Tegretol because the medication was not available and the same for 8:00 AM and 2:00 PM and 8:00 PM on Saturday.

On 06/22/2020, I conducted an interview with Ms. Tesheila Smith, and she stated she was the assistant to the Home Supervisor. She reported that she has worked for MOKA for three years. She confirmed that that the residents' cycle medications had come to the home and she had checked them in, but she did not know the date they arrived. I asked her where she had put Resident A's Tegretol. She stated she had put them in a tote/tub in the basement and the door to the basement was locked. I asked if others had keys to the basement and she said they did have the keys. She also stated that she had worked on Saturday, but she said, "I did my administrative duties." I asked her if she had told anyone where she had put Resident A's medications and she said she did not tell anyone. She said that she did not think that Resident A's Tegretol was not due until Monday. That is why she told Ms. Henderson that she would take care of the matter on Monday. She stated that "This was my mis-judgement." She stated that Monday was June 1, 2020 and that is when the new cycle of medications would start. She stated that she is no longer employed by MOKA.

On 07/07/2020, I conducted an exit conference with the Licensee Designee, Tracey Hamlet and she agreed with my findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A was prescribed Carbamazepine (Tegretol) 200 mgs., take 1 tablet by mouth three times daily. Scheduled Daily at 08:00, Daily at 14:00, Daily at 20:00. Ms. Tesheila Smith stated she had put Resident A's medication in a tote/tub in the basement and did not tell anyone where she had put his medications. Ms. Hoffer, the Home Supervisor, acknowledged that Resident A missed four doses of Tegretol because the medication was not in the locked medication cabinet and therefore the staff could not administer the medication on the last weekend in May 2020. Resident A did not receive his medication of Carbamazepine (Tegretol) as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: On 06/17/2020, I conducted a telephone interview with Direct Care Staff, Angeline Henderson. She had acknowledged that she discovered that Resident A's prescribed medication Tegretol had not been administered on 05/29/2020 at 8:00 PM, 05/30/2020 at 8:00 AM, 2:00 PM and 8:00 PM and 05/31/2020 at 8:00 AM. This is a total of 5 missed pills. I asked her if she had contacted a health care professional when she discovered that Resident A had missed five doses of his prescribed Tegretol. She said she did not call anyone except her Home Supervisor, Ms. Beth Hoffer. She stated she was not aware that she was required to contact anyone about Resident A's missed medications.

On 06/17/2020 I conducted an interview with the Direct Care Staff, Michael White who had worked on the weekend Friday on second shirt and Saturday on first and second shift. He stated that on 05/29/2020 he was not able to administer Resident A's 8:00 PM dose of Tegretol because the medication was not available and the same for 8:00 AM and 2:00 PM on Saturday. I asked him if he had contacted a health care professional when he could not administer Resident A's prescribed Tegretol. He stated that he did not know that staff were required to call a health care professional if Resident A did not receive his medications. He acknowledged that he did not call a health care professional.

On 07/07/2020, I conducted an exit conference with the Licensee Designee, Tracey Hamlet and she agreed with my findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Both Direct Care Staff, Ms. Henderson and Mr. White were unable to administer Resident A's, prescribed Tegretol and acknowledged that they did not call a health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Arlene B. Smith 07/07/2020

Arlene B. Smith MSW Date
Licensing Consultant

Approved By:

07/07/2020

Jerry Hendrick Date
Area Manager