GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 26, 2021

Godwin Ilonze
Annextra Healthassist Associates, LLC
451 N. Hanlon Street
Westland, MI 48185

RE: License #: AS630386442
Investigation #: 2021A0605040
Annextra Healthassist Associates

Dear Mr. Ilonze:

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:

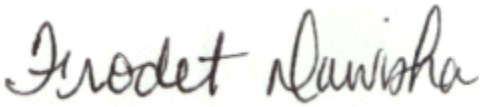
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance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

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

If you desire technical assistance in addressing these issues, please feel free to 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630386442
Investigation #:	2021A0605040
Complaint Receipt Date:	07/09/2021
Investigation Initiation Date:	07/12/2021
Report Due Date:	09/07/2021
Licensee Name:	Annextra Healthassist Associates, LLC
Licensee Address:	388 W. Hayes Avenue Hazel Park, MI 48030
Licensee Telephone #:	(313) 377-4486
Administrator/Licensee Designee:	Godwin Ilonze
Name of Facility:	Annextra Healthassist Associates
Facility Address:	388 W. Hayes Ave. Hazel Park, MI 48030
Facility Telephone #:	(313) 377-4486
Original Issuance Date:	12/07/2018
License Status:	REGULAR
Effective Date:	06/07/2021
Expiration Date:	06/06/2023
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Licensee Godwin Ilonze is violently verbally and emotionally assaulting Resident A. Mr. Ilonze was yelling and shouting at Resident A and threatened to evict Resident A when he refused to take his medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/09/2021	Special Investigation Intake 2021A0605040
07/12/2021	Special Investigation Initiated - Telephone I left a voice mail message for Adult Protective Services (APS) Darlene Thompson regarding these allegations.
07/12/2021	APS Referral Adult Protective Services (APS) made referral.
07/12/2021	Referral - Recipient Rights I forwarded the referral via email to Office of Recipient Rights (ORR) Kathleen Garcia.
07/12/2021	Contact - Document Received I received an email from ORR Kathleen Garcia.
07/12/2021	Inspection Completed On-site I conducted an unannounced on-site investigation. I interviewed Residents A, B, C, D, and E. I also interviewed direct care staff (DCS) Cynthia Thompson and licensee designee Godwin Ilonze regarding the allegations.
08/18/2021	Contact - Telephone call made I interviewed Resident B's case manager Rachel Shango regarding the allegations.
08/18/2021	Contact - Telephone call made I left a voice mail message for case manager Christy Gatto regarding Resident D.

08/18/2021	Contact - Telephone call received I received a return call from Resident D's supports coordinator Christy Gatto with Easter Seals.
08/19/2021	Contact – Document received I received an email from APS worker Darlene Thompson stating she is closing her case.
08/19/2021	Exit Conference I left a voice mail message for licensee Godwin Ilonze to conduct the exit conference regarding my findings.
08/26/2021	Exit Conference I left an updated voice mail message for licensee Godwin Ilonze advising him of the recommendation to change the status of the license to a provisional.

ALLEGATION:

Licensee Godwin Ilonze is violently verbally and emotionally assaulting Resident A. Mr. Ilonze was yelling and shouting at Resident A and threatened to evict Resident A when he refused to take his medications.

INVESTIGATION:

On 07/09/2021, intake #180613 was received from Adult Protective Services (APS) regarding verbal and emotional abuse of Resident A by licensee designee Godwin Ilonze. Also, Mr. Ilonze threatens to evict Resident A if he does not take his medications.

On 07/12/2021, I contacted APS worker Darlene Thompson regarding the allegations. Ms. Thompson stated she contacted Resident A and interviewed him via telephone. She stated Resident A told her that Godwin Ilonze is “picking on him.” Ms. Thompson reported that Resident A originally worded it as if Mr. Ilonze hit him, but then Resident A denied getting hit by Mr. Ilonze.

On 07/12/2021, I made a referral to Office of Recipient Rights (ORR) worker, Kathleen Garcia. I received a return email from Ms. Garcia stating the following: "We did receive this APS referral regarding Resident A. We do not contract with the home and therefore it is outside our jurisdiction. Resident A is only open to case management services with Oakland County Housing Network (OCHN).”

On 07/12/2021, I conducted an unannounced on-site investigation and interviewed Residents A, B, C, D, and E. I also interviewed direct care staff (DCS) Cynthia Thompson and licensee designee Godwin Ilonze.

I interviewed Resident A regarding the allegations. Resident A is his own guardian and has lived here for about two in a half year. Resident A stated that Mr. Ilonze is the provider but also works at this group home. He stated Mr. Ilonze is constantly checking in on DCS Ms. Thompson and all the residents. Resident A described Mr. Ilonze as being “too strict,” and “too many rules.” On 07/08/2021, Resident A was in his bedroom along with his roommate Resident B. Resident A was on his cellphone talking to the receptionist at Easter Seals to help schedule Resident B’s psychiatric appointment. Resident A stated, “I always help schedule Resident B’s appointments because Godwin asks me to do it several times.” He stated, “I always call on Resident B’s behalf.” Resident A asked Resident B would you rather travel to your appointment or conduct the appointment via Telehealth? Resident B stated, “Telehealth,” to avoid traveling if it was unnecessary. Resident A stated as he was talking on the cellphone, “Godwin burst into my bedroom and said, “Resident A, what are you doing.” Resident A replied, “I’m setting a meeting for Resident B with Easter Seals.” Mr. Ilonze stated, “I want Resident B to be seen in person by his psychiatrist, not Telehealth.” Resident A stated he was sitting on his bed while talking on the cellphone and that is when Mr. Ilonze began walking towards him saying, “I want Resident B to be seen by the doctor in person.”

Resident A stated that Mr. Ilonze was yelling and screaming while Resident A was still on the phone but then handed the phone to Mr. Ilonze because, “I was protecting myself from him hitting me because his (Mr. Ilonze) hand was up.” Resident A stated Mr. Ilonze never physically assaulted him, but that Resident A thought he was. Resident A stated that Mr. Ilonze cancelled the appointment that Resident A scheduled for Resident B and began to yell and curse at Resident A. Resident A stated, “I was balled up on my bed,” and then Mr. Ilonze left the bedroom. Resident A stated that Resident B was present during this incident and witnessed everything. Resident A stated that Mr. Ilonze consistently yells and screams at him and the other residents when they do not do what Mr. Ilonze wants or says. Resident A stated that Mr. Ilonze has never been physically abusive towards him or any other resident; just verbally and emotionally abusive.

Resident A stated that on 07/07/2021, Mr. Ilonze verbally threatened to evict Resident A if Resident A did not take his medications. Resident A was talking on his cellphone around 9:45PM and knew he had to take his medications at 10PM. Mr. Ilonze called Resident A to take his medications around 9:57PM, Resident A told Mr. Ilonze, “I’m still on the phone and I’m almost done.” Mr. Ilonze then said to Resident A, “I’m ordering you to take them now because you always take your medications after Resident B takes his.” Resident A stated, “No. I take my meds at 10PM and I still have three minutes.” Mr. Ilonze told Resident A, “If you don’t take your meds right now, there’s the door. You’re going to be evicted.” Resident A stated he took his medications at 10PM and went to his bedroom.

Resident A stated Mr. Ilonze also makes them go into their bedrooms after taking their medications and their lights must be off by 10:30PM. He stated lights were off initially at 11PM, but Mr. Ilonze keeps decreasing the time their lights are off.

I interviewed Resident B regarding the allegations. Resident B is also his own guardian and has lived at this group home for three years. Resident B receives services with Easter Seals and has an assigned case manager. Resident B stated that Resident A helps make his appointments because Resident A has a tablet, so Resident B can have Telehealth appointments with his psychiatrist. According to Resident B, Mr. Ilonze does not want Resident A to schedule any of Resident B's medical appointments, but Resident A still does. Resident B does not know why Mr. Ilonze does not want Resident A to schedule the appointments. Regarding the incident, Resident B stated that Resident A was on his cellphone scheduling Resident B's psychiatric appointment with Easterseals. Mr. Ilonze opened the door and was standing at the doorway the entire time speaking loudly to Resident A. Resident B stated he does not recall what Mr. Ilonze was saying but Resident B stated he never saw Mr. Ilonze walk towards Resident A nor did Resident B see Mr. Ilonze raise his hands to Resident A.

Resident B stated he and Resident A receive their medications at 10PM. Resident B is usually first to take his medications and then Resident A is right after. Resident B stated he took his medications and went directly into his bedroom; therefore, he was not present when Resident A took his medications. However, Resident B stated that Resident A told Resident B that Mr. Ilonze threatened to evict him if Resident A did not take his medications. Resident B stated he does not have many interactions with Mr. Ilonze and that Mr. Ilonze usually picks on Resident A.

Resident B stated he and all the other residents have a curfew of 10:30-11PM where everyone must be in their bedrooms and lights out. Resident B stated, there shouldn't be a time to turn off the lights if we're already in our rooms. He's (Mr. Ilonze) is making us turn the lights earlier every time."

I interviewed Resident C regarding the allegations. Resident C is his own guardian and has lived at this group home for about six months. He stated that Mr. Ilonze "yells at everybody," and is "sometimes rude." Resident C stated, "If I have my shoes on in the house, he tells me to take them off, so I do." Resident C stated he never witnessed or heard Mr. Ilonze yell or curse at Resident A because he was not present, but "believes it happened," because Mr. Ilonze yells. Resident C stated he has nothing further to add and ended the interview.

I interviewed Resident D regarding the allegations. Resident D is his own guardian and moved into this group home on 01/29/2021. He stated, "It is ok living here, but that Mr. Ilonze is too controlling, too many rules." Resident D described Mr. Ilonze as "mean and yells a lot." One-time, Resident D had one of his legs/foot on the couch and Mr. Ilonze saw this and yelled so loud, "put your foot down." Resident D stated, "This is my house so I don't know why I can't put my foot on the couch." Resident D reported that Mr. Ilonze "makes them turn their bedroom lights out at 10PM and doesn't let us leave our bedrooms." He reported that Mr. Ilonze is "very cruel to Resident A," and Mr. Ilonze "has no respect for Resident A and treats Resident A like a child." Resident D stated he has heard Mr. Ilonze yell and curse at Resident A. The curse word Resident D heard Mr. Ilonze say to Resident A is "shit." Resident D stated that Resident A answers back to

Mr. Ilonze as Resident A “tries to defend himself,” but that Mr. Ilonze is “very controlling.” Resident D has never witnessed Mr. Ilonze hit Resident A or any other resident including Resident D. On 07/05/2021, Resident D heard the argument between Resident A and Mr. Ilonze. Resident A was on the phone with a lady when Resident D heard Resident A say, “I need protection from this man.” Resident D stated the lady was from Easterseals. Resident D stood at the doorway of Resident A’s bedroom and saw Mr. Ilonze walk towards Resident A yelling at Resident A to hand him the phone. Resident D never saw Mr. Ilonze raise his hands to hit Resident A but Resident D did see Mr. Ilonze point his finger at Resident A.

Resident D stated he did not witness the incident regarding Resident A’s medications but that Mr. Ilonze during a “house meeting,” which the residents have twice monthly with Mr. Ilonze that if “residents do not take their medications, then there’s the door.” Resident D stated, “at these meetings, Mr. Ilonze does all the talking and the talking is about all his rules.”

I attempted to interview Resident E, but Resident E stated he did not want to be interviewed.

I interviewed DCS Cynthia Thompson regarding the allegations. Ms. Thompson stated she began working for Mr. Ilonze and at this group home on 07/08/2021. She works alone daily from 8AM-8PM. Ms. Thompson stated that she was not present on 07/05/2021 to witness the incident of Mr. Ilonze yelling at Resident A; however, she has heard Mr. Ilonze “talk loud,” not “yell” at Resident A about going to bed at 10PM. She was present during the medication incident where Mr. Ilonze wanted Resident A to take his medications two minutes before 10PM, but Resident A refused. She stated, “Mr. Ilonze sounds like he’s yelling, because he talks loud, so maybe that’s why Resident A says Mr. Ilonze is yelling.” She stated she has no other information to offer.

DCS Cynthia Thompson stated she has not completed any trainings since working here and that she is passing medications to all the residents. Ms. Thomson stated she has not had to complete a background check, provide a medical statement from a licensed physician nor provide a negative communicable tuberculosis (TB) test.

On 07/12/2021, Mr. Ilonze was interviewed regarding the allegations. Mr. Ilonze stated that he has informed Resident A numerous times not to make any of Resident B’s medical appointments, but Resident A continues to interfere. Mr. Ilonze had already schedule Resident B’s psychiatric appointment in person as that is what Resident B’s case manager (CM 1) had requested. Resident B’s CM 1 arranged transportation for Resident B on the date/time of the appointment. On 07/05/2021, Mr. Ilonze heard Resident A talking on the phone with Easterseals in his bedroom trying to make Resident B’s appointment as a Telehealth appointment. Mr. Ilonze knocked on the door and said, “No Resident A, you can’t do this. The appointment is already arranged.” Mr. Ilonze asked Resident A if Mr. Ilonze can speak to Easterseals on the phone. Mr. Ilonze stated, “the next thing I see is that Resident A grabbed the phone cowering down saying, no, no.” Mr. Ilonze stated, “I saw the situation and left. I never yelled or cursed

at Resident A. I just left the room and let Resident A finish the call with Easterseals." Mr. Ilonze stated he then called Easterseals and told them to change Resident B's appointment back to in person instead of Telehealth and the receptionist at Easterseals said, "OK." Mr. Ilonze stated transportation never showed up on the date/time of Resident B's appointment. Mr. Ilonze called Resident B's CM 1 who said that due to Resident A canceling the original appointment from in person to Telehealth, that automatically cancelled the transportation. Mr. Ilonze stated, "CM 1 was very upset because Resident B was out of his medications and needed this appointment." Mr. Ilonze stated he never asked Resident A to make any of Resident B's appointments including the one to Easterseals. Mr. Ilonze stated he never raised his hands to Resident A or any other resident. Mr. Ilonze stated, "Resident A's mental illness is weighing heavy on Resident A as he was an electrical engineer and now, he must follow house rules so Resident A is having difficulty following rules."

Mr. Ilonze was interviewed regarding the medication incident. Mr. Ilonze stated that he usually passes medications around 8PM or 9PM because all the residents must be in bed by 10PM. He stated, "Resident A had a problem with that, so I extended the bedtime to 10:30PM, which means lights off." He stated, "It's my house rules, and if they don't abide by these rules, they (residents) would be up till 3AM-4AM." He then stated, "I told them (residents) if you don't abide by my rules, you may have to go somewhere else."

On 08/18/2021, I interviewed Resident B's CM 1 regarding the incident on 07/05/2021. CM 1 stated that Mr. Ilonze contacted her regarding Resident B's transportation not arriving to pick Resident B up for his appointment. CM 1 found out that due to Resident A cancelling the in-person appointment, that cancelled Resident B's transportation. CM 1 told Mr. Ilonze it would be best if all Resident B's appointments are scheduled between CM 1 and Mr. Ilonze only and not Resident A. CM 1 stated that Resident B has not reported any concerns to her regarding Mr. Ilonze or this group home. CM 1 was advised of the concerns regarding DCS Ms. Thompson working unsupervised without any formal training, background check and administering medications to Resident B. CM 1 will be following up with Resident B at the group home.

On 08/18/2021, I interviewed Resident D's CM 2 via telephone regarding concerns expressed by Resident B. CM 2 stated, "Resident D does not like it at this group home and wants to live someone else." She stated that Resident D also told her that "if residents stop taking medications, Mr. Ilonze with threaten to call 911 on them, so residents cannot refuse any of their medications." CM 2 has heard other CM's described Mr. Ilonze as a "slumlord that overcharges." CM 2 stated that Resident D is currently at Havenwyick because he was on new medication, not feeling well and was forced to take his medications even when he reported to Mr. Ilonze he was not feeling well. CM 2 was advised of the concerns regarding DCS Ms. Thompson working unsupervised without any formal training, background check and administering medications to Resident B.

On 08/19/2021, I received an email from APS worker Darlene Thompson indicating she is closing her case.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (m) The right to refuse treatment and services, including the taking of medication, and to be made aware of the consequences of that refusal.
ANALYSIS:	Based on my investigation and information gathered, licensee designee Godwin Ilonze violated Resident A's and Resident D's resident rights when he threatened to evict Resident A and threatened to call 911 on Resident D when they refused taking their medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: (o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.
ANALYSIS:	Based on my investigation, Resident A, Resident B, Resident C, and Resident D were not treated with consideration and respect when licensee designee Godwin Ilonze forces these residents to remain in their bedrooms and turn their lights off at 10PM. In addition, Mr. Ilonze yells at Resident C to take off his shoes in his own home and yells at Resident D to put his foot down off the couch.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse. (iv) Threats.
ANALYSIS:	Based on my interviews with Resident A, Resident B, Resident C, and Resident D, licensee Godwin Ilonze is subjecting all the residents to mental or emotional cruelty, verbal abuse, and threats when he forces his house rules on them. The residents reported that Mr. Ilonze is "controlling, yells and threatens to evict or call 911 if the residents refuse to take their medications."
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/12/2021, DCS Cynthia Thompson stated she has not completed any trainings since working in the home and that she is passing medications to all the residents. Ms. Thomson stated she has not completed a background check, provided a medical statement from a licensed physician nor provided a negative communicable tuberculosis (TB) test.

I interviewed Mr. Ilonze regarding DCS Ms. Thompson not having her background check, training, medical and TB completed prior to working at this group home unsupervised. He stated, "I needed someone so quickly but I'm working on these things." Mr. Ilonze was advised that Ms. Thompson should not be administering medication if she has not completed her medication training. He stated, "she does not pass medications, I'm always here with her."

On 08/19/2021, I left a voice mail message for licensee designee Godwin Ilonze conducting the exit conference with my findings.

On 08/26/2021, I left an updated voice mail message for licensee Godwin Ilonze advising him of the recommendation to change the status of the license to a provisional.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006, but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on my investigation, DCS Cynthia Thompson did not have her background check including fingerprinting completed when she was hired on 07/08/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases.
ANALYSIS:	Based on my investigation, DCS Cynthia Thompson did not complete any of the above training when she was hired on 07/08/2021. Therefore, she was not competent before performing assigned tasks when providing care to Residents A, B, C, D, and E.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.
ANALYSIS:	Based on my investigation, DCS Cynthia Thompson did not have a statement signed by a licensed physician attesting to the knowledge of her physical health within 30 days of her hire date of 07/08/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

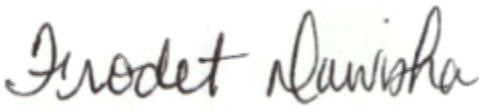
APPLICABLE RULE	
R 400.14205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.
ANALYSIS:	Based on my investigation, DCS Cynthia Thompson did not have her communicable tuberculosis prior to her hire date on 07/08/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	During my on-site investigation on 07/12/2021, there was insufficient direct care staff on duty for the supervision, personal care, and protection of Residents A, B, C, D, and E due to DCS Cynthia Thompson was not fully trained to provide the services specified in the residents' resident care agreements and assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Based on my investigation, DCS Cynthia Thompson did not complete medication training at the time of her hire date on 07/08/2021. Therefore, she was not trained in the proper handling and administration of medication to Residents A, B, C, D, and E. Ms. Thompson stated she administers medications to Residents A, B, C, D, and E.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

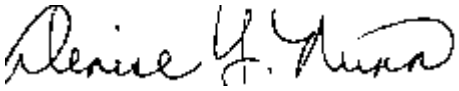
Contingent upon receiving an acceptable corrective action plan, I recommend the license to be modified to a provisional.



08/26/2021

Frodet Dawisha Date
Licensing Consultant

Approved By:



08/26/2021

Denise Y. Nunn Date
Area Manager