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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2021

Ramon Beltran
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS390406162
Investigation #: 2022A0581004
Beacon Home at Sprinkle

Dear Mr. Beltran:

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 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 (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406162
Investigation #:	2022A0581004
Complaint Receipt Date:	10/29/2021
Investigation Initiation Date:	10/29/2021
Report Due Date:	12/28/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Ramon Beltran
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Sprinkle
Facility Address:	6457 N. Sprinkle Rd. Kalamazoo, MI 49004
Facility Telephone #:	(269) 488-8118
Original Issuance Date:	02/18/2021
License Status:	REGULAR
Effective Date:	08/18/2021
Expiration Date:	08/17/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS:

	Violation Established?
Residents are not receiving their prescribed medication, as required.	Yes
Resident medication was not adequately stored at the facility to prevent someone from taking it.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/29/2021	Special Investigation Intake 2022A0581004
10/29/2021	Referral - Recipient Rights Kalamazoo Recipient Rights Officer (RRO), Suzie Suchyta, is investigating; therefore, a referral is not necessary.
10/29/2021	APS Referral- Confirmed with RRO, Ms. Suchyta, she made an APS referral.
10/29/2021	Referral - Law Enforcement- Confirmed with Ms. Suchyta she made a LE referral online
10/29/2021	Special Investigation Initiated – Letter received Resident A's Behavior Support Plan and protocol for medication via email from Ms. Suchyta
11/02/2021	Inspection Completed On-site- Interviewed residents and staff.
11/02/2021	Contact - Telephone call made- Left voicemail with LD, Ramon Beltran
11/02/2021	Contact - Document Sent- Sent email to Mr. Beltran regarding fire safety issues.
11/30/2021	Contact - Document Received- Received resident assessment plans via email.
12/15/2021	Inspection Completed-BCAL Sub. Compliance
12/17/2021	Exit conference with licensee designee, Ramon Beltran, via telephone.

ALLEGATION:

- **Residents are not receiving their prescribed medication, as required.**

- **Resident medication was not adequately stored at the facility to prevent someone from taking it.**

INVESTIGATION:

On 10/29/2021, I received this complaint through the Bureau of Community Health Systems (BCHS) on-line complaint system. The complaint alleged it was discovered at Resident A's medication review that he had not received his Lorazepam/Ativan medication for three weeks. The complaint alleged the medication was stolen from the facility after it was delivered. The complaint alleged the facility's District Director, Navi Kaur, was aware of the medication missing for over a week but did nothing about it. The complaint also indicated Kalamazoo's Office of Recipient Rights (ORR) was aware of the allegations.

On 10/29/2021, I confirmed with Kalamazoo Recipient Rights Officer (RRO), Suzie Suchyta, that her office received the allegations and was investigating. She stated she had also made an Adult Protective Services (APS) and law enforcement referral. Ms. Suchyta indicated she had requested the facility's electronic *Medication Administration Records* (eMARs) but had not received them yet.

Ms. Suchyta stated it was discovered Resident A had not received his Lorazepam/Ativan prescription for several weeks during a medication review. Ms. Suchyta stated Ms. Kaur provided ORR with an Incident Report (IR), which she would forward to me.

On 11/02/2021, I reviewed two IRs provided by Ms. Suchyta. The first IR was an Integrated Services of Kalamazoo (ISK) Incident Report completed by Resident A's ISK case manager. The IR, dated 10/27/2021, indicated Resident A's case manager had contacted Resident A after his medication review. The case manager indicated in the IR she spoke to both Resident A and direct care staff, Jennifer Zoulek. The IR indicated Ms. Zoulek stated Resident A had not had his Lorazepam in the facility for an extended period of time. The IR indicated Ms. Zoulek reported she had only been working in the facility for approximately three weeks but indicated he had taken his last dose around the time she started working.

The second IR provided by Ms. Suchyta was an *AFC Licensing Division – Incident / Accident Report* (IR), dated 10/28/2021, which was submitted by Ms. Kaur. The IR indicated on 10/28/2021, direct care staff, Aamani Spivey, noticed Resident A's Ativan prescription was missing from the facility. The IR indicated Ms. Kaur was notified and the pharmacy was contacted; however, the pharmacy would not send more Ativan until he was due for a refill of the medication. The IR indicated the

facility's medical nurse was contacted who notified Ms. Kaur if Resident A was experiencing agitation, then to take him to the hospital for "extended-release Ativan if needed". The corrective measures on the IR indicated staff would "monitor the narcotics count" and also posted a shift change agenda and the "DMA responsibilities in the medication area as a precaution for future issues."

Ms. Schuyta also forwarded me Resident A's Protocol for Urgent Administration of Medication from ISK, which confirmed an Ativan 1mg tab was prescribed for Resident A on 06/30/2021 with the following instruction, "Take 0.5 each Twice per day (as needed). For Anxiety. Take one 30 minutes before medical Appointments and procedures for anxiety and agitation. May repeat after 45 minutes". The documentation also provided additional instruction and reasons for administering the medication to Resident A and was reviewed by the prescribing physician on 09/08/2021.

On 11/02/2021, Ms. Suchyta and I interviewed direct care staff, Brianna Green, via MiTeams. Ms. Green indicated she had just become a medication passer at the facility within the last week. Ms. Green indicated Resident A was prescribed a Lorazepam/Ativan prescription, but she was unable to recall if the medication was at the facility or if he was out of it. Ms. Green indicated Resident B also had a Lorazepam medication, which wasn't in the medication closet and Resident C was missing his Advair inhaler. Ms. Green was unable to provide any indication as to why these medications were missing. Ms. Green indicated the medication closet was "kind of broken" because the hinges were off track. She indicated that while the bi-fold doors, when brought together, could be locked together to prevent someone from accessing the resident medications, she stated if someone pulled hard enough on the left side door it could come off track allowing someone direct access to resident medications. She stated the resident medications were located on shelves directly behind the bi-fold doors. Ms. Green stated she was not aware of any direct care staff taking resident medications.

On 11/02/2021, Ms. Suchyta forwarded me the September and October 2021 eMARs she received from the facility for the five ISK residents, which included Resident A, Resident B, Resident C, Resident D, and Resident F.

According to documentation on Resident A's generated eMAR from the facility's NextStep program for the month of September 2021, Resident A was prescribed the following medication, but the eMARs had missing staff initials:

- Depakote, 500 mg, delayed release, to be administered every night at bedtime. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Divolproex, 250 mg, delayed release, to be administered twice daily. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication at 8 am on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16. 09/17,

09/18, 09/21, 09/23, 09/25, 09/27, 09/29 and 09/30. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this mediation at 4 pm on 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/12, 09/13, 09/14, 09/15, 09/20, and 09/29.

- Fenofibrate, 54 mg, to be administered once per day. Missing staff initials indicated Resident A did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, 09/29, and 09/30.

- Guafacine ER, 4 mg, to be administered once at bedtime. Missing staff initials indicated Resident A did not receive this medication on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Lorazepam, 0.5 mg, to be administered twice daily at 12 pm and 4 pm. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication at 12 pm on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, 09/17, 09/19, 09/20, 09/21, 09/22, 09/23, 09/27, 09/29, and 09/30. Missing staff initials indicated Resident A's eMAR indicated Resident A did not receive this medication at 4 pm on 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/12, 09/13, 09/14, 09/15, 09/20, and 09/29.

- Metformin, 500 mg, to be administered once daily. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, 09/29, and 09/30.

- Paliperidone ER, 3 mg, to be administered at bedtime. Missing staff initials on Resident eMAR indicated Resident A did not receive this medication on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Propranolol ER, 60 mg, to be administered daily. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, 09/29 and 09/30.

- Quetiapine, 50 mg, to be administered at bedtime. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this mediation on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Vitamin B Complex, to be administered once daily. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, 09/29, and 09/30.

Resident A's eMAR also indicated he had a PRN, or as needed, Lorazepam, 1 mg, medication to be administered twice daily, as needed, for anxiety; however, there were no staff initials on the eMAR indicating this medication was administered to Resident A for September.

According to documentation on Resident B's generated eMAR from the facility's NextStep program for the month of September 2021, Resident B was prescribed the following medication, but the eMARs had missing staff initials:

- Benztropine, 1 mg, to be administered twice daily. Missing staff initials on Resident B's eMAR indicated Resident B did not receive this medication at 8 am on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, and 09/30. Missing staff initials on Resident B's eMAR indicated Resident B did not receive this medication at 8 pm on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Lorazepam, 2 mg, to be administered every night at bedtime. Missing staff initials on Resident B's eMAR indicated Resident B did not receive this medication on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Oxybutynin, 5 mg, to be administered twice daily. Missing staff initials on Resident B's eMAR indicated Resident B did not receive this medication at 8 am on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, and 09/30. Missing staff initials on Resident B's eMAR indicated Resident B did not receive this medication at 8 pm on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Trazadone, 150 mg, to be administered every night at bedtime. Missing staff initials indicated Resident B did not receive this medication on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

According to documentation on Resident C's generated eMAR from the facility's NextStep program for the month of September 2021, Resident C was prescribed the following medication, but the eMARs had missing staff initials:

- Advair Diskus, inhaler, to be administered twice daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 8 am on 09/01, 09/04, 09/05, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/29, and 09/30. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 8 pm on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Amlodipine, 10 mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/29, and 09/30.

- Azelastine, 0.15%, to be administered by spraying into each nostril daily twice a day. Missing staff initials indicated Resident C did not receive this medication at 8 am on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/29, and 09/30. Missing staff initials indicated Resident C did not receive this medication at 8 pm on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Banophen, 25mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Boost, drink 1 bottle, to be administered twice daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 8 am on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/29, and 09/30. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 3 pm on 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/12, 09/13, 09/14, 09/15, 09/17, 09/19, 09/20, 09/21, 09/22, 09/23, 09/25, and 09/29.

- BuSpar, 30 mg, to be administered twice daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 8 am on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/29, and 09/30. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 8 pm on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Docusate Sodium, 100 mg, to be administered every night at bedtime. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Ferrous Sulf, 324 mg, to be administered with lunch. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, 09/17, 09/19, 09/20, 09/21, 09/22, 09/23, 09/27, and 09/29.

- Ibuprofen, 200 mg, to be administered three tablets every 8 hours. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 7 am on 09/01, 09/02, 09/03, 09/04, 09/05, 09/07, 09/08, 09/09, 09/10, 09/11, 09/12, 09/13, 09/15, 09/16, 09/17, 09/18, 09/19, 09/21, 09/22, 09/23, 09/24, 09/25, 09/26, 09/28, 09/29, and 09/30. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 3 pm on 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/12, 09/13, 09/14, 09/15, 09/17, 09/19, 09/20, 09/22, 09/23, 09/25, and 09/29. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this

medication at 11 pm on 09/03, 09/05, 09/07, 09/09, 09/10, 09/13, 09/14, 09/15, 09/16, 09/22, 09/25, 09/27, 09/29, and 09/30.

- Incruse Ellipta, 62.5 mcg/INH, to be administered by 1 puff daily into mouth. Missing staff initials indicated Resident C did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/29, and 09/30.

- Montelukast, 10 mg, to be administered every morning. Missing staff initials indicated Resident C did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/29/ and 09/30.

- Multivitamin, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/29, and 09/30.

- Omeprazole, 40mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/29, and 09/30.

- Pristiq, 50 mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/29, and 09/30.

- Terazosin, 5 mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Zyrtec, 10 mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/29 and 09/30.

Resident C's September eMARs indicated there were 17 "exceptions" for Resident C's medications not being administered. These 17 exception indicated medication wasn't available or wasn't in stock; however, upon my review of the eMAR, there was no way to determine what days and times the medications were unavailable or not in stock as direct care staff members did not make any notation on the eMAR on which specific dates those exceptions applied.

According to documentation on Resident D's generated eMAR from the facility's NextStep program for the month of September 2021, Resident D was prescribed the following medication, but the eMARs had missing staff initials:

- Blood sugar was to be documented four times per day at 8 am, 12 pm, 5 pm, and 8 pm; however, missing staff initials on Resident D's eMAR indicated Resident D did not have his blood sugar tested at 8 am on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, 09/29, and 09/30. Missing staff initials on Resident D's eMAR indicated Resident D did not have his blood sugar tested at 12 pm on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, 09/17, 09/18, 09/19, 09/20, 09/21, 09/22, 09/23, 09/26, 09/27, and 09/29. Missing staff initials on Resident D's eMAR indicated Resident D did not have his blood sugar tested at 5 pm on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/12, 09/13, 09/14, 09/15, 09/16, 09/20, 09/25, 09/26, 09/29 and 09/30. Missing staff initials on Resident D's eMAR indicated Resident D did not have his blood sugar tested at 8 pm on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Aspirin EC, 81 mg, to be administered once daily before a meal. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, 09/17, 09/18, 09/19, 09/20, 09/21, 09/22, 09/23, 09/26, 09/27, and 09/29.

- Atorvastatin, 20mg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, 09/17, 09/18, 09/19, 09/20, 09/21, 09/22, 09/23, 09/26, 09/27, and 09/29.

- Coumadin, 6 mg, ½ tablet (3 mg) to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/03, 09/06, 09/10, 09/13, and 09/15. This medication was then discontinued effective 09/18.

- Coumadin, 2 mg, 1.5 tablet (3 mg) to be administered once daily on Tuesday, Wednesday, Thursday, Saturday, and Sunday. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/19.

- Famotidine, 20 mg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, 09/17, 09/18, 09/19, 09/20, 09/21, 09/22, 09/23, 09/26, 09/27, and 09/29.

- Humulin 70/30 Kwikpen, to be administered by injecting 32 units, every morning, subcutaneously with the note staff must monitor to ensure proper units are injected. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, 09/29 and 09/30.

- Humulin 70/30 Kwikpen, to be administered by injecting 33 units subcutaneously, every evening, at 5pm with the note to discard 10 days after opening and that staff must monitor to ensure proper units are injected. Missing staff initials on Resident D's eMAR indicated Resident D did not receive his 5 pm Humulin on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/12, 09/13, 09/14, 09/15, 09/16, 09/20, 09/25, 09/26, 09/29, and 09/30.

- Kayexalate/sodium polystyrene sulfonate, 15 gm, to be administered by adding powder to 4 oz of water, stirring and taking by mouth five times weekly on Monday, Tuesday, Wednesday, Thursday, and Friday. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/01, 09/02, 09/03, 09/06, 09/07, 09/08, 09/09, 09/14, 09/15, 09/16, 09/17, 09/20, 09/21, 09/22, 09/23, 09/27, and 09/29.

- Lisinopril, 20 mg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, 09/17, 09/18, 09/19, 09/20, 09/21, 09/22, 09/23, 09/25, 09/26, and 09/29.

- Metoprolol Tartrate, 50 mg, to be administered twice daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 am on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, 09/29, and 09/30. Missing initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 pm on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Mycophenolate, 500 mg, to be administered twice daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 am on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, 09/29 and 09/30. Missing initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 pm on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Olanzapine, 10 mg, to be administered twice daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 am on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, 09/29, and 09/30. Missing initials on Resident D's eMAR

indicated Resident D did not receive this medication at 8 pm on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Prednisone, 5mg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, 09/17, 09/18, 09/19, 09/20, 09/21, 09/22, 09/23, 09/26, 09/27, and 09/29.

- Sensipar, 60mg. to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, and 09/17. There was indication on the eMAR this medication was discontinued effective 09/18.

- Sensipar, 90 mg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/21, 09/23, 09/25, 09/27, 09/29, and 09/30.

- Sertraline, 50 mg, to be administered every morning. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, 09/17, 09/18, 09/19, 09/20, 09/21, 09/22, 09/23, 09/26, 09/27, and 09/29.

- Synthroid, 150 mcg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, 09/17, 09/18, 09/19, 09/20, 09/21, 09/22, 09/23, 09/26, 09/27, and 09/29.

- Tacrolimus, 1 mg, to be administered every 12 hours. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 am on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, 09/29, and 09/30. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 pm on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Vitamin D2, 2000 un, once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/09, 09/12, 09/14, 09/15, 09/16, 09/17, 09/18, 09/19, 09/20, 09/21, 09/22, 09/23, 09/26, 09/27, and 09/29.

Resident D's September eMAR indicated there were 17 "exceptions" for Resident D's medications not being administered. These 17 exceptions indicated medication wasn't available or wasn't in stock; however, upon my review of the eMAR, I was

unable to determine what days and times the medications were unavailable or not in stock.

According to documentation on Resident F's generated eMAR from the facility's NextStep program for the month of September 2021, Resident F was prescribed the following medication, but the eMARs had /missing staff initials:

- Aripiprazole, 20 mg, to be administered every morning. Missing staff initials on Resident F's eMAR indicated Resident F did not receive this medication on 09/04, 09/05, 09/07. 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/27, and 09/30.

- Metformin, 500 mg, to be administered twice daily. Missing staff initials on Resident F's eMAR indicated Resident F did not receive this medication at 8 am on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 06/27, and 09/30. Missing staff initials on Resident F's eMAR indicated Resident F did not receive this medication at 5 pm on 09/01, 09/02, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/12, 09/13, 09/14, 09/15, 09/16, 09/20, 09/26, 09/29, and 09/30.

- Metoprolol Succinate ER, 25 mg, to be administered once daily. Missing staff initials on Resident F's eMAR indicated Resident F did not receive this medication on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/27, and 09/30.

- Omeprazole DR, 40 mg, to be administered once daily. Missing staff initials on Resident F's eMAR indicated Resident F did not receive this medication on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/27, and 09/30.

- Oxybutynin, 5 mg, to be administered twice daily. Missing staff initials on Resident F's eMAR indicated Resident F did not receive this medication at 8 am on 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, and 09/30. Missing staff initials on Resident F's eMAR indicated Resident F did not receive this medication at 8 pm on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Pravastatin, 40mg, to be administered every night before bedtime. Missing staff initials on Resident F's eMAR indicated Resident F did not receive this medication on 09/03, 09/06, 09/10, 09/13, 09/15, 09/19, and 09/27.

- Quetiapine, 100 mg, to be administered every night at bedtime with 400 mg = 500 mg. Missing staff initials on Resident F's eMAR indicated Resident F did not receive this medication on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

- Quetiapine, 400 mg, to be administered every night at bedtime. Missing initials on Resident F's eMAR indicated Resident F did not receive this medication on 09/03, 09/06, 09/10, 09/13, 09/15, and 09/19.

According to documentation on Resident A's generated eMAR from the facility's NextStep program for the month of October 2021, Resident A was prescribed the following medication, but the eMARs had missing staff initials:

- Depakote, 500 mg, delayed release, to be administered every night at bedtime. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

- Divolproex, 250 mg, delayed release, to be administered twice daily. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication at 8 am on 10/01,10/02, 10/06, 10/09, 10/11, 10/12, 10/14, 10/18, 10/23, and 10/29. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this mediation at 4 pm on 10/05, 10/06, 10/10, 10/18, 10/20, and 10/29.

- Fenofibrate, 54 mg, to be administered once per day. Missing staff initials indicated Resident A did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/22, 10/23, and 10/29.

- Guafacine ER, 4 mg, to be administered once at bedtime. Missing staff initials indicated Resident A did not receive this medication on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

- Lorazepam, 0.5 mg, to be administered twice daily at 12 pm and 4 pm. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication at 12 pm on 10/01, 10/02, 10/05, 10/06, 10/07, 10/10, 10/12, 10/13, 10/18, 10/19, 10/20, 10/21, 10/21, 10/22, 10/23, 10/24, 10/25, and 10/26. Missing staff initials indicated Resident A's eMAR indicated Resident A did not receive this medication at 4 pm on 10/05, 10/06, 10/10, 10/18, 10/20, 10/21, 10/22, 10/23, 10/24, 10/25, 10/26 and 10/29.

- Metformin, 500 mg, to be administered once daily. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/11, 10/14, 10/18, 10/23, and 10/29.

- Paliperidone ER, 3 mg, to be administered at bedtime. Missing staff initials on Resident eMAR indicated Resident A did not receive this medication on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

- Propranolol ER, 60 mg, to be administered daily. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/23, and 10/29.

- Quetiapine, 50 mg, to be administered at bedtime. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this mediation on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

- Vitamin B Complex, to be administered once daily. Missing staff initials on Resident A's eMAR indicated Resident A did not receive this medication on 09/01, 09/04, 09/05, 09/07, 09/11, 09/12, 09/16, 09/17, 09/18, 09/21, 09/23, 09/25, 09/27, 09/29, and 09/30.

Resident A's eMAR also indicated he had a PRN, or as needed, Lorazepam, 1 mg, medication to be administered twice daily, as needed, for anxiety; however, there were no staff initials on the eMAR indicating this medication was administered to Resident A for October.

Resident A's October eMAR indicated there were 17 "exceptions" for Resident A's medications not being administered. These 17 exceptions indicated the medication was not available or was not in stock. Upon my review of the eMAR, the notation "17" was also included with staff initials for Resident A's 4 pm Lorazepam, 0.5 mg, on 10/15. Resident A's eMAR did not include any other notations with the number "17" indicating when direct care staff used this exception.

According to documentation on Resident B's generated eMAR from the facility's NextStep program for the month of October 2021, Resident B was prescribed the following medication, but the eMARs had missing staff initials:

- Benztropine, 1 mg, to be administered twice daily. Missing staff initials on Resident B's eMAR indicated Resident B did not receive this medication at 8 am on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/23, and 10/29. Missing staff initials on Resident B's eMAR indicated Resident B did not receive this medication at 8 pm on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18 and 10/19.

- Lorazepam, 2 mg, to be administered every night at bedtime. Missing staff initials on Resident B's eMAR indicated Resident B did not receive this medication on 10/04, 10/06, 10/10, 10/12, 10/18, and 10/19.

- Oxybutynin, 5 mg, to be administered twice daily. Missing staff initials on Resident B's eMAR indicated Resident B did not receive this medication at 8 am on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/23 and 10/29. Missing staff initials on Resident B's eMAR indicated Resident B did not receive this medication at 8 pm on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18 and 10/19.

- Trazadone, 150 mg, to be administered every night at bedtime. Missing staff initials indicated Resident B did not receive this medication on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, 10/19 and 10/21.

Resident B's October eMAR also indicated there were 17 "exceptions" for Resident B's medications not being administered. These 17 exceptions indicated the medication was not available or was not in stock. Upon my review of the eMAR, the notation "17" was also included with staff initials for Resident B's bedtime Lorazepam, 2 mg, on 10/28. Resident B's eMAR did not include any other notations with the number "17" indicating when direct care staff used this exception.

According to documentation on Resident C's generated eMAR from the facility's NextStep program for the month of October 2021, Resident C was prescribed the following medication, but the eMARs had missing staff initials:

- Advair Diskus, inhaler, to be administered twice daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 8 am on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, 10/28, and 10/29. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 8 pm on 10/04, 10/06, 10/12, 10/14, 10/18, and 10/19.

- Amlodipine, 10 mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, and 10/29.

- Azelastine, 0.15%, to be administered by spraying into each nostril daily twice a day. Missing staff initials indicated Resident C did not receive this medication at 8 am on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, and 10/29. Missing staff initials indicated Resident C did not receive this medication at 8 pm on 10/04, 10/06, 10/12, 10/14, 10/18, and 10/19.

- Banophen, 25mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 10/04, 10/06, 10/12, 10/14, 10/18, and 10/19.

- Boost, drink 1 bottle, to be administered twice daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 8 am on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/22, 10/23, 10/24, 10/26, 10/28, and 10/29. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 3 pm on 10/03, 10/06, 10/08, 10/15, 10/18, 10/19, 10/20, 10/21, 10/23, 10/24, 10/25, 10/26, 10/27, and 10/29.

- BuSpar, 30 mg, to be administered twice daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 8

am on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, and 10/29. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 8 pm on 10/04, 10/06, 10/12, 10/14, 10/18, and10/19.

- Docusate Sodium, 100 mg, to be administered every night at bedtime. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 10/04, 10/06, 10/12, 10/14, 10/18, and 10/19.

- Ferrous Sulf, 324 mg, to be administered with lunch. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 10/01, 10/02, 10/03, 10/06, 10/10, 10/12, 10/13, 09/14, 10/18, 10/19, and 10/20.

- Ibuprofen, 200 mg, to be administered three tablets every 8 hours. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 7 am on 10/01, 10/02, 10/03, 10/04, 10/05, 10/06, 10/07, 10/08, 10/09, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, 10/25, 10/27, 10/28, 10/29, and 10/30. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 3 pm on 10/03, 10/06, 10/08, 10/15, 10/18, 10/19, 10/20, 10/21, 10/24, and 10/29. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication at 11 pm on 10/02, 10/04, 10/06, 10/07, 10/08, 10/10, 10/12, 10/13, 10/14, 10/15, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, and 10/31.

- Incruse Ellipta, 62.5 mcg/INH, to be administered by 1 puff daily into mouth. Missing staff initials indicated Resident C did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, and 10/29.

- Montelukast, 10 mg, to be administered every morning. Missing staff initials indicated Resident C did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, and 10/29.

- Multivitamin, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, and 10/2930.

- Omeprazole, 40mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, and 10/29.

- Pristiq, 50 mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/22, 10/23, and 10/29.

- Terazosin, 5 mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 10/04, 10/06, 10/12, 10/14, 10/18, and 10/19.

- Zyrtec, 10 mg, to be administered once daily. Missing staff initials on Resident C's eMAR indicated Resident C did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, and 10/29.

Resident C's October eMARs indicated there were 17 "exceptions" for Resident C's medications not being administered. These 17 exceptions indicated the medication was not available or was not in stock. Upon my review of the eMAR, the notation "17" was also included with staff initials for Resident C's Advair Diskus (inhaler) on 10/28. Resident C's eMAR did not include any other notations with the number "17" indicating when direct care staff used this exception.

According to documentation on Resident D's generated eMAR from the facility's NextStep program for the month of October 2021, Resident D was prescribed the following medication, but the eMARs had missing staff initials:

- Blood sugar was to be documented four times per day at 8 am, 12 pm, 5 pm, and 8 pm; however, missing staff initials on Resident D's eMAR indicated Resident D did not have his blood sugar tested at 8 am on 10/01, 10/02, 10/09, 10/12, 10/14, 10/15, 10/18, 10/21, 10/23, 10/27, 10/28, and 10/29. Missing staff initials on Resident D's eMAR indicated Resident D did not have his blood sugar tested at 12 pm on 10/01, 10/02, 10/03, 10/06, 10/10, 10/12, 10/13, 10/18, 10/19, 10/20, and 10/23. Missing staff initials on Resident D's eMAR indicated Resident D did not have his blood sugar tested at 5 pm on 10/01, 10/02, 10/03, 10/04, 10/05, 10/06, 10/07, 10/09, 10/10, 10/13, 10/14, 10/15, and 10/29. Missing staff initials on Resident D's eMAR indicated Resident D did not have his blood sugar tested at 8 pm on 10/04,10/06, 10/10, 10/12, 10/14, 10/18, 10/19, and 10/21.

- Aspirin EC, 81 mg, to be administered once daily before a meal. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/01, 10/02, 10/03, 10/06, 10/10, 10/12, 10/13, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, and 10/25.

- Atorvastatin, 20mg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/01, 10/02, 10/03, 10/06, 10/10, 10/12, 10/13, 10/18, 10/19, 10/20, and 10/23.

- Coumadin, 2 mg, to be administered once daily on Monday and Friday. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/04 and 10/18.

- Coumadin, 3 mg, to be administered once daily on Tuesday, Wednesday, Thursday, Saturday, and Sunday. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/03, 10/06, 10/10, 10/12, 10/14, and 10/19.

- Famotidine, 20 mg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/01, 10/02, 10/03, 10/06, 10/10, 10/12, 10/13, 10/18, 10/19, 10/20, and 10/23.

- Humulin 70/30 Kwikpen, to be administered by injecting 32 units, every morning, subcutaneously with the note staff must monitor to ensure proper units are injected. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/01, 10/02, 10/09, 10/12, 10/14, 10/15, 10/18, 10/21, 10/23, 10/27, and 10/29.

- Humulin 70/30 Kwikpen, to be administered by injecting 33 units subcutaneously, every evening, at 5pm with the note to discard 10 days after opening and that staff must monitor to ensure proper units are injected. Missing staff initials on Resident D's eMAR indicated Resident D did not receive his 5 pm Humulin on 10/01, 0/02, 10/03, 10/04, 10/05, 10/06, 10/07, 10/09, 10/10, 10/13, 10/14, 10/15, 10/18, 10/19, 10/20, and 10/29.

- Kayexalate/sodium polystyrene sulfonate, 15 gm, to be administered by adding powder to 4 oz of water, stirring, and taking by mouth five times weekly on Monday, Tuesday, Wednesday, Thursday, and Friday. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/01, 10/06, 10/12, 10/13, 10/18, 10/19, 10/20, 10/29.

- Lisinopril, 20 mg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/01, 10/02, 10/03, 10/06, 10/10, 10/12, 10/13, 10/18, 10/19, 10/20, 10/22, and 10/23.

- Metoprolol Tartrate, 50 mg, to be administered twice daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 am on 10/01, 10/02, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, 10/27, and 10/29. Missing initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 pm on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

- Mycophenolate, 500 mg, to be administered twice daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 am on 10/01, 10/02, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, 10/27, and 10/29. Missing initials on Resident D's eMAR indicated Resident D did not

receive this medication at 8 pm on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

- Olanzapine, 10 mg, to be administered twice daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 am on 10/01, 10/02, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, 10/27, and 10/29. Missing initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 pm on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

- Prednisone, 5mg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/01, 10/02, 10/03, 10/06, 10/10, 10/12, 10/13, 10/18, 10/19, 10/20, and 10/23.

- Sensipar, 90 mg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/01, 10/02, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, 10/27, and 10/29.

- Sertraline, 50 mg, to be administered every morning. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/01, 10/02, 10/03, 10/06, 10/10, 10/12, 10/13, 10/18, 10/19, 10/20, and 10/23.

- Synthroid, 150 mcg, to be administered once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/01, 10/02, 10/03, 10/06, 10/10, 10/12, 10/13, 10/18, 10/19, 10/20, 10/21, 10/22, and 10/23.

- Tacrolimus, 1 mg, to be administered every 12 hours. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 am on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, 10/21, 10/23, 10/27, and 10/29. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication at 8 pm on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

- Vitamin D2, 2000 un, once daily. Missing staff initials on Resident D's eMAR indicated Resident D did not receive this medication on 10/01, 10/02, 10/03, 10/06, 10/10, 10/12, 10/13, 10/18, 10/19, 10/20, and 10/23.

Resident D's October eMARs indicated there were 17 "exceptions" for Resident D's medications not being administered. These 17 exceptions indicated the medication was not available or was not in stock. Upon my review of the eMAR, the notation "17" was also included with staff initials for Resident D's Synthroid, 150 mcg, on 10/15 and Vitamin D2, 2000 un, on 10/15. Resident D's eMAR did not include any

other notations with the number “17” indicating when direct care staff used this exception.

According to documentation on Resident F’s generated eMAR from the facility’s NextStep program for the month of October 2021, Resident F was prescribed the following medication, but the eMARs had /missing staff initials:

- Aripiprazole, 20 mg, to be administered every morning. Missing staff initials on Resident F’s eMAR indicated Resident F did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, and 10/29.

- Metformin, 500 mg, to be administered twice daily. Missing staff initials on Resident F’s eMAR indicated Resident F did not receive this medication at 8 am on10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23 and 10/29. Missing staff initials on Resident F’s eMAR indicated Resident F did not receive this medication at 5 pm on 10/01, 10/02, 10/03, 10/04, 10/05, 10/06, 10/07, 10/09, 10/10, 10/13, 10/14, 10/15, 10/18, 10/19, 10/20, and 10/29.

- Metoprolol Succinate ER, 25 mg, to be administered once daily. Missing staff initials on Resident F’s eMAR indicated Resident F did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21,10/23, and 10/29.

- Omeprazole DR, 40 mg, to be administered once daily. Missing staff initials on Resident F’s eMAR indicated Resident F did not receive this medication on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23, and 10/29.

- Oxybutynin, 5 mg, to be administered twice daily. Missing staff initials on Resident F’s eMAR indicated Resident F did not receive this medication at 8 am on 10/01, 10/02, 10/06, 10/09, 10/12, 10/14, 10/18, 10/21, 10/23 and 10/29. Missing staff initials on Resident F’s eMAR indicated Resident F did not receive this medication at 8 pm on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

- Pravastatin, 40mg, to be administered every night before bedtime. Missing staff initials on Resident F’s eMAR indicated Resident F did not receive this medication on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

- Quetiapine, 100 mg, to be administered every night at bedtime with “400 mg = 500 mg”. Missing staff initials on Resident F’s eMAR indicated Resident F did not receive this medication on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

- Quetiapine, 400 mg, to be administered every night at bedtime. Missing initials on Resident F's eMAR indicated Resident F did not receive this medication on 10/04, 10/06, 10/10, 10/12, 10/14, 10/18, and 10/19.

On 11/02/2021, I conducted an unannounced on-site inspection, as part of my investigation. I interviewed direct care staff, Shianne McGee and Montiece Sanders. Ms. McGee indicated she had only been a medication passer for approximately two weeks. She showed where the resident medications are locked up which is in a locked closet behind a set of bi-fold doors. It should be noted a maintenance person was fixing the bi-fold doors while I was on-site. The maintenance person indicated the bi-fold doors were not on their tracks correctly but would be before he left.

Ms. McGee indicated that prior to maintenance coming out and fixing the bi-fold doors, staff were only able to open the right bi-fold door; however, she indicated she was able to continue locking the doors to prevent anyone from getting into the closet. She denied being aware of anyone taking resident medications. I asked Ms. McGee if any resident medication wasn't in the facility or was out of stock. She indicated Resident D's Synthroid was not in stock at the facility today or yesterday. She indicated she inputted the information about the medication not being in stock as a "miscellaneous note" in the facility's online program, NextStep. Ms. McGee indicated she hadn't reported the missing medication to any management because no one was in the home to report the error. Ms. McGee showed me the miscellaneous note, dated 11/01/2021 and 11/02/2021, confirming Ms. McGee's statement.

I reviewed Resident A's, Resident B's, Resident C's, and Resident D's list of medications from the facility's eMAR system and cross checked them the medications located in the medication closet and determined the following:

- Resident A's Lorazepam tab .5 mg, twice daily medication, was present in the medication closet (dispersed date of 10/26/2021); however, his Lorazepam 1 mg tab PRN medication was unable to be found.
- Resident B's medications were all accounted for in the facility, including his Ativan prescription.
- Resident C's medications were all accounted for in the facility, including his Advair inhaler; however, his Boost was unable to be located during the inspection.
- Neither of Resident D's Coumadin/Warfarin 2 mg medication nor his Synthroid 150 mg were present in the medication closet.
- Resident E nor Resident F had missing medication.

I requested to review each resident's October eMAR monthly report; however, Ms. McGee stated she was unable to run those types of reports due to not having that type of access to the eMAR system. She indicated only management could run an entire month report. Ms. McGee was unable to access the facility's paper MARs while I was on-site; therefore, I was unable to review these records.

I was unable to interview Mr. Sanders regarding the allegations as he indicated he had only worked at the facility for a couple of days and did not administer medications. Additionally, neither Ms. McGee nor Mr. Sanders could produce a maintenance or work order for the facility's broken medication closet doors.

I interviewed Resident A and Resident D during the inspection. Resident A stated he talked to Ms. Kaur about not receiving his Ativan medication; however, he was unable to provide specifics regarding when he told her or if anyone else was present when this conversation took place. Resident A provided no additional information regarding his medication. Resident D indicated he was receiving his medication on a regular basis, which included receiving his Coumadin/Warfarin the previous day.

On 12/16/2021, I re-interviewed Ms. McGee and Mr. Sanders, via telephone regarding the administration of Resident D's insulin. Both Ms. McGee and Mr. Sanders indicated Resident D receives his insulin on a regular basis. They both indicated he self-administers the insulin while staff supervise and monitor. They also both indicated medication documentation had been an issue, but this has been addressed by incoming staff checking over the eMARs and paper MARs to ensure staff documented they administered resident medication during their shift.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Bases on my investigation, which included reviewing resident's September and October 2021 electronic *Medication Administration Records,* the facility's Incident Reports, and interviewing direct care staff, Brianna Green, Shianne McGee, and Montiece Sanders, and my observations of resident medications during my on-site inspection on 11/02/2021, there is evidence indicating multiple residents were not provided with their medications due to the medications not being available at the facility and no staff initials documenting resident medications had been administered. During my inspection the following medications were not available to residents as indicated by their eMARs: Resident A's Lorazepam 1 mg tab PRN medication, Resident C's Boost, and Resident D's Coumadin/Warfarin 2 mg medication nor his Synthroid 150 mg. Additionally, Resident A did not receive his scheduled Lorazepam .05 mg tab, twice a day, medication from 10/20/2021 through 10/26/2021, as required.
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.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	Based on my investigation, which included a review of the facility's electronic *Medication Administration Records* (eMAR) for Resident A, Resident B, Resident C, Resident D, and Resident F and interviews with direct care staff, Montiece Sanders and Shianne McGee, there is evidence indicating direct care staff are not initialing after administering resident medication, as required, as demonstrated by extensive missing staff initials throughout the September and October 2021 eMARs. Direct care staff indicated when medication was on-site it was administered to residents; however, the documentation of administering medication was not consistent. This inconsistency makes it unclear if medication is being administered but not initialed after administration or simply not administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my investigation, there is no evidence indicating resident medication was being stolen from the facility, which includes Resident A's Lorazepam prescription; however, there is evidence the facility's medication closet bi-fold doors were off track and not functioning properly in order to prevent resident medication from being accessed or taken by someone to whom the medication wasn't prescribed. Despite the facility's maintenance person being on-site to address the broken medication closet doors there is evidence they weren't functioning, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my on-site inspection at the facility, I observed Resident C's room to have excessive personal items in it causing concern for fire safety. Resident C's room was located at the bottom of the facility's stairs to the right. Resident C's bedroom has an

exit door leading to the outside. I observed seven to eight guitars gathered near the center of Resident C's bedroom, which did not allow an unobstructed exit to the door. Additionally, near the guitars, but located on the floor were shoes, hats, guitar straps, empty pop bottles, CD cases, extension cords, power strips, and other musical equipment, which all creating obstructions and potential tripping hazards when ambulating around Resident C's bedroom or trying to exit the room.

Additionally, there were multiple extension cords and powers strips being used within Resident C's bedroom. Specifically, there were power strips and extension cords plugged into other power strips, creating a potential fire hazard.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Resident C's bedroom was not presenting in a comfortable, clean, or orderly manner based on my observation of it during my unannounced on-site investigation on 11/02/2021. Resident C's bedroom was observed in disarray and having excessive clutter. The floor was littered with a variety of Resident C's personal items (i.e., seven to eight guitars, empty pop bottles, clothing, CD cases, music equipment, power, and extension cords) creating obstructions to move about the bedroom and potentially causing tripping hazards in the event of an emergency.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14512	**Electrical service.**
	(1) The electrical service of a home shall be maintained in a safe condition. **(2) Where conditions indicate a need for inspection, the electrical service shall be inspected by a qualified electrical inspection service. A copy of the written approval from the qualified inspection service shall be submitted to the department and a copy shall be maintained in the adult foster care small group home and shall be available for department review.**

ANALYSIS:	On 11/02/2021, I observed numerous extension cords and power strips plugged into additional power strips within the Resident C's bedroom. An electrical inspection by a qualified electrical inspection service is needed based on these conditions due to Resident C's need for extensive use of extension cords and power strips. It should be noted that "A qualified electrical inspection service" is the Michigan Department of Licensing and Regulatory Affairs Electrical Division, the local electrical inspection authority, an electrical contractor, or a licensed electrician.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/17/2021, I conducted the exit conference with licensee designee, Ramon Beltran, via telephone. Mr. Beltran acknowledged my findings. He indicated the facility's electronic Medication Administration Record system through NextStep has been experiencing issues. Additionally, he stated when the facility's internet is spotty it also creates blanks in a resident eMAR. Mr. Beltran indicated the issues are being corrected by having the direct care staff assigned as medication passers to review the eMARs at the end of their shifts to ensure all medications have been passed and initialed. He indicated if the eMAR has holes or blanks from staff not passing then staff are expected to initial the paper MARs. Mr. Beltran indicated a form has been created to assist staff in reviewing the MARs.

Mr. Beltran was unable to report what happened to Resident A's Lorazepam/Ativan prescription. He indicated he had expected former management at the facility to address the issue, but acknowledged it is an issue, nonetheless. He indicated a manager is back in the facility, which has helped immensely on making sure paperwork and medications are handled appropriately.

Mr. Beltran stated the facility no longer has a closet medication room. He acknowledged this former arrangement was not conducive to preventing inappropriate access to medications. He stated the medication is now kept within a locked room.

Mr. Beltran also indicated he had spoken to Resident C regarding the number of personal belongings in his room and how they were creating an unsafe space in the event of an emergency and/or fire hazard. He indicated Resident C was responsive to his suggestions. Mr. Beltran indicated he would conduct a follow up onsite to ensure the bedroom was safe for Resident C. Mr. Beltran acknowledged understanding for why an electrical inspection was needed, particularly in Resident C's bedroom. I discussed with Mr. Beltran how it may be necessary to put in extra outlets within the bedroom or some of the electrical items may need to be stored elsewhere in the facility to prevent a fire or electrical issue within the facility.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

12/22/2021

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Cathy Cushman — Date
Licensing Consultant

Approved By:

12/22/2021

_____

Dawn N. Timm — Date
Area Manager