GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 21, 2021

Kehinde Ogundipe
Eden Prairie Residential Care, LLC
G 15 B
405 W Greenlawn
Lansing, MI 48503

RE: License #: AS630405489
Investigation #: 2022A0605004
Genesis Home

Dear Mr. Ogundipe:

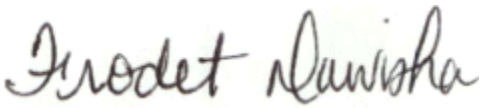
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
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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

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| **License #:** | AS630405489 |
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| **Investigation #:** | 2022A0605004 |
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| **Complaint Receipt Date:** | 10/25/2021 |
| | |
| **Investigation Initiation Date:** | 10/26/2021 |
| | |
| **Report Due Date:** | 12/24/2021 |
| | |
| **Licensee Name:** | Eden Prairie Residential Care, LLC |
| | |
| **Licensee Address:** | G 15 B 405 W Greenlawn<br>Lansing, MI 48503 |
| | |
| **Licensee Telephone #:** | (214) 250-6576 |
| | |
| **Administrator/Licensee Designee:** | Kehinde Ogundipe |
| | |
| **Name of Facility:** | Genesis Home |
| | |
| **Facility Address:** | 21004 Reimanville Ferndale, MI 48220 |
| | |
| **Facility Telephone #:** | (214) 250-6576 |
| | |
| **Original Issuance Date:** | 10/04/2021 |
| | |
| **License Status:** | TEMPORARY |
| | |
| **Effective Date:** | 10/04/2021 |
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| **Expiration Date:** | 04/03/2022 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Per incident report, direct care staff propositioned and exposed themselves to Resident A in a sexual manner. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

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| 10/25/2021 | Special Investigation Intake<br>2022A0605004 |
| 10/26/2021 | APS Referral<br>Adult Protective Services (APS) referral made. |
| 10/26/2021 | Special Investigation Initiated - Telephone<br>Adult Protective Services Nina Higgins stated that APS worker Candid Jamerson is investigating these allegations. |
| 10/26/2021 | Contact - Document Sent<br>I emailed Oakland County Office of Recipient Rights (ORR) Brittany Navetta advising her that I will be investigating these allegations. |
| 10/27/2021 | Inspection Completed On-site<br>I along with ORR conducted an unannounced on-site investigation. I interviewed Resident B and Resident C, direct care staff (DCS) Elizabeth Poole, and Eden Prairie's administrator Dayo Ogundipe. I reviewed medications and medication logs and residents' assessment plans. |
| 10/27/2021 | Contact - Document Received<br>ORR emailed Residents A, B, C, and D's individual plans of services (IPOS) and crisis plans. |
| 11/01/2021 | Contact - Telephone call made<br>I interviewed licensee designee Ken Ogundipe regarding the allegations. |

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| 11/01/2021 | Contact - Document Received<br>I received an email from licensee Ken Ogundipe with the staff's contact names and telephone numbers. |
| 11/15/2021 | Contact - Face to Face<br>I made a scheduled face-to-face contact at Genesis Home. The licensee Ken Ogundipe, Dayo Ogundipe, the home manager Abimbola (Ola) Adekunle, DCS Shaquila Love, Resident B, Resident C, and Resident D were present. I reviewed residents' and employees' records. |
| 12/14/2021 | Contact - Telephone call made<br>I followed up with licensee Ken Ogundipe and the home manager Ola Adekunle regarding Resident A. |
| 12/14/2021 | Contact - Telephone call received<br>APS worker Candid Jamerson provided an update to her investigation. |
| 12/20/2021 | Exit Conference<br>I conducted the exit conference with licensee Ken Ogundipe regarding my findings. |

**ALLEGATION:**

**Per incident report, direct care staff propositioned and exposed themselves to Resident A in a sexual manner.**

**INVESTIGATION:**

On 10/26/2021, intake #182894 was referred by Oakland County Office of Recipient Rights (ORR) regarding Resident A reported that a direct care staff (DCS) (unknown name) propositioned him and exposed themselves to Resident A in a sexual manner at Genesis Home. NOTE: Genesis Home's license was issued on 10/04/2021.

On 10/26/2021, I initiated my investigation by emailing ORR Brittany Navetta advising her that I will be investigating these allegations and conducting an unannounced on-site investigation on 10/27/2021.

On 10/27/2021, I along with ORR conducted an unannounced on-site investigation. Upon arriving to Genesis Home, I observed Eden Prairie Residential Care, LLC administrator Dayo Ogundipe pull up to the home too with Resident D. Dayo stated he and Resident D returned from a court hearing this morning. Resident A moved into Genesis Home on 10/22/2021. Dayo stated that Resident A eloped from Genesis Home three days ago and has not returned. I interviewed Resident B, Resident C, DCS

Elizabeth Poole and Dayo regarding the allegations. Although, Resident D was present, I was unable to interview him as he then left with DCS Shaquila Love to a doctor's appointment immediately after arriving home. Resident D moved into Genesis Home on 10/08/2021.

On 10/27/2021, I interviewed Resident B regarding the allegations. Resident B moved into Genesis Home on 10/22/2021. Resident B stated that Resident A lives here and that Resident B saw Resident A just a couple of days ago. Resident B stated, "he (Resident A) lies. He lies to me and lies to everyone." Resident B stated he has never witnessed any DCS expose themselves or make any explicit sexual comments to Resident A or any other resident at this home.

On 10/27/2021, I interviewed Resident C regarding the allegations. Resident C moved into Genesis Home on 10/22/2021. Resident C stated just moved in a couple of days ago and does not know who Resident A is. Resident C denied any DCS exposing themselves to any resident and denied that any DCS have said any inappropriate sexual comments to any resident here.

On 10/27/2021, I interviewed DCS Elizabeth Poole regarding the allegations. Ms. Poole began employment with Eden Prairie Residential Care on 10/25/2021. Ms. Poole stated she met Resident A when she interviewed for the DCS position on 10/24/2021, but Resident A was not present when she began her first shift on 10/25/2021. Ms. Poole stated she has not heard from other staff or residents that any DCS has exposed themselves to residents. Ms. Poole also denied hearing from any resident or any DCS that DCS have made inappropriate statements to residents. Ms. Poole denied exposing herself to any resident and denied making any inappropriate sexual statements towards any resident.

On 10/27/2021, I interviewed Eden Prairie Residential Care, LLC administrator Dayo Ogundipe regarding the allegations. Resident A was residing at Eden Prairie Resident Care's group home located in Flint. Resident A wanted to live closer to family; therefore, Resident A was moved into Genesis Home. Dayo stated that Resident A was issued a 30-day discharge notice because, "Resident A was bringing drugs into the home." Dayo stated that Resident A has community access and after returning home, staff have found crackpipes and Resident A was bringing "woman from crack houses," into Genesis Home. Dayo stated that Resident A accused him of having sex with "all the female staff." Dayo denied these allegations and stated that Resident A was sexually inappropriate with all the female staff at Genesis. One day, the live-in DCS was taking a shower and Resident A opened bathroom door and walked in on her. Dayo stated this DCS no longer is employed with Eden Prairie Residential Care, because "she did not have proper identification for a background check." Dayo asked Resident A, "Why did you open the bathroom door and Resident A stated, sorry I didn't know." Dayo reported that Resident A began calling the female staff late at night when they were not working to ask her out. Dayo denied any DCS exposing themselves to Resident A or making any inappropriate sexual statements towards Resident A or any other resident. Dayo stated

there has not been any DCS or resident that came to him to inform him that a DCS exposed themselves to a resident.

On 11/01/2021, I interviewed licensee designee Ken Ogundipe regarding the allegations. Mr. Ogundipe stated that staff have been having issues with Resident A and that Resident A is the person who is sexually harassing the female staff. Mr. Ogundipe stated that there is no DCS at Genesis Home exposing themselves or making any inappropriate statements in a sexual manner towards residents.

On 12/14/2021, I followed up with licensee Ken Ogundipe regarding Resident A. Mr. Ogundipe stated he continues to have issues with Resident A. Ms. Jamerson came out to Genesis Home last week and had to call the police on Resident A. Mr. Ogundipe stated that Resident A was “very aggressive towards Ms. Jamerson.” Due to this incident, Mr. Ogundipe reached out to Resident A’s CNS Healthcare’s case manager Freddy Powell requesting Resident A to be a 1:1 DCS. Mr. Ogundipe stated that the 1:1 DCS was approved, and Mr. Ogundipe hopes this will ensure both other residents and staff’s safety until Mr. Powell is able to locate alternative placement for Resident A. Mr. Ogundipe stated he issued Resident A the 30-day discharge notice due to Resident A’s significant behaviors and Resident A not following their house rules.

On 12/14/2021, I called the home manager (HM) Abimbola Adekunle who was working at Genesis Home to interview Resident A regarding the allegations. The HM stated Resident A was still in the hospital since the incident with MS. JAMERSON but will be discharged to Genesis Home today. The HM stated she will have Resident A call me as soon as he gets home.

On 12/14/2021, I interviewed Resident A regarding the allegations via telephone. Resident A stated, “I do not want to talk about that,” referring to the allegations of DCS propositioned him and exposed themselves to him in a sexual manner. Resident A then ended the call.

On 12/14/2021, I received a telephone call from Adult Protective Services worker, Ms. Candid Jamerson, regarding the allegations. Ms. Jamerson stated she interviewed Resident A at Genesis Home. Resident A told Ms. Jamerson he lied about DCS exposing themselves to him. Ms. Jamerson stated during her interview with Resident A, Resident A was belligerent calling Ms. Jamerson a “hood rat,” and making other derogatory statements. Ms. Jamerson stated Resident A was having extreme behaviors; therefore, she called the police. When the police arrived at Genesis Home, one of the police officers told Ms. Jamerson that Resident A is being investigated by Ferndale Police for sexual harassment towards a 16-year-old. Ms. Jamerson stated police transported Resident A to the hospital due to his behaviors. Ms. Jamerson also stated she called Resident A’s guardian and was informed by the guardian that “Resident A lies and makes up stories and has significant behavioral concerns.”

| APPLICABLE RULE | |
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| **R 400.14305** | **Resident protection.** |
| | (3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act. |
| **ANALYSIS:** | Based on my investigation, Resident A was treated with dignity and his or her personal needs, including protection and safety, was attended to at all times by DCS at Genesis Home. I interviewed Resident A regarding DCS propositioning and exposing themselves to him, but Resident A did not want to discuss these allegations. I interviewed Resident B and Resident C who denied witnessing any DCS exposing themselves to Resident A or any other resident. Ms. Jamerson stated Resident A told her he lied about the allegations and according to Resident A's guardian, Resident A is known to "make up stories." In addition, Ferndale Police told Ms. Jamerson that police are currently investigating Resident A for sexually harassing a 16-year-old female. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 10/27/2021, during my on-site investigation, I learned from DCS Elizabeth Poole that she had not completed her background check, TB test, and training prior to working her shift unsupervised on 10/25/2021. Ms. Poole also reported she had been administering medications to Resident C whom she is responsible for at Genesis Home.

On 10/27/2021, Dayo Ogundipe confirmed that DCS Elizabeth Poole had not had a criminal background check, a TB test or any of her training including medication administration at the time of her hire date of 10/25/2021. Dayo acknowledged that Ms. Poole cannot be left unsupervised with any resident and cannot administer medications to Resident C or any other resident without completed medication administration training.

On 11/01/2021, licensee designee Ken Ogundipe stated since he learned that licensing was at Genesis Home, all DCS have been registered to complete their trainings including medication administration. Mr. Ogundipe stated he was providing the training and did not know that training must have been completed by either Macomb-Oakland Regional Center (MORC) and/or Training and Treatment Innovations (TTI) because of

the specialized certification. Mr. Ogundipe stated all DCS are going through TTI to complete all training. Mr. Ogundipe hired a home manager Abimbola Adekunle whom he feels will be an asset to Eden Prairie Residential Care. Mr. Ogundipe acknowledged that I would be making another visit to Genesis Home on 11/15/2021, to review the medication logs and employee files to ensure they are completed properly.

On 11/02/2021, ORR Kathleen Garcia emailed me her interviews with licensee designee Ken Ogundipe and Trudi Clark, Eden Prairie's Program Director regarding concerns that staff were providing direct care services and were untrained. The following are her interviews:

> "Ken stated that he was unaware of the requirements that the staff needed to be fully trained when working with individuals served. Ken stated that he was not aware that Oakland County Housing Network (OCHN) required that the staff be trained through either MORC and/or TTI. Ken admitted that the staff in the home were not fully trained and reported that he was currently at the home making sure the staff went through the appropriate training. Ken further stated that he had reached out to TTI and MORC to find out more information about sending his staff through their trainings. Ken continued to repeat that he is a "certified trainer" and when I asked him, "in what" he stated "behavioral health". I'm not sure what he is referring to here. Ken called back a short while later and informed me that he had heard back from TTI, and he would be scheduling his staff to go to TTI. Ken stated there are four residents served in the home: Resident A, Resident B, Resident C and Resident D. There are five staff who work in the home and the Home Manager is Ola Adekunle.
>
> Trudi stated that she was not involved in the opening of the Genesis Home in Ferndale and that it was Dayo Ogundipe (Ken's brother and co-administrator) who was working on opening the home. Trudi further stated that she was not aware that the staff at the Genesis Home was not fully trained and providing services to the individuals served. Trudi also stated that she is responsible for providing all the trainings to the staff who work in the homes in Flint which also have OCHN Individuals. Trudi stated that she provides ALL trainings to the staff, including Recipient Rights, except for CPR/First Aid as that is completed online. Trudi stated that she uses Sanilac County's training book for Recipient Rights and will walk through the training with the staff. Christian (last name unknown and position unknown) was working with Dayo on getting the home operational. Trudi stated that she went to the home today (11/01/2021) and started the trainings with the staff."

On 11/02/2021, I received an email from licensee designee Ken Ogundipe stating that he has scheduled additional training for all his staff other than medication administration and ORR. He submitted confirmation for each staff and the trainings they are registered for, which meets the departments requirements.

On 11/15/2021, I conducted a scheduled follow-up visit at Genesis Home. I reviewed Resident A's, Resident B's, Resident C's, and Resident D's medication logs and DCS

Shaquila Love and the HM, Abimbola Adekunle's employee files. All the medication logs were completed correctly, and the discontinued medications were disposed of properly. I reviewed the employee files and background checks in addition to the medical statements and TB tests were in the file along with trainings completed with TTI. The HM and Ms. Love were completing their medication administration training during my visit via Zoom. Resident A was at the hospital; therefore, I was unable to interview him regarding the allegations.

On 12/20/2021, I conducted the exit conference with licensee designee Ken Ogundipe regarding my findings. Mr. Ogundipe stated he understands the findings and has corrected many of these violations. He stated he will continue to achieve and maintain compliance and will submit a corrective action plan.

| **APPLICABLE RULE** | |
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| **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; determination of existence of national criminal history; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.** |
| | (2) Except as otherwise provided in subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents after April 1, 2006, until the adult foster care facility conducts a criminal history check in compliance with subsections (4) and (5). 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. Beginning April 1, 2009, an individual who is exempt under this subsection 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 (12). 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. That individual may transfer to another adult foster care facility that is under the same ownership with which he or she was employed or under contract. If that individual wishes to transfer to an adult foster care facility that is not under the same ownership, he or she may do so provided that a criminal history check is conducted by the new facility in accordance with subsection (4). If an individual who is exempt under this subsection is subsequently |

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| | convicted of a crime or offense described under (1)(a) through (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 subsection (1)(a), he or she is no longer exempt and shall be terminated from employment or denied employment. |
| **ANALYSIS:** | Based on my investigation, DCS Elizabeth Poole did not have a criminal history or fingerprint check when she was hired on 10/25/2021. On 11/15/2021, licensee designee Ken Ogundipe provided the background checks for all DCS. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED (BUT CORRECTED)** |

| **APPLICABLE RULE** | |
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| **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:<br>(a) Reporting requirements.<br>(b) First aid.<br>(c) Cardiopulmonary resuscitation.<br>(d) Personal care, supervision, and protection.<br>(e) Resident rights.<br>(f) Safety and fire prevention.<br>(g) Prevention and containment of communicable diseases. |
| **ANALYSIS:** | Based on my investigation, DCS Elizabeth Poole had not completed any of the above training after her hire date of 10/25/2021; however, she was providing direct care services to Residents A, B, C, and D unsupervised. On 11/15/2021, during a follow-up on-site inspection, licensee designee Ken Ogundipe provided the required training for all staff that were completed through TTI. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED (BUT CORRECTED)** |

| APPLICABLE RULE | |
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| **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 Elizabeth Poole did not have her communicable tuberculosis completed at the time of hire on 10/25/2021. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

On 10/27/2021, I was informed by Dayo Ogundipe that Resident A had eloped three days ago and has not returned. In addition, Dayo stated DCS have written several incident reports (IR) regarding Resident A due to his behaviors, leaving and not returning. I requested to review the incident reports (IR) regarding Resident A but was advised by Dayo that the IRs were not available for review as the IRs were at their corporate office.

| APPLICABLE RULE | |
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| **R 400.14311** | **Investigation and reporting of incidents, accidents, illnesses, absences, and death.** |
| | (7) A copy of the written report that is required to subrules (1) and (6) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department. |
| **ANALYSIS:** | Based on my investigation, Genesis Home did not have Resident A’s IRs for my review regarding incidents of Resident A eloping from the home. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

On 10/27/2021, I observed over the counter vitamins and discontinued medications in a box located in the medication closet. Dayo stated that some of the residents' guardians/family members bring the over-the-counter medications for the resident, but that the residents' primary physician has not provided a script for any of the over-the-counter medications. I reviewed Resident B's and Resident C's October 2021, medications and medication logs and found the following medication errors:

- Resident B's **Buspirone HCL 15MG**: *take one tablet by mouth three times a day* was given on 10/25/2021 and 10/26/2021 at 2PM and on 10/26/2021 at 8PM but DCS did not initial the medication log.
- Resident B's **Nicotine Transdermal 14MG**: *use one patch under the skin daily* was applied on 10/23/2021-10/27/2021 at 8AM, but staff did not initial the medication log.
- Resident B's **Carbamazepine 200MG**: *take one tablet by mouth three times a day* was given on 10/26/2021 at 8AM and 8PM, 10/25/2021 and 10/26/2021 at 2PM and 10/27/2021 at 8AM but staff did not initial the medication log.
- Resident B's **Divalproex 250MG**: *take one by mouth twice daily* was given on 10/23/2021-10/26/2021 at 8AM but staff did not initial the medication log.
- Resident B's **Olanzapine 15MG**: take one by mouth daily was not given from 10/22/2021-20/26/2021 at 8PM as the pills were still in the blister pack.
- Resident B's **Sertraline 100MG**: *take one by mouth daily* was not given from 10/23/2021-10/25/2021 at 8AM as the pills were still in the blister pack.
- Resident B's **Sertraline 50MG**: *take one by mouth daily* was not given from 10/23/2021-10/25/2021 at 8AM as the pills were still in the blister pack.
- Resident B's **Trazodone 150MG**: *take one tab by mouth at bedtime* was given from 10/22/2021-10/25/2021 at 8PM but staff did not initial the medication log.
- Resident B's **Levetiracetam 750MG**: *take one tab by mouth two times a day* was given from 10/22/2021-10/24/2021 at 8AM and 8PM and on 10/26/2021 at 8PM but staff did not initial the medication log.
- Resident C's **Calcium Magnesium Zinc**: *one tab AM and one tab PM*; **Source of Life Gold Multi-Vitamins**; **Probiotic 15-35** did not have the time of day documented on the medication log and the multi-vitamin and the probiotic did not have the instructions, nor the time of day written on the medication log. Also, there was no script from Resident B's primary physician for these over-the-counter medications.
- Resident C's **Metformin HCL 500MG**: *take one tab three times a day* were given from 10/22/2021-10/25/2021 at 8AM, 12PM and 5PM, but staff did not initial the medication log. On 10/27/2021, DCS Elizabeth Poole passed the 8AM medication to Resident C as her initials are on the medication log. Ms. Poole did not complete medication administration training.
- Resident C's **Latuda 60MG**: *take one tab by mouth at night* was not given at all from 10/22/2021-10/26/2021 at 8PM.

| APPLICABLE RULE | |
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| **R 400.14312** | **Resident medications.** |
| | (1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required. |
| **ANALYSIS:** | Based on my review of Resident C's October 2021 medication logs, Resident C was taking over-the-counter vitamins and probiotics supplied by Resident C's family, but there was no script for these over-the-counter medications from Resident C's primary physician. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| APPLICABLE RULE | |
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| **R 400.14312** | **Resident medications.** |
| | (2) Medication shall be given, taken, or applied pursuant to label instructions. |
| **ANALYSIS:** | Based on my review of Resident B's medications and medication logs, Resident B's medication were not given pursuant to label instructions.<br>• Resident B's **Olanzapine 15MG**: take one by mouth daily was not given from 10/22/2021-20/26/2021 at 8PM as the pills were still in the blister pack.<br>• Resident B's **Sertraline 100MG**: *take one by mouth daily* was not given from 10/23/2021-10/25/2021 at 8AM as the pills were still in the blister pack.<br>• Resident B's **Sertraline 50MG**: *take one by mouth daily* was not given from 10/23/2021-10/25/2021 at 8AM as the pills were still in the blister pack.<br>• Resident C's **Latuda 60MG**: *take one tab by mouth at night* was not given at all from 10/22/2021-10/26/2021 at 8PM. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| APPLICABLE RULE | |
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| **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:<br>(a) Be trained in the proper handling and administration of medication. |
| **ANALYSIS:** | Based on my investigation, interview with DCS Elizabeth Poole and review of Resident C's medication logs; Ms. Poole was administering medication to Resident C when she had not completed the medication administration training.<br>On 10/27/2021, DCS Elizabeth Poole passed Resident C's **Metformin HCL 500MG** at 8AM as her initials were on the medication log. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| APPLICABLE RULE | |
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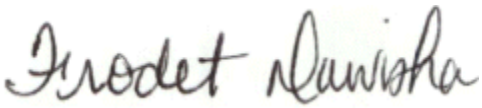
| **R 400.14312** | **Resident medications.** |
| | (4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:<br>(b) Complete an individual medication log that contains all of the following information:<br>(ii) The dosage.<br>(iii) Label instructions for use.<br>(iv) Time to be administered.<br>(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given. |
| **ANALYSIS:** | Based on my review of Resident B's and Resident C's medication logs, I found the following errors:<br>• Resident B's **Buspirone HCL 15MG**: *take one tablet by mouth three times a day* was given on 10/25/2021 and 10/26/2021 at 2PM and on 10/26/2021 at 8PM but DCS did not initial the medication log.<br>• Resident B's **Nicotine Transdermal 14MG**: *use one patch under the skin daily* was applied on 10/23/2021-10/27/2021 at 8AM, but staff did not initial the medication log. |

| | |
|---|---|
| | • Resident B's **Carbamazepine 200MG**: *take one tablet by mouth three times a day* was given on 10/26/2021 at 8AM and 8PM, 10/25/2021 and 10/26/2021 at 2PM and 10/27/2021 at 8AM but staff did not initial the medication log.<br>• Resident B's **Divalproex 250MG**: *take one by mouth twice daily* was given on 10/23/2021-10/26/2021 at 8AM but staff did not initial the medication log.<br>• Resident B's **Trazodone 150MG**: *take one tab by mouth at bedtime* was given from 10/22/2021-10/25/2021 at 8PM but staff did not initial the medication log.<br>• Resident B's **Levetiracetam 750MG**: *take one tab by mouth two times a day* was given from 10/22/2021-10/24/2021 at 8AM and 8PM and on 10/26/2021 at 8PM but staff did not initial the medication log.<br>• Resident C's **Calcium Magnesium Zinc**: *one tab AM and one tab PM*; **Source of Life Gold Multi-Vitamins**; **Probiotic 15-35** did not have the time of day documented on the medication log and the multi-vitamin and the probiotic did not have the instructions, nor the time of day written on the medication log. Also, there was no script from Resident B's primary physician for these over-the-counter medications.<br>• Resident C's **Metformin HCL 500MG**: *take one tab three times a day* were given from 10/22/2021-10/25/2021 at 8AM, 12PM and 5PM, but staff did not initial the medication log. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14312** | **Resident medications.** |
| | (7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist. |
| **ANALYSIS:** | During the on-site investigation on 10/27/2021, I observed a box of discontinued medications sitting on the shelf of the medication cabinet belonging to residents at Genesis Home that were not disposed of properly. On 11/15/2021, during a follow-up on-site the discontinued medications were disposed of properly. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED (BUT CORRECTED)** |

## IV. RECOMMENDATION

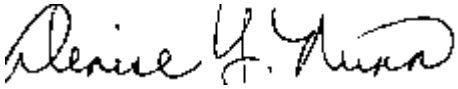
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



12/20/2021

Frodet Dawisha — Date
Licensing Consultant

Approved By:



12/21/2021

Denise Y. Nunn — Date
Area Manager