GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 23, 2022

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

RE: License #: AS390406162
Investigation #: 2022A1024020
Beacon Home at Sprinkle

Dear Mr. Ramon 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 was required. On March 17, 2022, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406162
Investigation #:	2022A1024020
Complaint Receipt Date:	01/26/2022
Investigation Initiation Date:	01/26/2022
Report Due Date:	03/27/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Melissa Williams
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. ALLEGATION(S)

	Violation Established?
Resident A did not go to required medical appointments while in the home.	Yes
Staff does not provide supervision to the residents	Yes
Additional Findings	Yes

III. METHODOLOGY

01/26/2022	Special Investigation Intake 2022A1024020
01/26/2022	Special Investigation Initiated – Telephone with Recipient Rights Officer Suzie Suchyta
01/26/2022	Contact - Document Received-Adult Protective Service (APS) Denied complaint
01/26/2022	Contact - Document Received-Resident A's *Death Certificate*
01/27/2022	Contact - Document Received-new allegations from Intake #184788 regarding supervision in the home
01/27/2022	Contact - Telephone call made with Recipient Rights Officer Michele Schiebel
02/01/2022	Inspection Completed On-site with home manger Margo Lewis, direct care staff members Brandon Hewitt, Montiese Sanders, Resident B, Resident C, Resident D, and Resident E
02/01/2022	Contact - Telephone call made with district director Ramon Beltran
02/01/2022	Contact - Document Received-Resident A's *Providers Notes*, *After Visit Summary*, *AFC Licensing Division- Accident/Incident Report* and Resident A's *Health Care Appraisal, Assessment Plan for AFC Register.*
02/03/2022	Contact - Document Received-*Resident Register*
02/15/2022	Contact - Telephone call made with Resident A's public guardian Molly Chase
02/15/2022	Contact - Telephone call made with nurse Terry Cross from Bronson Anticoagulation

02/18/2022	Contact - Document Received-new allegations from Intake #185286 regarding Resident B and supervision
02/18/2022	Contact - Telephone call made with Recipient Rights Officer Suzie Suchyta
02/18/2022	Contact - Document Received- *Resident B's Assessment Plan for AFC Resident* and Resident B's *Behavior Treatment Plan*
02/18/2022	Contact - Document Received-*AFC Licensing Division-Accident/Incident Report* for Resident B
02/18/2022	Contact - Telephone call made with district direct Ramon Beltran
02/18/2022	Contact - Telephone call made with home manager Margo Lewis and direct care staff member Montiese Sanders
03/16/2022	Exit Conference with licensee designee Ramon Beltran
03/16/2022	Corrective Action Plan Requested and Due on 03/16/2022
03/17/2022	Corrective Action Plan Received
03/17/2022	Corrective Action Plan Approved

ALLEGATION:
Resident A did not go to required medical appointments while in the home.

INVESTIGATION:
On 1/26/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged Resident A did not go to required medical appointments while in the home. This complaint further alleged that on 11/18/2021 Resident A was hospitalized for severe gangrene infection and the facility was not able to provide medical documents to verify that he attended any medical appointments prior to getting infection. According to the complaint allegations, Resident A required medical care due to severe diabetes and needed coumadin clinic lab withdraws. This complaint also stated Resident A passed away on 1/20/2022 from the gangrene infection.

On 1/26/2022 I conducted an interview with Recipient Rights Officer Suzie Suchyta regarding this investigation. Ms. Suchyta stated she is also investigating this complaint but had not been able to obtain any medical records to verify Resident A attended any medical appointments prior to sustaining an infection to his leg on 11/18/2022. Ms. Suchyta stated Resident A was admitted to the hospital on

11/18/2022 for this infection and then placed in a nursing home facility for rehabilitation. Ms. Suchyta stated Resident A did not return to Beacon Home at Sprinkle after his initial hospital admission. Ms. Suchyta stated while in the nursing home Resident A passed away on 1/20/2022. Ms. Suchyta stated when Resident A resided at Beacon Home at Sprinkle, she observed the facility to be poorly managed and medical appointments for Resident A were not obtained due to the facility being short staffed.

On 1/26/2022, I received a denied complaint from Adult Protective Services (APS) through the BCHS online complaint system which stated this allegation will not be investigated by APS.

On 1/26/2022, I reviewed Resident A's *Death Certificate* that showed a date of death of 1/20/2022. According to this certificate, Resident A manner of death was natural with an underlying cause of Peripheral Vascular Disease with Gangrene lower extremities.

On 2/1/2022, I conducted an onsite investigation at the facility with home manager Margo Lewis. Ms. Lewis stated she was unaware that Resident A had a sore or infection on his leg until 11/18/2021 when he complained of having leg pain and was found on the floor in his bedroom. Ms. Lewis stated Resident A performed his own activities of daily living therefore direct care staff did not observe any areas of Resident A's body that were regularly covered with clothing such his arms and legs. Ms. Lewis stated Resident A never mentioned that he had a sore nor did he mention that he had pain in his leg prior to 11/18/2021. Ms. Lewis stated 911 was immediately contacted when Resident A notified staff of the sore on his leg and Resident A was transported to the hospital where he was admitted and eventually transferred to a nursing home facility to recover. Ms. Lewis stated she was not made aware of any updates regarding Resident A after he left for the hospital on 11/18/2022 and Ms. Lewis believed Resident A was discharged from the facility to a nursing home which is why he never returned to the facility. Ms. Lewis stated Resident A was required to see a medical specialist at Bronson Anticoagulation Office regularly due to taking Warfarin medication that needed to be monitored. Ms. Lewis stated she went on medical leave in September 2021 and subsequently there was not enough staff to provide transportation to these medical appointments after August 2021 up until Resident A was discharged on after being admitted to the hospital on 11/18/21. Ms. Lewis also stated the administrator that was in position during this time did not manage the home properly and did not ensure direct care staff were able to get Resident A to these appointments. Ms. Lewis stated this administrator is no longer at the facility and operations of the home are much better now that the home is under a change in administration.

I also conducted an interview with direct care staff member Montiese Sanders. Mr. Sanders stated he regularly worked with Resident A and was not aware that he had a sore on his leg until 11/18/21. Mr. Sanders stated Resident A wore sweatpants everyday and did not expose his legs or complain of having pain in his leg. Mr.

Sanders stated he took Resident A to medical appointments regularly however due to staff shortages after his home manager went on medical leave, staff was unable to take Resident A to his appointments between September of 2021 and November 2021. Mr. Sanders stated when staff discovered that Resident A had a sore on his leg, medical care was immediately obtained at which time Resident A was admitted to the hospital.

I also conducted an interview with direct care staff member Brandon Hewitt. Mr. Hewitt stated he worked regularly with Resident A and on 11/18/2021 he found Resident A on the floor complaining of leg pain. Mr. Hewitt stated this was first time Resident A complained of having any leg pain and Mr. Hewitt had no knowledge that Resident A had a sore on his leg. Ms. Hewitt stated Resident A was independent in his personal care and did not require any hands-on assistance which could have allowed staff members to observe the sore on Resident A's sooner. Mr. Hewitt stated Resident A was transported and admitted to the hospital when he found on the floor and ultimately relocated to a nursing home facility for rehabilitation for the wound found on this leg. Ms. Hewitt stated he was unaware if Resident A missed medical appointments prior to his discharge from the home on 11/18/2021 however was aware that the facility experienced issues with staff shortages when the home manager went on medical leave.

I also conducted interviews with Residents B, C, D and E who all stated that they did not hear Resident A complain of being in pain or needing medical care when he resided in the home.

On 2/1/2022, I conducted an interview with district director Ramon Beltran who stated that the facility experienced staff shortages and was mismanaged by a staff member who is no longer working at the facility during the last 6 months of 2021 therefore medical appointment may have been missed due to these challenges. Mr. Beltran stated since then they have hired new staffing therefore the operations of the home have improved tremendously.

On 2/1/2022, I reviewed Resident A's *Providers Notes*. According to these notes Resident A seen a medical provider from Bronson Anticoagulation on 3/31/2021, 5/19/2021, 5/26/2021, 6/9/2021, and 8/4/2021 for follow-up rechecks. It should be noted according to the provider note on 8/4/2021, Resident A was scheduled for a next appointment date on 8/18/2021 at 4pm and no record of this appointment was found.

I also viewed Resident A's *Bronson After Visit Summary* for anticoagulation for dates 3/18/2021, 4/14/2021, 5/5/2021, 5/26/2021, 6/9/2021, and 8/4/2021. I also reviewed summary dated 4/13/21 that stated Resident A was seen by a Urologist for Microscopic hematuria and having blood in urine.

I also reviewed Resident A's *AFC Licensing Division- Accident/Incident Report* dated 11/18/2021 written by direct care staff member Shianne McGee. According to this

report staff Ms. McGee went downstairs to prompt Resident A for his morning medications and discovered Resident A on the floor. Staff Ms. McGee stated Resident A informed staff that when he got up to use the bathroom he fell to the floor. Staff Ms. McGee then called 911 and while cleaning James due to an accident he made on the floor, staff Ms. McGee noticed an infection on his right leg. This report stated once the paramedics arrived, they helped Resident A to the bed and encouraged Resident A to go the hospital however Resident A refused to go. This report stated after Resident A talked to home manager, his guardian and his sister, Resident A agreed to be taken to the hospital.

I also reviewed Resident A's *Assessment Plan for AFC Residents* dated 7/28/2020. According to this plan, Resident A can perform his own personal care need tasks however requires prompting to take baths and wear clean clothes.

I also reviewed Resident A's *Health Care Appraisal* dated 7/20/2021. According to this appraisal Resident A is diagnosed with Paranoid Schizophrenia and Chronic Kidney Disease. This appraisal stated Resident A sees Bronson Anticoagulation Clinic and Bronson Urology.

On 2/3/2022, I reviewed the facility's *Resident Register.* According to this register Resident A was discharged to a nursing home on 11/18/2021.

On 2/15/2022, I conducted an interview with Resident A's public guardian Molly Chase. Ms. Chase stated that she was notified on two occasions that Resident A missed his medical appointments. Ms. Chase stated she believe the staff members did not take Resident A to his medical appointments regularly due to staff shortages in the home. Ms. Chase stated she attempted to contact the home regarding the missed appointments however Ms. Chase was not able to make contact with anyone in the home. Ms. Chase also stated when the home manager went on medical leave, she visited the home, and the staff members did not seem familiar with the residents and were not able to answer questions she had regarding Resident A's medical appointments. Ms. Chase further stated she was unaware Resident A had a sore on his leg prior to being hospitalized on 11/18/21 and Resident A did not report to her of being in pain.

On 2/15/2022, I conducted an interview with nurse Terry Cross from Bronson Anticoagulation. Ms. Cross stated Resident A attended his regularly required appointments monthly up until 8/18/2021 and did not attend his next follow up appointment which was supposed to occur 2 weeks after his last visit. Ms. Cross stated Resident A regularly was seen by a medical provider to monitor the Warfarin medication that he was taking. Ms. Cross stated these visits did not require Resident A to remove his clothing therefore, there were no observations made on areas of Resident A's body such as his leg to determine if he had any sores. Ms. Cross further stated Resident A never mentioned that he had any problem areas on his body or complained of being in any pain during any visit.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Based on this investigation which included interviews with Recipient Rights Officer Suzie Suchyta, home manager Margo Lewis, district director Ramone Beltran, direct care staff members Montiese Sanders, Brandon Hewitt, Residents B, C, D, E, public guardian Molly Chase, Bronson nurse Terry Cross, review of Resident A's Health Care Appraisal, medical records, incident reports, Resident Register, and Resident A's *Assessment Plan for AFC Residents,* there is evidence to support the allegation Resident A was not taken to required medical appointments while in the home. According to direct care staff member Ms. Lewis, Mr. Sanders, Mr. Beltran, and Mr. Hewitt the facility experienced staff shortages in the home in 2021 causing Resident A to miss required routine medical appointments regarding his coumadin medication. Ms. Cross from Bronson Anticoagulation stated Resident A was required to be seen by a provider monthly for medication monitoring and discontinued coming to the office after 8/18/2021. According to the facility's provider notes and hospital documentation, there is no record of Resident A attending any medical appointments after 8/4/2021. Ms. Lewis, Mr. Sanders, Mr. Hewitt, and Ms. Chase all stated that they had no knowledge of Resident A having a sore or being in pain prior to his hospitalization for an infection on his leg on 11/18/2021. Resident A was capable of performing his own personal care tasks including bathing and dressing therefore there was no need for staff to see his leg where the sore was located. Upon learning of Resident A's leg pain and the sore on his leg, medical care was immediately obtained. Although the staff obtained care for Resident A immediately when a sore on his leg was found, Resident A missed required scheduled appointments regarding his coumadin medication due to staff shortages beginning in August of 2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Staff does not provide supervision to the residents.

INVESTIGATION:
On 1/27/2022, I received additional allegations through the BCHS online complaint alleging staff does not provide supervision to the residents.

On 1/27/2022, I conducted an interview with Recipient Rights Officer Michele Schiebel who stated on 1/25/2022 recipient rights officer Ms. Suzie Suchyta called to

speak to home manger Margo Lewis regarding a resident in the home and a resident answered the phone. Ms. Schiebel stated this resident informed Ms. Suchyta he was unable to locate any staff members in the home. Ms. Suchyta stayed on the phone with the resident for an undetermined amount of time and assisted the resident in looking for a staff member. Ms. Schiebel stated Ms. Suchyta was able to instruct the resident to go outside and the resident was able to locate a staff member sitting inside their vehicle.

On 2/1/2022, I conducted an onsite investigation at the facility with home manager Margo Lewis who stated that she was made aware that direct care staff member Montiese Sanders was sitting inside his personal vehicle smoking a cigarette while five residents were inside the home. Ms. Lewis stated Mr. Sanders was not approved to sit in his vehicle as this is considered a “off campus break” which must be approved by the manager. Ms. Lewis further stated Mr. Sanders did not inform the residents of his whereabouts and was not readily available to the residents by sitting in his car while the residents were inside.

I also conducted an interview with direct care staff member Montiese Sanders. Mr. Sanders stated on 1/25/2022 he went inside his car, leaving five residents alone in the home, as he had to make phone calls to find staff coverage. Mr. Sanders stated he wanted to find staff coverage because he felt uncomfortable working with a resident who was just diagnosed with COVID-19. Mr. Sanders stated he was inside his personal vehicle for about 15 minutes and did not inform the residents of his whereabouts.

I also conducted interviews with Residents B, C, D and E. Resident B stated he has never been left home alone unsupervised. He stated on 1/25/2022 he came home and found staff outside smoking a cigarette after looking for the staff indoors for about 5 minutes. Resident B stated he feels safe and supervised in the home.

Resident C stated he has never been left at home unsupervised. Resident B stated there is always a staff present at the home but there are times the staff members will to outside to smoke cigarettes however he is able to go outside and speak to them.

Resident D stated he has never been left unsupervised in the home. Resident D stated there have been a few times he has needed staff however staff would be outside smoking a cigarette. Resident D stated he is unsure of the time frame and frequency when staff is outside smoking a cigarette and he simply waits for staff to come back inside to gets staff’s attention.

On 2/18/2022, I received additional allegations through the BCHS online complaint that stated staff does not provide supervision to the residents.

On 2/18/2022, I conducted an interview with Recipient Rights Officer Suzie Suchyta who stated that Resident B has a behavior plan that limits his freedom of movement and requires staff supervision while in the community. Ms. Suchyta stated on

multiple occasions from November 2021 to January 2022, Resident B went to the hospital without being accompanied by staff due to the home being short staffed. Ms. Suchyta stated Resident B was transported by Emergency Medical Services (EMS) and direct care staff members failed to follow him to the hospital however would eventually go and pick him up once he was discharged from the hospital.

On 2/18/2022, I reviewed *Resident B's Assessment Plan for AFC Residents* (assessment plan) dated 12/15/2021. According to this assessment plan Resident B requires supervision while in the community and at work. This assessment plan also stated Resident B is his own guardian and can conduct his own personal care needs with some prompting for bathing, grooming and reminders to wear weather appropriate clothing.

I also reviewed Resident B's *Behavior Treatment Plan* dated 2/23/2021. According to this treatment plan, due to Resident B's history of aggression and inappropriate behaviors that has put himself and others at risk of injury, Resident B will be supervised by staff when he in the community unless he is on an approved visit with a family member.

On 2/18/2022, I reviewed Resident B's *AFC Licensing Division-Accident/Incident Reports* dates 12/2/2021, 12/3/2021, 12/4/2021, 12/5/2021, 12/20/2021, 1/10/2022 and 1/25/2022. According to these reports, Resident B called 911 and was transported to the hospital by EMS without staff being present with Resident B while at the hospital on all of the above dates.

On 2/18/2022, I conducted an interview with district director Ramon Beltran. Mr. Beltran stated the facility experienced direct care staffing shortages and was not able to sit with Resident B at the hospital every time he called EMS for non-emergency situations. Mr. Beltran stated changes to the administration and the staffing issues have been resolved at this facility so this is no longer an issue.

On 2/18/2022, I conducted interviews with home manager Margo Lewis and direct care staff member Montiese Sanders. Ms. Lewis and Mr. Sanders both stated Resident B would often call 911 for non-emergency reasons and asked to be transported to the hospital by EMS. Ms. Lewis and Mr. Sanders both stated during the months of November 2021 and January 2022 the home experienced extreme direct care staffing shortages which prevented a direct care staff from accompanying Resident B every time he was transported to the hospital. Both stated a direct care staff member picked up Resident B after being notified by the hospital that he was ready for discharge. Ms. Lewis and Mr. Sanders stated Resident B is required staff supervision while in the community, including the hospital.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on this investigation which included interviews with Recipient Rights Officer Suzie Suchyta, Michele Schiebel, home manager Margo Lewis, district director Ramone Beltran, direct care staff member Montiese Sanders, Residents B, C, D, E, review of Resident B's incident reports, *Assessment Plan for AFC Residents and Behavioral Plan* there is evidence to support the allegation direct care staff did not provide supervision to residents per their assessment plan, specifically to Resident B. Resident B's *Behavior Treatment Plan* dated 2/23/2021 requires Resident B to be supervised while in the community which includes the hospital. This did not happen on at least seven occasions in December 2021 and January 2022 when Resident B went to hospital unsupervised by direct care staff due to a staffing shortage. Also, on 1/25/2021 direct care staff member Mr. Sanders was determined to be on an "on a off campus break" in his vehicle which was not approved by a manager leaving the residents unaware of his whereabouts and unavailable to assist residents as needed. Consequently, protection and supervision were not provided as required by direct care staff members on these occasions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 2/01/2022, I received Resident A's *Assessment Plan for AFC Residents* dated 7/28/2020. Ms. Lewis and Mr. Beltran both stated they were not able to locate a more recently updated plan for Resident A to verify that his plan was reviewed with the resident at least annually.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	I received Resident A's *Assessment Plan for AFC Residents* dated 7/28/2020. Ms. Lewis and Mr. Beltran both stated they were not able to locate an updated plan for Resident A to verify that his plan was reviewed with the resident at least annually.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, I was not able to review Resident A's written *Resident Care Agreement*. Ms. Lewis and Mr. Beltran both stated the facility was not managed properly by an administrator who no longer works for the home therefore they were not able to locate Resident A's written *Resident Care Agreement* for the department to review.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal.** **(b) A description of services to be provided and the fee for the service.**

	(c) A description of additional costs in addition to the basic fee that is charged. **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.** **(e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission.** **(f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule.** **(g) An agreement by the resident to follow the house rules that are provided to him or her.** **(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident.** **(i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures.** **(j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.14315.** **(k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met.** **(l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.**
ANALYSIS:	While at the facility, I was not able to review a copy of Resident A's written *Resident Care Agreement*. Ms. Lewis and Mr. Beltran both stated the facility was not managed properly by an administrator who no longer works for the home therefore they were not able to locate Resident A's written *Resident Care Agreement* for the department to review.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility, I was not able to review medication administration records for Resident A. Ms. Lewis and Mr. Beltran both stated the facility was not managed properly by an administrator who no longer works for the home therefore they were not able to locate medication administration records in Resident A's resident record.

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.**
ANALYSIS:	Ms. Lewis and Mr. Beltran both stated the facility was not managed properly by an administrator who no longer works for the home therefore they were not able to locate medication administration records for Resident A's resident record.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I received and approved an acceptable corrective action plan; therefore, I recommend the current license status remain unchanged.

Ondrea Johnson 3/18/2022

Ondrea Johnson Date
Licensing Consultant

Approved By:

Dawn Timm 03/23/2022

Dawn N. Timm Date
Area Manager