GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2022

Appolonia Okonkwo
Lakeside Manor Inc
8790 Arlington
White Lake, MI 48386

RE: License #: AL630086778
Investigation #: 2022A0605043
Lakeside Manor Inc

Dear Mrs. Okonkwo:

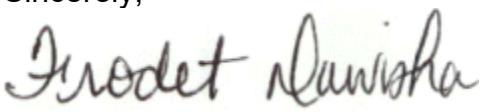
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630086778
Investigation #:	2022A0605043
Complaint Receipt Date:	09/02/2022
Investigation Initiation Date:	09/06/2022
Report Due Date:	11/01/2022
Licensee Name:	Lakeside Manor Inc
Licensee Address:	8790 Arlington White Lake, MI 48386
Licensee Telephone #:	(248) 666-9010
Administrator/Licensee Designee:	Appolonia Okonkwo
Name of Facility:	Lakeside Manor Inc
Facility Address:	8790 Arlington White Lake, MI 48386
Facility Telephone #:	(248) 666-9010
Original Issuance Date:	11/13/2000
License Status:	REGULAR
Effective Date:	07/07/2021
Expiration Date:	07/06/2023
Capacity:	20
Program Type:	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A feels as though he is being overmedicated. On 06/08/22, Resident A was admitted to the hospital for taking too much Ativan, fell and he had an adverse reaction, and he was discharged on 06/14/22.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/02/2022	Special Investigation Intake 2022A0605043
09/02/2022	APS Referral Adult Protective Services (APS) denied referral.
09/06/2022	Special Investigation Initiated - Telephone Left message for reporting person (RP)
09/07/2022	Inspection Completed On-site I conducted an unannounced on-site investigation and interviewed direct care staff (DCS) Monica Siple, Residents A, B, C, D, E, F, G, H, I, J, K, L, M, N, and the home manager (HM) Nancy Huntington regarding the allegations.
09/08/2022	Contact - Telephone call made Call with Veteran Affairs (VA) social worker, Veronica Presnall.
09/26/2022	Contact - Telephone call made Interviews with DCS Noelle Heller and Carlee Ragatz regarding the allegations.
09/27/2022	Contact - Telephone call made Follow-up with HM.
09/27/2022	Contact - Telephone call made Left message for Veteran Affairs (VA) social worker, Veronica Presnall.
09/28/2022	Contact - Telephone call made The HM will fax Resident A and Resident H assessment plan.

09/28/2022	Contact - Document Received Email received from the HM.
10/03/2022	Contact - Telephone call received Interviewed VA social worker Veronica Presnall and Dr. Polavarapu regarding the allegations.
10/11/2022	Exit Conference Conducted exit conference with licensee designee Appolonia Okonkwo via telephone with my findings.

ALLEGATION:

Resident A feels as though he is being overmedicated. On 06/08/2022, Resident A was admitted to the hospital for taking too much Ativan, fell and had an adverse reaction. He was discharged on 06/14/2022.

INVESTIGATION:

On 09/07/2022, intake 189914 was assigned for investigation regarding Resident A was being overmedicated by staff at Lakeside Manor.

On 09/07/2022, I conducted an unannounced on-site investigation. I interviewed direct care staff (DCS) Monica Siple, Residents A, B, C, D, E, F, G, H, I, J, K, L, M, and N and the home manager (HM) Nancy. I reviewed Resident A's medications and medication logs for the past six months. Ms. Siple contacted the HM via telephone who was with Resident A at a lab as Resident A was getting blood work done. Ms. Siple stated that the HM and Resident A were returning to Lakeside Manor.

I interviewed DCS Monica Siple regarding the allegations. Ms. Siple was working alone with 12 residents present. Ms. Siple also had her three young children sitting in the kitchen. One of the young children was a baby in the car seat placed on the kitchen counter. Ms. Siple stated her normal working schedule is 3PM-11PM, but that she had to work the morning shift today; therefore, had to bring her three young children to work. She stated that someone will be coming to Lakeside Manor this morning to pick the kids up. Ms. Siple has worked for this corporation for four years. Ms. Siple stated Resident A received his last Invega injection on 09/01/2022. She stated that Resident A has not been prescribed with Invega tabs and that she has never administered Invega tabs to Resident A. Ms. Siple stated that she only is aware of Resident A receiving Invega injections and nothing else. She stated she does not know anything about Resident A being overmedicated as she gives Resident A all his medications that are prescribed. Resident A uses a cane because of arthritis in his knee and Resident A began having unsteady gait after getting Covid. Ms. Siple stated, "To my knowledge he has never fell during my shift, but I was on maternity leave from 03/2022-05/2022, so I don't know if

he fell at that time." Ms. Siple stated that Resident A's cat only eats cat food to her knowledge.

Resident A returned to Lakeside Manor and was interviewed regarding the allegations. Resident A receives services from the VA. He stated he receives the Invega injection every four weeks. Resident A was then prescribed with Invega tablets by the visiting physician, Dr. Ruza at Lakeside Manor. Resident A stated, "after I was taking the Invega tabs, I started falling and had to use a cane." Resident A stated he no longer uses the cane. Resident A stated that the VA was unaware that Dr. Ruza was prescribing Resident A the Invega tabs in addition to Resident A already receiving the Invega injection. Resident A stated then Dr. Ruza prescribed Resident A with Ativan. Resident A stated, "the Ativan and the Invega tabs were meant to slow me down. I am verbal and outgoing, and staff don't like that." Resident A stated he more than once because he then fell again after being on Ativan. Resident A stated after the second fall, Dr. Ruza stopped the medication Ativan but continued the Invega tabs. Resident A stated the Invega tabs in addition to the Invega injection make him unsteady; therefore, he must continue to use the cane. Resident A stated his cat is no longer eating dog food, just cat food.

Resident B was interviewed regarding the allegations. Resident B did not say much. She reported getting her medications and stated she witnessed Resident A fall but does not know why or how he fell.

Resident C was interviewed regarding the allegations. Resident C stated, "I don't like it here because no freedom. I pretty much sit on the couch all day." Resident C stated he gets his medications regularly and has no problems with his medications. He stated he has never witnessed Resident A fall, but that he heard from Resident N that Resident A fell, and Resident N had to help pick Resident A off the floor. Resident C stated he has no information regarding the fall.

Resident D was interviewed regarding the allegations. Resident D stated he has lived here for about two years. Resident D stated, "this place is better than the other place I was at. I get a little more freedom here." Resident D stated he gets his medications daily and has no issues regarding his medications. Resident D stated he has never witnessed Resident A fall but stated he would not be surprised if Resident A fell, because "Resident A is a heavy smoker."

Resident E refused to be interviewed.

Resident F refused to be interviewed.

Resident G was interviewed regarding the allegations. Resident G has lived here for 19 years. He stated, "it's alright," when asked how he liked living here. He stated he receives his medications as prescribed and has no concerns about that. Resident G stated all residents have access to outside and that staff take them on outings

sometimes. Resident G stated his sister visits and takes him out. Resident G stated he has never witnessed Resident A fall and does not know anything about that.

Resident H was interviewed regarding the allegations. Resident H uses a cane to ambulate. Resident H has lived here for 40 years. He stated he is “ready to go home back to Georgia.” Resident H stated he was originally from Alabama but then moved to Georgia and wants to return there because he has family in Georgia. Resident H stated he receives his medications as prescribed and has no issues about that. Resident H stated he fell about two months ago which resulted in knee injury and use of a cane. Resident H stated he has no information regarding Resident A falling and does not know anything about that.

Note: Resident H stated his bedroom is on the second floor as there are no bedrooms on the main floor of Lakeside Manor. Resident H’s mobility has been compromised for months and continues to use his cane and must climb stairs to get to his bedroom.

Resident I refused to be interviewed.

Resident J refused to be interviewed.

Resident K refused to be interviewed.

Resident L was interviewed regarding the allegations. Resident L stated, “I get too much medication because I was drooling but they (staff) don’t do anything. I told staff (cannot recall who he told) but staff keep giving me too much.” Resident L stated he does not know which medications he is receiving too much of but that he was drooling but that has since stopped. Resident L stated he has never seen anyone fall including Resident A.

Resident M was hospitalized during this visit, therefore, was not interviewed regarding the allegations.

Resident N was interviewed regarding the allegations. Resident N has been living here for about six years. Resident N stated, “I like it here.” He gets his medications as prescribed and has no issues. Resident N stated that Resident A “fell and he (Resident N) had to help.” He stated, “Resident A fell in his bedroom, and I had to help get him up. I helped Nancy and Drew (Nancy’s son) to get Resident A up because Resident A was dead weight.” Resident N stated that Resident A “does not walk very well,” and “falls out of bed a lot,” therefore, Resident N is always being asked to help. Resident N stated that “Drew always asks me (Resident N) to help get Resident A up off the floor after he falls.” Resident N stated he noticed that Resident A falls prior to getting his medications and not after. He was unable to provide additional information as to how he knew the falls occurred prior to Resident A receiving the medication.

The HM Nancy was interviewed regarding the allegations. The HM stated that Dr. Theodore Ruza prescribed Resident A with the Invega tabs about five years ago

because “Resident A was difficult, and the Invega injection plus the Invega tabs were keeping Resident A where he is supposed to be at with his behaviors.” The HM stated that Resident A was “acting out,” and “fighting with other residents.” She stated that, “staff was unable to redirect Resident A and then Resident A would get agitated with staff.” Resident A’s behaviors increased about a few months ago, so Dr. Ruza prescribed Resident A with Ativan. Resident A began complaining about the Ativan “making him (Resident A) too tired,” and then “Resident A fell.” Resident A had only taken the Ativan for a couple of days and the HM was unaware that Resident A had fallen because Resident A’s fall was unwitnessed. The HM stated that she became aware of the fall after Resident A told the HM he fell. Dr. Ruza then discontinued the Ativan. The HM stated after Dr. Ruza prescribed the Invega tabs, the medication was getting filled by the VA; therefore, the VA was aware of Resident A being administered the Invega tabs in addition to the Invega injection. The HM stated that Resident A sees the psychiatrist at the VA twice yearly, but the HM feels that Resident A needs to see the psychiatrist more frequently so because of Resident A’s behaviors, the HM has Dr. Ruza see Resident A. The HM stated she nor her staff are over medicating Resident A, and that Resident A is only receiving his medications as prescribed.

I reviewed Resident A’s medications and medication logs from January 2022-September 2022 and found the following errors:

- **Aspirin 81 Mg Chewable TAB**: chew and swallow one tablet by mouth every day was given at 8AM on 09/07/2022, but staff did not initial the medication log.
- **Multivitamin TAB**: take one tablet by mouth every day was given at 8AM on 09/07/2022, but staff did not initial the medication log.
- **Omeprazole Dr 20 Mg Capsule**: take one capsule by mouth every day with food was given at 8AM on 09/07/2022, but staff did not initial the medication log.
- **Paliperidone Er 6 Mg TAB**: take one tablet by mouth every day was given at 8AM on 09/07/2022, but staff did not initial the medication log.
- **Vitamin D3 25 Mg TAB**: take one tablet by mouth every day was given at 8AM on 09/07/2022, but staff did not initial the mediation log.
- **Benztropine Mes 2 Mg TAB**: take one tablet by mouth as needed for shakiness twice daily was given on 09/05/2022 at 8AM and on 09/06/2022 at 8PM but staff did not record the reasons for this as needed medication.
- **Atorvastatin 80 Mg TAB**: take ½ tablet by mouth every day was given at 8PM on 07/30/2022, but staff did not initial the medication log.
- **Divalproex Sod Dr. 500 Mg**: take four tablets by mouth at bedtime was given at 8PM on 07/30/2022, but staff did not initial the medication log.
- **Acetaminophen 500 Mg TAB**: take two tablets by mouth three times daily was given at 8PM on 07/30/2022, but staff did not initial the medication log.
- **Docusate 100 Mg**: take one capsule daily was refused by Resident A at 8AM from 08/07/2022-08/29/2022 and on 08/30/2022, but Resident A’s physician was contacted, but physician contact was not recorded regarding physician’s instructions.

- **Naproxen 500 Mg TAB**: take one tablet by mouth twice daily was given at 8PM on 05/23/2022, but staff did not initial the medication log.

While at the on-site investigation, Dr. Theodore Ruza, the psychiatrist, and Dr. Marlana Geha who is Resident A's case manager with Resident A's guardian Barbara Safran's office called to discuss Resident A. Dr. Geha stated she has known Resident A since 1991 as Resident A had a fiduciary appointed to him but then the fiduciary discharged Resident A in 1993 and that is when Barbara Safran became the guardian. Dr. Geha stated that Resident A required a guardian due to being violent. Resident A has been working with Dr. Ruza for the past four years. Resident A has been in many placements due to his disruptive behaviors and Lakeside Manor has been the only placement that has been working with Resident A and has not discharged him. Dr. Geha stated that Resident A's behaviors usually becomes an issue 3 weeks after receiving the Invega injection. Dr. Geha stated the Invega injection should be administered every three weeks because at the fourth week, Resident A decompensates. Dr. Geha stated that Resident A is not motivated and does not want to participate in mental health therapy or receive physical therapy for his unsteady gait. Resident A wants staff to do everything for him such as his personal hygiene. Dr. Geha stated, "Resident A would rather be cared for then do things himself. He wants to be served by others. He wanted to go to a nursing home, but Resident A does not qualify; however, Resident A will continue to try to get into a nursing home." Dr. Geha stated she discussed this with Resident A but informed Resident A that a nursing home would be the next step, but that Resident A was not near that stage in his life.

Dr. Ruza stated he has been seeing Resident A since Resident A moved into Lakeside Manor. Dr. Ruza stated he worked with the VA after he prescribed the Invega tablets and the VA is now filling the prescription; therefore, the VA is aware of all the medications Resident A is currently on. Dr. Ruza stated that the VA wants autonomy over Resident A's medical and mental health needs, but when the VA does not see Resident A often, this is difficult because Resident A requires a higher level of mental health care. Dr. Ruza stated Resident A is not being over medicated and that Resident A was on Ativan, but Dr. Ruza discontinued that medication as soon as Resident A stated it was making him feel tired and that Resident A had a fall. Dr. Ruza stated that Resident A has always had an unsteady gait and his gait worsened about six months ago after Resident A got Covid. Dr. Ruza stated that the Invega injection and the Invega tablets have been the best medication combination for Resident A in a long time as these medications are helping Resident A with his behaviors.

Dr. Geha stated that the VA receives a copy of all Resident A's medications and treatment plan as evident by the VA filling all Resident A's medications that are being prescribed to Resident A by Dr. Ruza.

The HM stated that Resident A does not care for his cat and that the cat is not being fed dog food, but there is dog food in the kitchen for dogs that come to visit and that the cat choses to eat the dog food. The HM stated that the staff is now caring for the cat because Resident A was hiding the cat droppings in his dresser drawers or his bag.

Staff have been told to go into Resident A's bedroom daily to make sure Resident A is not hiding the cat droppings and that the cat droppings are being disposed of properly. The HM stated that DCS Monica Siple usually brings her kids to work for a couple of hours until the babysitter comes to Lakeside Manor and picks them up. The HM stated that Ms. Siple usually works from 3PM-11PM but because the HM had to take Resident A to get bloodwork, Ms. Siple worked the morning shift and had to bring her kids.

On 09/08/2022, I contacted the social worker, Veronica Presnall from the VA regarding Resident A. Ms. Presnall stated she is unable to discuss Resident A without a signed letter from the division's director stating why this information is needed.

On 09/12/2022, I emailed the social worker, Veronica Presnall the signed letter she requested so I can discuss the allegations pertaining to Resident A.

On 09/26/2022, I interviewed DCS Noelle Heller via telephone regarding the allegations. Ms. Heller has been with this corporation for 20 years. She stated that Resident A is not being overmedicated and that she only administered medications that are prescribed to Resident A. Ms. Heller stated she is the person who drives Resident A to the VA for all his Invega injections every four weeks. Ms. Heller stated she has never witnessed Resident A fall nor has Resident A or anyone else informed her that Resident A fell. Ms. Heller stated she is not aware of any concerns with Resident A's medications. Ms. Heller stated that Resident A uses a cane due to "bad knees," as Resident A has "arthritis." Ms. Heller stated that Resident A was using a walker after his last hospitalization around June 2022, but not anymore. Ms. Heller stated she does not know who prescribed the cane to Resident A and reported that even with the cane, Resident A can climb stairs to get to his bedroom on the second floor.

On 09/26/2022, I contacted DCS Carlee Ragatz via telephone regarding the allegations. Ms. Ragatz has been working for this corporation since 2017. Ms. Ragatz stated that Resident A has been on the same medications for a while and that she administers all his medications as prescribed. Ms. Ragatz stated she has not witnessed Resident A fall nor has Resident A or any other resident reported that Resident A has fallen. Ms. Ragatz stated that Resident A uses the cane due to "arthritis in his right knee." She stated that Resident A can climb stairs with the cane and has no issues to get to the second floor where his bedroom is located. Ms. Ragatz does not know which physician prescribed the cane, because "Resident A has had the cane for a while." She stated there are only three steps to climb to get to the second floor. Ms. Ragatz stated that Resident H had a cane but does not use it often as his walking has improved.

On 09/29/2022, I received a call from the social worker, Veronica Presnall stating she received the signed letter, but would prefer to speak with me next week as she needs to review Resident A's file.

On 10/03/2022, I received a call from the social worker, Veronica Presnall and from Dr. Polavarapu who is Resident A's VA psychiatrist. Dr. Polavarapu stated that he has been Resident A's psychiatrist since Resident A has been with the VA. He stated he was

unaware that Resident A was seeing another psychiatrist with Lakeside Manor. Dr. Polavarapu stated he only found out because Resident A was hospitalized in June 2022 due to a fall that resulted in an adverse effect of the Ativan that was prescribed to Resident A by the civilian psychiatrist Dr. Ruza. Dr. Polavarapu stated he would not have known that Resident A was being prescribed with Ativan if it had not been for Resident A being hospitalized. He stated that he advised Lakeside Manor that Resident A cannot have two psychiatrists treating him and that Resident A would need to decide of which psychiatrist Resident A wants to continue with. Dr. Polavarapu stated, "regarding mental health, there is no co-managing. It's one psychiatrist or the other. Resident A must make a choice." Dr. Polavarapu stated he does only see Resident A twice a year; however, he was never contacted for additional appointments by Resident A or anyone from Lakeside Manor regarding Resident A's behaviors. Dr. Polavarapu stated if he was contacted by Lakeside Manor for additional appointments, he would have ensured that Resident A would have been seen by him or another psychiatrist within the VA. Dr. Polavarapu stated he was not aware of the Invega tabs as well even though the medication was being filled by the VA. He knew about the Invega tabs at the same time Resident A was hospitalized in June 2022.

Ms. Presnall stated Resident A has not had behavioral concerns that she is aware of but that she does not see Resident A regularly. However, she stated that Resident A advised Ms. Presnall that he cannot speak openly because the home manager Nancy Huntington is "around," when Resident A is on the phone.

On 10/11/2022, I conducted the exit conference with licensee designee Appolonia Okonkwo regarding my findings. Ms. Okonkwo stated she recently purchased this facility and was not aware of any of these allegations. She stated she was at the facility last week Thursday and that the home manager, Nancy Huntington only mentioned that Resident A had a cane, and that Resident A cannot have a bedroom on the second floor of this facility. Ms. Okonkwo stated she will be going to the facility tomorrow to speak with Resident A and the staff.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation and the information gathered, Resident A was prescribed with the Invega tabs and the Ativan by a prescribing psychiatrist, Dr. Ruza; therefore, staff were administering these medications as prescribed. However, due to Resident A falling in June 2022 and was hospitalized due to the Ativan, the Ativan was discontinued by Dr. Ruza. Resident A stated he is no longer taking Ativan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	During the on-site investigation on 09/07/2022, I reviewed Resident A's medications and medication logs and found the following errors: • **Aspirin 81 Mg Chewable TAB**: chew and swallow one tablet by mouth every day was given at 8AM on 09/07/2022, but staff did not initial the medication log. • **Multivitamin TAB**: take one tablet by mouth every day was given at 8AM on 09/07/2022, but staff did not initial the medication log. • **Omeprazole Dr 20 Mg Capsule**: take one capsule by mouth every day with food was given at 8AM on 09/07/2022, but staff did not initial the medication log. • **Paliperidone Er 6 Mg TAB**: take one tablet by mouth every day was given at 8AM on 09/07/2022, but staff did not initial the medication log. • **Vitamin D3 25 Mg TAB**: take one tablet by mouth every day was given at 8AM on 09/07/2022, but staff did not initial the mediation log. • **Atorvastatin 80 Mg TAB**: take ½ tablet by mouth every day was given at 8PM on 07/30/2022, but staff did not initial the medication log. • **Divalproex Sod Dr. 500 Mg**: take four tablets by mouth at bedtime was given at 8PM on 07/30/2022, but staff did not initial the medication log. • **Acetaminophen 500 Mg TAB**: take two tablets by mouth three times daily was given at 8PM on 07/30/2022, but staff did not initial the medication log. • **Naproxen 500 Mg TAB**: take one tablet by mouth twice daily was given at 8PM on 05/23/2022, but staff did not initial the medication log.
CONCLUSION:	**VIOLATION ESTABLISHED**

R 400.15312	**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: (c) Record the reason for each administration of medication that is prescribed on an as needed basis.
ANALYSIS:	During the on-site investigation on 09/07/2022, I reviewed Resident A's medication logs and found the following errors: **Benztropine Mes 2 Mg TAB**: take one tablet by mouth as needed for shakiness twice daily was given on 09/05/2022 at 8AM and on 09/06/2022 at 8PM but staff did not record the reasons for this as needed medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuse prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	During the on-site investigation on 09/07/2022, I reviewed Resident A's medication logs and found the following errors: **Docusate 100 Mg**: take one capsule daily was refused by Resident A at 8AM from 08/07/2022-08/29/2022 and on 08/30/2022, but Resident A's physician was contacted, but physician contact was not recorded regarding physician's instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

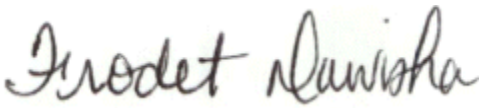
During the on-site investigation on 09/07/2022, Resident A reported that he was prescribed with a cane after being discharged from the hospital in June 2022. However, his bedroom was located on the second floor, and he had to climb stairs with his cane to get to his bedroom. I verified Resident A's script for his cane. I observed Resident H utilizing a cane for ambulation too. Resident H stated he has been using the cane for over a month and that his bedroom was located on the second floor. The home manager Nancy Huntington stated that the cane was prescribed by Resident H's physician but that she did not have a script for the cane and that Resident H can climb three stairs with his cane to get to his bedroom.

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Based on my investigation, Resident H did not have an authorization in writing by a licensed physician for the cane in his file at the time of my on-site investigation on 09/07/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15408	**Bedrooms generally.**
	(9) A resident who has impaired mobility shall not sleep in or be assigned a bedroom that is located above the street floor of the home.
ANALYSIS:	Based on my investigation, Resident A's mobility and Resident H's mobility were impaired as both utilize a cane to ambulate sometimes and their bedrooms are located on the second floor of this facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

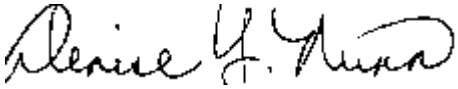
Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.



10/11/2022

Frodet Dawisha Date
Licensing Consultant

Approved By:



10/12/2022

Denise Y. Nunn Date
Area Manager