GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 7, 2025

Simbarashe Chiduma
Open Arms Link
Suite 130
8161 Executive Court
Lansing, MI 48917

RE: License #: AM190396226
Investigation #: 2025A1033009
Boichot

Dear Mr. Chiduma:

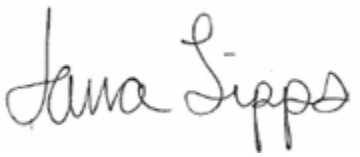
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190396226
Investigation #:	2025A1033009
Complaint Receipt Date:	12/12/2024
Investigation Initiation Date:	12/12/2024
Report Due Date:	02/10/2025
Licensee Name:	Open Arms Link
Licensee Address:	Suite 130 8161 Executive Court Lansing, MI 48917
Licensee Telephone #:	(517) 455-8300
Administrator:	Mascline Chiduma
Licensee Designee:	Simbarashe Chiduma
Name of Facility:	Boichot
Facility Address:	14120 Boichot Road Lansing, MI 48906
Facility Telephone #:	(517) 455-8300
Original Issuance Date:	11/20/2018
License **Status:**	REGULAR
Effective Date:	05/20/2023
Expiration Date:	05/19/2025
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Jakyra Pittman, administered Resident A's seizure medications via incorrect route and dosage, leading to an adverse medical event for Resident A.	Yes
Direct care staff are not properly trained to administer resident medications.	No
Additional Findings	Yes

III. METHODOLOGY

12/12/2024	Special Investigation Intake 2025A1033009
12/12/2024	APS Referral- Assigned to Adult Services Worker, Tom Hilla.
12/12/2024	Contact - Telephone call made- Attempt to interview APS, Tom Hilla. Voicemail message left, awaiting response.
12/12/2024	Special Investigation Initiated – Telephone call made. Interview conducted with APS, Tom Hilla, via telephone.
12/16/2024	Inspection Completed On-site- Interviews conducted with direct care staff, Alexis Brown, Nisalo Mulondani, and Operations Manager, Anastasia Ngugi. Attempt to review Resident A's medications and resident record initiated.
12/16/2024	Inspection Completed-BCAL Sub. Compliance
12/16/2024	Contact - Document Sent- Email correspondence sent to licensee designee, Sibarashe Chiduma.
12/16/2024	Exit Conference conducted via email with licensee designee, Simbarashe Chiduma. Mr. Chiduma noted he was traveling out of the country and acknowledged the violations being cited through email correspondence.
12/17/2024	Contact - Document Received- Email correspondence from Operations Manager, Anastasia Ngugi. Requested documents received.
12/26/2024	Contact – Document Sent-

	Email correspondence sent to Ms. Ngugi, requesting additional documentation.
12/27/2024	Contact – Document Received Requested documents received via email from Ms. Ngugi.
12/30/2024	Contact – Document Received Email communication held with Ms. Ngugi.
12/30/2024	Contact – Telephone call made Attempt to interview home manager/direct care staff, Sherry Henderson.
12/30/2024	Contact – Telephone call made Attempt to interview direct care staff, Jakyra Pittman, via telephone. Voicemail message left, awaiting response.
01/03/2025	Contact – Telephone call made Interview conducted with direct care staff/home manager, Sherry Henderson.

ALLEGATION:

- **Direct care staff, Jakyra Pittman, administered Resident A's seizure medications via incorrect route and dosage, leading to an adverse medical event for Resident A.**

- **Direct care staff are not properly trained to administer resident medications.**

INVESTIGATION:

On 12/12/24 I received an online complaint regarding the Boichot adult foster care facility (the facility). The complaint alleged on 12/11/24 direct care staff member, Jakyra Pittman, administered Resident A's seizure medication, Valium, nasally, instead of by rectal route, which is how the mediation was prescribed to be administered. The complaint further alleged that Ms. Pittman administered 12.5mg of this medication but did not indicate what the prescribed dosage should be. Also, on 12/12/24, a second online complaint was received regarding these allegations. The second complaint reported that Resident A suffered an overdose of the medication as a result of Ms. Pittman's incorrect medication administration. The allegation suggests that Resident A was sent to the hospital due to this event.

On 12/12/24 I interviewed Adult Protective Services (APS), Adult Services Worker, Tom Hilla, regarding the allegations. Mr. Hilla reported that he is assigned to this investigation. He reported that he had spoken with Guardian A1 and a hospital staff member (name unknown) at Sparrow Hospital and both parties confirmed that a medication error had been identified for Resident A on 12/11/24. Mr. Hilla reported that he was told, through these contacts, that Ms. Pittman administered Resident A's rectal Valium, via nasal route on 12/11/24.

On 12/16/24 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff, Alexis Brown, at this time. Ms. Brown reported that she had been working with Ms. Pittman on 12/11/24 when Resident A was administered her Valium medication, nasally, instead of rectally. Ms. Brown reported that she has not been trained in medication administration and was paired with Ms. Pittman as a co-worker on this shift as Ms. Pittman has been medication trained and was the designated medication administrator on this shift. Ms. Brown reported that Resident A began to experience a seizure and neither she, nor Ms. Pittman, have ever witnessed Resident A have a seizure. Ms. Brown reported that Resident A was sitting up in her wheelchair, in the living room, when the seizure began. Ms. Brown reported that Ms. Pittman asked for her assistance with Resident A and then contacted direct care staff/home manager, Sherry Henderson, via telephone, to request guidance on how to manage Resident A's seizure. Ms. Brown reported that she could not hear Ms. Henderson's directions during this telephone conversation. She reported that Ms. Pittman administered a medication, nasally, to Resident A. She reported that after Ms. Pittman completed the medication administration, she looked down at the medication package and noted that the package read to administer the medication rectally. Ms. Brown reported that Ms. Henderson was still on the telephone and discovered that Ms. Pittman had administered the medication via the wrong route and then called 911 for assistance. Ms. Brown reported that after the medication was administered to Resident A, via her nose, the resident went into a deep sleep, began drooling, and sliding down in her wheelchair. Ms. Brown reported that the paramedics arrived at the facility, took Resident A to the hospital, and she returned home on the same day. Ms. Brown reported that Resident A is not back to her baseline functional level yet. She reported that Resident A is usually able to feed herself and now requires direct care staff to assist with all meals. She further reported that Resident A was previously shaking and nodding her head to communicate "yes" and "no" answers. Ms. Brown reported that Resident A no longer communicates in this manner. Ms. Brown was feeding Resident A her lunch during this investigation. Resident A was sitting in a wheelchair during this investigation.

During the on-site investigation I interviewed the facility Operations Manager, Anastasia Ngugi. Ms. Ngugi reported that she was aware of the incident that occurred with Resident A's medications on 12/11/24. Ms. Ngugi reported that Resident A has been diagnosed with a seizure disorder and has two different medications for her seizures. She reported that one of the medications is to be administered nasally and one of the medications is to be administered rectally. Ms. Ngugi reported that on 12/11/24 Resident A experienced a seizure and Ms. Pittman

“panicked” and called Ms. Henderson via telephone for assistance. Ms. Ngugi reported that Ms. Henderson instructed Ms. Pittman how to administer the seizure medication, via telephone, and Ms. Pittman administered the rectal medication via Resident A’s nose. She further reported that when it was discovered that this was incorrect, Ms. Henderson called 911 for Resident A to receive emergency medical services.

During the on-site investigation on 12/16/24, I requested to review Resident A’s medications. I was told by Ms. Brown, and direct care staff, Nisalo Mulondani, that the key for the medication cart was currently missing, and they were unable to access resident medications. They explained that Ms. Henderson has an extra key, but she is off-site with a resident at a medical appointment and cannot bring the extra key until the appointment has ended. Ms. Ngugi arrived at the facility and noted that she did not have an extra key for the medication cart and was not able to access the medications either. I inquired of Ms. Brown, Ms. Mulondani, & Ms. Ngugi, how an as needed medication could be administered to a resident if they could not access the medication cart. None of the three individuals questioned had any idea of how to access the medications in the cart. Ms. Ngugi reported that two of the current residents have a diagnosed seizure disorder and may require emergency medication intervention and these medications were currently locked in the medication cart.

On 12/16/24 I had email communication with licensee designee, Simbarashe Chiduma, regarding the allegations. Mr. Chiduma reported that he acknowledged the incident which occurred with Resident A’s seizure medication being administered via the wrong route and incorrect dosage. He reported that he is working on a corrective action plan to provide additional training to direct care staff members on proper administration of all “PRN” or as needed medications. Mr. Chiduma also acknowledged the fact that the medications in the medication cart were not accessible to the direct care staff working when I arrived for the on-site investigation on 12/16/24. He reported that he is working on a corrective action plan to address this issue to prevent a reoccurrence.

On 12/16/24 I received the following documentation, via email, from Ms. Ngugi.

- *AFC Licensing Division – Incident/Accident Report*, for Resident A, dated 12/11/24. This form had an attached narrative document which read, “Jakyra Pittman was on meds she called to tell me [Resident A] was having a seizure, she asked to face time me, because I was not present I just dropped off another residents urine at the lab I was in my truck, I was able to see [Resident A] have the seizure, she had a little bit of convulsions for about 30 seconds, her lips turned blue, and she stopped breathing, the seizure lasted almost 3 minutes. I felt it was serious enough to use her medication that was a protocol for seizures, I instructed Jakyra to grab [Resident A’s] Nayzilam for her nostrils, which the directions say to instill 1 spray into one nostril once as needed for seizure, I explained to her there are 2 types one for the Anus and the other is for the nostril, but she was panicking and set the phone down, I couldn’t see what she had grabbed, she grabbed Diazepam for the anus and

put it in her nostrils, I told her to use two of them which was not correct. I asked her to hold up what she used for [Resident A]. She held up the Anal/Diazepam seizure medication protocol to show me. I immediately called the Ascensions pharmacy and asked what we should do about the mistake we made, the pharmacist said she didn't have an answer and to call 911. So I proceeded to call 911 for an ambulance." This narrative was signed by Ms. Henderson. Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Will get a secure protocol from her doctor and neurologist to train staff."

- *Health Care Appraisal,* for Resident A, dated 2/13/24. Under section, *7. Diagnoses*, it reads, "Seizure disorder, cerebral palsy, anxiety". Under section, *11. Mental/Physical Status and Limitations*, it reads, "non-verbal". Under section, *12. Mobility/Ambulatory Status*, "Uses Wheelchair", is marked.
- *Medication Administration Record (MAR),* for Resident A, for the month of December 2024. The following medications are prescribed to Resident A for her seizure disorder diagnosis:
    - *Lamotrigine 200mg Tablet (Lamictal 200 MG Tablet). Take one tablet by mouth twice daily.*
    - *Lacosamide 100 MG Tablet (Vimpat 100 MG Tablet). Take one tablet by mouth twice daily.*
    - Diazepam 10mg Rectal Gel SYS (Diastat Acudial 5-7.5-10mg KT). Place 7.5mg rectally 5 minutes into seizure and call 911 15 minutes after seizure starts. This medication is initialed as being administered by Ms. Pittman on 12/11/24.
    - Nayzilam Nasal Spray 5mg/0.1ML. Instill 1 spray into one nostril once as needed for seizure. This medication is not marked on the MAR as being administered at any time during the month of December.
- *PCP/IPOS Inservice Sign in Sheet*, for Resident A. Ms. Pittman and Ms. Brown, have both signed this document attesting to the training they received regarding Resident A's *Individual Plan of Service* through Community Mental Health (CMH).
- *Community Mental Health Training Unit* documentation that Ms. Pittman completed medication administration training on 7/25/24.
- *Community Mental Health Training Unit* documentation identifying that Ms. Mulondani completed medication administration training on 5/23/23.

On 12/27/24 I requested, via email, that Ms. Ngugi provide additional documentation for review. Ms. Ngugi provided the following documentation which was reviewed on 12/30/24:

- *Assessment Plan for AFC Residents* form for Resident A, dated 1/19/24. On page one, section, *I. Social/Behavioral Assessment*, subsection, *B. Communicates Needs*, the document is marked "No" with the narrative, "Individual is nonverbal, but will use body language and nod her head." This document does not indicate that Resident A has a seizure disorder or a protocol for seizure activity. This document does not note that Resident A uses a wheelchair.

- *Treatment Plan Annual/Initial*, for Resident A, dated 8/6/24. This document was completed by Clinton/Eaton/Ingham Community Mental Health case manager, Michelle Robinson, LLBSW. On page 8, under section, *How does the person communicate wants and needs*, it reads, "[Resident A] is able to say a few words such as "go bye-bye", "mama" and "hi". She also communicates by pointing, nodding, clapping, body language, yelling, smiling, and laughing. [Resident A] will cry or yell if she is upset or overly excited." This document does not identify her seizure disorder or protocol for seizure activity.
- *Medication Administration Training Records* reviewed for direct care staff, Chisomo Mazhangara, Divine Uwamahoro, Lashela Niyokwizera, Millichelle Deleon, & Sherry Henderson.

On 12/30/24 I had email correspondence with Ms. Ngugi and inquired whether there had been a seizure protocol in Resident A's resident record for direct care staff to review, prior to the seizure Resident A experienced on 12/11/24. Ms. Ngugi reported that prior to the event on 12/11/24, the seizure protocol was not available in Resident A's resident record. Ms. Ngugi reported that since the incident the seizure protocol has been obtained from Resident A's primary care physician.

On 1/3/25 I interviewed Ms. Henderson via telephone. Ms. Henderson reported that she is the current home manager at the facility. She reported she has worked at the facility since July 2022. Ms. Henderson reported that on 12/11/24 she had the day off work from the facility. She reported that Ms. Pittman and Ms. Brown were working, and she received a request from them to FaceTime with them on their cellphone. Ms. Henderson reported that she conducted a FaceTime call with Ms. Pittman and Ms. Brown and was informed that Resident A was having a seizure. She reported that she could see Resident A on the video and knew she was having a seizure as she had witnessed Resident A have a seizure previously. Ms. Henderson reported that Ms. Pittman and Ms. Brown did not know what to do regarding the seizure and Ms. Henderson had to provide education via the FaceTime video call to instruct Ms. Pittman how to administer Resident A's emergency seizure medication. Ms. Henderson reported that Resident A has a rectal and a nasal seizure medication for emergency use. She reported that Resident B also has seizures, and she was trying to remember the protocol for Resident A and Resident B at the time in order to tell Ms. Pittman what to administer to Resident A. She reported that she instructed Ms. Pittman to administer two sprays of Resident A's nasal medication into her nostril. Ms. Henderson reported that Ms. Pittman did this and she had put the telephone down so Ms. Henderson could not see what had been administered. She reported that she asked Ms. Pittman to hold up the medication she had administered to double check it was the correct medication. Ms. Henderson reported that Ms. Pittman held up the medication and she then realized she had administered the rectal medication, nasally, to Resident A. Ms. Henderson reported that she immediately made a telephone call to the pharmacy and advised what had occurred. She reported that the staff member at the pharmacy advised her to call 911 for Resident A as they did not know whether there would be an adverse

reaction for her due to the medication error. Ms. Henderson reported that she also realized she had instructed Ms. Pittman to administer two sprays of the medication into Resident A's nostril but she realized this was the protocol for Resident B. Ms. Henderson reported that she made a telephone call to 911 and then drove directly to the facility. She reported that she arrived before the paramedics and found Resident A beginning to come out of the effects of the seizure. She reported that Resident A was beginning to arouse but was still groggy. Ms. Henderson reported that the paramedics arrived and one of the paramedics inquired whether the direct care staff members were "licensed" to administer medications. She reported that she stated to this individual (name unknown) that they are not licensed and tried to explain that they do not have to be licensed, just trained, but the paramedic would not listen to her. Ms. Henderson reported that she followed Resident A to the hospital and by the time she got to the hospital, Resident A was speaking and awake. Ms. Henderson reported that Resident A is now back to her baseline functioning except for feeding herself. Ms. Henderson reported that this is typical for Resident A after she has a seizure to regress a little with her physical abilities. Ms. Henderson reported that Resident A is back to communicating with some words and shaking and nodding her head. Ms. Henderson reported that prior to this event, there was no protocol in Resident A's resident record for how to manager her seizures. She reported that Resident A has been diagnosed with a seizure disorder for many years. She reported that in the past year Resident A has experienced three seizures, that Ms. Henderson was aware of on this date. Ms. Henderson reported that Resident B has a seizure protocol in his resident record, but Resident A did not have one until recently, as a result of this event. Ms. Henderson reported that prior to Resident A's seizure on 12/11/24, the direct care staff were not directly trained to Resident A's seizure protocol as there was not a written protocol in her resident record.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon interviews conducted with Mr. Hilla, Ms. Brown, Ms. Ngugi, Ms. Henderson, as well as email correspondence received from Mr. Chiduma, and review of Resident A's resident record and employee files, as well as observations made during the unannounced, on-site investigation, it can be determined that Ms. Pittman did not administer Resident A's seizure medication correctly on 12/11/24. It can also be determined that on 12/16/24, Ms. Brown & Ms. Mulondani, were not able to administer any medications during at least a one-to-two-hour period, due to the medication cart keys being missing and not having access to a backup key for the medication cart.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	After review of the direct care staff documentation provided by Ms. Ngugi, it was determined that all direct care staff who have signed off on Resident A's MAR for the month of December 2024, had completed a medication administration training through Community Mental Health. Ms. Brown and Ms. Ngugi reported that not all the direct care staff have been trained to administer medications. They further noted that each shift is staffed with at least one direct care staff member who has been trained in medication administration.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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 upon interviews with Ms. Brown, Ms. Ngugi, Mr. Hilla, Ms. Henderson, as well as review of Resident A's resident record, it can be determined that Resident A has a documented history of a seizure disorder, as noted on her Health Care Appraisal. She has been prescribed two routine medications for this disorder as well as two as needed medications in the event of a seizure. The direct care staff demonstrated a lack of knowledge related to Resident A's seizure disorder or protocol to follow in the event of a seizure. It was noted direct care staff "panicked" and administered Resident A's seizure medication via an incorrect route and an incorrect dosage on12/11/24. Ms. Ngugi & Ms. Henderson acknowledged that there was not an active seizure protocol available in Resident A's chart prior to the seizure she experienced on 12/11/24. The licensee designee is responsible to ensure that instructions for resident health care needs are kept in the resident record and able to be provided in the facility. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	Based upon interviews conducted and documentation reviewed during this investigation, it has been identified that the direct care staff had not been properly trained to Resident A's seizure protocol. It was reported that Ms. Pittman & Ms. Brown "panicked" when Resident A experienced a seizure on 12/11/24, did not know how to handle the situation and chose to contact Ms. Henderson, who was not scheduled to be working on this date, to obtain assistance. Ms. Pittman and Ms. Brown did not know how to manage Resident A's emergency medical event, failed to contact the paramedics, and took instruction on how to manage Resident A's seizure, via a FaceTime conversation with Ms. Henderson. Ms. Henderson reported that she could not recall the dosage of Resident A's seizure medications and mistakenly instructed Ms. Pittman to administer an incorrect dosage to Resident A. As a result of Ms. Pittman and Ms. Brown being ill-prepared to handle this emergency situation, Resident A received her seizure medication via an incorrect route and was administered an incorrect dosage, which led to Resident A requiring emergency medical services. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation conducted on 12/16/24 I requested to review Resident A's resident record. Ms. Brown and Ms. Mulondoni were the only direct care staff members present in the facility when I arrived. Both, Ms. Brown & Ms. Mulondoni, reported that they could not access Resident A's resident record as it was locked in the office, and they did not have a key to the office. When I inquired how they would know the care plans for each resident and emergency information found in a resident record, they did not know how to answer this question. I asked Ms. Brown and Ms. Mulondoni if they could show me Resident A's MAR on the laptop at the medication cart. Ms. Brown reported that she does not access the laptop as she is not medication trained. Ms. Mulondoni opened the computer and was able to show me Resident A's medication list but was not able to show me the MAR with the initialed doses of each medication.

During the on-site investigation, Ms. Ngugi arrived at the facility. I inquired about obtaining information from Resident A's resident record. Ms. Ngugi reported that all resident documentation can be found on the computer located at the medication cart. She reported that this computer is accessible to all direct care staff members. I asked her to have Ms. Mulondoni access Resident A's resident files from the computer. Ms. Mulondoni did not know how to access Resident A's resident records and required the assistance of Ms. Ngugi, guiding her through the computer

program, to find the requested documents. Ms. Ngugi reported that resident information is also kept in the facility office, but the office was locked, and Ms. Ngugi did not have a key to access this information.

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: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(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.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.**

	(i) Resident funds and valuables record and resident refund agreement. **(j) Resident grievances and complaints.**
ANALYSIS:	Based upon the interviews conducted with Ms. Brown, Ms. Mulondoni, Ms. Henderson, & Ms. Ngugi, as well as observations made during the on-site investigation, it was demonstrated that the direct care staff did not have proper access to resident records due to the office being locked, where resident information is housed, and the direct care staff not having adequate training to access the resident record in the electronic format on the provided laptop. Direct care staff members are not able to access required assessment plans and emergency contact information to adequately provide for resident care.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 12/16/24 I conducted an on-site investigation at the facility. I observed Resident A sitting at the dining room table in a wheelchair at this time. I interviewed Ms. Brown, who reported that Resident A utilizes a wheelchair.

I reviewed the following documentation for this investigation:

- *Health Care Appraisal,* for Resident A, dated 2/13/24. Under section, *12. Mobility/Ambulatory Status*, "Uses Wheelchair", is marked.
- *Assessment Plan for AFC Residents* form for Resident A, dated 1/19/24. This document does not indicate that Resident A has a seizure disorder or a protocol for seizure activity. This document does not note that Resident A uses a wheelchair. On page two, under section, *II. Self Care Skill Assessment*, subsection, *G. Walking/Mobility*, it reads, "Individual needs staff assistance and a gait belt for walking." Under section, *III. Health Care Assessment*, subsection, *D. Special Equipment Used (Wheel chair, Walker, Cane, etc.)*, it reads, "Gait belt and shower chair."

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.

ANALYSIS:	Based upon observations made during the on-site investigation and review of Resident A's resident record it can be determined that Resident A requires the use of a wheelchair as an assistive device. A wheelchair is indicated on the *Health Care Appraisal* document, but the *Assessment Plan for AFC Residents* form fails to document the use of the wheelchair ordered for Resident A. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon approval of acceptable corrective action plan, no change to the status of the license recommended at this time.

1/3/25

_____

Jana Lipps Date
Licensing Consultant

Approved By:

01/06/2025

_____

Dawn N. Timm Date
Area Manager