GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 1, 2025

Davina Draughn
Stallworth AFC 1 Corporation
645 E Grand Blvd.
Detroit, MI 48207

RE: License #: AM820010096
Investigation #: 2025A0992020
Stallworth Afc

Dear Davina Draughn:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.
notified in writing of the department's action and your options for resolution of this matter.

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 (313) 456-0439.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM820010096
Investigation #:	2025A0992020
Complaint Receipt Date:	03/20/2025
Investigation Initiation Date:	03/26/2025
Report Due Date:	04/19/2025
Licensee Name:	Stallworth AFC 1 Corporation
Licensee Address:	645 E Grand Blvd. Detroit, MI 48207
Licensee Telephone #:	(313) 662-5113
Administrator:	Davina Draughn
Licensee Designee:	Davina Draughn
Name of Facility:	Stallworth Afc
Facility Address:	1221 E Grand Blvd Detroit, MI 48211
Facility Telephone #:	(313) 499-8446
Original Issuance Date:	05/14/1991
License Status:	REGULAR
Effective Date:	07/12/2023
Expiration Date:	07/11/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
It was reported that staff is lying about Resident A not taking her medications. There are concerns Resident A was improperly discharged for not taking her medication.	Yes
Direct care staff, Mitchelle Brown threatened Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/20/2025	Special Investigation Intake 2025A0992020
03/24/2025	Contact - Telephone call made Resident A was not available. Mailbox full, unable to leave a message. A text message was sent.
03/25/2025	Contact - Telephone call made Resident A was not available. Mailbox full, unable to leave a message. A text message was sent.
03/26/2025	Special Investigation Initiated - Telephone Office of Recipient Rights (ORR), Charles Carter
03/26/2025	Contact - Telephone call made Resident A was not available. Mailbox full, unable to leave a message. A text message was sent.
03/28/2025	Contact - Telephone call received Message received from Resident A.
03/31/2025	Inspection Completed On-site Licensee Designee, Davina Draughn.
03/31/2025	Contact - Telephone call made Resident A was not available. Mailbox full, unable to leave a message.
03/31/2025	Contact - Telephone call made Resident A's former guardian, LaChell Bussell with Law office of LaChell C. Bussell.

03/31/2025	Contact - Telephone call made Resident A's guardian, Kelly Devereaux with Infinity Guardian Services
03/31/2025	Contact - Telephone call made Resident A
03/31/2025	Contact - Telephone call made Social Worker, Gabby Shalhope with Receiving Hospital Social Work Department, she was not available. Message was left.
03/31/2025	Referral - Recipient Rights
04/01/2025	Contact - Telephone call made Gabby
04/01/2025	APS Referral
04/10/2025	Contact - Telephone call made Ms. Devereaux
04/10/2025	Contact - Telephone call made Gabby
04/10/2025	Contact - Telephone call made Mr. Carter
04/10/2025	Contact - Telephone call made Resident A
04/10/2025	Contact - Telephone call made Direct care staff, Michelle Brown was not available. No voicemail system setup.
04/10/2025	Contact - Telephone call made Adult protective services, Janet Mills.
04/11/2025	Contact - Telephone call made Ms. Brown
04/15/2025	Contact - Telephone call made Former direct care staff, Alexis Crawley.
04/15/2025	Exit Conference Ms. Draughn

ALLEGATION: It was reported that staff is lying about Resident A not taking her medications. There are concerns Resident A was improperly discharged for not taking her medication.

INVESTIGATION: On 03/26/2025, I contacted Office of Recipient Rights (ORR), Charles Carter regarding the allegation. Mr. Carter denied having any knowledge of Resident A being improperly discharged. He stated he received a complaint involving Resident A and it is alleged direct care staff, Mitchelle Brown threatened to slap the “shit” out of Resident A. I made Mr. Carter aware that I will be submitting an ORR complaint regarding the reported allegation.

On 03/31/2025, I completed an unannounced onsite inspection and interviewed licensee designee, Davina Draughn. Ms. Draughn confirmed Resident A was discharged. She stated Resident A would often refuse to take her medication timely and exhibited threatening behaviors towards staff. She stated when Resident A was initially admitted on 01/2025, she did not have threatening behaviors and there were no issues. She stated it wasn’t until Resident A started having problems with her guardian that she became verbally aggressive. She stated Resident A’s behaviors have progressed. Ms. Draughn stated there were several instances of Resident A being threatening toward staff, which was all documented. Ms. Draughn stated on 3/07/2025, Resident A was petitioned into psychiatric care at Detroit Receiving Hospital due to aggressive behavior and not taking her medications as prescribed. I observed Resident A’s room was in disarray. Ms. Draughn stated staff had been asking her to clean it up, but she refused. Ms. Draughn stated there was also blood all in the resident’s bathroom. I did not observe Resident A’s room to be in a disarray, and I did not observe blood in the bathroom. Ms. Draughn stated staff cleaned Resident A’s room while Resident A was in the community. Ms. Draughn stated when Resident A returned to the home, she was angry that staff cleaned her room. Ms. Draughn stated Resident A became aggressive and threatening.

Ms. Draughn is uncertain whether Resident A has been discharged from psychiatric care at Detroit Receiving Hospital or has been relocated to another placement. I requested a copy of all documents supporting Resident A’s threatening behavior, including incident reports, progress notes and the petition which Ms. Draughn agreed to provide. She identified Resident A’s public guardian as LaChell Bussell and provided her contact information.

I reviewed Resident A’s medication administration records (MARs) from February 2025 to present and several medications were not initialed. The following medications were not initialed and no explanation was provided:

February 2025
• Divalproex sodium 500mg. Take 1 tab by mouth every 12 hours was not initialed at 8:00 a.m. on 2/07/2025, 2/21/2025, 2/26/2025 or 2/28/2025.
• Divalproex sodium 500mg. Take 1 tab by mouth every 12 hours was not initialed at 8:00 p.m. on 2/04/2025, 2/12/2025, 2/21/2025, 2/23/2025, 2/26/2025, or 2/28/2025.
• Chlorpromazine HCL 50mg, take 1 tab by mouth 2x a day was not initialed at 8:00 a.m. on 2/07/2025, 2/21/2025 or 2/28/2025.
• Chlorpromazine HCL 50mg. Take 1 tab by mouth 2x a day was not initialed at 8:00 p.m. on 2/21/2025, 2/23/2025 or 2/28/2025.
• Chlorpromazine HCL 100mg. Take 1 tab by mouth every evening at bedtime was not initialed at 8:00 p.m. on 2/21/2025, 2/23/2025, 2/26/2025, or 2/28/2025.

March 2025
• Levothyroxm Tab 150mg. Take one tablet by mouth was not initialed at 8:00 a.m. on 3/02/2025, 3/05/2025 or 3/06/2025.

Ms. Draughn was unable to explain why the medications were not initialed. Ms. Draughn initially stated Resident A often refused her medication, but I did not observe documentation of Resident A refusing on the MARs. Ms. Draughn stated Resident A would refuse her medication at the time the medications were to be given but she would take it later, but eventually admitted that was untrue and Resident A did receive her medications as prescribed.

On 03/31/2025, I contacted Resident A's former guardian, LaChell Bussell with Law office of LaChell C. Bussell regarding Resident A. Ms. Bussell stated she is no longer Resident A’s guardian and has no knowledge of the allegation. She identified Resident A’s current guardian as Kelly Devereaux with Infinity Guardian Services and provided her contact information.

On 03/31/2025, I contacted Ms. Devereaux regarding the allegation. Ms. Devereaux stated she was recently appointed as Resident A’s guardian and has minimal knowledge of what transpired. She stated she is aware that Resident A was discharged from Stallworth adult foster care and is currently in the hospital pending placement. Ms. Devereaux stated she is actively seeking placement but has not been successful. She stated Resident A is very particular about her placement. Ms. Devereaux also stated she is not familiar with placement in Wayne County, and she is working with the Detroit Wayne Integrated Health Network (DWIHN). She confirmed Resident A remains hospitalized and that she has been in contact with the social worker, Gabby Shalhope regarding Resident A’s status.

On 03/31/2025, I contacted Resident A and interviewed her regarding the allegation, which she confirmed. Resident A stated the home had her petitioned stating she was not taking her medications and that is not true. Resident A stated she was taking her medications regularly. She stated staff went in her bedroom without her permission and mixed her clean clothes with her dirty clothes, and she was upset. She stated she told the staff that they cannot touch her belonging without her approval.

Resident A stated she called ORR and the next thing she knew the police were at the home, they transported her to the hospital, and she was petitioned. Resident A stated she was upset but her actions did not require her to be discharged. Resident A stated the petition was falsified. Resident A was adamant that she was improperly discharged. Resident A suggested I contact Gabby.

On 04/01/2025, I contacted Gabby with Detroit Receiving Hospital Social Work Department. Gabby stated according to Resident A and the petition; it was alleged that Resident A was not taking her medication, which is not true. Gabby stated according to the treating physician, Resident A's medication levels reflected levels that support her receiving her medication as prescribed. Gabby stated Resident A has been stable since she was admitted into the hospital. She stated Resident A was unjustly admitted into the hospital which is unfair to her and unfair to someone that needs the hospital bed that Resident A is occupying. She stated Resident A has not been discharged because she does not have a placement at this time. Gabby stated she has been in contact with Ms. Devereaux and understands she is trying to secure placement.

On 04/01/2025, I received multiple progress notes, two incident reports (dated 3/2/2025 and 3/07/2025) and the petition. Documenting Resident A's behaviors.

- On 2/21/2025, the progress note stated, "Consumer [Resident A] got into an argument with Resident B about her being on the phone, in asking [Resident A] if she can keep her singing down while being on the phone."

- On 2/21/2025, the progress note stated "Consumer [Resident A] is giving me issues she is starting stuff with [Resident B] and [Resident C] and she won't stop."

- On 2/25/2025, the progress note stated, "Consumer [Resident A] had an interview today and she was cussing at staff and telling the lady a bunch of lies saying she was court ordered to be here so she didn't know why they came and when interview was over the lady told staff she didn't want her she wasn't fit for her house that she was a ticking bomb."

- On 2/25/2025, the progress note stated, "Consumer [Resident A] was fussing at staff because staff woke her up to take her medications she didn't want to get up."

- On 2/28/2025, the progress note stated, "Consumer [Resident A] got into it with staff because she didn't want her knowing about her medications when staff was on the phone with the pharmacy she didn't mean to slam the door in my face but when she realize she did she open the door in apologized and explain she wasn't mad at me and why she got mad we talked about it and she was good after and there was no more issues."

- On 3/02/2025, the progress note stated, “Consumer [Resident A] was arguing with a consumer [Resident D] [Resident A] stated that [Resident D] put her hands on her, but [Resident C] stated [Resident A\ was lying that [Resident D] did not out her hands on her [Resident A] called the police police came and left.”

- On 3/04/2025, the progress note stated, “Consumer [Resident A] stated she had a dentist appointment she had transportation. A Vallery called from DWYNN for [Resident A] when staff told her she had a phone call she would not come to the phone she stated that DWYNN should not be calling her on the house phone they suppose to call her on her cell phone. Vallery stated she was new to (Resident A’s) case”

- On 3/02/2025, the incident report stated “staff was in the office and heard [Resident A] hollering saying [Resident D] keep your hands off me. When staff got to the living room an asked what was going on consumer [resident] was calling the police.” Action taken by the staff “Staff told [Resident D] to come into the office so they could stop arguing staff then notified administrator.”

- On 3/07/2025, the incident report stated “[Resident A] returned to the home and got mad because the staff had cleaned up her room. She started threatening the staff and residents.” Action taken by the staff, “I tried to redirect her she still was going off and threatening everybody, so I called 911 and petitioned her.” This incident report was authored by Alexis Crawley.

- On 3/07/2025, the petition documented Resident A was “threatening staff consumers [residents] and refusing to take her medications.”

On 04/10/2025, I made follow-up contact with Ms. Devereaux. She stated Resident A was discharged from the hospital on 4/09/2025, after being hospitalized for 29 days. Ms. Devereaux stated Resident A was successfully placed. She stated Stallworth Afc refused to take Resident A back, so it took longer than expected to secure placement.

On 04/10/2025, I made follow-up contact with Gabby. Gabby confirmed Resident A was discharged from the hospital on 4/09/2025 and was adamant that Resident A should never been admitted. Gabby stated essentially Resident A was ready for discharge the day she was petitioned because her levels remained the same throughout her hospitalization. Gabby stated the only reason Resident A remained hospitalized is because she did not have a placement.

On 04/10/2025, I contacted adult protective services (APS), Janet Mills regarding the allegation. Ms. Mills stated she attempted to interview Resident A, but Resident A

refused to meet with her. Ms. Mill stated due to Resident A's lack of cooperation; her complaint will be closed.

On 04/15/2025, I completed an exit conference with Ms. Draughn. Based on the investigative findings there is sufficient evidence to support the allegation that Resident A was improperly discharged. The behaviors outlined in the documentation did not support an emergency discharge. If she felt as though Resident A's behavior posed a substantial risk due to the inability of the home to meet Resident A's needs or assured the safety and well-being of other residents of the home; she needed to document as such, contact Resident A's guardian, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. Resident A remained hospitalized for 29 days due to lack of placement and that the hospital is not a place to discharge a resident. The petition contained false information because there was no documentation to support Resident A who refused her mediations. Based on the findings, the allegation is substantiated, and a written corrective action plan is required. Ms. Draughn denied having any questions or concerns. She agreed to review the report and contact me if necessary.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge.** **If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not**

	agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency **or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	During this investigation, I interviewed licensee designee, Davina Draughn; Resident A's guardian, Kelly Devereaux; social worker, Gabby Shalhope; APS, Janet Mills and Resident A regarding the allegations. Resident A stated she was petitioned and improperly discharged from the home. Resident A was adamant that the staff falsified the petition, alleging she refused her medication. Ms. Draughn confirmed Resident A was issued an emergency discharge, due to threatening behavior and failure to take her medication. Gabby was adamant that Resident A should never been admitted into the hospital. She stated the only reason Resident A remained hospitalized was because she did not have placement. The progress notes, incident reports, petition and emergency discharge notice I reviewed contained insufficient information. The documentation did not support an emergency discharge; Resident A was improperly discharged. Based on the findings, there is sufficient evidence to support the allegation. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff, Mitchelle Brown threatened Resident A.

INVESTIGATION: On 03/26/2025, I contacted Office of Recipient Rights (ORR), Charles Carter regarding the allegation. Mr. Carter stated he received a complaint involving Resident A and it is alleged direct care staff, Mitchelle Brown threatened to "slap the shit out of [Resident A]." He stated Ms. Brown was talking to direct care staff, Alexis Crawley and Resident A interrupted their conversation without saying excuse me. He stated Ms. Brown told Resident A before interrupting the conversation, she should say "excuse me." Mr. Carter stated Resident A was triggered and she started yelling using profanity and said, "your momma," to Ms. Brown. Mr. Carter stated Ms. Brown responded by saying, "I should slap the shit out of you," to Resident A. Mr. Carter stated direct care staff, Alexis Crawley confirmed she heard Ms. Brown. Mr. Carter stated he interviewed Ms. Crawley, but she has since been terminated. Mr. Carter stated he intends to interview Resident A; and that she is currently hospitalized at Detroit Receiving Hospital.

On 03/31/2025, I completed an unannounced onsite inspection and interviewed licensee designee, Davina Draughn regarding the allegation. Ms. Draughn stated she was not present when the alleged incident occurred. Ms. Draughn stated ORR investigated and he is substantiating the allegation. She stated as a result Ms. Brown received a write-up and in-service. Ms. Draughn stated one thing she does not tolerate is belittling or threatening the residents. Mr. Draughn provided contact information for Ms. Brown and Ms. Crawley. She stated Ms. Crawley no longer works for the company.

On 03/31/2025, I contacted Resident A's guardian, Kelly Devereaux with Infinity Guardian Services. Ms. Devereaux stated she was recently appointed as guardian and denied having any knowledge of the allegation.

On 04/01/2025, I received a copy of Michelle Brown's, employee notice of discipline. According to the notice Ms. Brown received a write-up for Resident A being called out of her name and threatened. According to the corrective action, Ms. Brown was in-serviced including recipient rights training; abuse and neglect; and on how to properly treat residents.

On 04/10/2025, I made follow-up contact with Mr. Carter. Mr. Carter stated he had an opportunity to interview Resident A and Ms. Crawley, both of which confirmed the allegation. He stated he has completed his investigation and will be substantiating the allegation.

On 04/10/2025, I contacted Resident A regarding the allegation, which she confirmed. Resident A stated she interrupted Ms. Brown while she was talking to Ms. Crawley and although she apologized for interrupting her, Ms. Brown kept talking about it. Resident A stated she yelled out "your momma," and Ms. Brown stated, "I should slap the shit out of you." She stated Ms. Brown chased her around with a knife. I asked if anyone witnessed Ms. Brown chase her with a knife, and she stated

she did not know. Resident A stated Ms. Brown plotted to have her discharged because she was mad.

On 04/10/2025, I contacted adult protective services (APS), Janet Mills regarding the allegation. Ms. Mills stated she attempted to interview Resident A, but Resident A refused to meet with her. Ms. Mill stated due to Resident A's lack of cooperation; she is closing her case. She stated Resident A is no longer at Stallworth Afc and she is safe.

On 04/11/2025, I contacted Ms. Brown and interviewed her regarding the allegation. Ms. Brown denied saying, "I should slap the shit out of you" to Resident A. She stated she was talking to Ms. Crawley and Resident A interrupted their conversation. Ms. Brown stated she tried to explain to Resident A that she should say "excuse me," before interrupting someone's conversation. She stated Resident A started yelling "bitch your momma." Ms. Brown stated she recently loss her mom, so she became emotional and went outside. She stated she did not threaten to slap the shit out of Resident A. Ms. Brown denied chasing Resident A with a knife.

On 04/15/2025, I contact Ms. Crawley and interviewed her regarding the allegation, which she confirmed. Ms. Crawley stated she was talking to Ms. Brown, when Resident A interrupted their conversation. She stated Resident A started yelling and at some point, she said "your momma" to Ms. Brown. She stated Ms. Brown threatened to "slap the shit out of [Resident A]" and they were going back-and-forth. I asked Ms. Crawley if Ms. Brown chased Resident A with a knife. She stated Ms. Brown did have a knife in her hand, but she did not chase Resident A. She stated the knife was in Ms. Brown's hand while they were talking. She stated Ms. Brown put the knife in the kitchen drawer.

On 04/15/2025, I conducted an exit conference with Ms. Draughn. Based on the investigative findings, there is sufficient evidence to support the allegation. Ms. Draughn denied having any questions or concerns.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**

ANALYSIS:	During this investigation, I interviewed licensee designee, Davina Draughn; direct care staff, Michelle Brown and Alexis Crawley; ORR, Charles Carter; and Resident A regarding the allegations. Ms. Draughn was not present when the incident occurred, but stated she does not tolerate threatening residents and upon investigation, she issued Ms. Brown a writeup and in-service training. Ms. Crawley, Mr. Carter and Resident A confirmed the allegation. Ms. Crawley stated she was present and heard Ms. Brown threaten Resident A. Mr. Carter stated based on his findings, he is substantiating the allegation. Resident A presented as competent and articulated herself well. Based on the investigative findings, there is sufficient evidence to support the allegation that direct care staff Michelle Brown threatened Resident A. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 03/31/2025, I reviewed Resident A's medication administration records (MARs). I reviewed Resident A's MARs from February 2025 to present. The following medications were not initialed and no explanation was provided:

<u>February 2025</u>
• Divalproex sodium 500mg. Take 1 tab by mouth every 12 hours was not initialed at 8:00 a.m. on 2/07/2025, 2/21/2025, 2/26/2025 or 2/28/2025.
• Divalproex sodium 500mg. Take 1 tab by mouth every 12 hours was not initialed at 8:00 p.m. on 2/04/2025, 2/12/2025, 2/21/2025, 2/23/2025, 2/26/2025, or 2/28/2025.
• Chlorpromazine HCL 50mg, take 1 tab by mouth 2x a day was not initialed at 8:00 a.m. on 2/07/2025, 2/21/2025 or 2/28/2025.
• Chlorpromazine HCL 50mg. Take 1 tab by mouth 2x a day was not initialed at 8:00 p.m. on 2/21/2025, 2/23/2025 or 2/28/2025.
• Chlorpromazine HCL 100mg. Take 1 tab by mouth every evening at bedtime was not initialed at 8:00 p.m. on 2/21/2025, 2/23/2025, 2/26/2025, or 2/28/2025.

<u>March 2025</u>
• Levothyroxm Tab 150mg. Take one tablet by mouth was not initialed at 8:00 a.m. on 3/02/2025, 3/05/2025 or 3/06/2025.

I brought the medication concerns to Ms. Draughn attention, and she was unable to explain why the medications were not initialed.

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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Direct care staff did not initial for the medication at the time the medication is given.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

5/1/2025

_____

Denasha Walker Date
Licensing Consultant

Approved By:

5/1/2025

_____

Ardra Hunter Date
Area Manager