GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 4, 2025

Lauren Gowman
Grand Pines Assisted Living Center
1410 S. Ferry St.
Grand Haven, MI 49417

RE: License #: AH700299440
Investigation #: 2025A1028059
Grand Pines Assisted Living Center

Dear Lauren Gowman:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH700299440
Investigation #:	2025A1028059
Complaint Receipt Date:	05/23/2025
Investigation Initiation Date:	05/27/2025
Report Due Date:	07/22/2025
Licensee Name:	Grand Pines Assisted Living LLC
Licensee Address:	950 Taylor Ave., Grand Haven, MI 49417
Licensee Telephone #:	(616) 846-4700
Administrator:	Ami Moy
Authorized Representative:	Lauren Gowman
Name of Facility:	Grand Pines Assisted Living Center
Facility Address:	1410 S. Ferry St., Grand Haven, MI 49417
Facility Telephone #:	(616) 850-2150
Original Issuance Date:	07/08/2009
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	177
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B are not provided care in accordance with the service plans.	No
Resident A was not administered medication in accordance with physician orders.	Yes
Additional Findings	No

III. METHODOLOGY

05/23/2025	Special Investigation Intake 2025A1028059
05/27/2025	Special Investigation Initiated - On Site
05/27/2025	APS Referral
05/27/2025	Contact - Face to Face Interviewed the administrator at the facility.
05/27/2025	Contact - Face to Face Interviewed family member 1 at the facility.
05/27/2025	Contact - Document Received Received requested documentation from the administrator.
05/28/2025	Contact - Telephone call made Interviewed complainant by telephone.
06/01/2025	Contact - Document Received Received documentation from the complainant via email.

This special investigation will only address allegations pertaining to violations of the rules and regulations of Homes for the Aged (HFA).

The allegation of the facility being understaffed will not be addressed in this special investigation because it was addressed in the recent 2025 facility survey inspection report.

The allegations pertaining to service plan/care level billing and costs will not be addressed in this special inspection report because it does not pertain to a violation of HFA rules and regulations.

ALLEGATION:

Resident A and Resident B are not provided care in accordance with the service plans.

INVESTIGATION:

On 5/23/2025, the Bureau received the allegations through the online complaint system.

On 5/27/2025, I interviewed the facility administrator at the facility who reported Resident A expired at a hospice facility on 5/26/2025. Resident B still currently resides at the facility, but Resident B's family is planning to move Resident B out of the facility. The administrator reported Resident A and Resident B were provided care in accordance with [their] service plans and that multiple care conferences were completed with Resident A's and Resident B's authorized representative (AR) to ensure care, but the AR would not initially agree to increases in care. As Resident A began to demonstrate a decline in health and function, the facility offered one to one personal care, but the AR declined. The administrator reported the family chose to provide one to one care for Resident A with Resident A being admitted to hospice services on 5/16/2025. The administrator reported it was explained to the AR during the care conferences that Resident A and Resident B's service plans direct the care that the resident will receive and if a care provision is not in the service plan, then it will not be completed. The administrator reported the AR demonstrated understanding but then would want staff to complete care provisions not listed in the service plan. Staff were willing to assist Resident A and Resident B with needs, but the AR was not in agreement with increasing the service plan level. The administrator reported the AR wanted staff to begin assisting Resident A and Resident B with eating, but there was not a care provision for eating listed in the service plan, even though the facility had discussed an increase in care for both residents. The administrator reported the AR would not agree to an increase in the service plan care level and that the facility recommended hospice services for Resident A and memory care services for Resident B to ensure health and wellbeing. The administrator reported the AR declined the recommended hospice services for Resident A but selected another hospice company of their choosing. The AR also declined the facility's memory care services recommendations for Resident B. The AR has given the facility notice that [they] are seeking an alternative placement for Resident B. I received the requested documentation from the administrator.

The administrator reported that the call-light system failed due to an issue from the storms last week. The call lights that were affected were on a section of hallways E,

H, I, and J with 20 residents total being affected. The facility immediately contacted the call light system contractor and the IT department to correct the issue. Facility staff were required to check on residents every 1-2 hours dependent upon the resident's acuity and functional level. The administrator reported Resident A and Resident B were checked on regularly by staff and that the residents' families were also in the facility during the call light failure as well. The system was partially running on 5/21/2025 and fully repaired and running 5/22/2025. There have been no issues with the call light system since.

The administrator reported Resident A and Resident B were provided assistance with showers in accordance with [their] service plans. Resident A and Resident B would refuse intermittently, but staff would use reapproach techniques, but both residents would still refuse. The administrator reported all residents are provided showers in accordance with their service plans and if a resident refuses, staff will reapproach, but residents have the right to refuse. If a resident continues to refuse, then the appropriate authorized representative and/or physician would be notified to address the continued refusals and to ensure the resident's health.

On 5/27/2025, I interviewed family member 1 at the facility who reported call lights were out for days prior to the issue being fixed. Family member 1 reported knowledge that Resident A would refuse showers and food intermittently. Family member 1 reported food trays for Resident A and Resident B were left in the room and no eating assistance was provided for either resident.

On 5/27/2025, I observed Resident B in [their] room who was clean, content, and visiting with family members. Resident B did not participate in the interview due to cognition. Food trays were observed in the room on the kitchenette counter. No other concerns were noted during the observation.

On 5/28/2025, I interviewed the complainant by telephone who confirmed Resident A expired at a hospice facility on 5/26/2025.The complainant also expressed concern about the call lights being out at the facility for several days and alleged Resident A and Resident B were not checked on every 1-2 hours during the call light system failure. The complainant reported Resident A and Resident B missed showers, were not given assistance with showers, and that staff reported to [them] that Resident A and Resident B refused. The complainant also reported Resident A and Resident B were not provided assistance with eating and that room trays were often left in the room. The complainant confirmed care conferences with the facility occurred with most recent being on 5/22/2025. The complainant reported [they] would email me with [their] notes pertaining to Resident A and Resident B's care at the facility.

On 6/1/2025, I received the documentation from the complainant. The documentation provided has some time frames notated but there are no dates on the documentation. During the review of documentation, it was noted that the

complainant's allegations and personal documentation conflict. The documentation alleges the following:

- Staff are not assisting Resident A or Resident B with eating, and [they] are going without meals.
- Other than some yogurt, Resident A is not eating but can feed self.
- Hygiene and grooming provided by hospice, family, and Resident A [their self].
- Family assists Resident A with toileting and rarely have 1-staff assist with toileting. Resident A is bed bound with briefs.
- Nightly mobility checks were not completed for Resident A or Resident B.
- Resident A had dementia, was confused, cried out in pain, was unable to participate in conversation and could not understand conversation.
- Resident B is not receiving assistance with showering and went without a shower for 3 weeks. No time frame or date provided.
- Resident B does not require assistance with dressing and can dress self.
- Resident B can feed self but needs reminders to eat.
- Resident B independently goes to meals, but meals are also brought to room.
- Staff will cue Resident B and walk [them] to the dining room intermittently.
- Resident B had to get new glasses because other glasses went missing.
- Resident B can comb own hair but requires assistance with nail trimming.
- Resident B makes own bed.
- On 5/28/2025, Resident B was only checked on at 12:00 am and again at 5:00 am. However, Resident B's service plan shows Resident B declined nightly checks and prefers not to be disturbed at night.
- Call lights not answered for 45 minutes.
- Hospice services recommended for Resident A.
- Memory care services recommended for Resident B.

On 6/2/2025, I reviewed the requested documentation. I first reviewed Resident A's service plan dated 2/25/2025 for comparison of care levels. It revealed the following:

- Resident A demonstrated a significant change in condition.
- Resident A and the AR participated in the service plan development.
- Resident A required 1-person assist with showers, preferred showers in the evenings, and family needs to be called when showering so the family can come and change the wound dressing.
- Resident A was independent with dressing with spouse helping at times.
- Did not require any assistance with eating but staff to offer fluids when in room to prevent dehydration.
- Resident A has a poor appetite and normally refuses breakfast. Required lower sugar snacks/desserts.
- Independent with grooming, oral care, transfers, and mobility with use of power chair.
- Required 1-person assist with toileting and peri-care.
- Due to cognition, Resident A demonstrated some resistive behaviors and could become accusatory of others.

I then reviewed Resident A's most recent service plan dated 5/22/2025 which included a care increase that the AR and facility agreed upon. The review of the service plan revealed the following:

- Resident A and the AR participated in the service plan development.
- Resident A was a 2-person assist with showers, dressing, hygiene, grooming, oral care, toileting, and peri care.
- Resident A required 1 person assist with feeding as needed. Resident A has a poor appetite. Requires lower sugar snacks/desserts.
- Required checks 2 times nightly.
- Required 2-person assist for transfers.
- Facility managed housekeeping and medication management.
- Resident A was a high fall risk.
- Resident A was receiving hospice services from 5/16/2025 to 5/26/2025.

I reviewed Resident A's record which revealed the following:

- On 5/1/2025, Resident A refused lunch. Family notified.
- On 5/2/2025, Resident A refused breakfast.
- On 5/2/2025 at 4:59 pm, Resident A refuse to go the dining room for dinner. Resident A provided meal tray in room.
- On 5/2/2025 at 4:37 pm, Resident A refused supplemental drink.
- On 5/4/2025 at 3:00 pm, Resident A incurred a fall due to attempting to toilet self and missing the toilet when lowering body to sit. Resident A also lost control of the walker and reported [they] did not hit [their] head. Family was already present, and Resident A did not receive emergency services. Facility staff assisted Resident A up from the floor.
- On 5/4/2025 at 4:45 pm, Resident A unable to pull self-up in bed during medication administration and reported pain in right leg and coccyx. Physician was contacted for further instructions.
- On 5/5/2025 at 9:40 am and 5:07 pm, Resident A refused supplemental drink.
- On 5/6/2025, Resident A was assessed and reported varying appetite, that [they] did not like going to dining room for mealtime and did not want to "come down for activities." Resident A reported [they] get assistance with showers.
- On 5/6/2025, Resident A received mobile x-ray services due to fall on 5/4/2025 with complaints of pain.
- On 5/6/2025 at 8:59 am, Resident A refused supplemental drink.
- On 5/7/2025, the facility received Resident A's mobile x-ray results which revealed mild osteoporosis, mild degenerative changes in right and left hip joint space, sacrum and bony pelvis were intact, and no fracture or dislocation in the right or left hip. Vascular calcifications noted and clinical correction recommended. The AR was notified of findings.
- On 5/11/2025, Resident A refused to go to dining room for dinner due to going out to eat with family earlier. Resident A was very tired and received a room tray.

- On 5/14/2025, Resident A was noted to be very confused and reported feeling more anxious with spouse because the “spouse did not remember anything.” Reported constant pain despite Lidocaine patch. Monitoring continued for Resident A.
- On 5/14/2025, Resident A was observed to be in bed most of the week and it was hard for [them] to sit up in bed to receive medication due to severe pain.
- On 5/16/2025, Resident A was admitted to hospice services.
- On 5/16/2025, Resident A refused nighttime care.
- On 5/17/2025, concerns were noted that Resident A was bedbound, refusing showers, eating but not talking very much and cannot sit up in bed due to pain level. Resident A was observed talking nonsense and could not make conversation or full sentence.
- On 5/18/2025 at 12:15 pm, Resident A was observed not feeling well and said, “leave me alone”, “don’t touch me”, and “help me”. Resident A started a new medication, and hospice was notified to send hospice nurse to assess.
- On 5/18/2025 at 2:15 pm, hospice visited Resident A with AR present. Resident A was reported to be in extreme pain in lower back and had difficulty with taking medication due to dementia. New medication orders were prescribed by hospice for Resident A and hospice communicated new orders to facility staff.
- On 5/18/2025, Resident A refused to go to dining room for lunch despite encouragement from staff. After medication administration, Resident A took a nap and staff had difficulty waking Resident A later. The shift supervisor was called and also had difficulty waking Resident A. Hospice was notified and new medication changes and orders were entered for Resident A.
- On 5/20/2025, hospice social worker provided the AR and family education on Resident A’s diagnosis and decline through end of life.
- On 5/21/2025, Resident A refused dinner.
- On 5/22/2025 at 11:45 am, Resident A’s care level increased from a level to 2 to a level 12. Resident A’s care level increased to 2-person assist for dressing, grooming, hygiene, peri-care, toileting, oral care, showering, and transfers. Resident A was previously independent to 1-person assist with care levels.
- On 5/22/2025 at 12:45 pm, hospice completed a partial bed bath for Resident A. Resident A consumed some yogurt but refused all other food items. Family was present.
- On 5/23/2025 at 12:00 pm, Resident A was observed hallucinating and with restlessness. Resident A attempted to use bathroom every 45 minutes to an hour but would not void. Hospice team and physician notified.
- On 5/23/2025 at 1:45 pm, the AR reported to staff that Resident A pushed spouse and kicked visiting family member.
- On 5/24/2025 at 6:00 am, Resident A was very weak and confused. Difficult to transfer.
- On 5/24/2025 at 10:00 am, it was noted Resident A was not eating at least 50% of meals. Facility staff awaiting further instruction from hospice team and physician.

- On 5/24/2025 at 1:00 pm, hospice visited to assess Resident A. Family requested Resident A be transferred to hospice facility.
- On 5/25/2025 at 12:45 pm, Resident A transferred to inpatient hospice facility.
- On 5/26/2025, Resident A discharged from facility due to move to inpatient hospice facility.

On 6/26/2025, I reviewed Resident B's service plan from 2/25/2025 which revealed the following:

- Resident B and the AR participated in development of the service plan.
- Resident B required 1-person assist with showering and peri-care.
- Resident B required minimal assistance with dressing which included staff assisting with laying out of clothes, cueing for clothing changes if soiled, and to ensure compression socks are worn.
- Resident B required assistance to clean eyeglasses with staff ensuring Resident B wears glasses daily.
- Resident B required cueing and set-up with hygiene and grooming.
- Resident B is independent with eating, oral care, toileting, transfers, and mobility.
- Facility managed housekeeping and medication administration.
- Resident B's nightly checks by staff were declined on service plan.

On 6/26/2025, I reviewed Resident B's service plan from 5/22/2025 which revealed the following:

- Resident B and the AR participated in the development of the service plan.
- Resident B required 1-person assist with cueing for showering, dressing, oral care, and peri-care.
- Resident B required set-up and cueing for hygiene and grooming.
- Resident B was independent with eating, toileting, and transfers.
- Resident B required cueing and/or 1-person assistance with directions and mobility to and from meals and activities.
- Facility managed housekeeping and medication administration.
- Resident B's nightly checks by staff were declined on service plan.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	It was alleged that Resident A and Resident B were not provided care in accordance with the service plans. Interviews, on-site investigation, and review of documentation reveal there is no evidence to support this allegation. The facility demonstrated care in accordance with Resident A's and Resident B's service plans. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not administered medication in accordance with physician orders.

INVESTIGATION:

On 5/27/2025, the administrator reported the facility followed all physician orders for medication administration for Resident A. The administrator also reported there were multiple medication changes for Resident A as well. The administrator provided me with the requested documentation for my review.

On 5/27/2025, family member 1 reported there were issues with Resident A receiving Haldol and that facility staff would not give Resident A the prescribed pain medication.

On 5/28/2025, the complainant reported there were multiple medication administration issues, and that staff would not provide Resident A pain medication even though Resident A was screaming and crying out in pain. The complainant also reported issues with Resident A's diabetic medication. The complainant provided me with [their] documentation.

On 6/5/2025, I reviewed Resident A's medication administration record (MAR) and documentation record for May 2025 which revealed the following:

- On 5/6/2025 at 4:19 pm, Resident A refused medication administration of Timolol Mal 0.5% eye drops and supplemental drink.
- On 5/7/2025 at 4:49 pm, Resident A refused supplemental drink.
- On 5/8/2025 at 12:01 pm, Resident A refused lunch and Humalog 100 units/ML Kwikpen was refused as well.
- On 5/8/2025 at 4:30 pm, Resident A refused supplemental drink.
- From 5/7/2025 to 5/25/2025, Resident A was prescribed to take 2 tablets by mouth every 4 hours of 500 mg caplet of Acetaminophen as needed for pain. No medication errors were noted on the May 2025 MAR for this medication.
- On 5/9/2025 at 1:00 am, Resident A's Lidocaine patches arrived at the facility, but there was not an active physician order for it. The facility contacted the

physician to request the order. From 5/13/2025 to 5/25/2025, Resident A was prescribed a Lidocaine 4% patch for pain. The patch was to be applied to Resident A's back and it was to be worn 12 hours on and 12 hours off.

- On 5/9/2025 at 5:45 pm, the facility received the physician order for the Lidocaine 4% patch. The patch was to be applied once daily to back. The AR was notified of the physician order.
- On 5/11/2025 at 4:58 pm, Resident A refused dinner and supplemental drink.
- On 5/12/2025, Resident A was observed with Lidocaine 4% patch on from previous day.
- On 5/12/2025 at 10:30 am, Resident A refused supplemental drink.
- On 5/13/2025, Resident A refused administration of Gavilax Powder 238 gm.
- On 5/13/2025 at 4:11 pm, Resident A refused supplemental drink.
- On 5/14/2025 at 3:45 pm, Resident A reported constant pain despite use of Lidocaine 4% patch. Monitoring continued for Resident A.
- On 5/14/2025 at 4:09 pm, Resident A refused administration of Gavilax Powder 238 gm and supplemental drink.
- On 5/14/2025 at 4:15 pm, Resident A requested and received 2 500 mg tablets of Acetaminophen due to pain.
- On 5/15/2025 at 4:07 pm, Resident A refused administration of Gavilax Powder 238 gm and Timolol Mal 0.5% eye drops.
- On 5/15/2025 at 8:20 pm, Resident A refused administration of Lidocaine 4% patch.
- On 5/16/2025, the facility received a new order for Resident A to receive 2 tablets of Oxycodone 5 mg by mouth every 12 hours routine and every 4 hours as needed for pain from 5/17/2025 to 5/18/2025.
- On 5/16/2025 at 4:15 pm, Resident A refused supplemental drink.
- On 5/17/2025 at 5:30 pm, Resident A refused all PM medications.
- On 5/17/2025, the facility received a new order change for Resident A for 2 tablets of Oxycodone 5 mg by mouth every 4 hours as needed for pain and/or shortness of breath from 5/19/2025 to 5/19/2025.
- On 5/18/2025 at 2:15 pm, the facility received hospice orders to discontinue multivitamin, Humalog mealtime insulin, ferrous sulfate, senna, pravastatin, and oxycodone. New medication administration orders were to be prescribed and sent to facility by hospice.
- On 5/19/2025 at 10:27 am, Resident A refused administration of Lidocaine 4% patch.
- On 5/19/2025 at 5:30 pm, the facility received new orders to discharge previous medication orders and to now "give Resident A 1 tablet by mouth of Oxycodone 5 mg three times a day routinely with meals and every 4 hours as needed for moderate to severe pain. Check blood sugar three times a day before meal. Give Humalog per sliding scale of patient eats at least 50% of meal."
- On 5/19/2025 at 6:11 pm, Resident A ate 0%v of evening meal.
- On 5/19/2025 at 11:30 pm, Resident A's Morphine count was verified.
- On 5/20/2025 at 10:13 am, Resident A refused supplemental drink.

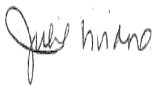
- On 5/20/2025, Resident A refused lunch.
- On 5/20/2025 at 2:00 pm, Resident A was very painful in bed and refused pain medications. Hospice physician “was able to provide Resident A with medications after much encouragement.”
- On 5/20/2025 at 4:30 pm, Resident A refused all evening medications and supplemental drink. Hospice and the AR notified.
- On 5/21/2025 at 12:30 am, the facility received a new order for Morphine. Resident A was to receive 0.25 ml 3 times daily and every 4 hours as needed. Hold Oxycodone 5 mg. The AR was notified.
- On 5/20/2025, Resident A refused lunch.
- On 5/21/2025 at 3:30 pm, the facility received orders to discontinue Oxycodone 5 mg. The AR was notified.
- On 5/21/2025 at 4:54 pm, Resident A refused medication administration of Timolol Mal 0.5% eye drops and supplemental drink.
- On 5/22/2025, Resident A did not eat breakfast or lunch.
- On 5/22/2025, Resident A refused all afternoon medications and supplemental drink.
- On 5/23/2025, Resident A did not eat lunch and afternoon medications were refused.
- On 5/23/2025 at 4:15 pm, the facility received new orders to discharge pravastatin, vitamin E and to give 1 tablet by mouth of Ativan 0.5 mg every 6 hours as needed for anxiety and restlessness. Resident A was to be given one tablet of Haldol 0.5 mg by mouth every 6 hours as needed for agitation and hallucinations. The AR was notified of new orders.
- On 5/23/2025 at 5:45 pm, the facility received new orders to increase Ativan to every 4 hours as needed. The AR was notified.
- On 5/24/2025 at 10:00 am, the facility notified hospice that Resident A was not eating 50% of meals and blood sugar was elevated. The facility awaited further instruction from hospice.
- On 5/24/2025, Resident A did not eat lunch.
- On 5/24/2025, Resident A refused afternoon medications and supplemental drink.
- On 5/24/2025 at 1:00 pm, the facility received new orders which included medications could be crushed, Ativan 0.5 mg tablet to be given three times a day and to give with meals. Continue Ativan as needed. The Morphine order was changed to 0.25 (5 mg) to 4 times a day and to continue as needed. The AR was notified.
- On 5/24/2025, hospice noted it appeared Resident A is transitioning.
- On 5/25/2025 at 7:45 am, the facility called hospice to get clarification on order for Haldol.
- On 5/25/2025 at 9:15 am, the facility received a new order for Haloperidol (Haldol) 0.5 mg to be given by mouth every 6 hours routine and every 4 hours as needed. Ativan 0.5 mg may be given every 4 hours as needed. May crush Haloperidol (Haldol) and mix with Morphine. May crush Haloperidol (Haldol) and slurry in 0.25-0.5 ml of water. The AR was notified.

- On 5/25/2025, Resident A refused administration of Timolol Mal 0.5% eye drops, Prostat S.f., and Lidocaine 4% patch. Resident A did not eat breakfast.
- On 5/25/2025 at 9:45 am, the facility received new orders to discontinue all medications except Ativan, Haloperidol, and Morphine. Continue current dosing and schedule of Haloperidol. Continue PRN (as needed) dosing of Ativan and Morphine. Give Morphine 5 mg and Ativan 0.5 mg every 4 hours routinely and continue PRN Morphine and Ativan. Discontinue supplemental drinks and blood sugar checks. The AR was notified.
- On 5/25/2025 at 10:30 am, family requesting Resident A be transferred to inpatient hospice facility.
- On 5/25/2025 at 12:45 pm, Resident A transferred to hospice inpatient facility and all medications signed for and sent with the AR.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	It was alleged Resident A was not administered medication in accordance with physician orders. Interviews, on-site investigation, and review of documentation reveal the facility communicated consistently with Resident A's physician, hospice team, and the authorized representative to ensure correct and appropriate medication administration throughout Resident A's demonstrated decline in health. However, review of the medication administration record documentation revealed that on 5/12/2025, Resident A was observed by facility staff with Lidocaine 4% patch on from previous day. Facility staff did not follow physician orders because the Lidocaine 4% patch was to be applied to the affected area (back) and to be removed after 12 hours and left off for 12 hours. Due to this medication administration error, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remains the same.



6/24/2025

Julie Viviano Date
Licensing Staff

Approved By:

07/31/2025

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section