GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 4, 2026

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

RE: License #: AL820007645
Investigation #: 2026A0993007
Stallworth AFC

Dear Ms. Draughn:

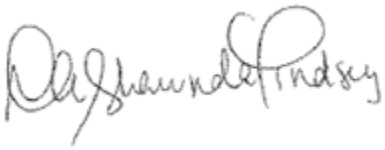
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- 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 (313) 456-0380.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820007645
Investigation #:	2026A0993007
Complaint Receipt Date:	03/31/2026
Investigation Initiation Date:	03/31/2026
Report Due Date:	04/30/2026
Licensee Name:	Stallworth AFC 1 Corporation
Licensee Address:	645 E Grand Blvd. Detroit, MI 48207
Licensee Telephone #:	(313) 955-3950
Administrator:	Davina Draughn
Licensee Designee:	Davina Draughn
Name of Facility:	Stallworth AFC
Facility Address:	651 E Grand Boulevard Detroit, MI 48207
Facility Telephone #:	(313) 469-7183
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	06/21/2024
Expiration Date:	06/20/2026
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Staff are often under the influence of drugs or alcohol.	No
The owner is being aggressive towards a resident and attempting to evict the resident due to a disagreement.	No
There is a bed bug infestation in the facility.	No
There is not enough food in the facility.	No
Medications are not administered properly.	Yes

III. METHODOLOGY

03/31/2026	Special Investigation Intake 2026A0993007
03/31/2026	Referral - Recipient Rights Forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights
03/31/2026	Contact - Telephone call made Telephone call made to complainant. Mailbox was full. Sent a text message to request a callback.
03/31/2026	APS Referral Forwarded allegations to Adult Protective Services (APS)
03/31/2026	Special Investigation Initiated - Telephone Telephone call made to DWIHN recipient rights officer Frank Lewis
04/03/2026	Inspection Completed On-site Conducted an unannounced onsite investigation with DWIHN recipient rights officer Frankie Lewis. We interviewed staff Tyann Shelton as well as Resident A, Resident B, Resident C, and Resident D. I also interviewed compliance manager Belinda Lewis.
04/08/2026	Contact - Telephone call made Telephone call made to licensee designee Davina Draughn
04/08/2026	Contact - Telephone call made

	Telephone call made to staff Latoya Johnson. Sent a text message.
04/08/2026	Contact - Telephone call made Telephone call made to staff Christina Abbott
04/08/2026	Contact - Telephone call made Telephone call made to staff Tamira White. Left a message.
04/08/2026	Contact - Telephone call made Telephone call made to staff Brian Cornelius. Left a message.
04/08/2026	Contact - Telephone call made Telephone call made to staff Brittany Clayton
04/15/2026	Contact - Telephone call made Telephone call made to licensee designee Davina Draughn
04/16/2026	Contact - Document Received Received documentation
04/17/2026	Contact - Telephone call made Telephone call made to maintenance staff John Denham
04/20/2026	Exit Conference Held with licensee designee Davina Draughn
04/21/2026	Contact - Telephone call made Telephone call made to case manager A1. Left a message.
04/21/2026	Contact - Telephone call made Telephone call made to case manager G1
04/22/2026	Contact - Telephone call made Telephone call made to case manager A1. Left a message.
04/22/2026	Contact - Telephone call made Telephone call made to case manager B1, case manager C1, case manager D1, case manager E1, and case manager F1. Left a message.
04/23/2026	Contact - Telephone call received Telephone call received from case manager B1, case manager C1, case manager D1, case manager E1, and case manager F1
04/24/2026	Contact - Telephone call made

	Telephone call made to case manager A1
05/01/2026	Contact - Telephone call received Telephone call received from owner Anthony Lawton
05/01/2026	Exit Conference Held with licensee designee Davina Draughn

ALLEGATION:

Staff are often under the influence of drugs or alcohol.

INVESTIGATION:

On 03/31/2026, I received allegations from Licensing and Regulatory Affairs (LARA) Bureau of Community Health Systems (BCHS) Online Complaints.

On 03/31/2026, I forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights.

On 03/31/2026, I contacted the complainant with no success. I sent a text message to request a callback.

On 03/31/2026, I forwarded allegations to Adult Protective Services (APS).

On 03/31/2026, I conducted a telephone interview with DWIHN recipient rights officer Frankie Lewis. He confirmed he is investigating the allegations. He recently conducted an onsite investigation and interviewed staff Nikole Pearson and compliance manager Belinda Lewis. Mr. Lewis stated they did not appear to be under the influence of drugs or alcohol.

On 04/03/2026, Mr. Lewis and I conducted an unannounced onsite investigation. We interviewed staff Tyann Shelton as well as Resident A, Resident B, Resident C, and Resident D. Resident E did not wish to be interviewed. Resident F left to go to the day program prior to being interviewed. Resident G was already at the day program.

In separate interviews, Ms. Shelton as well as Resident B, Resident C, and Resident D denied that staff are under the influence of drugs or alcohol while working in the facility. Resident A stated staff Felicia (last name not provided) and Mary (last name not provided) were under the influence of drugs or alcohol, but they no longer work in the facility. Resident A did not provide the date(s) of these incidents.

I interviewed compliance manager Belinda Lewis as well. Ms. Lewis denied that staff are under the influence of drugs or alcohol.

At the time of the onsite investigation, Ms. Shelton and Ms. Lewis did not appear to be under the influence of drugs or alcohol.

On 04/08/2026, I conducted a telephone interview with licensee designee Davina Draughn. Ms. Draughn denied staff are under the influence of drugs or alcohol while working in the facility.

On 04/08/2026, I conducted a telephone interview with staff Christina Abbott. Ms. Abbott denied staff are under the influence of drugs or alcohol while working in the facility.

On 04/08/2026, I conducted a telephone interview with staff Brittany Clayton. Ms. Clayton denied staff are under the influence of drugs and alcohol while working in the facility.

On 04/21/2026, I conducted a telephone interview with case manager G1. She denied knowledge of staff being under the influence of drugs or alcohol while working in the facility.

On 04/23/2026, I conducted a telephone interview with case manager B1, case manager C1, case manager D1, case manager E1, and case manager F1. He denied knowledge of staff being under the influence of drugs or alcohol while working in the facility.

On 04/24/2026, I conducted a telephone interview with case manager A1. She denied knowledge of staff being under the influence of drugs or alcohol while working in the facility.

On 05/01/2026, I conducted a telephone interview with owner Anthony Lawton. He stated there was an incident about one and a half years ago where a female staff was at the facility while under the influence of drugs or alcohol. Mr. Lawton could not recall the name of the staff. That staff was terminated immediately. He stated there have not been any other incidents involving staff being under the influence of drugs or alcohol while working in the facility.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	I interviewed several staff, residents, and case managers who denied that staff are under the influence of drugs and alcohol while working in the facility. Mr. Lawton stated about one and a

	half years ago, a staff was terminated due to being under the influence of drugs or alcohol. He stated there have not been any other incidents involving staff being under the influence of drugs or alcohol while working in the facility. On 03/31/2026, DWIHN recipient rights Frankie Lewis stated he recently conducted an onsite investigation, and Ms. Pearson and Ms. Lewis did not appear to be under the influence of drugs or alcohol. On 04/03/2026, Mr. Lewis and I conducted an unannounced onsite investigation, and Ms. Shelton and Ms. Lewis did not appear to be under the influence of drugs or alcohol. Evidence does not support staff are not capable of meeting the physical, emotional, intellectual, and social needs of each resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The owner is being aggressive towards a resident and attempting to evict the resident due to a disagreement.

INVESTIGATION:

On 04/03/2026, Mr. Lewis and I conducted an unannounced onsite investigation. We interviewed staff Tyann Shelton as well as Resident A, Resident B, Resident C, and Resident D.

Ms. Shelton stated the owner of the facility is Anthony (last name not provided). The administrator is Davina Draughn. Ms. Shelton denied ever seeing the owner or Ms. Draughn being aggressive towards any of the residents or trying to evict a resident due to a disagreement.

Resident A stated the owner is John Denham, and Mr. Denham has been aggressive towards him. Mr. Denham told him that he must move out of the facility due to Resident A not allowing him to be involved in a conversation with the social security administration.

Resident B stated the owner of the facility is Stallworth. Resident B denied that Stallworth has been aggressive towards him or any of the residents. Resident B stated that Mr. Denham threatened to evict Resident A from the facility. Police came to the facility one day. Resident B was unsure about the details surrounding that incident.

Resident C stated he did not know who the owner of the facility was. He denied any knowledge of staff or management being aggressive towards a resident or attempting to evict a resident due to a disagreement.

Resident D stated he believed Mr. Denham was the owner of the facility. Resident D denied seeing Mr. Denham, staff or management being aggressive towards a resident or trying to evict a resident due to a disagreement.

I interviewed compliance manager Belinda Lewis as well. Ms. Lewis stated the owner of the facility is Anthony (last name unknown). Mr. Denham does maintenance. Ms. Draughn issues discharge notices. Ms. Lewis denied observing Mr. Denham or Ms. Draughn being aggressive towards a resident or trying to evict a resident due to a disagreement. Ms. Lewis stated Resident A was issued a discharge notice due to breaking tvs, punching holes in the walls, etc.

On 04/08/2026, I conducted a telephone interview with licensee designee Davina Draughn. Ms. Draughn denied that staff or management are being aggressive towards a resident or trying to evict a resident due to a disagreement.

On 04/08/2026, I conducted a telephone interview with staff Christina Abbott. Ms. Abbott denied knowledge of the owner being aggressive towards a resident or trying to evict a resident due to a disagreement.

On 04/08/2026, I conducted a telephone interview with staff Brittany Clayton. Ms. Clayton stated Resident A was issued a discharge notice due to destroying property, punching holes in the walls, throwing a phone and breaking a window, etc. Ms. Draughn issued Resident A a discharge notice. Ms. Clayton denied observing Ms. Draughn being aggressive towards any resident or trying to evict a resident due to a disagreement.

On 04/15/2026, I received a copy of an emergency discharge notice issued to Resident A. The notice was issued on 03/30/2026 due to destruction of property.

On 04/16/2026, I conducted a telephone interview with maintenance staff John Denham. Mr. Denham denied being the owner of the facility. He denied being aggressive towards a resident or trying to evict a resident due to a disagreement.

On 04/21/2026, I conducted a telephone interview with case manager G1. She denied knowledge of the owner being aggressive towards a resident or trying to evict a resident due to a disagreement.

On 04/23/2026, I conducted a telephone interview with case manager B1, case manager C1, case manager D1, case manager E1, and case manager F1. He denied knowledge of the owner being aggressive towards a resident or trying to evict a resident due to a disagreement.

On 04/24/2026, I conducted a telephone interview with case manager A1. She stated Resident A told her Mr. Denham got aggressive with him while they were on a telephone call with the social security administration. Resident A acknowledged he received an eviction notice after breaking a window in the facility three times.

On 05/01/2026, I conducted a telephone interview with owner Anthony Lawton. Mr. Lawton denied that he or any other staff have been aggressive towards a resident. In addition, he denied that he or any other staff have threatened to evict a resident due to a disagreement.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility 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.** **(iv) Threats.**
ANALYSIS:	I interviewed several staff, residents, residents and the owner who denied that staff or management have been aggressive towards a resident. Evidence does not support the licensee, staff, volunteers or any person living in the facility subjected a resident to mental or emotional cruelty, verbal abuse, derogatory remarks or threats.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(5) The licensee may discharge a resident before the 30-day notice when it has been documented that there is a substantial risk or occurrence of any of the following: **(e) Destruction of property.**
ANALYSIS:	I interviewed several staff and residents who denied that staff or management tried to evict a resident due to a disagreement. Resident A was issued an emergency discharge notice on 03/30/2026 due to destruction of property. Per licensing rules, a licensee may discharge a resident before the 30-day notice

	when it has been documented that there is destruction of property.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is a bed bug infestation in the facility.

INVESTIGATION:

On 04/03/2026, Mr. Lewis and I conducted an unannounced onsite investigation. We interviewed staff Tyann Shelton as well as Resident A, Resident B, Resident C, and Resident D.

Ms. Shelton denied seeing bed bugs in the facility. She stated there is a company that comes out monthly to spray the facility. Ms. Shelton did not know the name of the company.

Resident A stated he was bit by a bed bug on 03/31/2026. He left his window open afterwards and has not seen a bed bug since. Resident A stated that someone used to come out consistently to spray the facility, but now someone only comes out once a month, if that.

Resident B stated there used to be bed bugs in the facility. He has not seen a bed bug in about two months.

In separate interviews, Resident C and Resident D denied seeing bed bugs in the facility.

I interviewed compliance manager Belinda Lewis as well. Ms. Lewis confirmed the facility used to have bed bugs. The bed bugs came from the STEP program. The facility is treated for bed bugs two to three times per month. Ms. Lewis stated the facility was treated today.

During the onsite investigation, I inspected the kitchen, living room, dining room, bathrooms as well as the residents' bedrooms. I observed three tiny bedbugs in Resident G's bed. I did not observe bed bugs in the other inspected areas of the facility.

On 04/08/2026, I conducted a telephone interview with licensee designee Davina Draughn. Ms. Draughn denied there is a bed bug infestation in the facility. She stated a company comes out to the facility every two weeks to spray. In addition, staff vacuums daily. Residents are asked to put their clothes in the dryer when they return from the STEP program. These measures were put in place to stop the spread of bed bugs in the facility.

On 04/08/2026, I conducted a telephone interview with staff Christina Abbott. Ms. Abbott denied seeing bed bugs in the facility.

On 04/08/2026, I conducted a telephone interview with staff Brittany Clayton. Ms. Clayton denied seeing bed bugs in the facility.

On 04/16/2026, I received Terry's Exterminating Service receipts. The facility was treated for bed bugs on 01/09/2026, 02/07/2026 and 03/06/2026.

On 04/21/2026, I conducted a telephone interview with case manager G1. She denied knowledge of a bed bug infestation in the facility.

On 04/23/2026, I conducted a telephone interview with case manager B1, case manager C1, case manager D1, case manager E1, and case manager F1. He denied knowledge of a bed bug infestation in the facility.

On 04/24/2026, I conducted a telephone interview with case manager A1. She denied knowledge of a bed bug infestation in the facility.

On 05/01/2026, I conducted a telephone interview with owner Anthony Lawton. He denied that there is a bed bug infestation in the facility. Per Mr. Lawton, the facility is treated for bed bugs monthly.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of residents.
ANALYSIS:	During the onsite investigation, I inspected the kitchen, living room, dining room, bathrooms as well as the residents' bedrooms. I observed three tiny bedbugs in Resident E's bed. I did not observe bed bugs in the other inspected areas of the facility. The facility was treated on 01/09/2026, 02/07/2026 and 03/06/2026 by Terry's Exterminating Service. Evidence supports an insect, rodent or pest control program is maintained and carried out in a manner that continually protects the health of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is not enough food in the facility.

INVESTIGATION:

On 04/03/2026, Mr. Lewis and I conducted an unannounced onsite investigation. We interviewed staff Tyann Shelton as well as Resident A, Resident B, Resident C, and Resident D.

Ms. Shelton stated there is enough food in the facility. If residents asked for more food, they would be given more food. Ms. Shelton stated staff go grocery shopping every Saturday.

In separate interviews, Resident B, Resident C and Resident D stated there is enough food in the facility.

Resident A stated there is enough food in the facility, but the residents are not given enough food to eat. Residents are hungry and are not given more food if they ask for more.

I interviewed compliance manager Belinda Lewis as well. Ms. Lewis stated there is enough food in the facility.

During the onsite investigation, I observed the food supply. I observed an adequate amount of food in the facility. I also observed the menu. There was a meal listed for breakfast, lunch and dinner. The ingredients needed to make the meals listed on the menu were observed in the facility.

On 04/08/2026, I conducted a telephone interview with licensee designee Davina Draughn. Ms. Draughn stated there is enough food in the facility. Staff go grocery shopping weekly.

On 04/08/2026, I conducted a telephone interview with staff Christina Abbott. Ms. Abbott stated there is enough food in the facility.

On 04/08/2026, I conducted a telephone interview with staff Brittany Clayton. Ms. Clayton stated there is enough food in the facility, but sometimes residents may have to be given substitutions. For instance, if there are no more chicken wings, residents will be given chicken leg quarters.

On 04/21/2026, I conducted a telephone interview with case manager G1. She denied knowledge of there not being enough food in the facility.

On 04/23/2026, I conducted a telephone interview with case manager B1, case manager C1, case manager D1, case manager E1, and case manager F1. He denied knowledge of there not being enough food in the facility.

On 04/24/2026, I conducted a telephone interview with case manager A1. She stated Resident A has mentioned to her that there is not enough food in the facility.

On 05/01/2026, I conducted a telephone interview with owner Anthony Lawton. He stated there is enough food in the facility. Staff go grocery shopping monthly.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	I interviewed several staff and residents as well as the owner. They stated there is enough food in the facility. I also interviewed case managers who denied knowledge of there not being enough food in the facility. During the onsite investigation, I observed the food supply. I observed an adequate amount of food in the facility. I also observed the menu. There was a meal listed for breakfast, lunch and dinner. The ingredients needed to make the meals listed on the menu were observed in the facility. Evidence supports that the residents are provided with a minimum of 3 nutritious meals.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications are not administered properly.

INVESTIGATION:

On 04/03/2026, Mr. Lewis and I conducted an unannounced onsite investigation. We interviewed staff Tyann Shelton as well as Resident A, Resident B, Resident C, and Resident D.

Ms. Shelton stated staff administered medications as prescribed. She confirmed she completed medication administration training.

Resident A stated staff are inconsistent with administering him his medications. He believes staff are intentionally withholding his medications from him. Sometimes, staff give him his medications at night when he is supposed to get them in the morning.

In separate interviews, Resident B, Resident C, and Resident D stated they are receiving their medications as prescribed.

During the onsite investigation, I reviewed the residents' medications and medication administration records (MAR). I observed the following errors:

Resident A:

- Staff prematurely initialed the MAR to show administration of Mirtazapine 30mg on 04/03/2026 at 8pm.

Resident B:

- Staff did not initial the MAR to show Chlorhexidine Glu 0.12% Sol and Polyethylene Glycol 3350 17gm/scoop from 04/01/2026 to 04/03/2026 at 8am.
- Staff prematurely initialed the MAR to show administration of Benztropine Mes 1mg, Risperidone 2mg and Trazodone HCL 100mg on 04/03/2026 at 8pm.

Resident C:

- Staff prematurely initialed the MAR to show administration of Banophen 25mg, Metformin 1,000mg, Pharma Ch Alcohol 70% Sq. and Simvastatin 20mg on 04/03/2026 at 8pm.
- Staff initialed the MAR to show administration of Omeprazole 20mg on 04/01/2026 and 04/02/2026 at 8am, but no pills were missing from the bubble pack.
- Staff did not initial the MAR to show administration of Omeprazole 20mg on 04/03/2026 at 8am.

Resident D:

- Staff prematurely initialed the MAR to show administration of Quetiapine Fum 200mg on 04/03/2026 at 8pm.

Resident E:

- Staff prematurely initialed the MAR to show administration of Atorvastatin Calcium 40mg, Haloperidol 10mg, and Trazadone HCL 50mg on 04/03/2026 at 8pm.

Resident G:

- Staff prematurely initialed the MAR to show administration of Atorvastatin Calcium 40mg on 04/03/2026 at 8pm.
- Staff did not initial the MAR to show administration of Carvedilol 3.125mg on 04/02/2026 at 8pm.
- Staff did not initial the MAR to show administration of HCTZ/Losartan 12.5mg/50mg from 04/01/2026 to 04/03/2026 at 8am.

On 04/08/2026, I conducted a telephone interview with licensee designee Davina Draughn. Ms. Draughn stated staff administered medications as prescribed. All staff who administered medications have been trained to do so.

On 04/08/2026, I conducted a telephone interview with staff Christina Abbott. Ms. Abbott stated she does not have know if all staff have been trained to administer medications. She has only worked in the facility for 30 days.

On 04/08/2026, I conducted a telephone interview with staff Brittany Clayton. Ms. Clayton stated staff administered medications as prescribed. All staff who administered medications have been trained to do so.

On 04/20/2026, I contacted licensee designee Davina Draughn and conducted an exit conference. I informed her of the findings. Ms. Draughn stated she has repeatedly instructed staff to only initial the MAR when they administer the medications. The facility is upgrading their medication administration system. This should prevent future medication administration errors. Ms. Draughn agreed to review the report and support a corrective action plan.

On 04/21/2026, I conducted a telephone interview with case manager G1. She denied knowledge of staff not administering medications as prescribed.

On 04/23/2026, I conducted a telephone interview with case manager B1, case manager C1, case manager D1, case manager E1, and case manager F1. He denied knowledge of staff not administering medications as prescribed.

On 04/24/2026, I conducted a telephone interview with case manager A1. She stated Resident A stated that he does not always receive his medications as prescribed.

On 05/01/2026, I conducted a telephone interview with owner Anthony Lawton. He stated staff administered medications as prescribed. All staff who administered medications have been trained to do so.

05/01/2026, I conducted a follow-up exit conference with licensee designee Davina Draughn. I informed her there is no change in the department's recommendation.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	I reviewed the residents' medications and MARs. Staff did not initial Resident B's MAR to show Chlorhexidine Glu 0.12% Sol and Polyethylene Glycol 3350 17gm/scoop from 04/01/2026 to 04/03/2026 at 8am. Staff initialed Resident C's MAR to show administration of Omeprazole 20mg on 04/01/2026 and 04/02/2026 at 8am, but

	no pills were missing from the bubble pack. Staff did not initial the Resident C's MAR to show administration of Omeprazole 20mg on 04/03/2026 at 8am. Staff did not initial Resident G's MAR to show administration of Carvedilol 3.125mg on 04/02/2026 at 8pm. Staff did not initial Resident G's MAR to show administration of HCTZ/Losartan 12.5mg/50mg from 04/01/2026 to 04/03/2026 at 8am. Evidence supports that medications were not given, taken, or applied prescribed, ordered, or directed by an appropriately licensed health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(v) Initials of the individual who administered the medication at the time given.**
ANALYSIS:	I reviewed the residents' medications and MARs. Staff prematurely initialed Resident A's MAR to show administration of Mirtazapine 30mg on 04/03/2026 at 8pm. Staff prematurely initialed Resident B's MAR to show administration of Benztropine Mes 1mg, Risperidone 2mg and Trazodone HCL 100mg on 04/03/2026 at 8pm. Staff prematurely initialed Resident C's MAR to show administration of Banophen 25mg, Metformin 1,000mg, Pharma Ch Alcohol 70% Sq. and Simvastatin 20mg on 04/03/2026 at 8pm. Staff prematurely initialed Resident D's MAR to show administration of Quetiapine Fum 200mg on 04/03/2026 at 8pm. Staff prematurely initialed Resident E's MAR to show administration of Atorvastatin Calcium 40mg, Haloperidol 10mg, and Trazadone HCL 50mg on 04/03/2026 at 8pm.

	Staff prematurely initialed Resident G's MAR to show administration of Atorvastatin Calcium 40mg on 04/03/2026 at 8pm. Evidence supports that staff did not initial the MAR at the time the medication was administrated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED.** Licensing Study Report, 06/05/2024, CAP 06/18/2024.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action, I recommend no change in the license status.

05/04/2026

_____

DaShawnda Lindsey Date
Licensing Consultant

Approved By:

05/04/2026

_____

Ardra Hunter Date
Area Manager