GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 17, 2021

Sunil Bhattad
Drake Wood Manor Inc
1040 S. State Road
Davison, MI 48423

RE: License #: AL630280923
Investigation #: 2021A0991021
Caremore Assisted Living

Dear Mr. Bhattad:

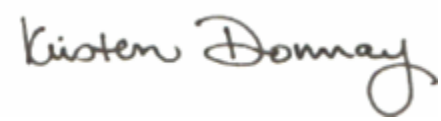
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630280923
Investigation #:	2021A0991021
Complaint Receipt Date:	04/23/2021
Investigation Initiation Date:	04/23/2021
Report Due Date:	06/22/2021
Licensee Name:	Drake Wood Manor Inc
Licensee Address:	1040 S. State Road Davison, MI 48423
Licensee Telephone #:	(248)797-8519
Licensee Designee:	Sunil Bhattad
Name of Facility:	Caremore Assisted Living
Facility Address:	4353 W. Walton Blvd. Waterford, MI 48329
Facility Telephone #:	(248) 674-2658
Original Issuance Date:	08/21/2006
License Status:	REGULAR
Effective Date:	03/19/2020
Expiration Date:	03/18/2022
Capacity:	18
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The home is understaffed, and two residents fell under the assistant manager's watch.	No
Staff, Akilah Halliburton, is mean to the residents. She yanks the residents up by their arms and throws them around.	No
One of the residents has sores under her breasts and staff are not treating the sores appropriately.	No
In February, staff reported to management that a resident was not feeling well and was crying in pain. The manager told staff that "she is just being dramatic" and told staff not to call 911. The resident passed away the following day.	No
Additional Findings	Yes

III. METHODOLOGY

04/23/2021	Special Investigation Intake 2021A0991021
04/23/2021	Special Investigation Initiated - Telephone Call to Adult Protective Services (APS) worker, Ra'Shawnda Robertson
04/23/2021	APS Referral Referral received from adult protective services (APS)
04/26/2021	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and residents
04/29/2021	Contact - Telephone call made Left message for direct care worker, Erica Schloss
04/29/2021	Contact - Telephone call made Left message for direct care worker, Akilah Halliburton
05/13/2021	Contact - Telephone call made Left message for Resident G's guardian

05/13/2021	Contact - Telephone call made Left message for direct care worker, Angela Horton
05/13/2021	Contact - Telephone call made To Akilah Halliburton- phone number not in service
06/15/2021	Contact - Telephone call made Interviewed home manager, Amanda D'Amore
06/15/2021	Contact - Telephone call made Interviewed direct care worker, Maria Bishop
06/15/2021	Contact - Telephone call made To Akilah Halliburton- phone number not in service
06/15/2021	Contact - Telephone call made Left message for direct care worker, Angela Horton
06/15/2021	Contact - Telephone call made Left message for APS worker- received return email- not substantiating allegations
06/16/2021	Inspection Completed On-site Interviewed home manager and received documentation
06/16/2021	Contact - Document Received Assessment plans, medication administration records, staff logs
06/16/2021	Contact - Telephone call made To Akilah Halliburton - new phone number from home manager, not in service
06/17/2021	Exit Conference Via telephone with licensee designee, Sunil Bhattad

ALLEGATION:

The home is understaffed, and two residents fell under the assistant manager's watch.

INVESTIGATION:

On 04/23/21, I received a complaint from Adult Protective Services (APS) alleging that Caremore Assisted Living is understaffed and two residents fell under the assistant

manager's watch. I initiated my investigation on 04/23/21 by contacting the assigned APS worker, Ra'Shawnda Robertson.

On 04/26/21, I conducted an unannounced onsite inspection and interviewed the assistant home manager, Kaitlynn O'Hara and direct care worker, Autumn Potter. Ms. O'Hara indicated that she was not on shift when Resident A or Resident B fell. Resident A fell on 04/09/21. Resident A has diabetes and sometimes gets dizzy. She was in the front living room area when she fell. There were two staff on shift when Resident A fell. Resident A is very independent and ambulates on her own. She uses a four-wheeled walker. Resident A was transported to the hospital after she fell. She returned to the home and started physical therapy. Ms. O'Hara indicated that she did not believe there was anything staff could have done differently to prevent Resident A from falling.
Ms. O'Hara indicated that Resident B fell on 04/16/21 during the midnight shift. He was getting up to got to the bathroom when he fell. Prior to falling, Resident B was very independent and did not require staff assistance to go to the bathroom. Resident B was transported to the hospital after his fall and had surgery, as he broke his hip. Ms. O'Hara stated that there was one staff working the midnight shift when Resident B fell. Ms. O'Hara indicated that there are typically one or two staff scheduled per shift. The home currently has seven residents, so one staff person can meet the needs of the residents. Ms. O'Hara indicated that three of the residents require assistance with toileting, Resident B, Resident C, and Resident E. One staff person can assist them with toileting.

On 04/26/21, I interviewed direct care worker, Autumn Potter. Ms. Potter indicated that she is new to the home and is still in the process of being trained. There are always two staff on shift when she is working in the home. Ms. Potter stated that she was previously a hospice aid and visited the home to work with residents who were receiving hospice services. She stated that there were always two staff on shift when she visited the home. Ms. Potter indicated that three residents require assistance with toileting. She stated that Resident C requires two people to assist with transferring.

Ms. O'Hara provided copies of the incident reports that were completed regarding Resident A and Resident B's falls. The incident report indicates that on 04/09/21 at 11:50am, Resident A was walking to the table when she lost her balance and fell. She hit the right side of her head, arm, and leg. Resident A stated that she was dizzy and lost consciousness for a few seconds. She started sweating when she regained consciousness. Staff called 911 and Resident A was transported to the hospital. The incident report notes that Amanda D'Amore and Tita Cowart were on shift when Resident A fell.

An incident report dated 04/16/21 at 1:34am indicates that Resident B was in the bathroom when he lost his balance and fell. Resident B fell on his left side. He stated that his left elbow and left hip hurt. Staff put a bandage on Resident B's elbow and called Resident B's son to transport him to the hospital. The incident report notes that staff, Maria Bishop, was working at the time of Resident B's fall.

I reviewed a copy of Resident A's assessment plan dated 02/01/21. It indicates that she has increased confusion and utilizes a walker for mobility. She requires staff assistance for bathing, dressing, and personal hygiene, as well as reminders to use the bathroom. The assessment plan does not indicate that she requires staff assistance while ambulating.

I reviewed a copy of Resident B's assessment plan dated 04/27/20. It indicates that Resident B requires assistance for bathing, dressing, and personal hygiene. It does not indicate that Resident B requires staff assistance while ambulating.

During the onsite inspection, I interviewed Resident B, Resident C, Resident D, Resident E, and Resident F. Resident B stated that he did not recall falling. He had a difficult time answering questions due to limited cognitive and verbal abilities. Resident F stated that the staff in the facility take good care of her. She could not provide any additional information. Resident D stated that she did not have concerns about the home or the staff. She stated that there are enough staff on shift and they take good care of the residents. Resident E stated that she did not have any concerns about the home. She stated that the staff are very good. She has lived in a lot of different facilities and she feels that the staff at Caremore do a very good job. There are times when there is only one staff person on shift. It seems difficult for one staff person to do everything when they are required to cook, clean, and assist the residents, but staff are able to prioritize, and Resident E did not think it negatively affects anyone.

On 06/15/21, I interviewed the home manager, Amanda D'Amore, via telephone. Ms. D'Amore stated that there are currently seven residents living in the facility, but one is hospitalized at this time. They typically have one or two staff per shift due to having fewer residents in the home. The shifts are from 7:00am-3:00pm, 10:00am-6:00pm, 3:00pm-11:00pm, and 11:00pm-7:00am, so there is some overlap in the shifts. Ms. D'Amore indicated that none of the residents in the home require a two person assist for transferring. Resident C can be somewhat difficult to transfer depending on her mood or how she is feeling. She will sometimes stand and pivot transfer or staff can use a Hoyer lift. One staff person can safely transfer Resident C. Ms. D'Amore indicated that she was working with Tita Cowan when Resident A fell on 04/09/21. Ms. Cowan no longer works at the facility. Ms. D'Amore indicated that Resident A was able to walk on her own using a walker prior to her fall. Resident A was walking to the table when she lost her footing and fell. Ms. D'Amore was in the same room as Resident A when Resident A fell. She did not feel that she could have prevented the fall. Ms. D'Amore indicated that Maria Bishop was working when Resident B fell on 04/16/21, Resident B did not require staff assistance with ambulating at the time of his fall. He fell when he got up to use the bathroom at night.

On 06/15/21, I interviewed direct care worker, Maria Bishop, via telephone. Ms. Bishop indicated that she works the midnight shift and she typically works alone. She stated that she was working when Resident B fell in the bathroom. Resident B's bedroom was downstairs at the time and Ms. Bishop was upstairs cleaning. Resident B got up to use the bathroom and fell. Prior to falling, Resident B was able to walk on his own and did

not require assistance to walk to the bathroom. Ms. Bishop contacted Resident B's son and he was transported to the hospital. Upon returning to the home, Resident B's bedroom was moved upstairs. Ms. Bishop stated that it is difficult for one staff person to supervise all of the residents in the home. She indicated that the kitchen is located downstairs, so if staff are preparing a meal, it is difficult to supervise the residents upstairs. She stated that she practices fire drills during the midnight shift and it typically takes about five or six minutes to evacuate the residents.

I conducted an onsite inspection on 06/16/21. I observed two staff on shift. I reviewed the assessment plans for the seven residents in the home. None of the assessment plans indicated that anyone required a two person assist with transferring or that anyone required hands on assistance with ambulating. I reviewed copies of the facility's fire drills for 2021. The drills indicate that it takes from 3-5 minutes to evacuate the residents. It took 5 minutes to evacuate with one staff on shift during the midnight shift.

On 06/17/21, I interviewed the licensee designee, Sunil Bhattad, via telephone. Mr. Bhattad indicated that they are in the process of hiring additional staff for the home. He indicated that he would continue to monitor and adjust the staffing ratio if more residents are admitted to the home. He stated that he is trying to get an additional staff person to work during the daytime shifts and focus more on meal preparation while the other staff person monitors the residents.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that the home does not have sufficient staff on duty to attend to the protection and safety of the residents. Resident A and Resident B did have falls at the facility; however, prior to falling they were able to ambulate independently and did not require staff assistance. The facility has one or two staff on shift with seven residents in care. None of the assessment plans indicate that the residents require a two person assist or require hands on assistance for ambulating.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff, Akilah Halliburton, is mean to the residents. She yanks the residents up by their arms and throws them around.

INVESTIGATION:

On 04/23/21, I interviewed the Adult Protective Services (APS) worker, Ra'Shawnda Robertson, via telephone. Ms. Robertson indicated that it was alleged that Akilah Halliburton was being aggressive towards Resident C. Ms. Robertson spoke with Resident C and three other residents in the home. They all denied that staff was aggressive towards the residents. None of the residents who were interviewed had concerns about the staff in the home.

On 04/26/21, I interviewed the assistant home manager, Kaitlynn O'Hara. Ms. O'Hara stated that Akilah Halliburton has worked in the home for three or four months. She recently found another job and will no longer be working at the home. Ms. O'Hara stated that she never witnessed Ms. Halliburton being physically or verbally aggressive towards any of the residents. She never saw Ms. Halliburton being mean and none of the residents have ever complained about Ms. Halliburton to Ms. O'Hara. Ms. O'Hara indicated that Resident C loves Ms. Halliburton and has never complained about her. Ms. O'Hara stated that another staff person, Erica Schloss, raised concerns to the home manager about Ms. Halliburton pulling on Resident C's arms. The home manager addressed this issue with Ms. Halliburton. Ms. Schloss no longer works in the home.

On 04/26/21, I interviewed direct care worker, Autumn Potter. Ms. Potter indicated that she was recently hired as a staff person at the home and has not worked shifts with Ms. Halliburton. She did interact with Ms. Halliburton when she was visiting the home as a hospice aide. Ms. Halliburton always seemed very attentive and kind towards the residents. She stated that the residents appear to be well cared for in the home and she did not have any concerns about how the staff treat the residents. None of the residents have ever complained to her about staff mistreating them.

During the onsite inspection, I interviewed Resident B, Resident C, Resident D, Resident E, and Resident F. Resident B was unable to answer questions due to limited cognitive and verbal functioning. Resident C stated that the staff in the home are nice. She did not recall staff grabbing her or pulling her arms. She could not recall a staff person named Akilah. Resident D stated that she never heard or saw staff being mean, yelling, or being physically aggressive towards the residents. She felt the staff take good care of the residents. She never saw any staff person being rough with the residents. Resident E stated that the staff are very good. She never saw any staff person be physically aggressive, demeaning, or rude towards any of the residents. She stated that there is a staff person who works midnights who is naturally loud. She did not know her name. Resident E stated that this staff person is not mean, she is just loud. She never saw any staff person being abusive towards the residents. She stated that staff have

never hurt her. Resident F stated that staff take good care of the residents. She did not have any concerns.

On 06/15/21, I interviewed the home manager, Amanda D'Amore, via telephone. Ms. D'Amore stated that Ms. Halliburton no longer works in the home due to finding a job at another facility. She never had any concerns about Ms. Halliburton and felt she was a great worker. She never saw Ms. Halliburton being verbally or physically aggressive towards any of the residents. She stated that staff, Erica Schloss, brought to her attention that Ms. Halliburton pulled on Resident C's hands to help pull her up and readjust her to sit up more. Ms. D'Amore spoke with Ms. Halliburton about this and informed Ms. Halliburton that she could inadvertently injure the residents by using this technique. Ms. Halliburton was receptive to the correction and stated that she would not do it again. Ms. D'Amore did not feel that Ms. Halliburton was being rough or physically aggressive towards the residents. Resident C did not sustain any injuries.

I attempted to contact Ms. Schloss and Ms. Halliburton, but I did not receive return phone calls. Ms. Halliburton's phone number is no longer in service.

On 06/15/21, I received an email from the assigned APS worker, Ra'Shawnda Roberts. Ms. Roberts indicated that she did not substantiate the allegations.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff, Akilah Halliburton, mistreated the residents. None of the residents or staff who were interviewed witnessed Ms. Halliburton being physically or verbally aggressive towards the residents. Resident C denied that Ms. Halliburton mistreated her.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

One of the residents has sores under her breasts and staff are not treating the sores appropriately.

INVESTIGATION:

On 04/26/21, I interviewed the assistant home manager, Kaitlynn O'Hara. Ms. O'Hara indicated that Resident D has a yeast infection under her breasts. Resident D is overweight and has issues with moisture under her breasts. This is being addressed with Resident D's doctor, who recently visited Resident D. They have tried various creams and powders to address the issue. Resident D is currently prescribed Nystatin powder, which seems to be helping. Ms. O'Hara felt that staff were addressing the issue properly, as they are following the physician's orders.

On 04/26/21, I interviewed Resident D. Resident D stated that she has a bad rash under her breasts. She talked with her doctor about this issue. Staff apply a powder to the area every day, which seems to be helping. Resident D stated that she feels staff are doing what they have to do to help address this issue.

On 06/15/21, I interviewed the home manager, Amanda D'Amore, via telephone. Ms. D'Amore indicated that Resident D was prescribed Nystatin powder two times a day to address the rash under her breasts. Staff tried to help Resident D keep the area dry and applied the powder twice a day, as prescribed. Ms. D'Amore indicated that staff were doing what they were instructed to do by Resident D's physician, and she felt this was being addressed appropriately. Resident D's doctor indicated that this would be an ongoing issue for Resident D.

I reviewed a copy of Resident D's medication administration records, which showed that she was receiving Nystatin powder two times daily. The staff notes on 04/23/21, indicate that the doctor visited with Resident D and stated that the rash under her breasts is going to be an ongoing battle and staff should continue to administer the Nystatin powder twice a day.

APPLICABLE RULE	
R 400.15310	**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: (a) Medications. (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 on my investigation, there is insufficient information to conclude that staff were not properly treating the rash under Resident D's breasts. Resident D's medication records show that staff were applying Nystatin powder twice a day as

	prescribed by the physician to address the rash under Resident D's breasts.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

In February, staff reported to management that a resident was not feeling well and was crying in pain. The manager told staff that "she is just being dramatic" and told staff not to call 911. The resident passed away the following day.

INVESTIGATION:

On 04/26/21, I interviewed the assistant home manager, Kaitlynn O'Hara. Ms. O'Hara indicated that Resident G passed away in February 2021. Resident G suffered from chronic pain, so it was not unusual for her to be complaining about pain. Ms. O'Hara indicated that on the night before Resident G passed away, staff contacted her because Resident G was constipated and was complaining because she could not have a bowel movement. Ms. O'Hara instructed staff to give Resident G her PRN for milk of magnesia. Ms. O'Hara stated that they never discussed calling 911 and she did not say that Resident G was being dramatic. Resident G ended up having a bowel movement the following day and was having diarrhea, so they gave her fluids so she would not get dehydrated. Ms. O'Hara indicated that she was walking by Resident G's room and noticed that she was unconscious. The home manager began CPR and they called 911. The paramedics arrived and continued doing CPR, but Resident G was pronounced dead at the home.

On 06/15/21, I interviewed the home manager, Amanda D'Amore. She stated that Resident G suffered from chronic pain. On the day prior to her death, staff contacted the assistant home manager, Kaitlynn O'Hara because Resident G could not have a bowel movement. Ms. D'Amore instructed Ms. O'Hara to tell staff to pass Resident G's PRN for milk of magnesia. Resident G has a standing medical order to receive milk of magnesia for constipation. Ms. D'Amore denied ever stating that Resident G was being dramatic. She stated that sending Resident G to the hospital was not discussed because the issue was that Resident G was constipated. They typically try milk of magnesia, then a suppository, and then an enema if it is not successful per the standing medical orders. Resident G had a bowel movement the following day. She was having diarrhea, so they gave her fluids. Later that day, they found Resident G unconscious. Ms. D'Amore began CPR until the paramedics arrived. Ms. D'Amore indicated that Erica Schloss and Alicia Castillo were working the shift the evening prior to Resident G passing away. Ms. Schloss and Ms. Castillo no longer work in the home.

I reviewed a copy of the incident report dated 02/16/21 at 12:36pm. It indicates that Resident G has a history of coronary artery disease. While passing by her room, staff noticed that Resident G was on the floor. She was unresponsive. Staff initiated CPR and called 911. The paramedics arrived, but life saving measures were unsuccessful. Resident G's family and the Waterford Police Department were notified. Ms. D'Amore indicated that the police did not investigate Resident G's death. The family did not raise any concerns regarding the circumstances of Resident G's death. I attempted to contact Resident G's guardian, but I did not receive a return phone call.

I reviewed a copy of Resident G's medication administration record (MAR) from February 2021 and the staff notes. The MAR indicates that Resident G received a PRN for milk of magnesia at 8:10pm on 02/15/21 for constipation as well as her PRN for Tramadol due to pain at 8:46pm, 12:26am, and 5:44am. The staff notes entered by direct care worker, Angela Horton, indicate that on 02/15/21, Resident G was having a very bad night. She was yelling in pain and yelling at staff to give her more pain medication. She was up throughout the night crying, but there were no tears. Staff tried to comfort her and talk with her, but it did not help. Staff gave her a Tramadol at 12:00am and Resident G calmed down a little bit. At 2:21am, staff assisted Resident G with changing her brief and bed pad. She was not crying or yelling. At 5:45am, staff noted that Resident G was up again and could not relax. Staff tried to comfort and redirect Resident G, but it did not help. Resident G received another Tramadol at 5:40pm. Ms. D'Amore indicated that it is not unusual for Resident G to be up throughout the night crying. Resident G suffered from chronic pain and would frequently wake up throughout the night and yell or cry. It was not out of the ordinary for Resident G to say that she was in pain.

On 06/17/21, I interviewed the licensee designee, Sunil Bhattad, via telephone. Mr. Bhattad indicated that he was not sure what Resident G's cause of death was, but she had a heart condition. He indicated that the family did not have an autopsy conducted following her death.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff did not obtain needed care immediately following a sudden adverse change in Resident G's condition. Resident G suffers from chronic pain and it was not unusual for her to be up at night crying or complaining about pain. Resident G received PRN medications for constipation and pain on 04/15/21. The home

	manager and assistant home manager both denied stating that Resident G was being dramatic, and they indicated that calling 911 was not discussed with staff, as Resident G's symptoms were not unusual for her. When Resident G was found unresponsive on 04/16/21, 911 was called immediately.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During my investigation, the home manager, Amanda D'Amore indicated that Resident C has a Hoyer lift that is used on an as needed basis for transfers. I reviewed a prescription from Resident C's physician which indicates that staff may use a Hoyer lift as needed. I reviewed a copy of Resident C's assessment plan dated 12/17/20. The assessment plan does not specify the use of a Hoyer lift.

APPLICABLE RULE	
R 400.15306	**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:	Resident C's assessment plan did not specify the use of a Hoyer lift which was prescribed on an as needed basis by her physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my investigation, I reviewed a copy of Resident G's medication administration record (MAR) from February 2021 and her prescription for the PRN Tramadol. The instructions on the prescription state "Tramadol HCL Tab 50mg- take one tablet by mouth twice a day as needed (may crush)". The February 2021 MAR indicates that Resident G received Tramadol on 02/15/21 at 8:46pm and on 02/16/21 at 12:26am, 5:44am, and 5:48am. The home manager, Amanda D'Amore stated that the entry at 5:48am was entered in error. She stated that Resident G could get the pain medication twice a day. According to the MAR, Resident G received Tramadol three times during a time period of less than twelve hours. Ms. D'Amore stated that she did not know how many hours apart the doses should be given. She was unsure if twice a day meant in a 24-hour time period or during waking hours. The prescription did not provide clear guidelines for how the medication should be administered.

On 06/17/21, I conducted an exit conference via telephone with the licensee designee, Sunil Bhattad. Mr. Bhattad indicated that he would submit a corrective action plan to address the violations identified.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4)(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.
ANALYSIS:	Based on my investigation, there is sufficient information to conclude that staff initialed Resident G's medication log in error as they indicated that Tramadol was passed at 5:44am and 5:48am on 02/16/21. The prescription and medication log for Resident G's PRN for Tramadol did not include specific instructions for use or the time frame for administering a second dose.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kristen Donnay 06/17/2021

Kristen Donnay Date
Licensing Consultant

Approved By:

Denise Y. Nunn 06/17/2021

Denise Y. Nunn Date
Area Manager