GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 17, 2021

Ramon Beltran, II
DuNord, Inc
Suite 110
890 North 10th Street
Kalamazoo, MI 49009

RE: License #: AM390259947
Investigation #: 2021A0462044
Beacon Home at River Run

Dear Mr. Beltran, II:

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

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

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

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

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM390259947
Investigation #:	2021A0462044
Complaint Receipt Date:	08/02/2021
Investigation Initiation Date:	08/02/2021
Report Due Date:	10/01/2021
Licensee Name:	DuNord, Inc
Licensee Address:	555 Railroad Street Bangor, MI 49013
Licensee Telephone #:	(269) 344-7972
Administrator:	Navi Kaur
Licensee Designee:	Ramon Beltran, II
Name of Facility:	Beacon Home at River Run
Facility Address:	716 Leenhouts Kalamazoo, MI 49048
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	05/12/2006
License Status:	REGULAR
Effective Date:	01/20/2021
Expiration Date:	01/19/2023
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Home manage Brittany Miller withheld Resident B's personal money as a form of punishment for her negative behavior.	No
Resident B was not allowed to wash her urine soaked clothing for four days.	No
Facility staff members refuse to administer Resident B her prescribed as-needed pain medication.	No
Facility staff members refused to provide Resident B with transportation back to the facility following visits to the emergency room.	Yes
Additional findings.	Yes

III. METHODOLOGY

08/02/2021	Special Investigation Intake 2021A0462044
08/02/2021	Special Investigation Initiated – Email to Complainant.
08/06/2021	Contact- Received additional allegations via the BCHS' online complaint system.
08/10/2021	Contact- Telephone interview with APS Specialist Jessica Mellen. Contact- Requested and received documentation from facility home manager Brittany Miller.
08/12/2021	Unannounced investigation onsite. Face-to-face interviews with Residents A and B, home manager Brittany Miller and assistant home manager Anne Wiley. Contact- Requested and received documentation. Referral to Kalamazoo County ORR made.
08/13/2021	Referral made to Kalamazoo County Office of Recipient Rights. Contact- Face-to-face interview with Recipient Right's Officer Lisa Smith.
09/08/2021	Referral made to Kalamazoo County Office of Recipient Rights.
09/09/2021	Exit conference with licensee designee Ramon Beltran via telephone.

ALLEGATION: Home manage Brittany Miller withheld Resident B's personal money as a form of punishment for her negative behavior.

INVESTIGATION: On the 08/02/2021 the Bureau of Community and Health Systems (BCHS) received this complaint via the BCHS on-line compliant system. According to the written compliant, on an unknown date Resident A requested her personal money from home manager Brittany Miller. When Ms. Miller told Resident A she would need to wait, Resident A "stormed off". The written complaint indicated Ms. Miller told direct care worker (DCW) TaiTiana Walker Resident A would now have to wait longer to receive her personal money.

Via email exchange, I notified Complainant I was assigned to investigate this allegation. According to Complainant, the above information was reported to her. Subsequently, Complainant had no additional information and/or details regarding the allegation, including when the allegation occurred.

On 08/12 I conducted an unannounced investigation at the facility and interviewed Ms. Miller and Resident A separately. According to Ms. Miller, Resident A participated in the facility's voluntary "incentive program." Ms. Miller stated that by voluntarily participating in this program, residents could earn up to .90 a day for completing tasks such as taking their medications as prescribed, participating in their personal hygiene, keeping their bedrooms clean, and working on the personal goals outlined in their community mental health (CMH) treatment plans. According to Ms. Miller, earned "incentive money" was distributed to residents on a weekly basis. Ms. Miller stated Resident A "did well" in the program and often earned close to .90 a day. According to Ms. Miller, Resident A did not entrust her own personal funds to the facility for safekeeping. Subsequently, earned incentive money was the only money facility staff members distributed to Resident A. Ms. Miller denied the allegation. According to Ms. Miller, facility staff members distributed earned incentive money to residents in alphabetic order. Ms. Miller stated she could not recall an occasion when Resident A became upset because she had to wait to receive her incentive money. According to Ms. Miller, TaiTiana Walker was a former employee at the facility. Ms. Miller stated Ms. Walker no longer worked at the facility due to performance concerns.

Resident A denied the allegation. Resident A's statements regarding the facility's voluntary incentive program were consistent with the statements Ms. Miller provided to me. Resident A confirmed she did not entrust her own personal funds to the facility for safekeeping.

APPLICABLE RULE	
R 400.14308	**Resident behavior intervention 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:

	(a) Use any form of punishment.
ANALYSIS:	Based upon my investigation, it has been established Resident A did not entrust personal funds to the facility for safekeeping. Subsequently, earned incentive money was the only money facility staff members distributed to Resident A. Both home manager Brittany Miller and Resident A denied the allegation. It has been established that, other then what was indicated in the written complaint, there is no evidence to substantiate the allegation Ms. Miller withheld Resident B's personal money as a form of punishment for her negative behavior.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident B was not allowed to wash her urine soaked clothing for four days.

INVESTIGATION: On 08/09 Adult Protective Services (APS) forwarded this complaint to the BCHS via the BCHS on-line compliant system. According to the written complaint, on either 08/03 or 08/04 Resident B urinated in her bed. The written compliant indicated facility staff members would not allow Resident B to wash her soiled clothing for four days.

On 08/10 I conducted a telephone interview with APS Specialist Jessica Mellen who informed me she investigated this allegation. According to Ms. Mellen, Resident B reported that at the time she urinated in her bed, she was told it was “too late” to wash her soiled bedding, linens, and clothing. Ms. Mellen stated that according to Resident B, she washed her soiled items “the next day”. In the interim, Resident B reported facility staff members gave her a clean set of linens and a blanket. Subsequently, Ms. Mellen stated there was no evidence to substantiate the allegation.

While at the facility on 08/12, I conducted a separate face-to-face interview with Ms. Miller and Resident B. Ms. Miller denied the allegation. Ms. Miller stated she was not aware Resident B recently urinated in her bed.

Resident B’s statements regarding the allegation were similar to the statements Ms. Mellen provided to me. However, according to Resident B, she was unable to wash her soiled items for two days after she urinated in her bed, as other residents were using the facility’s washer and dryer. Resident B confirmed that while waiting to use the facility’s washer and dryer she was provided with a clean set of linens and blankets. Resident B also stated she had extra clean clothing to wear. According to Resident B, she had no concerns regarding the facility’s provisions for the laundering of her linens, bedding, and personal laundry.

Resident B appeared to be wearing clean clothing at the time of our interview. I inspected Resident B’s mattress, linens, and bedding, which appeared to be clean and in good condition.

APPLICABLE RULE	
R 400.14404	**Laundry.**
	A home shall make adequate provision for the laundering of a resident’s personal laundry.

ANALYSIS:	Based upon my investigation, which consisted of separate interviews with APS Specialist Jessica Mellen, home manager Brittany Miller, and Resident B, it has been established that, other than what was indicated in the written complaint, there is no evidence to substantiate the allegation Resident B was not allowed to wash her urine soaked clothing for four days. Resident B was provided with clean clothing and linens while waiting to use the laundry facilities due to the washer/dryer being used by other residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Facility staff members refuse to administer Resident B her prescribed as-needed pain medication.

INVESTIGATION: On 08/09 APS forwarded this complaint to the BCHS via the BCHS on-line compliant system.

During my telephone interview with Ms. Mellen on 08/10, Ms. Mellen informed me she also investigated this allegation. According to Ms. Mellen, Resident B was prescribed an as-needed pain medication. Ms. Mellen stated that per her review of facility documentation, facility staff members appeared to administer Resident B this medication as prescribed. Subsequently, Ms. Mellen stated there was not enough evidence to substantiate the allegation. Ms. Mellen informed me Resident B made frequent visits to the emergency room (ER) and, due to a substance abuse addiction, was possibly seeking additional pain medication.

During my unannounced investigation on 08/12, I confirmed Resident B was prescribed one Hydrocodone 5mg-Acetaminophen 325mg tablet (substitution for the medication Norco), to be administered up to three times daily, as-needed. I requested and reviewed the physician's order for this medication, a current list of Resident B's prescribed medications, the labeling instructions on the medication bubble pack, and a copy of Resident B's Medication Administration Records (MARs) for July and August 2021. Neither the physician's written order for this medication, the list of Resident B's current medications, the labeling instructions on the medication bubble pack, or documentation on Resident B's July and August MARs indicated what this medication was prescribed for. According to facility staff members' initials on Resident B's July and August MARs, while Resident B was not administered this medication every day, she did receive this medication on a consistent basis. Documentation on the MARs indicated what days Resident B received this medication. However, it did not indicate how many tablets she was administered in a day and at what times she was administered the medication.

During my face-to-face interview with Ms. Miller on 08/12, Ms. Miller confirmed the as-needed medication Hydrocodone 5mg-Acetaminophen 325mg had been prescribed to Resident B for pain. Ms. Miller denied the allegation facility staff

members refused to administer this medication to Resident B as prescribed. Ms. Miller stated that while Resident B had a past history of substance abuse, she did believe Resident B was experiencing pain.

Resident B denied the allegation during my separate face-to-face interview with her on 08/12. Resident B confirmed she was prescribed the as-needed medication Hydrocodone 5mg-Acetaminophen 325mg for significant ongoing pain in her back, hips, and legs. Resident B stated her primary concern was that she did not think facility staff members believed she was experiencing pain. However, according to Resident B, she typically requested her as-needed pain medication one-two times daily and facility staff members had never refused to administer it to her when she requested it. Resident B stated she recently had no choice but to seek medical treatment at the ER due to her uncontrolled pain. I informed Resident B she was prescribed one Hydrocodone 5mg-Acetaminophen 325mg tablet, as-needed, up to three times daily for pain. Subsequently, per the written order, should she continue to feel painful after one to two doses of this medication in a day, she could request a second or third dose. Resident B stated she was aware of this. However, she did not like taking up to three doses of this medication in one day.

While onsite, Ms. Miller provided me with a facility form titled *Daily Controlled Medication Chart*, which documented the administration of Hydrocodone 5mg-Acetaminophen 325mg to Resident B for the month of August so far. Documentation on this form indicated the following:

- On 08/01 Resident B was not administered this medication.
- On 08/02 Resident B was administered one dose of this medication.
- On 08/03 Resident B was administered two doses of this medication.
- On 08/04 Resident B was not administered this medication.
- On 08/05 Resident B was administered one dose of this medication.
- On 08/06 Resident B was administered one dose of this medication.
- On 08/07 Resident B was not administered this medication.
- On 08/08 Resident B administered one dose of this medication.
- On 08/09 Resident B was administered two doses of this medication.
- On 08/10 Resident B was not administered this medication.
- On 08/11 Resident B was not administered this medication.

Ms. Miller and assistant home manager Anne Wiley unsuccessfully attempted to locate the *Daily Controlled Medication Chart* for the month July and both stated they believed the only copy of this form was given to APS Specialist Jessica Mellen on accident.

While onsite, Ms. Miller provided me with a copy of the facility's electronic case notes for Resident B from 07/01 to present. According to documentation in the facility's electronic case notes, at 3:20PM on 07/17 Resident B informed facility staff members she was going to the ER indicating hip pain and an upset stomach. Documentation in the facility's electronic case notes indicated facility staff members

offered Resident B a PRN for pain. However, Resident B declined and stated she wanted to go to the ER.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	It has been established Resident B was prescribed one Hydrocodone 5mg-Acetaminophen 325mg tablet (substitution for the medication Norco), to be administered up to three times daily, as-needed for pain. During separate face-to-face interviews, both home manager Brittany Miller and Resident B denied the allegation. According to Resident B, she typically requested her as-needed pain medication one-two times daily because she did not like taking this medication three times in one day. Documentation on a facility form titled *Daily Controlled Medication Chart* for the month of August 2021, confirmed Resident B's statements. Based upon my investigation, other than what was indicated in the written complaint, there is no evidence to substantiate the allegation facility staff members refused to administer Resident B her prescribed as-needed pain medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Facility staff members failed to provide Resident B with transportation back to the facility following visits to the emergency room.

INVESTIGATION: On 08/09 APS forwarded this complaint to the BCHS via the BCHS on-line compliant system. According to the written complaint, upon Resident B's recent discharge from the ER on an unidentified date, facility staff members refused to provide Resident B with transportation back to the facility. Subsequently, Resident B was forced to seek transportation from friends.

Ms. Mellen informed me during my telephone interview with her on 08/10, she established Resident B made frequent unnecessary visits to the ER. According to Ms. Mellen, Resident B was not legally guarded and was able to access the community independently. Subsequently, according to facility staff members, Resident B was responsible for her own transportation back to the facility from the ER when facility staff members were unable to provide it.

Via email, I requested and received from Ms. Miller a copy of Resident B's written *Resident Care Agreement* (RCA), *Assessment Plan for AFC Residents* (assessment plan), CMH Treatment Plan (TP) and CMH Behavior Assessment Plan (BAP).

During my unannounced investigation at the facility on 08/12, I interviewed Ms. Miller and assistant home manager Anne Wiley regarding this allegation. Both Ms. Miller and Ms. Wiley confirmed Resident B frequently sought medical treatment at the ER. According to Ms. Miller, facility staff members typically provided Resident B with transportation to/from the ER. However, there were a few occasions when there were not enough facility staff members available to provide Resident B with transportation to/from the ER. Ms. Miller confirmed Resident B was not legally guarded and was able to access the community independently. Ms. Miller stated Resident B "signed herself in and out of the facility" and always informed facility staff members when she "needed a ride". Both Ms. Miller and Ms. Wiley were unable to tell me when Resident B last visited the ER. Ms. Miller stated she believed Resident B may have visited the ER once or twice within the last 30 days.

I requested and reviewed Resident B's records of physician's contacts and was able to establish Resident B recently visited the ER at the local hospital Ascension Borgess on 07/10 and 07/17. Documentation on Resident B's ER discharge paperwork indicated that on both occasions, Resident B presented at the ER with complaints of acute hip and lower back pain. According to documentation on Resident B's ER discharge paperwork, on both occasions Resident B was not prescribed any additional medication and/or treatments to address her complaints of pain upon her discharge from the ER.

Resident B confirmed the allegation during my face-to-face interview with her on 08/12. Resident B stated she suffered from significant ongoing pain in her back, hips, and legs that resulted in her seeking medical treatment at the ER on various occasions. Resident B confirmed that on "some" occasions, facility staff members told her that due to a staffing shortage, she needed to find her own transportation back to the facility from the ER. Resident B stated she was "forced" to seek transportation from a friend back to the facility following her visit to the ER on 07/17, as there were no facility staff members available to pick her up.

While onsite, Ms. Miller provided me with a copy of the facility's electronic case notes for Resident B from 07/01 to present. According to documentation in the facility's electronic case notes, at 3:20PM on 07/17 Resident B informed facility staff members she was going to the ER indicating hip pain and an upset stomach. Documentation in the facility's electronic case notes indicated Resident B informed facility staff members her friend was "paying for a Lyft for her to come home" and Resident B returned to the facility by 11:30PM. There was no documentation in the facility's electronic case notes indicating that Resident B requested transportation back to the facility and/or, due to a staffing shortage, facility staff members were unable to provide Resident B with transportation back to the facility.

I reviewed the copy of Resident B's RCA and assessment plan, provided to me, via email, by Ms. Miller on 08/10. Documentation on Resident B's RCA indicated Resident B and Resident B's responsible agency agreed to pay the facility the basic fee of $907.50 a month for adult foster care (AFC) services. Documentation on

Resident B's RCA read, "No fee for local transportation". According to documentation on Resident B's RCA, additional fees (current mileage rate) were changed for transportation provided to Resident B outside of the "local area". There was no documentation on Resident B's RCA indicating local transportation would only be made available to Resident B for "prearranged appointments" and/or only when facility staff members were available to provide it. Documentation on Resident B's RCA also indicated there was no additional attachment to the RCA further explaining transportation services and/or transportation fees.

There was no documentation on Resident B's assessment plan regarding the transportation services provided to Resident B by facility staff members.

On 08/13 I referred this allegation to the Kalamazoo County Office of Recipient Rights.

I conducted a face-to-face interview with Kalamazoo County Recipient Right's Officer Lisa Smith via Microsoft Teams. According to Ms. Smith, the facility received specialized AFC funding from Resident B's responsible agency Interact of Michigan, in exchange for providing Resident B with specialized AFC programing. Ms. Smith stated this specialized programing included transportation to all Resident B's medical appointments, which would also include transportation back to the facility following visits to the ER.

I reviewed the copy of Resident B's CMH TP and CMH BAP, provided to me, via email, by Ms. Miller on 08/10. There was no documentation on Resident B's TP or BAP specifically regarding transportation services to be provided to Resident B by facility staff members. According to documentation on Resident B's BAP, while residing at previous AFC facilities, Resident B had a history of eloping with her boyfriend and/or her friends and admitted to using alcohol and illegal drugs during those times. Documentation on Resident B's BAP confirmed Resident B currently had independent access in the community as long as she abided by specific guidelines, such as refraining from alcohol and/or illegal drug use while out in the community unsupervised.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following:

	(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.
ANALYSIS:	According to the terms of Resident B's RCA, facility staff members were to provide Resident B with local transportation, as this was included in the basic fee for AFC services. There was no documentation on Resident B's RCA indicating local transportation would only be available to Resident B for "prearranged appointments" and/or only when facility staff members were available to provide it. While there is not enough evidence to support the allegation that Resident B was "forced" to seek transportation from a friend back to the facility following her visit to the ER on 07/17, home manager Brittany Miller admitted that on a few occasions, facility staff members were not available to provide Resident B with transportation to/from the ER, due to staffing shortages. Based upon my investigation, it has been established that "on a few occasions" facility staff members failed to provide Resident B with transportation to/from the ER.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 330.1805	**Accessibility**
	Common use areas of the facility are accessible to all clients in residence or an individual plan of service addresses the removal of imposed restrictions. The facility shall be capable of meeting the transportation needs of all clients the facility accepts for service.
ANALYSIS:	According to Kalamazoo County Recipient Right's Officer Lisa Smith, facility staff members were to provide Resident B with specialized AFC programing. Ms. Smith stated specialized programming included transportation to/from all Resident B's medical appointments, including transportation back to the facility following visits to the ER. Facility home manager Brittany Miller admitted that on a few occasions, facility staff members were not available to provide Resident B with transportation to/from the ER, due to staffing shortages. Subsequently, it has been established that on these occasions, the facility was unable to meet Resident B's transportation needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During my unannounced investigation on 08/12, I confirmed Resident B was prescribed one Hydrocodone 5mg-Acetaminophen 325mg tablet (substitution for the medication Norco), to be administered up to three times daily, as-needed. While onsite, I requested and reviewed Resident B's July and August MARs. I first established the labeling instructions for use and the time to be administered was not included on Resident B's July and August MARs for this medication. According to facility staff members' initials on Resident B's July and August MARs, Resident B was administered this medication on a regular basis. However, while facility staff members' documentation indicated what days Resident B received this medication, it did not indicate how many tablets of this medication Resident B was administered in a day and at what times she was administered the medication.

While onsite, Ms. Miller provided me with a facility form titled *Daily Controlled Medication Chart*, which documented the administration of as-needed Hydrocodone 5mg-Acetaminophen 325mg tablets to Resident B for the month of August. Documentation on this form indicated, in part, the following:

- On 08/03 Resident B was administered two doses of this medication.
- On 08/08 Resident B administered one dose of this medication.
- On 08/09 Resident B was administered two doses of this medication.
- On 08/10 Resident B was not administered this medication.

However, upon comparing the documentation on Resident B's August MAR, I established documentation on the facility's *Daily Controlled Medication Chart* was not consistent with the documentation on Resident B's August MAR. The absence of facility staff member's initials on Resident B's August MAR indicated Resident B was not administered her as-needed Hydrocodone 5mg-Acetaminophen 325mg tablet on 08/03, 08/08, or 08/09, as indicated on the *Daily Controlled Medication Chart.* According to a facility staff member's initials on Resident B's August MAR, Resident B was administered this medication on 08/10.

According to Resident B, she was prescribed as-needed Hydrocodone 5mg-Acetaminophen 325mg tablets for significant ongoing pain in her back, hips, and legs. However, facility staff members did not record the reason for each administration of this medication to Resident B on Resident B's July and August MARs.

While onsite, I established Resident B had one partially full bubble pack of Hydrocodone 5mg-Acetaminophen 325mg tablets left in the facility. According to documentation on the facility's *Daily Controlled Medication Chart* for the month of August, on 08/01 there were 27 tablets in the bubble pack. Documentation on the facility's *Daily Controlled Medication Chart* indicated Resident B had been administered 9 Hydrocodone 5mg-Acetaminophen 325mg tablets for the month of August so far. Resident B was last administered this medication on 08/10. According to documentation on the facility's *Daily Controlled Medication Chart,* there were 18

Hydrocodone 5mg-Acetaminophen 325mg tablets left in the bubble pack. However, upon counting the remaining tablets left in the bubble pack, I established there were only 16.

On 09/08 I reported this information to the Kalamazoo County Office of Recipient Rights, via an email to Ms. Smith.

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:** **(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.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.** **(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.**
ANALYSIS:	Based upon my investigation, it has been established Resident B was prescribed one as-needed Hydrocodone 5mg-Acetaminophen 325mg tablet to be administered up to three times a day. It was established the labeling instructions for use and the time to be administered was not indicated on Resident B's July and August MARs for this medication. While facility staff members' documentation on Resident B's July and August MARs indicated what days Resident B received this medication, it did not indicate how many tablets of this medication Resident B was administered in a day and at what times she was administered the medication. Subsequently, there was no way to determine how many Hydrocodone 5mg-Acetaminophen 325mg tablets had been administered to Resident B for the months of July and August by reviewing Resident B's MARs. Based upon my investigation, it has been established documentation on the facility's *Daily Controlled Medication Chart*, regarding the administration of Resident B's as-needed Hydrocodone 5mg-Acetaminophen 325mg tablets for the month of August, was not consistent with facility's staff members' documentation on Resident B's August MAR. Subsequently, I was unable to establish which document was accurate and/or

	how many Hydrocodone 5mg-Acetaminophen 325mg tablets had been administered to Resident B in August 2021 through the time of the investigation. Based upon my investigation, it has been established facility staff members did not record the reason for the administration of as-needed Hydrocodone 5mg-Acetaminophen 325mg to Resident B on Resident B's July and August MARs. According to documentation on the facility's *Daily Controlled Medication Chart* regarding the administration of Resident B's as-needed Hydrocodone 5mg-Acetaminophen 325mg tablets for the month of August, at the time of my onsite investigation on 08/12, there should have been 18 tablets left in the medication's bubble pack. However, upon counting the remaining tablets left in the only bubble pack of this medication available in the facility, I established there were only 16 tablets left. Based upon my investigation, two of Resident B's Hydrocodone 5mg-Acetaminophen 325mg tablets appeared to be unaccounted for.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: I reviewed all *AFC Licensing Division Incident/Accident Reports* (IR) submitted to the AFC licensing division for the month of July 2021 and established no IRs regarding Resident B's visits to the ER on 07/10 and 07/17 were submitted to the division.

During my unannounced investigation at the facility on 08/12, Ms. Miller and Ms. Wiley confirmed no IRs regarding Resident B's visits to the ER on 07/10 and 07/17 were written and submitted to the division, as they were both unaware they were required to do so. I explained to Ms. Miller and Ms. Wiley that the submission of a written report for every residents' hospitalization to the division, within 48 hours of hospitalization, was an AFC administrative licensing rule requirement. Subsequently, "hospitalization" included any sudden adverse change in a resident's condition and/or any accident that resulted in an unplanned visit to the ER, regardless of the duration of the resident's stay.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the

	following: **(c) Incidents that involve any of the following:** **(ii) Hospitalization.**
ANALYSIS:	Based upon my investigation, it has been established facility staff members did not submit a written report to the AFC licensing division regarding Resident B's visits to the ER on both 07/10 and 07/17, within 48 hours of Resident B's hospitalizations.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/09 I conducted an exit conference with licensee designee Ramon Beltran via telephone and shared with him the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

Michele Streeter 09/09/2021

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 09/17/2021

Dawn N. Timm Date

Area Manager