GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2022

Simbarashe Chiduma
Open Arms Link
Suite 130
8161 Executive Court
Lansing, MI 48917

RE: License #: AM190409578
Investigation #: 2022A0783040
Open Arms Stoll

Dear Mr. Chiduma:

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,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM190409578
Investigation #:	2022A0783040
Complaint Receipt Date:	04/20/2022
Investigation Initiation Date:	04/20/2022
Report Due Date:	06/19/2022
Licensee Name:	Open Arms Link
Licensee Address:	Suite 130 8161 Executive Court Lansing, MI 48917
Licensee Telephone #:	(517) 483-2489
Administrator:	Mascline Chiduma
Licensee Designee:	Simbarashe Chiduma
Name of Facility:	Open Arms Stoll
Facility Address:	Ste 130 3285 W Stoll Rd Lansing, MI 48906
Facility Telephone #:	(517) 455-8300
Original Issuance Date:	08/25/2021
License Status:	REGULAR
Effective Date:	02/25/2022
Expiration Date:	02/24/2024
Capacity:	9

Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

ALLEGATION(S)

	Violation Established?
Staff members neglected to take Resident A to a scheduled appointment with her dermatologist.	No
Resident A's medication was not taken to Bridges Crisis Unit (BCU) when she was admitted.	No
Staff member Manny pushed Resident A.	No
Resident A's medication was not given as prescribed because there were no refills remaining and staff members neglected to ensure Resident A had refills on her medications.	Yes

II. METHODOLOGY

04/20/2022	Special Investigation Intake – 2022A0783040
04/20/2022	Special Investigation Initiated – Telephone call with Complainant
06/01/2022	Inspection Completed On-site
06/01/2022	Contact - Face to Face interviews with direct care staff member and home manager Jada Moore, operations manager Brett Perhase, and Resident A
06/01/2022	Contact - Document Received – Resident A's resident record including physician's orders and medication administration records (MARS)
06/06/2022	Contact - Telephone call made to Community Mental Health (CMH) case manager Tresyr Friar
06/06/2022	Contact - Telephone call made to licensee designee Simbarashe Chiduma

06/06/2022	Contact - Telephone call made to administrator Mascline Chiduma
06/06/2022	Contact - Telephone call made to direct care staff member Travon Rogers
06/06/2022	Contact - Telephone call made to direct care staff member Fhingirai Mugadza
06/07/2022	Contact - Telephone call made to Resident A
06/07/2022	Contact - Telephone call made to direct care staff member and assistant home manager Miseal Saldivar
06/10/2022	Contact - Telephone call made to direct care staff member Nickiua Bridgeman
06/10/2022	Contact - Telephone call made to former direct care staff member Oluwasegun "Manny" Adebayo
06/10/2022	Contact - Telephone call made to direct care staff member Silvie Marian
06/13/2022	Contact - Telephone call made to Jerri Bright from Bridges Crisis Unit (BCU)
06/13/2022	Contact - Document Received – Resident A's current MAR
06/13/2022	Exit Conference with Simba Chiduma

ALLEGATION:

Staff members neglected to take Resident A to a scheduled appointment with her dermatologist.

INVESTIGATION:

On April 20, 2022, I received a complaint via centralized intake that stated Resident A's dermatologist called Guardian A1 because Resident A missed her scheduled appointment for April 18, 2022.

On April 20, 2022, I spoke to Guardian A1 who said Resident A has scheduled medical appointments on her own and that staff members do not properly monitor when Resident A needs to see a physician. Guardian A1 said Resident A told her that staff members have cancelled appointments she scheduled and never

rescheduled the appointments. Guardian A1 said someone from Resident A's dermatologist's office called her and told her Resident A missed an appointment on April 18, 2022. Guardian A1 said she was uncertain if Resident A or a staff member at the facility scheduled the appointment and said the appointment was "not urgent." On June 1, 2022, I interviewed Resident A who said she schedules her own medical appointments when staff members do not schedule the appointments for her and acknowledged that at times she does not notify anyone at the facility of the appointment until the day of the appointment. Resident A said she scheduled an appointment with her dermatologist in April that was missed because she did not have transportation and the appointment has not been rescheduled.

On June 6, 2022, I spoke to Resident A's assigned CMH case manager Tresyr Friar who said Resident A "has not missed any [medical] appointments without follow – up or rescheduling." Mr. Friar said staff members transport Resident A to her appointments and that they "track" appointments that Resident A schedules independently to ensure Resident A attends the appointment.

On June 1, 2022, I interviewed direct care staff member and home manager Jada Moore who said Resident A has not missed any medical appointments that were not rescheduled. Ms. Moore said typically she or another staff member schedules and transports residents to medical appointments but Resident A schedules appointments independently and does not tell staff at the facility that she needs transportation to the appointment until the day of the appointment. Ms. Moore said, "more than half the time," even when told at the last-minute staff members still transport Resident A to her independently scheduled medical appointments. Ms. Moore said if staff members cannot transport Resident A to an appointment, the appointment is rescheduled to another day when a staff member is available to transport Resident A, and she has not missed any appointments.

On June 1, 2022, I interviewed operations manager Brett Perhase who said residents' medical appointments are typically scheduled by a staff member and that staff members typically transport Resident A to her medical appointments. Mr. Perhase said Resident A frequently schedules medical appointments for herself and does not tell a staff member until the day of the appointment. Mr. Perhase said Resident A has not missed any medical appointments.

On June 6, 2022, I spoke to licensee designee Simbarashe Chiduma who said the general procedure at the facility is for the home manager to schedule appointments and ensure a staff member is available to transport the residents to each appointment. Mr. Chiduma said Resident A is "high functioning" and schedules her own medical appointments but does not notify Ms. Moore nor anyone else in advance of the appointment. Mr. Chiduma said medical appointments have been rescheduled but that Resident A has not missed any medical appointments.

On June 6, 2022, I spoke to facility administrator Mascline Chiduma who said the home manager is responsible for scheduling and arranging transportation to

residents' medical appointments. Ms. Chiduma said Resident A often schedules medical appointments for herself independently and does not tell a staff member or Ms. Moore until the day of the appointment and appointments have been rescheduled but never missed.

On June 7, 2022, I spoke to direct care staff member and facility assistant manager Miseal Saldivar who said the home manager schedules and transports residents to their medical appointments. Mr. Saldivar said at times Resident A schedules her own appointments that need to be rescheduled because she fails to notify staff members in sufficient time, but no appointment has ever been missed without being rescheduled.

On June 10, 2022, I spoke to direct care staff member Nickiua Bridgeman who said generally home manager Jada Moore schedules and transports residents to medical appointments but Resident A regularly schedules her own appointments and does not notify a staff member with sufficient time to arrange transportation. Ms. Bridgeman said Resident A's April 18, 2022, appointment with her dermatologist was rescheduled for June 28, 2022.

On June 6, 2022, I spoke to direct care staff members Travon Rogers and Fhingirai Mugadza who both said direct care staff member and home manager Jada Moore are responsible for scheduling Resident A' appointments and transporting her to those appointments. Both staff members denied being aware of any medical appointments that have been missed by Resident A.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on statements from Guardian A1, Resident A, Mr. Perhase, Ms. Moore, Mr. Friar, Mr. Chiduma, Ms. Chiduma, Mr. Saldivar, Ms. Bridgeman, Mr. Rogers, and Mr. Mugadza I determined that while staff at the facility are generally responsible for transporting Resident A to her medical appointments, Resident A regularly schedules appointments independently and does not provide timely notification to arrange transportation. The investigation revealed that while appointments have been rescheduled due to lack of transportation, medical appointments have not been left unaddressed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medication was not taken to Bridges Crisis Unit (BCU) when she was admitted.

INVESTIGATION:

On April 20, 2022, I received a complaint via centralized intake that stated the proper medications were not taken to the hospital at Resident A's appointment times or when needed.

On April 20, 2022, I spoke to Guardian A1 who said Resident A was admitted to Bridges Crisis Unit (BCU) on April 14, 2022 and staff members from the facility brought some of Resident A's medication, but not all of Resident A's medication to BCU . Guardian A1 said Resident A's medication administration records (MARs) were "messy," and it was not clear which medications Resident A was supposed to be taking. Guardian A1 said she emailed licensee designee Simbarashe Chiduma and he was unclear about which medications were currently prescribed to Resident A.

On June 6, 2022, I spoke to Tresyr Friar who is Resident A's assigned case manager via Community Mental Health (CMH). Mr. Friar stated a staff member from CMH transported Resident A to BCU from the adult foster care (AFC) facility and that the staff member relayed that all Resident A's medications were taken to BCU. Mr. Friar said he was told the medications were "correct" and "matched" her current medication administration record (MAR).

On June 6, 2022, I spoke to licensee designee Simbarashe Chiduma who said when Resident A initially went to BCU staff members did not send her medication because they thought they were to follow the same protocol for a typical hospital admission where they would send the MAR but not the medications. Mr. Chiduma said the former home manager Michael McConnell was directed to take Resident A's medication to BCU after he learned that the medication was needed and that Mr. McConnell did not take the medication because he received a telephone call from a nurse at BCU that stated some of Resident A's medication was still needed on April 17, 2022, which was three days after Resident A was admitted to BCU. Mr. Chiduma said the medication was delivered to BCU on April 18, 2022.

On June 6, 2022, I spoke to facility administrator Mascline Chiduma who said Resident A was admitted to BCU on April 14, 2022 and that all the medication on the MAR was sent with Resident A that day. Ms. Chiduma said on April 17, 2022, former facility manager Michael McConnell was directed to take additional creams and ointments prescribed to Resident A the medication was delivered to BCU on April 18, 2022.

On June 1 and June 7, 2022, I spoke to Resident A who said she recalled that some of her medications were “missing” when she was admitted to BCU but she was not certain which medications were missing.

On June 10, 2022, I spoke to direct care staff member Nickiua Bridgeman who said she was working the day Resident A went to BCU and that she was the person who “packed” Resident A’s medication. Ms. Bridgeman said she sent every medication on the MAR and that it took two trips for the CMH representative who transported Resident A to get all the medication.

On June 13, 2022, I spoke to Jerri Bright who is the nurse care manager at BCU and stated she was familiar with Resident A. Ms. Bright said when Resident A was admitted she had six baskets of medication, medication in a cupboard, plus a C-PAP machine, nebulizer, and glucose monitor. Ms. Bright said according to Resident A’s written MAR all the medications were brought to BCU when Resident A was admitted. Ms. Bright said on April 15, 2022, Resident A began requesting medication that was not on the written MAR and someone from the adult foster care (AFC) facility was contacted and on April 18, 2022 someone from the AFC facility brought more medication for Resident A. Ms. Bright said the amount of medication prescribed to Resident A and the number of providers prescribing medication was “unreal,” and described it as “very confusing.” Ms. Bright said Resident A was admitted to BCU “in an attempt to help consolidate” her medications and providers.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **(2) A licensee shall respect and safeguard the resident’s rights specified in subrule (1) of this rule.**

ANALYSIS:	Based on statements from Guardian A1, Resident A, Mr. Chiduma, Ms. Chiduma, Ms. Bridgeman, Mr. Friar, and Ms. Bright it appears that Resident A was admitted to BCU due to the fact she was on so many medications and had so many prescribing physicians. The investigation revealed that a facility staff member packed and sent all Resident A's medications on the MAR and that it was believed to be correct upon her admission to BCU on April 14, 2022. When staff members at BCU noted Resident A may have more medication they notified Mr. Chiduma and the medication was taken to BCU the following day.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff member "Manny" pushed Resident A.

INVESTIGATION:

On April 20, 2022, I spoke to Guardian A1 who said Resident A told her that direct care staff member "Manny" pushed Resident A out of the office after Resident A hit him. Guardian A1 said Resident A told her that "Manny" told Resident A she could not call the police following the incident.

On June 1, 2022, I interviewed Resident A who said direct care staff member "Manny" pushed her because according to "Manny," Resident A punched him in the stomach and in the face. Resident A said she hit "Manny" on the hand but did not punch him. Resident A said she hit "Manny" because he took her telephone and turned down the music she was playing. Resident A denied that she was injured nor that there were any witnesses when "Manny" pushed her. Resident A said "Manny" called the police because she hit him.

On June 10, 2022, I spoke to former direct care staff member Oluwasegun "Manny" Adebayo who said he no longer works at the facility and that his departure had nothing to do with Resident A. Mr. Adebayo said on a date he could not recall Resident A had music playing very loudly on her telephone which was bothering other residents so Mr. Adebayo asked Resident A to turn down the music. Mr. Adebayo said Resident A refused so he turned down the music which is when Resident A punched him. Mr. Adebayo denied that he pushed, restrained, nor touched Resident A. Mr. Adebayo said he telephoned police because Resident A hit him, and he believed he needed police intervention. Mr. Adebayo stated on another occasion Resident A went into the office where residents are prohibited so he "moved" her out of the office verbally. Mr. Adebayo denied that he harmed Resident A in any way and said he did not "push" nor "shove" Resident A at any time.

On June 10, 2022, I spoke to direct care staff member Silvie Marian who said she was working with former direct care staff member “Manny” Adebayo when Resident A entered the facility office where residents are not permitted so Mr. Adebayo verbally redirected Resident A out of the office. Ms. Marian denied that Mr. Adebayo pushed, restrained, nor hit Resident A nor that he touched Resident A in any way.

On June 6, 2022, I spoke to Tresyr Friar who is Resident A’s assigned case manager from CMH. Mr. Friar said Resident A mentioned that a staff member named “Manny” “restrained” her and he investigated it and found “no proof of that.”

On June 6, 2022, I spoke to licensee designee Simbarashe Chiduma who said direct care staff member “Manny” Adebayo is no longer employed at the facility due to lack of follow through on completing the required training and that he was not terminated as a result of anything concerning Resident A. Mr. Chiduma said Resident A and Mr. Adebayo both told him that Resident A hit Mr. Adebayo and Resident A claimed Mr. Adebayo restrained her. Mr. Chiduma said he spoke to Mr. Adebayo and direct care staff member Silvie Marian who was working with Mr. Adebayo at the time and found no evidence that Mr. Adebayo restrained nor pushed Resident A. Mr. Chiduma denied that any other resident, staff member, visitor, service provider etc. ever complained about or indicated that Mr. Adebayo was inappropriate toward Resident A nor anyone else.

On June 6, 2022, I spoke to facility administrator Mascline Chiduma who said former direct care staff member “Manny” Adebayo was terminated because he failed to complete the required training and not because he pushed or restrained Resident A. Ms. Chiduma said Resident A alleged that Mr. Adebayo hit her twice while he was working with direct care staff member Silvie Marian. Ms. Chiduma said she spoke with Mr. Adebayo, and he told her he did not touch Resident A in any way and did not hit, restrain, nor push Resident A which Ms. Marian confirmed. Ms. Chiduma denied that any other resident, staff member, visitor, or service provider ever expressed any concern regarding Mr. Adebayo.

On June 1, 2022 and June 6, 2022, I spoke to facility direct care staff members Jada Moore, Fhingirai Mugadza, Travon Rogers, Miseal Saldivar, and Nickiua Bridgeman who all denied having any concerns regarding former staff member Oluwasegun “Manny” Adebayo.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of

	the act.
ANALYSIS:	Based on statements from Guardian A1, Resident A, Mr. Adebayo, Ms. Marian, Mr. Frier, Mr. Chiduma, Mrs. Chiduma, Ms. Moore, Mr. Mugadza, Mr. Rogers, Mr. Saldivar, and Ms. Bridgeman there is lack of evidence to prove that Mr. Adebayo pushed, hit, nor that he restrained Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medication was not given as prescribed because there were no refills remaining and staff members neglected to ensure Resident A had refills on her medications.

INVESTIGATION:

On April 20, 2022, I received a complaint via centralized intake that stated Resident A was given several medications that were expired. The written complaint stated it was unknown if the medication was expired because it was an antibiotic or if the staff did not take Resident A to get her prescriptions refilled.

On April 20, 2022, I spoke to Guardian A1 who said Resident A's prescribed Gabapentin (see SIR #2022A0790006) and "several psych medications" were not administered as prescribed by staff members at the facility because the "prescription expired" and there were no refills remaining on the medication. Guardian A1 stated staff members at the facility neglected to notify the prescribing physician that refills were needed, and they should have been monitoring Resident A's prescriptions. Guardian A1 did not know when Resident A allegedly missed medication, what the medication was, and acknowledged "it may have been an antibiotic and it was the end of the prescription."

On June 1, 2022, I spoke to operations manager Brett Perhase who said the home manager is responsible for ordering medication as needed and contacting the physician if a refill is needed. Mr. Perhase said each resident's medications are checked weekly on Mondays to ensure each resident has all their medication for the week. Mr. Perhase said there was one occasion when Resident A did not get one of the medications prescribed to her because the medication was not available at the facility. Mr. Perhase could not recall the date nor the name of the medication.

On June 1, 2022, I spoke to direct care staff member and home manager Jada Moore who said once or twice weekly she checks each resident's medications and when there are "five to six" doses left she contacts the pharmacy who refills and delivers the medication before the last dose is used. Ms. Moore said she has regular

communication with the pharmacy and can “order” medication electronically so there is typically not a problem with not having medication at the facility to administer. Ms. Moore said on one occasion Resident A’s prescribed Oxybutynin 5 mg tablet was administered once that day instead of three times because she needed a prescription from the physician to get the medication refilled and “the pharmacy ordered [the medication] later than expected.” Ms. Moore stated that is the only instance she is aware of that Resident A was not administered a medication as prescribed.

On June 6, 2022, I spoke to direct care staff member Fhingirai Mugadza who said he administers medication to Resident A as part of his responsibilities at the facility. Mr. Mugadza said the facility home manager is responsible for tracking and acquiring refills on Resident A’s medication. Mr. Mugadza said he could recall one occasion where he could not administer one of Resident A’s medications because it was not at the facility. Mr. Mugadza could not recall the date nor the name of the medication.

On June 6, 2022, I spoke to direct care staff member and assistant manager Misael Saldivar who said he administers medication to Resident A as part of his job responsibilities at the facility. Mr. Saldivar said there have been instances where Resident A “missed” her medication “for a day or two.” Mr. Saldivar said one of the missed medications was Gabapentin (see SIR #2022A0790006) and he could not recall which other medication was not administered to Resident A as prescribed. Mr. Saldivar said it is the responsibility of the manager or assistant manager to ensure each resident’s prescribed medication is at the facility.

On June 10, 2022, I spoke to direct care staff member Nickiua Bridgeman who said she administers medication to Resident A as part of her job responsibilities and could recall “certain days or times” when some of Resident A’s medication was not at the facility. Ms. Bridgeman said she could not recall which medications where missing nor the date the medication was not administered. Ms. Bridgeman said it is the manager or assistant manager’s responsibility to ensure Resident A’s medication is at the facility to be administered.

On June 6, 2022, I spoke to facility administrator Mascline Chiduma who said Ms. Moore started her position as home manager in mid – April 2022 and the home manager prior to Ms. Moore was not competent at ensuring Resident A’s medications were refilled and at the facility so it is possible that Resident A did not get one or more of her medications because they were not at the facility. Ms. Chiduma said Resident A also schedules her own medical appointments and requests that the physician sends the medication to a different pharmacy than the one normally used, and staff members are not aware there is medication at another pharmacy unless Resident A informs them.

On June 6, 2022, I spoke to licensee designee Simbarashe Chiduma who said it is possible that Resident A did not get one or more of her medications as prescribed because Resident A’s medication was “very confusing.” Mr. Chiduma said a staff

member spent hours on the telephone with Resident A's physicians and pharmacies to resolve the confusion about Resident A's medication but ultimately Resident A was admitted to Bridges Crisis Unit (BCU) so that her medications could be reviewed and clarified. Mr. Chiduma said prior to going to BCU it was not clear which medications were discontinued and which were still active because Resident A made appointments and had prescriptions sent to different pharmacies independently.

On June 6, 2022, I spoke to Resident A's CMH case manager Tresyr Friar who said he was not aware that Resident A did not get any of her medication as prescribed due to lack of refills on the medication. Mr. Friar said Resident A made that allegation in the past and he reviewed her written MARs and believed all her medication was administered as prescribed.

On June 6, 2022, I interviewed Resident A who said there have been multiple occasions when her medication was not administered as prescribed because there was no medication at the facility to administer. Resident A could not recall specific dates or medications but said it makes her feel "bad" when her medication is not administered correctly.

On June 6 and June 13, 2022, I received Resident A's written MARs and written physician's orders for April 2022 – June 2022. I noted that in the month of April, according to the written MAR and physician's orders, the following medications were not administered as prescribed:

- April 21, 2022 – Flutacasone was not administered twice that day and the written physician's order and MAR state the medication should be administered twice daily
- April 4, 6, 12, 13, and 27, 2022 - Resident A's Novolog flex pen was not administered twice on those dates and according to the written physician's order and MAR the medication is to be administered every morning and every evening.
- April 30, 2022 - Pulmicort Flexhale was not administered twice and the written physician's order and MAR state the medication should be administered twice daily
- April 2, 8, 9, 27, 29, and 30, 2022 - Buspirone HCL 10 mg was not administered twice and the written physician's order and MAR state the medication should be administered twice daily for anxiety
- April 27, 2022 - Metoclopramide 10 mg was administered three times that day when the written physician's order and MAR state the medication should be administered four times daily

- April 18 and 19, 2022 - Trazodone 150 mg was not administered and the written physician's order and MAR state the medication should be administered every night at bedtime.
- April 27 and 28, 2022 - B Complex tablet was not administered and according to the written physician's order and MAR the medication is to be administered once daily
- April 2 and April 8, 2022 - Dexilant 60 mg was not administered and according to the written physician's order and MAR the medication is to be administered once daily before breakfast.
- April 22, 2022 – Oxybutynin 5 mg tablet was administered once and according to the written physician's order and MAR the medication is to be administered three times daily.

I noted that for the month of May 2022 according to the written MAR and physician's orders, the following medications were not administered as prescribed:

- May 15, 16, and 17, 2022 - Citrucel powder was administered twice and the written physician's order and MARS state the medication should be administered three times daily
- May 26, 2022 – Latuda 20 mg tablet was not administered and the written physician's order and MAR state the medication should be taken each evening
- May 27, 2022 – Aspirin 81 mg was not administered and the written physician's order and MAR state the medication should be administered once daily
- May 27, 2022 – Colace 50 mg was not administered and the written physician's order and MAR state the medication should be administered once daily

I noted that for the month of June 2022 according to the written MAR and physician's orders, the following medications were not administered as prescribed:

- June 1 – 8, 2022 - Vitamin D3 500 mg was not administered and according to the written physician's order and MAR the medication should be administered once daily

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on statements from Guardian A1, Resident A, Mr. Perhase, Ms. Moore, Mr. Mugadza, Mr. Saldivar, Ms. Bridgeman, Mr. Friar, Ms. Chiduma and Mr. Chiduma along with a review of the written physician's orders and MARs, I determined there were several different medications on various dates that were not administered as prescribed including medications prescribed by Resident A's mental health provider.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [REFERENCE SIR#2022A0790006 AND CORRECTIVE ACTION PLAN DATED 5/24/22]**

III. RECOMMENDATION

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

Leslie Herrguth 06/13/22

Leslie Herrguth Date
Licensing Consultant

Approved By:

Dawn Timm 06/13/2022

Dawn N. Timm Date
Area Manager