GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 2, 2023

Kimberlee Waddell
NRMI LLC
160
17187 N. Laurel Park Dr.
Livonia, MI 48152

RE: License #: AL630412118
Investigation #: 2023A0605015
North Ridge

Dear Ms. Waddell:

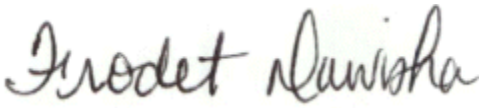
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630412118
Investigation #:	2023A0605015
Complaint Receipt Date:	01/18/2023
Investigation Initiation Date:	01/18/2023
Report Due Date:	03/19/2023
Licensee Name:	NRMI LLC
Licensee Address:	160 17187 N. Laurel Park Dr. Livonia, MI 48152
Licensee Telephone #:	(734) 646-1603
Administrator:	Tammy Zentz
Licensee Designee:	Kimberlee Waddell
Name of Facility:	North Ridge
Facility Address:	25911 Middlebelt Farmington Hills, MI 48336
Facility Telephone #:	(248) 516-1370
Original Issuance Date:	06/01/2022
License Status:	REGULAR
Effective Date:	12/01/2022
Expiration Date:	11/30/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A rarely gets turned at night.	No
Resident A did not receive his evening medications. A staff member attempted to give Resident A another resident's medication.	Yes

III. METHODOLOGY

01/18/2023	Special Investigation Intake 2023A0605015
01/18/2023	Special Investigation Initiated - Telephone Discussed allegations with reporting person (RP)
01/18/2023	Contact - Telephone call made Left message for Resident A
01/18/2023	Contact - Telephone call received Discussed allegations with Resident A
01/26/2023	Inspection Completed On-site Conducted unannounced on-site investigation. Interviewed Resident A, Resident B, Erica Mabry Residential Program Supervisor, Salina Brown Residential Program Supervisor, Registered Nurse (RN) Alissa Pelto, direct care staff (DCS) Brandy Warren and Kayla Jones. I reviewed medications.
02/15/2023	Contact - Telephone call made Discussed allegations with DCS Narshay Wright, Tanyika Oldham, RN Kim Day Mitchell, and Resident B's legal guardian. I left messages for DCS Astrid Locke, Jackie Bey, and texted JaQuin Jolly because his voice mail box was not set up.
02/15/2023	Contact - Telephone call received Discussed allegations with DCS Astrid Locke
02/21/2023	Contact - Telephone call made Discussed allegations with rehab assistant (RA) JaQuan Jolly. Left messages for DCS Marquetta Hunter and Jackie Bey

02/21/2023	Contact - Telephone call made Salina Brown will email Resident A's assessment plan
02/21/2023	Contact - Document Received Email from Salena Brown
02/23/2023	Contact - Telephone call made I called the number in our system for licensee designee, but a woman answered stating that "I had the wrong number." Left message for Tammy Zentz, program director for licensee designee's contact number to conduct the exit conference
02/23/2023	Contact - Telephone call received Ms. Zentz provided licensee designee's contact information
02/23/2023	Exit Conference Conducted exit conference via telephone with licensee designee Kim Waddell with my findings

ALLEGATION:

Resident A rarely gets turned at night.

INVESTIGATION:

On 01/18/2023, intake #192750 was assigned for investigation regarding Resident A was almost given another residents medication by a direct care staff (DCS) and Resident A is not being repositioned during the midnight shift.

On 01/18/2023, I initiated this special investigation by contacting the reporting person (RP) via telephone and discussed the allegations. The RP stated that Resident A is verbal and has been staying at North Ridge for respite care. Resident A is quadriplegic and requires total care from staff. Resident A reported to the RP that staff are not turning him at night as part of his treatment for his bedsores. This is happening during the midnight shift. The RP is concerned about Resident A’s care at North Ridge.

On 01/18/2023, I contacted Resident A via telephone and briefly discussed the allegations. Resident A is supposed to get turned every two hours as part of his treatment plan for his bedsores located on his coccyx area, but staff are not turning him every two hours during the midnight shift. Resident A does not know the DCS names but stated that some DCS turn him, and some do not. Resident A will be discharged from North Ridge next week and would like this worker to come after he has been discharged.

On 01/24/2023, I contacted via telephone Resident A as a follow-up to our conversation about his discharge. Resident A has not been discharged yet but will be next week. I advised Resident A I will need to conduct the on-site investigation this week and will need to interview him face-to-face. Resident A acknowledged.

On 01/26/2023, I conducted an unannounced on-site investigation. Resident A was at a doctor's appointment when I arrived at North Ridge. I interviewed Salina Brown and Erica Mabry who both were the Residential Program Supervisors regarding the allegations. Resident A expressed concerns directly to Ms. Brown about not getting showered daily after dinner. Ms. Brown has spoken with staff and advised staff to offer a shower to Resident A and if he refuses, to continue to offer the shower and then document his refusal or acceptance, which staff have been doing. Ms. Brown has a repositioning policy sheet for Resident A that all DCS must complete whenever Resident A is turned. Resident A stays on his right side for two hours and can only stay on his left side for one hour; therefore, depending on which side Resident A is on, DCS must reposition him either every one or two hours.

Note: I reviewed Resident A's repositioning sheet and Resident A was being repositioned every one to two hours daily.

On 01/26/2023, I interviewed DCS Brandy Warren regarding the allegations. Ms. Warren has been with North Ridge for six years, but this corporation since 03/27/2022 when they took over. She works the morning shift from 8AM-4PM. Ms. Warren is attentive to Resident A when she cares for him during her shift. Resident A complains a lot about other DCS that do not attend to his care when he uses his call button. Resident A wants to have a one-to-one DCS but that cannot happen with 19 other residents. Ms. Warren always repositions Resident A either one to two hours depending on the side he is laying on. Ms. Warren does not work the midnight shift; therefore, she does not know what if Resident A is being turned or not. Ms. Warren reported that Resident A was offered showers daily, but he refused because he wanted to be showered after dinner and sometimes staff were unable to shower him at that time. However, since his complaint, Resident A is now showered during the midnight shift daily.

On 01/26/2023, I attempted to interview Resident B, but Resident B is nonverbal. I observed Resident B lying in bed and had good hygiene and dressed appropriately.

On 01/26/2023, I interviewed DCS Kaylah Jones regarding the allegations. Ms. Jones has been with this corporation for three months. She too works the morning shift 8AM-4PM. Ms. Jones stated she does not reposition Resident A because by the time she arrives at her shift, the midnight shift has dressed Resident A and transferred him to his wheelchair. Resident A is in his wheelchair during Ms. Jones' shift, but then the

afternoon shift transfers Resident A back into bed. Both the afternoon (4PM-12AM) and the midnight (12AM-8AM) shift are responsible for repositioning Resident A during their shifts. Ms. Jones stated that Resident A has expressed his frustrations about the midnight shift not responding immediately to his call button and that he must press the call button “a long time,” before a DCS shows up. Ms. Jones was not informed by Resident A which DCS do not show up to assist him. Ms. Jones has not heard any complaints from Resident A about not being showered as the midnight shift offers him a shower and Resident A has been receiving showers.

On 01/26/2023, I interviewed Resident A who arrived at North Ridge during my visit. Resident A was wearing scrubs and sitting in his wheelchair. Resident A stated when he initially arrived at North Ridge it was difficult to get staff to assist him during the midnight shift. Resident A stated, “after I complained to management, everything is better now. The staff are doing what they’re supposed to be doing.” Resident A is getting repositioned every one to two hours now whereas it was difficult to get a DCS to come to his room when he was pressing the call button when he first arrived in December 2022. Resident A receives a shower whenever he wants and now staff are offering showers to him after dinner. He stated, “all the staff are now doing a good job.”

On 01/26/2023, I attempted to interview Resident B, but he was non-verbal. Resident B was lying in bed and appeared to have good hygiene and dressed appropriately for the day. There were no concerns noted.

On 01/26/2023, I interviewed Resident C regarding the allegations. Resident C was sitting in his wheelchair watching TV. He was dressed appropriately and had good hygiene. Resident C has dementia but did answer my questions appropriately. He reported that it was “alright,” living here and that staff “showed up sometimes and sometimes didn’t show up,” when he used his call button. Resident C does not know staff names but reported that staff usually don’t show up during the midnight shift. Resident C receives a shower daily and has no concerns about that.

On 02/15/2023, I interviewed via telephone DCS Narshay Wright regarding the allegations. Ms. Wright has been working for this corporation since October 2022. She works the midnight shift (12AM-8AM). Ms. Wright stated that Resident A was discharged from North Ridge last week. Whenever she worked with Resident A, she would go into his room every one to two hours depending on the side Resident A was lying on and she would turn him. Ms. Wright stated she had a good relationship with Resident A and that she heard other staff complain about Resident A “always asking for help.” Ms. Wright stated, “That’s our job. We must help the residents so whenever he used the call button, I helped him during my shift.” Ms. Wright had no problems with Resident A but reported that Resident A was not sleeping through the night when he initially arrived, but then he became acclimated with the facility and started sleeping. She stated that she would go into his room, reposition him and then Resident A would tell her when to return to reposition him, which she did.

On 02/15/2023, I interviewed DCS Kim Day Mitchell regarding the allegations. Ms. Mitchell stated she was hired on 02/06/2023 and works the afternoon shift (4PM-12AM) but that she has never worked with Resident A. She does not have any information regarding DCS not repositioning him. She is still in training and was unable to provide any information.

On 02/15/2023, I interviewed Resident C's son/guardian regarding the allegations. Resident C's son stated he visits Resident C about once or twice a week. During his visits, he has not seen his father with poor hygiene but reported that his most recent visit, his father's right arm, wrist, and hand were black. Resident C had multiple bruises and no DCS knew what happened. Resident C was taken to the hospital and had no breaks or fractures, but there were concerns about Resident C possibly falling. Resident C's son's concern is that Resident C may have had an unwitnessed fall, but that no DCS was able to tell him if Resident C had fallen. He stated that staff "normally do a decent job," and that Resident C's arm was the only issue he had with North Ridge.

On 02/21/2023, I received an email from Salina Brown with Resident A's assessment plan completed on 11/28/2022. I reviewed the assessment plan, and it was incomplete. The "Self-Care Skill Assessment," portion of the assessment plan was either not legibly written and a majority of Resident A's "needs," were blank. It was unclear what Resident A's needs were and how DCS will be meeting those needs.

On 02/15/2023, I interviewed DCS Tanyika Oldham regarding the allegations. Ms. Oldham began working for this corporation on 11/07/2022 but has since quit as of the end of January 2023. She worked the morning shift from 8AM-4PM. Ms. Oldham voluntarily quit because she did not like how North Ridge was "being run." She did not provide any additional information. Ms. Oldham was told by Resident A that he does not get turned at night and that staff he was "unhappy with the care," he was receiving at night. Ms. Oldham informed the RN, name unknown of Resident A's concerns. Ms. Oldham stated she did not have to reposition Resident A because he was in his wheelchair during her shift.

On 02/15/2023, I interviewed DCS Astrid Locke via telephone regarding the allegations. Ms. Locke as been working for this corporation since June 2022. She works the midnight shift from 12AM-8AM. Ms. Locke reported that during her shift, she would go into Resident A's room to turn him, but Resident A would refuse and ask her to return. Ms. Locke repositioned Resident A every one to two hours depending on the side he was laying on. Resident A complained about the midnight staff not turning him, but Resident A did not provide her with any names. She reported Resident A's complaint to management.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on my investigation and review of Resident A's assessment plan completed on 11/28/2022, the assessment plan was not completed fully, and it was unclear what Resident A's needs were and how staff were going to meet those needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**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 my investigation and information gathered, Resident A's personal needs was attended to at all times by DCS. DCS were repositioning Resident A every one to two hours depending on the side he was laying on as reported by the afternoon and midnight DCS and the review of the documentation on the repositioning tracking sheet for Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A did not receive his evening medications. A staff member attempted to give Resident A another residents medication.

INVESTIGATION:

On 01/18/2023, the RP stated that Resident A was due for his medications and a DCS brought Resident A's pills and Resident A recognized that the pills were not his medications. Resident A refused to take the medications and then the DCS realized that the pills were not Resident A's medications but belonged to another resident.

On 01/18/2023, Resident A it was the midnight staff that came into his room in the morning to pass his AM medications. Resident A stated he looked at the cup that was handed to him and did not recognize any of the pills. He told the RP he did not know the name of the DCS that handed him the pills. The RP suggested I speak with Resident A regarding his medications.

On 01/18/2026, I interviewed Resident A via telephone regarding his medications. Resident A could not recall the date, but reported it was soon after being admitted to North Ridge that a DCS (name unknown) came into his room with a cup of pills. It was around 8AM when this female DCS handed him a cup of pills to take. Resident A looked at the cup like he always does to ensure the medication he is taking is his and saw that there were too many pills. Resident A did not recognize any of the pills. Resident A refused to take the medications and told the DCS, "these are not mine. I don't recognize any of these pills." The DCS left his room with the pills and returned advising Resident A that he was right, the pills belonged to another resident. Resident A reported this was an isolated incident and that the DCS then brought him the correct medications to take.

On 01/26/2023, Ms. Brown reported that DCS Astrid Locke informed her that during her shift change, Ms. Locke was leaving as DCS Tanyika Oldham arrived, Ms. Locke said to Ms. Oldham, "these medications need to be given to Resident C." Instead of Ms. Oldham going into Resident C's room, Ms. Oldham went into Resident A's room and handed him the pills. Resident A did not recognize the pills and refused to take the medications. Ms. Oldham reported to Ms. Brown that she was "confused and walked into the wrong room." Ms. Brown stated disciplinary action was taken and Ms. Oldham was written up, but then Ms. Oldham chose to quit as she was a no call no show for her shift.

On 01/26/2023, I interviewed DCS Brandy Warren regarding the medication allegations. Ms. Warren denied passing incorrect medications to the wrong resident including Resident A. She stated she pops the blister packs at the time medication is being passed and makes sure she is giving the medications to the correct resident. Ms. Warren heard that one of the DCS went into Resident A's room with Resident C's medications but does not know who the DCS was. Ms. Warren did not have anything further to add.

On 01/26/2023, I interviewed DCS Kaylah Jones regarding the medication allegation. Ms. Jones heard that there had been a lot of medication errors during the midnight shift. The concerns were that the midnight shift was popping the pills out of the blister pack, leaving them in cups and not administering them to residents. The medication cabinet is locked with the pills in the cup, so she takes the medication cup to the RN on shift who verifies the medications and which resident they belong to. Ms. Jones denied giving medications to the wrong resident. She heard this happened to Resident A, but that Resident A recognized that the pills were not his and refused to take them.

On 01/26/2023, I interviewed Resident A face-to-face regarding his medications. Resident A stated he could not remember the date of when the medication error occurred but that he had just woken up and a DCS was in his room with a cup of pills. He saw the cup "full," of pills and thought it was odd because he did not take many medications. He looked closely at the pills and told the DCS, "these are not mine. I'm not taking them." The DCS did not say anything and just left with the cup. Resident A knows the medications he is on and always checks them before taking them. He stated since that incident and since he complained to management about the medication error, he has been getting his correct medications without any errors.

On 01/26/2023, I interviewed Resident C in his bedroom. Resident C stated he takes his medications given by staff and does not recall taking someone else's medications. He reported that staff administer his medications daily to him with no concerns.

Note: On 01/26/2023, I observed DCS Brandy Warren conducted a medication pass to Resident B. Ms. Warren completed her 5-rights of medication pass and the medication cabinet was locked. I observed inside the medication cart and there were no pills popped out of blister packs and placed inside cups.

I also reviewed Resident A and Resident C's medications and found the following medication errors for Resident A:

- **Diazepam Tab 5MG**: take one tablet by mouth three times daily as needed was given from 01/13/2023-01/15/2023 once daily, 01/16/2023-01/20/2023 twice daily, 01/21/2023-01/22/2023 once daily, 01/23/2023-01/24/2023 twice daily, and 01/25/2023-01/26/2023 once but a review process for this as needed medication with the prescribing physician was not conducted or recorded.
- **Medical Marijuana Gummy or Cookie**: may chew one gummy or cookie bid PRN was given from 01/01/2023-01/25/2023 once daily but a review process with the prescribing physician for this as needed medication was not conducted or recorded.
- **Metformin Tab 500MG ER**: take one tablet by mouth twice daily was not given at 7AM on 01/25/2023 and on 01/26/2023 but staff initialed the medication log.
- **Ertapenem INJ 1GM**: one gram reconstituted once daily for eight to 12 weeks for chronic osteomyelitis of sacrum was administered at 8AM on 01/19/2023 but staff did not initial the medication log.

On 02/15/2023, I interviewed DCS Narshay Wright regarding the allegations. Ms. Wright heard what happened with Resident A's medications. She heard that as DCS Astrid Locke was leaving her shift Ms. Locke told DCS Tanyika Oldham who was starting her shift to "take these meds," to Resident A. Ms. Wright heard that somehow Ms. Oldham had Resident C's pills in the cup and took those pills to Resident A who refused to take the pills because he did not recognize them. Ms. Wright does not know what pills Ms. Locke popped out of the blister pack to give to Ms. Oldham to pass, but that was not policy. The person who pops the pills out must pass them and then initial the medication log. Ms. Wright passing medications to the wrong resident and stated whenever she passes Resident A's medications, Resident A "always looks at his pills to make sure they're his."

On 02/15/2023, I interviewed DCS Kim Day Mitchell regarding the allegations. Ms. Mitchell heard from Resident A that another DCS "almost gave him the wrong meds." Ms. Mitchell did not have any further details but indicated she was working for a contract agency at that time, but now has been hired with this corporation so she does not pass medications, she just verifies medications and places them in the medication cart.

On 02/15/2023, I interviewed Resident C's son regarding medication allegations. Resident C's son stated whenever he visits with Resident C at North Ridge, Resident C receives his medications. He has no concerns or additional information to provide regarding medications.

On 02/15/2023, I interviewed rehab assistance JaQuan Jolly regarding the allegations. Mr. Jolly stated he works afternoon shift and was not present when a DCS almost gave Resident A the wrong medications. Mr. Jolly heard from Resident A that a midnight DCS almost gave him the wrong medications and that the only reason Resident A did not take them was because there were "too many meds in the cup." Mr. Jolly passes medications but denied administering medications to the wrong resident.

On 02/15/2023, I interviewed DCS Tanyika Oldham regarding the medication allegation. Ms. Oldham stated before her shift began, DCS Astrid Locke handed her pills in a cup and said, "give these to Resident A." Ms. Oldham stated, "I checked the pills, and they did not match Resident A's pills in our system." Ms. Oldham then took the pills to Resident A and asked Resident A, "Are these your medications?" Resident A stated, "No." Ms. Oldham then took the cup of pills to the RN (female, but name unknown) on shift and told her what happened. The RN reviewed the pills and later it was learned that the pills belonged to Resident C. Ms. Oldham stated there were times when she arrived on her shift and there were cups full of pills locked in the cabinet and she did not know who the pills belonged to. She would give the cup of pills to the RN and inform the RN that she found them in the medication cart.

On 02/15/2023, I interviewed DCS Astrid Locke regarding the medication allegations. Ms. Locke reported she was informed by Salina Brown that she had a medication error with Resident A's medications. Ms. Locke was confused because she never popped any of Resident A's pills out of the blister pack that day. She stated that Resident A's medications came in a prepackaged brown envelope when he was initially admitted into North Ridge and then after those were administered, Resident A's medications came in blister packs. Ms. Locke recalls ending her shift and DCS Tanyika Oldham arriving on her shift. Ms. Locke stated that Resident A was still sleeping so she told Ms. Oldham to pass Resident A's medications after he wakes up. Ms. Locke denied handing Ms. Oldham a cup of pills and just told Ms. Oldham to pass Resident A's pills that were in the medication cabinet. Ms. Locke believes that Ms. Oldham popped out Resident C's pills, put them in a cup and took them to Resident A who refused to take them because he recognized the pills were not his and that Ms. Oldham tried to cover herself and blamed Ms. Locke. Ms. Locke stated she has never administered wrong medications to the wrong resident. She always pops medications from the blister pack at the time of when the medication is administered and never puts them in a cup in the medication cart. Again, she stated "I believe Tanyika tried to blame me for her medication error."

On 02/23/2023, I conducted the exit conference via telephone with licensee designee Kimberlee Waddell with my findings. Ms. Waddell stated she will be addressing the medication error issues as well as the completion of the assessment plan with all staff. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my review of Resident A's medications and medications logs, I found the following errors: • **Metformin Tab 500MG ER**: take one tablet by mouth twice daily was not given at 7AM on 01/25/2023 and on 01/26/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**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: (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 review of Resident A's medications and medications logs, I found the following errors: • **Metformin Tab 500MG ER**: take one tablet by mouth twice daily was not given at 7AM on 01/25/2023 and on 01/26/2023 but staff initialed the medication log. • **Ertapenem INJ 1GM**: one gram reconstituted once daily for eight to 12 weeks for chronic osteomyelitis of sacrum was administered at 8AM on 01/19/2023 but staff did not initial the medication log.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**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: (d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.

ANALYSIS:	Based on my review of Resident A's medications and medication logs, I found the following errors: • **Diazepam Tab 5MG**: take one tablet by mouth three times daily as needed was given from 01/13/2023-01/15/2023 once daily, 01/16/2023-01/20/2023 twice daily, 01/21/2023-01/22/2023 once daily, 01/23/2023-01/24/2023 twice daily, and 01/25/2023-01/26/2023 once but a review process for this as needed medication with the prescribing physician was not conducted or recorded. • **Medical Marijuana Gummy or Cookie**: may chew one gummy or cookie bid PRN was given from 01/01/2023-01/25/2023 once daily but a review process with the prescribing physician for this as needed medication was not conducted or recorded.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Frodet Dawisha 02/27/2023

Frodet Dawisha Date
Licensing Consultant

Approved By:

Denise Y. Nunn 03/02/2023

Denise Y. Nunn Date
Area Manager