GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 7, 2023

Mr. John S. Thornton
2508 McIlwraith
Muskegon Heights, MI 49444

RE: License #:	AS610015096
Investigation #:	2023A0356055
	J.B.C. Home

Dear Mr. Thornton:

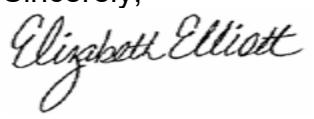
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610015096
Investigation #:	2023A0356055
Complaint Receipt Date:	09/11/2023
Investigation Initiation Date:	09/11/2023
Report Due Date:	11/10/2023
Licensee Name:	John S. Thornton & Rosie L. Thornton
Licensee Address:	2508 McIlwraith Muskegon Heights, MI 49444
Licensee Telephone #:	(231) 739-8820
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	J.B.C. Home
Facility Address:	2508 McIlwraith Street Muskegon Heights, MI 49444-1633
Facility Telephone #:	(231) 737-0015
Original Issuance Date:	12/01/1993
License Status:	REGULAR
Effective Date:	06/01/2022
Expiration Date:	05/31/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident medications are not administered as prescribed.	Yes
Staff are not trained in the administration of medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/11/2023	Special Investigation Intake 2023A0356055
09/11/2023	Special Investigation Initiated - Telephone Laura Ritchie, Health West.
09/11/2023	Contact - Document Received Sarah Cunningham, resident MARs.
09/11/2023	Contact - Document Received Amanda Abscher, ORR, Health West.
09/15/2023	Inspection Completed On-site
09/15/2023	Contact - Face to Face Sarah Cunningham, RN Health West, DCW Dwight Quinn.
09/15/2023	Contact - Document Received Reviewed Resident A, B & C's MAR.
09/19/2023	APS Referral Centralized Intake.
09/20/2023	Contact - Telephone call received. Anna Mater, APS worker.
10/05/2023	Contact-Face to Face. At Health West, Linda Wagner, ORR, Anna Mater, APS, Laura Ritchie HW supervisor, Kaja Thornton Hunter, D'Erika Lewis, home manager.
10/12/2023	Contact - Face to Face Kaja Thornton Hunter, D'Erika Lewis, Jeffery Walker, JBC management, Anna Mater, APS, Sarah Cunningham, Health West @ café.

10/12/2023	Inspection Completed On-site Anna Mater, APS, La'Drea Lewis, DCW, Resident's A, B, C, D, E.
10/12/2023	Contact - Document Received Facility documents for resident MARs.
11/07/2023	Exit Conference Kaja Thornton as approved by Licensee, John Thornton.

ALLEGATION: Resident medications are not administered as prescribed.

INVESTIGATION: On 09/11/2023, I received three Recipient Rights Complaints regarding Resident A, B, C, D, & E at the JBC Home. The complainant reported on 09/01/2023, she received an email from the facility's supervisor, D'Erika Lewis that documented she (Ms. Lewis) needed a refill of Resident A's Buspirone 30 mg and Sertraline 100mg but the complainant reported once a review of Resident A's chart was conducted, it was noticed that Resident A had not been seen for a medication review since 04/19/2023 where, at that time, medications were sent with just two refills. The complainant reported the HW (Healthwest) nurse reviewed when the medications were last filled, and they were filled on 06/23/2023 for a 30-day supply. The complainant reported the last dosage Resident A would have received for both medications should have been around 07/23/2023.

The second ORR complaint received is dated 09/01/2023. This documented that the HW nurse contacted the pharmacy to verify the last time Resident B's medication (Sertraline) Zoloft was sent to the home, because it had not been refilled since January 2023, but the facility had been marking the medication as passed on the MAR (medication administration record). The complainant reported Dr. Sue Huffstutter, MD sent in new refills to the pharmacy in March 2023 and June 2023, but the medication was never delivered to the facility. It was not included in the multipack of medications that included Resident B's Vitamin D. The complainant reported no one, including staff at the facility ever caught it. The complainant reported the medication was still being signed for as given on the resident Medication Administration Records (MARs).

The third ORR complaint received is dated 09/07/2023 and documented that the HW RN (registered nurse) received the MARs from the home manager, D'Erika Lewis. These showed that for Resident C there were discontinued medications signed for and still on the MAR and Resident C's current Clozaril order was not correct on the MAR. The RN, Sarah Cunningham took pictures of the MARs two weeks ago while at the facility and the MARs she received the week of this complaint were filled in compared to the ones she took pictures of two weeks ago. The complainant reported Resident C had almost two months' worth of 100mg Clozaril, almost a months' worth of the 50 mg and 100 Depakote when he should have had 90 for the month.

The complainant documented for Resident's A, B, C, D and E, staff are not following the 5 R's (right medication, right patient/person, right time, right dose and right route) when passing medications and making sure that they are utilizing the MAR while the med pass is happening. Instead, they are signing for the medications at the end of their shift. The complainant added Resident D missed medications for three days because the medication was not refilled in a timely manner. In addition, staff were utilizing a "med box" for passing medications.

On 09/11/2023, I interviewed Laura Ritchie, Health West supports coordinator supervisor. Ms. Ritchie stated a medication audit was conducted at the facility and the issues documented in the Recipient Rights complaint were discovered during the medication audit. Ms. Ritchie stated the resident MARs were not filled out and staff were trying to fill medications that had been discontinued months ago. Ms. Ritchie stated Ms. Cunningham conducted the audit and has more in-depth information about the issues discovered during the medication audit. Ms. Cunningham is working with facility staff to get the resident medication issues corrected.

On 09/11/2023, I received an email from Ms. Cunningham, Health West RN. Ms. Cunningham reported she went out on 09/06/2023 and conducted a medication review for all residents in the facility. Ms. Cunningham reported Resident A's medications Buspirone 30 mg and Sertraline 100 mg were last filled on 06/23/2023 for a 30-day supply and it appeared as though Resident A should have received his last dosages of these medications on or around 07/23/2023, yet the MAR was still being signed as if the medication was still being administered in August 2023.

Ms. Cunningham reported Resident B's Zoloft has not been refilled since January 2023, yet the medication is marked on the MAR as if it is still being administered. Ms. Cunningham explained that Dr. Huffstutter continued to send it in as an ordered medication to the pharmacy, the last time being in June 2023, but the medication has not been refilled by the facility since January 2023.

Ms. Cunningham reported Resident C had 28 pills left of his 100 mg, Clozaril for June 2023, 43.5 pills left for July 2023, and no August 2023 bottle of 100 mg Clozaril. Resident C had 49/60 pills of his 50 mg. Clozaril left for August, he had 100 pills of Depakote left when he should have 50 in the container for the month. Ms. Cunningham stated when Resident C returned from the hospital in June 2023, she took all the extra pills out of the home. Ms. Cunningham reported that Ms. Lewis emailed her twice during the week of August 28th requesting medications that had been discontinued when Resident C was in the hospital in June 2023. Ms. Cunningham explained that prior to Resident C's hospitalization in June 2023, he was getting Clozaril, 1 50mg tab, 2 times daily and upon discharge from the hospital and return to the facility in July 2023, Resident A's was prescribed Clozaril, 100mg, 1 tab 3 times daily and Resident A was never getting the 100mg tabs three times daily, staff continued to administer the 50mg tabs twice daily.

Ms. Cunningham reported that Resident D's medications were being passed out of a weekly medication box. Resident E's medication review resulted in no concerns as far as the medication counts however, the MARs for the month of August showed several dates not signed by staff, indicating the medications were not administered.

On 09/11/2023, Ms. Cunningham emailed the MARs for Residents B, C, D & E for the month of August 2023. Ms. Cunningham reported she took pictures of these MARs when she initially went to the facility on 09/01/2023. The first set of MARs showed numerous dates that are not signed for by staff as having been administered. Ms. Cunningham then received copies of the same resident MARs from Ms. Lewis on 09/07/2023 and noted that the dates that had been empty when she reviewed them on 9/1 were now filled in with staff signatures.

I reviewed the first set of resident MARs and noted the following:

- Resident A's MAR for August 2023 is not included in the email.
- Resident B's Sertraline (Zoloft) 100 mg tab, take 1 tablet by mouth in the morning was signed as administered August 1-19, 2023. There is no staff signature for 08/20/2023, staff signatures for 08/21/23 and 08/22/23, and no signatures for the remainder of the month of August.
- Resident C's August MAR documented Divalproex (Depakote) ER 500 Mg Tab, take 1 tablet by mouth three times a day, take 1 tablet morning, 1 tablet at 2pm, and 1 tablet at bedtime is signed by staff as administered August 1-18, 2023. For the 8:00a.m. and 2:00p.m. doses and there are no staff signatures for the remainder of the month. The MAR was signed by staff for August 1-21 for the 8:00p.m. dose of Divalproex. There are no staff signatures for the remainder of the month.
- Resident C's medication Clozapine (Clozapine) 50 Mg tab, take 1 tablet by mouth in the morning is signed by staff on the MAR, August 1-19, 2023, and again on August 22, 2023. There are no staff signatures for the remainder of the month of August on the MAR.
- Resident D's medication Olanzapine, 20mg take ½ tab by mouth twice daily, a.m. (morning) dose is signed as administered from August 1-19, 2023, and the 8:00p.m. dose is signed as administered from August 1-21, 2023. There are no staff signatures for remainder of the month.
- Resident D's medication Trazadone, 50 mg tab, take one tab by mouth at bedtime is signed as administered by staff August 1-21. The remainder of the month is not signed by staff as administered.
- Resident E's MAR documented all 17 medications for the month of August 2023. The medications were not signed by staff, indicating the medication was not administered 197 times.

On 09/11/2023, I reviewed a second set of MARs Ms. Cunningham sent to me via email. Ms. Cunningham received the MARs from Ms. Lewis on 09/07/2023 and noted that staff signatures were complete for the entire month of August 2023 on all the MARs documented above (Resident A and Resident D's MARs are not included

in the second set). A review of Resident B's first August 2023 MAR does not show the medication (Sertraline) Zoloft as 'DC'd' (discontinued) but the second signed August 2023 MAR documented the medication (Sertraline) Zoloft was marked as administered for the entire month of August 2023. It is also crossed through with a notation of 'DC' for discontinued. Ms. Cunningham stated Resident B's Zoloft was never discontinued and has not been refilled since January 2023.

On 09/15/2023, I conducted an unannounced inspection at the facility and interviewed DCW (direct care worker) Dwight Quinn with Ms. Cunningham. Mr. Quinn demonstrated how he passes medications now, by placing them in a cup and administering to residents one at a time and marking the MAR at the time of the medication administration. Mr. Quinn acknowledged that he was setting-up resident medications in daily "pill minders" for the next shift to administer. Mr. Quinn explained that shift staff would set up resident medications for the following shift and so on. Mr. Quinn acknowledged that he also signed the MAR later when he had time and did not sign the MAR immediately upon administration of the resident medications. Mr. Quinn stated Ms. Cunningham instructed him to stop passing medications as he had been and showed him how to properly administer resident medications and that is how he has been doing it since. Ms. Cunningham confirmed when she conducted the medication review in September 2023 that she instructed Mr. Quinn on how to properly administer the medications and to quit setting resident medications up in weekly pill minders.

Ms. Cunningham and I observed Resident D's medications in the medication cupboard set-up in a weekly pill minder. Ms. Cunningham and I did not observe any other resident medications set-up in weekly pill minders.

I reviewed the MARs for Resident A for the month of August 2023. The MAR documented that Resident A was administered (Sertraline) Zoloft 100mg and Buspirone 30mg each day during that month except for 8/29, 8/30 and 8/31/2023. Ms. Cunningham reported that Resident A's Zoloft and Buspirone were last filled on 06/23/2023 and should have run out on or about 07/23/2023.

I reviewed the MARs for Resident B for the months of March, April, May, June and August 2023. These MARs showed that the medication (Sertraline) Zoloft, 100mg tab was signed for every day as administered for all months when the medication reportedly had not been refilled since January 2023. I did not find the MAR for the month of July 2023.

I reviewed Resident C's MARs for July, August, and September 2023. Resident C was hospitalized in June 2023, and prior to hospitalization, Resident C was prescribed 50mgs of Clozaril, 1 tab, two times daily. Upon discharge from the hospital on 06/12/2023, Resident C was prescribed, 100mg Clozaril, 1 tab, three times daily, in addition to the 50mg tabs already prescribed. Upon review of Resident C's MARs for July, August, and September 2023, the MAR documented 50 mg tabs of Clozaril, 1 tab, two times daily but did not include the 100mg Clozaril until

the September MAR when it was caught by Ms. Cunningham and brought to staff's attention. The MARs reviewed showed that until Ms. Cunningham changed the MAR in September 2023, Resident C did not receive the 100mg Clozaril tabs three times daily as prescribed to him in June 2023.

I reviewed the MARs for Resident D for the month of August 2023. On the back of the MAR it was documented that the reason for not administering Olanzapine 20 mg 2x daily on 08/28, 08/29, 08/30/2023 was, '*Ran out, refill called in 08/28/2023, picked up 08/30.*'

On 10/12/2023, Ms. Mater, Ms. Cunningham and I met with home manager, Ms. Kaja Thornton and staff Ms. D. Lewis and Jeffrey Walker at Ms. K. Thornton's café to further review all the complaint allegations and medication issues noted during the medication review completed by Health West. Ms. Thornton and Ms. D. Lewis acknowledged they missed the call-in appointments for prescription refills in April and July 2023 for Buspirone and (Sertraline) Zoloft for Resident A. Resident A's MAR was marked from 07/23/2023-08/30/2023 indicating Resident A's Buspirone and Zoloft medication was administered even though the medication would have run out on 07/23/2023.

Ms. D. Lewis acknowledged Resident B's medication Zoloft (Sertraline) was not included in the packaged medication delivered to the facility by the pharmacy. Ms. D. Lewis stated staff at the facility were marking the medication as administered on the MARs when the pharmacy had not included it in the packaged medications. Ms. Cunningham stated even if the pharmacy did not deliver the medication, staff should have noticed the medication was not included in the medication package and followed-up with the pharmacy to discover why the medication was not included and that never occurred. Ms. Thornton and Ms. D. Lewis stated they did not receive a consent signed by Resident B's guardian for the medication and that is what they needed to get the medication. Ms. Cunningham stated the Zoloft consent form was signed and active and has been for years. Ms. Cunningham stated Resident B should have been out of the medication in February 2023, but the MARs are signed as administered through September 2023. Ms. D. Lewis stated they did not get Resident B's Zoloft but were marking the MAR. She acknowledged that was their mistake that they documented the resident received the medication when he did not.

Ms. Thornton and Ms. D. Lewis stated Resident C was in the hospital in June 2023 and at that time had a prescription for Clozaril 50mgs and upon release from the hospital, the new script increased the dose of Clozaril from 50mgs, 1 tab, 2 times daily to include 100mgs, 1 tab, 3 times daily. Ms. Thornton and Ms. D. Lewis stated they failed to add the 100mg Clozaril to the MAR so Resident A was getting 2, 50mgs doses of Clozaril daily in July, August, and early September 2023 when he should have been getting 100mg, 1 tab, 3 times daily plus the 2 times daily, 50mgs doses of Clozaril.

Ms. Thornton and Ms. D. Lewis acknowledged that Resident D's medications were set-up ahead of time in a weekly pill minder and night shift staff would set resident pills up in cups for the following shift. Ms. Thornton and Ms. D. Lewis acknowledged that Resident D missed three days of Olanzapine and Trazadone medication at the end of August 2023 because they ran out of the medication.

On 10/12/2023, Ms. Mater and I interviewed Residents A, B, C, D and E at the facility. The residents stated staff administer their medications and they all reported they get their medications as prescribed.

On 11/07/2023, I conducted an exit conference with Kaja Thornton, as approved by Licensee, John Thornton. Ms. Thornton stated she understands the information, analysis, and conclusion of this applicable rule. Ms. Thornton stated she will review the report and submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The complainant reported that Resident A, B, C, D and E's medications were not being administered properly by staff at the facility. Upon conducting a medication review, Ms. Cunningham discovered significant issues with the resident medications leading to the conclusion that the medications are not being administered as prescribed. After a review of the medication administration records coupled with Ms. Cunninghams medication review, it is apparent resident medications are not being administered as prescribed and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 the following provisions: **(b) Complete an individual medication log that contains all 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:	After a review of resident medication administration records staff are not initialing the MAR documenting the medication had been administered at the time the medication is given. A violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff are not trained in the administration of medication.

INVESTIGATION: On 09/11/2023, I received an ORR complaint that documented staff at the facility are not following the "5 R's" of medication administration.

On 09/15/2023, I conducted an unannounced inspection at the facility and interviewed Mr. Quinn. Mr. Quinn stated he had in-house training for medication administration by Ms. D. Lewis. Mr. Quinn stated he had been shown to set-up Resident D's meds in the weekly pill minder and did not know that was not allowed until Ms. Cunningham instructed him to stop setting up the medications and to pass medications and sign the MAR at the time they are given.

On 10/05/2023, I met with Ms. Mater, Ms. Ritchie, Ms. Wagner, Ms. Thornton, and Ms. Lewis at Health West. Ms. Thornton and Ms. D. Lewis acknowledged that staff have not been trained through Health West but rather in-house by Ms. D. Lewis. Ms. Thornton and Ms. D. Lewis stated they need to get all staff trained in the administration of medications through Health West, but it has been difficult to get them into classes and keep staffing at the facility. Ms. Thornton and Ms. Lewis stated staff have been instructed in the home how to pass medications, but they have not gone through training online or in person through Health West as is required for a specialized facility.

On 10/12/2023, I conducted an inspection at the facility and interviewed Ms. L. Lewis. Ms. L. Lewis stated she has been shown how to pass the medications at the

facility by Ms. D. Lewis but has not been trained on medications through Health West.

On 11/01/2023, I interviewed Ms. Wagner via telephone. Ms. Wagner stated Doug Striker, Health West trainer confirmed that Ms. D. Lewis has completed the medication training but no other staff from the facility have gone through the training.

On 11/07/2023, I conducted an exit conference with Kaja Thornton, as approved by Licensee, John Thornton. Ms. Thornton stated she understands the information, analysis, and conclusion of this applicable rule. Ms. Thornton stated they are working with Health West to get staff scheduled for medication training. Ms. Thornton stated she will review the report and submit an acceptable corrective action plan.

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: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Staff at the facility are not trained in the proper handling and administration of resident medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 09/15/2023, I conducted an unannounced inspection at the facility with Ms. Cunningham. I interviewed Mr. Quinn regarding resident medications. Mr. Quinn stepped outside the facility to use the telephone and Ms. Cunningham and I noticed the medication cupboard was not locked. Mr. Quinn stated since we were reviewing medications, he thought we needed to get into the cupboard and left it unlocked. Ms. Quinn stated he always keeps the resident medications locked.

On 10/05/2023, I met with Ms. Ritchie, Ms. Wagner, Ms. Mater, Ms. Thornton, and Ms. D'Erika Lewis at Health West to review complaint information. Ms. Hunter and Ms. Lewis stated the medication cupboard is always locked.

On 10/12/2023, I met with Ms. Mater, Ms. Cunningham, Ms. Thornton, Ms. D. Lewis and Mr. Walker at Ms. Thornton's café. Ms. Thornton stated the medication cabinet at the facility is always locked. Ms. Thornton stated Mr. Quinn was nervous when

Ms. Cunningham and I conducted an unannounced inspection at the facility on 09/15/2023 and that it why it was found unlocked.

On 10/12/2023, I conducted an inspection at the facility with Adult Protective Services (APS) worker, Anna Mater and we observed the medication cupboard open, unlocked, and no resident medications were being administered at the time. Ms. Mater and I interviewed DCW La'Drea Lewis, and she stated the lock on the cabinet is broke and cannot be locked. Ms. L. Lewis stated the broken lock on the cupboard has been that way for an unknown length of time. Ms. Mater and I requested that Ms. L. Lewis move the medications to a locked cabinet and Ms. L. Lewis showed us a set of cabinets she planned to move the resident medications to and demonstrated that the cabinet has a working lock.

On 11/07/2023, I conducted an exit conference with Kaja Thornton, as approved by Licensee, John Thornton. Ms. Thornton stated she understands the information, analysis, and conclusion of this applicable rule. Ms. Thornton stated Ms. L. Lewis moved the medications to a locked cupboard in the facility, so the medications are always locked. Ms. Thornton stated she will review the report and submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	The medication cabinet at the facility was not locked on 09/15/2023 and again on 10/12/2023. Mr. Quinn stated he left the medication cabinet unlocked for Ms. Cunningham and I to review medications on 09/15/2023 and the cabinet would be locked upon completion of the medication review. Ms. Thornton and Ms. D. Lewis stated the medication cabinet at the facility is always locked.

	Ms. Mater and I found the resident medication cupboard unlocked and unsupervised on 10/12/2023. Ms. L. Lewis reported the medication cabinet lock has been broken and not working for an unknown length of time. While Mr. Quinn may have left the medication cabinet unlocked for Ms. Cunningham & I's unannounced medication review on 09/15, on 10/12/2023, Ms. Mater and I found the medication cabinet unlocked during an announced inspection. During that inspection, Ms. L. Lewis acknowledged the lock had been broken for an unknown amount of time and the cabinet is left unlocked with resident medications inside because the cabinet cannot be locked. A violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan including proof of staff training in the administration, documentation, and storage of resident medications, I recommend the status of the license be changed to provisional based upon the above-cited quality of care violations.

Elizabeth Elliott

11/07/2023

_____

Elizabeth Elliott Date
Licensing Consultant

Approved By:

Jerry Hendrick

11/07/2023

_____

Jerry Hendrick Date
Area Manager