GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 22, 2024

Ira Combs, Jr.
Christ Centered Homes, Inc.
327 West Monroe Street
Jackson, MI 49202

RE: License #: AS380011360
Investigation #: 2024A0007018
Napoleon Rd Home

Dear Ira Combs, Jr.:

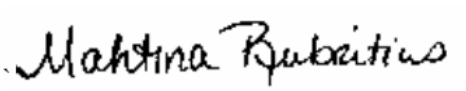
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 licensee designee 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) 284-9720.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380011360
Investigation #:	2024A0007018
Complaint Receipt Date:	02/27/2024
Investigation Initiation Date:	02/28/2024
Report Due Date:	04/27/2024
Licensee Name:	Christ Centered Homes, Inc.
Licensee Address:	327 West Monroe Street Jackson, MI 49202
Licensee Telephone #:	(517) 499-6404
Administrator:	Ira Combs, Jr.
Licensee Designee:	Ira Combs, Jr.
Name of Facility:	Napoleon Rd Home
Facility Address:	7722 Napoleon Road Jackson, MI 49201
Facility Telephone #:	(517) 250-7927
Original Issuance Date:	05/04/1992
License Status:	REGULAR
Effective Date:	09/23/2022
Expiration Date:	09/22/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On February 2, 2024, Resident A was hospitalized with a major bedsore. It is alleged that staff failed to provide proper intervention before the bedsore became worse. Concerns that there is no way that staff could have missed it, and the bedsore is described as "horrific."	Yes
Additional Findings	Yes

III. METHODOLOGY

02/27/2024	Special Investigation Intake - 2024A0007018
02/28/2024	Special Investigation Initiated - Face to Face contact with Devin Pickett, APS. Discussion.
02/28/2024	Contact - Document Received - Photos of bedsore.
03/05/2024	Contact - Face to Face with Devin Pickett, Adult Protective Services.
03/07/2024	APS Referral Made.
03/20/2024	Inspection Completed On-site Unannounced - Face to face contact with Paige Coleman, Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, and two direct care staff.
03/20/2024	Contact - Telephone call made- Interview with Rebecca Gray, Direct Care Staff.
03/21/2024	Contact - Face to Face with Devin Pickett, Adult Protective Services.
03/21/2024	Contact - Telephone call made - Interview with Kiesha Austin, Direct Care Staff.
03/21/2024	Contact - Telephone call made to Jody Rodriguez, Direct Care Staff/Quality Improvement.
03/29/2024	Contact - Telephone call made to Paige Coleman, Follow up questions.

03/29/2024	Contact - Telephone call made to Jody Rodriguez, Case Discussion.
04/02/2024	Contact - Telephone call made to Ashlee Griffes, Office of Recipient Rights. Discussion.
04/11/2024	Inspection Completed On-site - Unannounced - Face to face contact with Michelle Nelson, Direct Care Staff, Jordyn Winters, Direct Care Staff, Resident B and Resident D.
04/11/2024	Contact - Document Received - Person Centered Plan for Resident A.
04/12/2024	Contact - Telephone call made to Jody Rodriguez. Documents requested.
04/15/2024	Contact - Telephone call made to Guardian A1. Interview.
04/15/2024	Contact - Document Sent - Email to Ashlee Griffes, ORR. Her investigation is still pending.
04/15/2024	Contact - Telephone call made to Diane Bates, RN, RN, Lifeways.
04/15/2024	Contact - Document Received - AFC Assessment Plan & December Head- to-Toe body check form.
04/16/2024	Contact - Telephone call made to Jody Rodriguez, Discussion.
04/17/2024	Contact - Face to Face contact with Bill Rozema, APS, Discussion.
04/17/2024	Contact - Document Received - Medication logs for January and February 2024.
04/17/2024	Contact - Telephone call made to Paige Coleman, Follow-up questions.
04/19/2024	Contact - Telephone call made to Ira Combs, Jr., Licensee Designee. I requested a returned phone call to conduct the exit conference.
04/20/2024	Contact – Telephone message from Ira Combs, Jr., Licensee Designee.
04/22/2024	Contact - Telephone call made to Ira Combs, Jr., Licensee Designee.

04/22/2024	Exit Conference conducted with Ira Combs, Jr., Licensee Designee.

ALLEGATION:

On February 2, 2024, Resident A was hospitalized with a major bedsore. It is alleged that staff failed to provide proper intervention before the bedsore became worse. Concerns that there is no way that staff could have missed it, and the bedsore is described as "horrific."

INVESTIGATION:

On February 28, 2024, I made face-to-face contact with Devin Pickett, Adult Protective Services (APS). Devin Pickett, APS, informed me that he had a case assigned to him on February 2, 2024, and the APS on-call worker visited with Resident A in the hospital (the specific date was not given). Devin Pickett reported that he planned to visit Resident A within a week.

On March 5, 2024, I made face-to-face contact with Devin Pickett, (APS), and he stated that he made face-to-face contact with Resident A on 3/1/24. He interviewed Paige Coleman, Direct Care Staff, who has the role as home manager. Devin Pickett also observed Resident A sitting in her chair, at about a 45-degree angle, which would contribute to her getting a bedsore on her coccyx. Devin Pickett stated that Resident A is non-verbal, but she did smile when he spoke to her. Devin Pickett also stated that the wound care nurse comes to the home twice a week.

It should be noted that during Special Investigation #2024A0007014, I spoke to direct care staff member Paige Coleman regarding Resident A's hospitalization on February 2, 2024. Paige Coleman stated that when Resident A does not feel well, she does not eat a lot, and she sleeps a lot. Paige Coleman stated that Resident A had problems with kidney stones and urinary tract infections (UTI's); Resident A was given Tylenol. Paige Coleman stated they (Paige Coleman, Rebecca Gray, and Kiesha Austin), direct care staff, were concerned about Resident A's condition a couple of days before she went to the hospital; however, Resident A had no fever and she was eating her food, but sometimes appeared tired. Paige Coleman stated that Resident A also has dementia. I inquired what prompted them to contact 911 on February 2, 2024, and Paige Coleman stated it was because Resident A was "really sleepy and she had a fever" and because she thought Resident A had a UTI. Paige Coleman reported staff administered Tylenol because Resident A had a "little fever," and the Tylenol brought Resident A's temperature down. Paige Coleman informed me that they did not think that Resident A needed treatment at first, but her symptoms progressed and got worse. Paige Coleman informed me that staff documented Resident A's progress in an internal facility tracking system.

On March 20, 2024, I conducted an unannounced on-site investigation and made face-to-face contact with Paige Coleman, Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, and two direct care staff. While at the home, I observed Resident A in her room napping.

I also spoke to Paige Coleman and inquired about Resident A's bedsores, and when they first noticed them. She stated that Resident A had been in and out of the hospital several times, and she came home with a bedsore on her tailbone area. Paige Coleman reported that they were trying to make sure and keep the wounds clean, using gauze etc. She stated they were concerned for Resident A and that is when they contacted Jody Rodriguez, and Resident A was sent in for a medical evaluation. Paige Coleman informed me that because of the wounds, Resident A was septic and that is why she had to go to the hospital on February 2, 2024.

On March 20, 2024, I interviewed Rebecca Gray, Direct Care Staff, about Resident A's bedsores and when they first noticed them. Rebecca Gray informed me that Resident A had the bedsore on her "butt" when she came back from the hospital. She stated that Resident A had been in the hospital for surgery (prior to 2/2/24) and when she returned, she had the bedsore. According to Rebecca Gray, prior to Resident A being in the hospital, she did not have a bedsore.

On March 21, 2024, I made face-to-face contact with Devin Pickett, APS. He stated that he had been in contact with Resident A's guardian regarding the investigation. Devin Pickett also informed me that Resident A had been placed on hospice care. Devin Pickett further stated that he reached out to Dr. Andy Duda, Hospice, regarding the care that Resident A was receiving in the home. According to Devin Pickett, Dr. Andy Duda reported to have nurses in the home on a regular basis and staff had not documented seeing anything concerning. Devin Pickett reported that he would not be substantiating the allegations, and he would be closing the case.

On March 21, 2024, I interviewed Kiesha Austin, Direct Care Staff. I inquired when she first observed the bedsores on Resident A. Kiesha Austin informed me that Resident A had a procedure done on her kidney and when she returned from the hospital, she had a bedsore on the tailbone area and on her hip (left side). Keisha Austin stated direct care staff were instructed to clean, treat, and care for the sores and they were able to get the sore on her hip healed.

On March 21, 2024, I interviewed direct care staff member Jody Rodriguez, whose role is, Quality Improvement. Jody Rodriguez stated that Resident A had been in and out of the hospital multiple times with kidney issues since October of 2023. According to Jody Rodriguez, Resident A was in and out of the hospital multiple times and she would return home with bedsores. The staff would assist and care for Resident A, including bathing, administering topical skin creams, and changing her. They would also rotate and reposition Resident A, and they made sure she was clean and dry. This occurred every two hours. Jody Rodriguez also recalled that she

spoke with the hospice nurse (name unknown), who informed her that Resident A's organs had failed her, and she could not fight infections. Jody Rodriguez stated even a scratch or laceration to the skin could turn into something very serious. Jody Rodriguez informed me that Resident A was now on Hospice and the comfort care nurse, or the hospice nurse assists Resident A in the home every two days.

On March 29, 2024, I spoke with Paige Coleman, and she informed me that Resident A had surgery on January 11, 2024, to have a stint put in and to address her kidney issues. Paige Coleman was not sure when Resident A was discharged from the hospital but stated the information would be documented in the internal home tracking system.

On March 29, 2024, I spoke to Jody Rodriguez, who informed me that Resident A had a one day stay when she had the kidney procedure on January 11, 2024. The visiting doctor, Dr. Scott, came to the home on January 16, 2024. According to their records, staff first noticed the bedsore on January 29, 2024. On February 2, 2024, staff contacted 911 after noticing that Resident A was not acting like herself. Once ready for discharge, the hospital tried to send Resident A back to the facility with a PICC line; however, it was determined that she would go to a nursing home instead. Jody Rodriguez stated Resident A left the hospital, went to the nursing home and later Resident A returned to the facility on February 23, 2024. According to Jody Rodriguez, there were no physicians' instructions regarding wound care, prior to Resident A being released from the nursing home and hospital (on February 23, 2024). Jody Rodriguez also referenced wound care paperwork from February 24, 2024, which indicated nursing staff would visit the home on Tuesday's and Friday's.

On April 2, 2024, I spoke to Ashlee Griffes, Office of Recipient Rights. She informed me that Resident A passed away on April 1, 2024. Ashlee Griffes stated that Resident A was moved to the hospice home prior to passing away. Regarding data in the facility, Ashlee Griffes stated that the staff should have documented Resident A's condition on the skin integrity forms.

As a part of this investigation, I reviewed photographs of the wound. It appeared that there was an oval shaped sore, located around the tailbone region, it was approximately 1 ½ inches long, and ¾ wide. There was a yellow scab, and the skin around the sore appeared to be red and brown.

I also reviewed the *Hospital Stay Details* and information for Resident A, dated February 15, 2024 - February 23, 2024. It was noted that Resident A was admitted for Sepsis, and her diagnosis also included pressure injury of the sacral region, Stage 4.

On April 11, 2024, I conducted an unannounced on-site investigation and made face- to-face contact with Michelle Nelson, Direct Care Staff, Jordyn Winters, Direct Care Staff, Resident B and Resident D. Resident C and Resident F were in their rooms resting and Resident E was at an appointment.

I asked to review Resident A's resident record and staff informed that some of Resident A's resident record had been sent to the hospice home, with Resident A, and Guardian A1 was planning to return it when she picked up her belongings. While in the home, I was able to review data sheets for Resident A.

The *Head-to-Toe Body Check* data sheets were reviewed for Resident A. In December of 2023, there were no skin breakdowns noted. In January of 2024, staff documented on January 29, 2024, Resident A had a bedsore on her tailbone. According to the data sheets, there were no other skin breakdowns noted prior to that date. The data sheets reflected that staff documented the daily ADLs provided and when Resident A had bowel movements.

I also reviewed the *Assessment Plan for AFC Residents* for Resident A which documented Resident A required full assistance from staff with toileting, bathing, grooming (hair, nails etc.), dressing, and personal hygiene.

On April 15, 2024, I interviewed Resident A's guardian (Guardian A1), and she stated that on February 2, 2024, she was contacted by Bill Rozema, from Adult Protective Services regarding her sister, Resident A. Guardian A1 was informed that Resident A had an open wound on her coccyx; it was not just a bedsore. Guardian A1 stated that the people (direct care staff) from the home had contacted her and informed that Resident A was not acting like herself, she was not eating etc. Guardian A1 stated that Resident A had a kidney ablation on January 11, 2024, and they thought that maybe this was a UTI; thus, Resident A was sent to the hospital on February 2, 2024. Guardian A1 stated that Resident A was often in and out of the hospital.

Guardian A1 stated that infectious disease got involved and took photos of the wound to track her progress. Guardian A1 saw the photos and she spoke with other personal friends, who have medical experience; and they stated there was no way that staff should have missed the bedsore. Guardian A1 stated the photos were "horrific." I inquired when Guardian A1 first became aware that Resident A had a bedsore and she stated it wasn't until she went to the hospital on February 2, 2024. Guardian A1 stated that she spoke with Diana RN (last name not given), who was a travelling nurse, that treated Resident A. Diana informed her that there were times when Resident A would come home from the hospital with what appeared to be rug burns. According to Guardian A1, Diana RN was unaware of the bedsores. Guardian A1 informed me that Resident A was sent back to the ER on March 7, 2024, and returned home that same day. Guardian A1 informed me that Resident A passed away on April 1, 2024.

On April 15, 2024, I interviewed Diane Bates, RN, from Lifeways. Diane Bates, RN stated that Resident A had a medical procedure on January 11, 2024, and when she came back from the hospital, she had a urine burn, that appears like a rug rash (or irritation to the skin), on her buttocks; the skin was intact. Diane Bates, RN stated

the skin irritation was not at the very top of her buttocks. Diane Bates, RN stated direct care staff were given verbal instructions to provide good peri care, turning Resident A from side to side, keeping her off her back, washing her three times per day, administering barrier cream, and repositioning Resident A, so that she was sitting on her left buttock then her right buttock.

Diane Bates, RN stated that on January 25, 2024, she was at the facility to check on another patient. She stated she routinely inquires if any of the residents have skin breakdowns or problems, but direct care staff did not disclose any information to her about Resident A having any bedsores or an open wound. Diane Bates, RN informed me that they don't remove the residents clothing, unless there is an issue reported. Diane Bates, RN stated that she did not see the wound until she observed the pictures that Guardian A1 sent. Diane Bates, RN stated that she did not find out about the bedsores until February 6, 2024.

Diane Bates, RN stated that she has worked in the home for over nine years, and during this time she has never had a patient with a bedsore. She reported to be upset regarding Resident A's condition. Diane Bates, RN informed me that in her professional opinion, these types of sores do not occur overnight and that the wound had to be there for two to three weeks. I inquired if she had reviewed the data sheets, as staff documented that they first noticed the bedsore on January 29, 2024, and she stated they go to the home once a month, and she would have been scheduled to review the data in the beginning of February.

Diane Bates, RN stated that Resident A went to the hospital on February 2, 2024, and Guardian A1 wanted her to have nursing care. Diane Bates, RN informed Guardian A1 of the steps she would need to take to have this occur, including having an order from the doctor. After being discharged from the hospital, Resident A went to a nursing home for two days, before she was sent back to the hospital. Diane Bates, RN recalled that after Resident A returned to the facility (on February 24, 2024), she was there, along with home help and she observed them dressing the wound etc. Resident A was also sent home with a wound VAC. On this same day, Diane Bates, RN stated she also in-serviced the direct care staff about repositioning Resident A. I inquired if the staff had ever received any training to care for bedsores and she stated Resident A never had bedsores until this time. Further, that if a resident has a wound, nursing staff will come out and assess the situation. If the staff cannot provide the care needed, then they request home help, who would visit the home more often, assisting with care. Diane Bates, RN voiced concerns as the home used to have experienced staff, who knew what medical concerns or symptoms to pick up on.

On April 15, 2024, Jody Rodriguez, informed me that Resident A moved to the hospice home on March 25, 2024.

On April 16, 2024, I spoke to Jody Rodriguez, and inquired what staff did when they noticed the bedsore on January 29, 2024. Jody Rodriguez stated that she did not

recall the exact date, but when Resident A was discharged from the hospital previously, direct care staff were told to use antiseptic pads and barrier cream with every brief change. Jody Rodriguez stated that she could not recall the exact name, but the barrier cream was included in the box with the briefs and blue pads. I inquired if the name of the barrier cream was listed on the MAR, and she stated that it should be. She also informed me that she was trained in this home to use the barrier cream, that was included in the box, when changing a brief. Jody Rodriguez agreed to send me a copy of the January and February MARs for Resident A. On this same day, Jody Rodriguez informed me that the barrier cream was not listed on the MAR.

On April 17, 2024, I made face-to-face contact with Bill Rozema, Adult Protective Services. Bill Rozema informed me that he made face to face contact with Resident A on February 4, 2024, at 11:55 a.m. at the hospital. Resident A was unable to speak with him, as she was non-verbal. Bill Rozema spoke with medical personnel (RN), who informed him direct care staff sought care as there was a change in Resident A's mentation. It was unknown how long the facility staff waited to seek care for Resident A. Medical personnel also informed Bill Rozema that Resident A had many pressure ulcers to the point of infection and the doctors had cleaned and packed the ulcers yesterday. Bill Rozema was advised that Resident A had ulcers on her hip, right foot, her left ankle, and her left knee. Bill Rozema was advised that this was usually consistent with Resident A not moving her body around much.

On April 17, 2024, I received and reviewed the January and February MARs for Resident A. I noted that two tablets of Acetaminophen (Tylenol) 325mg, was listed as a PRN, to be administered by mouth every four hours as needed. There was no documentation that Tylenol had been administered to Resident A during the month of January or February 2024. I observed it was also noted on the coversheet that the name of the barrier cream was Peri-Guard ointment. This ointment was not listed as being administered to Resident A on the January and February MARs.

On April 17, 2024, I spoke with Paige Coleman and asked again what staff gave Resident A to bring down her temperature, and she stated it was Tylenol. I asked her to review the medication logs with me, as I did not see where any direct care staff documented that Tylenol had been administered to Resident A. Paige Coleman agreed that there was no documentation of PRN medication administration of Tylenol during January and February 2024. Paige Coleman informed me that when they noticed the bedsore on January 29, 2024, they put the barrier cream on the sore, and administered Tylenol, even though this was not documented on Resident A's January or February 2024 MARs. Paige Coleman stated shortly after that, they sent Resident A to the hospital because they could not treat the bedsore.

As a part of this investigation, I reviewed the *PCP and Treatment Plan* for Resident A. It was noted that Resident A was diagnosed with "unspecified schizophrenia spectrum and other psychotic disorder and Moderate Intellectual Disability." Resident A has "chronic medical conditions which require close treatment and

monitoring, including currently pending a second surgery to place a stint to pass another kidney stone." It was also documented in the treatment plan that staff were to "monitor skin daily, after a.m. care for any signs of breakdown, redness, or rash. Staff are to thoroughly clean and dry area after any incontinent episodes. Document any skin issues on a medical check list daily 100% of the time. Any non-healing or worsening skin issues, seek medical attention." It was also noted that the RN will "coordinate with, educate, in-service, home staff, review and interpret data collection and monitor per authorization." Nurse "(RN) will complete a physical assessment including blood pressure, pulse, oxygen saturations, respirations every visit.

On April 22, 2024, I conducted the exit conference with Ira Combs, Jr., Licensee Designee. We discussed the investigation, findings, and my recommendations. Ira Combs, Jr., stated that he would be providing additional training to the staff to address the violations. Ira Combs, Jr., also agreed to submit a written corrective action plan to address the established violations.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**

ANALYSIS:	Based on Resident A's *Assessment Plan for AFC Residents*, Resident A required full assistance from staff with toileting, bathing, grooming (hair, nails etc.), dressing, and personal hygiene. Also, According to Resident A's *PCP and Treatment Plan,* staff were to "monitor skin daily, after a.m. care for any signs of breakdown, redness, or rash. Staff are to thoroughly clean and dry area after any incontinent episodes. Document any skin issues on a medical check list daily 100% of the time. Any non-healing or worsening skin issues, seek medical attention." Consequently, direct care staff members should have noticed and documented the wound, rash or skin irritation observed on January 11, 2024, and January 29, 2024, while providing toileting and peri-care and sought medical attention once this condition worsened or did not appear to heal per Resident A's PCP. After Resident A's medical procedure on January 11, 2024, Diane Bates, RN, provided direct care staff members with verbal guidance and instruction to address the urine rash present on Resident A's lower buttocks and to alleviate any potential bedsores from developing. There was no documentation in Resident A's resident record that these instructions were followed to assure Resident A was turned, re-positioned, changed, and ointment applied regularly, per verbal direction by Diane Bates, RN. Further, direct care staff did not inform Diane Bates, RN, that Resident A was experiencing any bedsores or open wounds during her January 25, 2024, onsite visit, despite Diane Bates, RN inquiring. Diane Bates, RN, informed me that in her professional opinion, these types of sores do not occur overnight and that the wound had to be there for two to three weeks. Based on the information gathered during this investigation and provided above, it's concluded direct care staff did not follow the health care instructions with regard to Resident A's health care needs, by accurately documenting the skin breakdowns, monitoring the condition after the medical procedure on January 11, 2024, and notifying medical personnel in a timely manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On March 20, 2024, Paige Coleman reported that they were trying to make sure and keep the wounds clean, using gauze etc.

On March 21, 2024, I interviewed Kiesha Austin, Direct Care Staff, she reported that Resident A had a bedsore on the tailbone area and on her hip (left side). They were instructed to clean, treat, and care for the sores and they were able to get the sore on her hip healed.

On April 16, 2024, I spoke to Jody Rodriguez, and inquired what staff did when they noticed the bedsore on January 29, 2024. Jody Rodriguez stated that she did not recall the exact date, but when Resident A was discharged from the hospital previously, direct care staff were told to use antiseptic pads and barrier cream with every brief change. Jody Rodriguez stated that she could not recall the exact name, but the barrier cream was included in the box with the briefs and blue pads. I inquired if the name of the barrier cream was listed on the MAR, and she stated that it should be. She also informed me that she was trained in this home to use the barrier cream, that was included in the box, when changing a brief.

Diane Bates, RN, stated that staff were given verbal instructions to provide good peri care, turning Resident A from side to side, keeping her off her back, washing her three times per day, administering barrier cream, and repositioning Resident A

On April 17, 2024, I was informed that the name of the barrier cream was Peri-Guard ointment.

On April 17, 2024, I reviewed the January and February 2024 MARs for Resident A, and there was no documentation that the barrier cream, Peri-Guard, was administered.

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: **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**
ANALYSIS:	There was no documentation on the January and February 2024 MARs that the barrier cream, Peri-Guard, was administered and per verbal direction by Diane Bates RN.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of a very detailed acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.

04/22/2024

_____

Mahtina Rubritius Date
Licensing Consultant

Approved By:

04/22/2024

_____

Dawn N. Timm Date
Area Manager