GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 16, 2025

Carol DelRaso
Grandhaven Living Center LLC
Suite 200
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL330267336
Investigation #: 2025A1033019
Grandhaven Living Center 1 (Lighthouse)

Dear Ms. DelRaso:

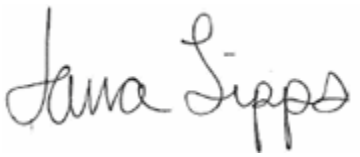
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL330267336
Investigation #:	2025A1033019
Complaint Receipt Date:	03/03/2025
Investigation Initiation Date:	03/04/2025
Report Due Date:	05/02/2025
Licensee Name:	Grandhaven Living Center LLC
Licensee Address:	Suite 200 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(517) 420-3898
Administrator:	Brandy Shumaker
Licensee Designee:	Carol DelRaso
Name of Facility:	Grandhaven Living Center 1 (Lighthouse)
Facility Address:	3135 W. Mount Hope Avenue Lansing, MI 48911
Facility Telephone #:	(517) 485-5966
Original Issuance Date:	07/15/2004
License Status:	REGULAR
Effective Date:	05/14/2023
Expiration Date:	05/13/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has been sexually assaulted at the facility.	No
Resident A's medications were not administered as ordered.	No
Direct care staff did not complete entries on Resident A's Medication Administration Record.	Yes

III. METHODOLOGY

03/03/2025	Special Investigation Intake 2025A1033019
03/04/2025	Special Investigation Initiated – Telephone- Interview with Adult Protective Services, Adult Services Worker, Robert Joyner, via telephone.
03/05/2025	Inspection Completed On-site- Interviews conducted with Executive Director/direct care staff, Marie Jonzun, direct care staff, Paulina Gruesbeck, and Annice Husband. Review of Resident A's resident record initiated.
03/05/2025	Contact - Document Sent- Email correspondence sent to Executive Director, Marie Jonzun, requesting additional documentation. Awaiting response.
03/05/2025	APS Referral- APS referral assigned to Robert Joyner.
03/19/2025	Contact - Telephone call made- Attempt to interview Relative A1 via telephone. Left voicemail message and awaiting returned call.
03/19/2025	Contact - Document Sent- Email correspondence sent to Careline Health Group, nurse practitioner, Jessica Bates. Awaiting response.
03/27/2025	Contact - Telephone call made- Interview conducted with Relative A1, via telephone.
03/27/2025	Contact - Document Sent- Email correspondence sent to Executive Director, Marie Jonzun, requesting copies of Resident A's Medication Administration Records for the months January and February 2025.

03/27/2025	Contact - Document Received- Requested MARs received via email from Ms. Jonzun.
03/28/2025	Contact – Document Sent- Email correspondence sent to Relative A1. Awaiting response.
03/28/2025	Contact – Telephone call made- Attempt to interview Resident A. Telephone call made to Relative A1 in attempts to interview Resident A. Voicemail message was left. Awaiting response.
04/04/2025	Contact – Telephone call made- Attempt to interview direct care staff, Shannon Marcum. Voicemail message left, awaiting response.
04/04/2025	Contact – Telephone call made- Attempt to interview direct care staff, Cherryl Charles. Voicemail message left, awaiting response.
04/04/2025	Contact – Telephone call received- Interview conducted with direct care staff, Shannon Marcum, via telephone.
04/07/2025	Exit Conference- Conducted via telephone call and voicemail message left for licensee designee, Carol DelRaso.

ALLEGATION: Resident A has been sexually assaulted at the facility.

INVESTIGATION:

On 3/3/25 I received an online complaint regarding the Grandhaven Living Center 1 (Lighthouse), adult foster care facility (the facility). The complaint alleged that Resident A may have been sexually assaulted while at the facility. On 3/4/25 I interviewed Adult Protective Services (APS), adult services worker, Robert Joyner, regarding the allegations. Mr. Joyner reported that he received these allegations while Resident A was hospitalized. He reported that she was hospitalized on 2/23/25 and he met with Resident A and Relative A1 at the hospital. Mr. Joyner reported that Resident A denied the allegations and stated that she had never been sexually assaulted at the facility. Mr. Joyner reported that he spoke with Relative A1 and she reported that Resident A has a diagnosis of dementia, but further stated that Resident A's dementia is not to the point where she would not recall being sexually assaulted. Mr. Joyner reported that Resident A was found to have physical signs of sexual assault, such as small lacerations near her vaginal area, swelling, and some blood in this region. Mr. Joyner reported that a Sexual Assault Nurse Examination (SANE) was declined by Resident A and Relative A1 during this hospitalization. Mr. Joyner reported that he had no further information to report and that his investigation would be closed due to a lack of evidence obtained.

On 3/5/25 I conducted an unannounced, on-site investigation at the facility. I spoke with Executive Director/direct care staff, Marie Jonzun, via telephone as she was not on-site at the time of the investigation. Ms. Jonzun reported that Relative A1 had stated to her that a complaint had been made regarding the facility, but she was not certain of the nature of the complaint. Ms. Jonzun reported that Resident A was currently hospitalized for multiple falls, resulting in injury. She reported that she has no direct knowledge of the direct care staff physically or sexually abusing Resident A. Ms. Jonzun reported that Resident A was mostly independent with dressing, toileting, and showering.

During the on-site investigation on 3/5/25 I interviewed direct care staff, Paulina Gruesbeck, regarding the allegation. Ms. Gruesbeck reported that she currently works first shift at the facility and she has worked at the facility for about 15 years. She reported that Resident A was admitted to the facility on 8/30/24. She reported that Resident A was very quiet and kept to herself. She reported that Resident A liked to stay in her bedroom at the facility. Ms. Gruesbeck reported that Resident A was mostly independent when it came to activities of daily living, such as showering, toileting, and dressing. Ms. Gruesbeck reported that she is not aware of any relationships Resident A had with any of the other residents. She reported that Resident A kept to herself and liked to eat her dinners in her own room. Ms. Gruesbeck reported that she has no knowledge of anyone physically harming Resident A while she was at the facility. Ms. Gruesbeck reported that Resident A did fall frequently and she was always feeling unwell. Ms. Gruesbeck reported that Resident A frequently asked to be sent to the hospital.

During the on-site investigation on 3/5/25, I interviewed direct care staff, Annice Husband. Ms. Husband reported that she has worked at the facility for about two years. Ms. Husband reported that Resident A was mostly independent with her activities of daily living, such as dressing, showering, and toileting. She reported that the direct care staff would assist Resident A with preparing meals, administering medications, and laundry services. Ms. Husband reported that Resident A had a dog in her room. She reported that Resident A would frequently stay in her room for meals and did not socialize much. Ms. Husband reported that Resident A always appeared to be unhappy and asked to return to her home on multiple occasions. Ms. Husband reported that prior to Resident A's most recent hospitalization, Resident A did experience an unwitnessed fall at the facility. She reported that a couple days later, Resident A experienced another unwitnessed fall and was sent to the emergency department for evaluation. Ms. Husband reported that she has no direct knowledge of anyone physically or sexually assaulting Resident A while she was residing at the facility.

During the on-site investigation on 3/5/25, I reviewed the following documents:

- *Charting Notes for [Resident A]*, for the period, 2/16/25 through 2/24/25. I made the following observations:
    - 2/16/25 @ 1:13AM: direct care staff, Cherryl Charles, recorded, "Resident let staff know that she fell in her room while going into her cupboard. Stated she hit her left eye. As of right now there is no visible sign of injuries. Encouraged res to use her walker said she will try. Informed her daughter and wellness director."
    - 2/16/25 @ 2:25PM: Ms. Gruesbeck recorded, "Resident appeared confused this morning. She thought it was evening and was looking for dinner. She refused to get up to get her weight."
    - 2/16/25 @ 11:25PM: Ms. Charles recorded, "Resident requested PRN Norco and nausea pill".
    - 2/17/25 @ 10:10PM: Ms. Charles recorded, "Resident refused her short-term insulin because her blood sugar was only 98. Requested prn Norco and nausea pill."
    - 2/20/25 @ 4:11PM: Direct care staff, Shanell Croom, recorded, "Res stated she did not feel good and she felt short of breath. I checked her vitals bp 147/83 hr 129 O2 was 82. EMT was called and daughter was contacted as well as our supervisor Susan. Res is currently at sparrow hospital."
    - 2/22/25 @ 2:36PM: Ms. Husband recorded, "Resident at breakfast. I was doing rounds when I saw her using the bathroom. She stated that she fell in living room trying to go to bathroom. She had BM everywhere in the bathroom feet, hands, legs, also the dog was licking up poop. We got her into wheelchair and got her into shower. She stated she wanted to go to hospital later said she do not want to go to hospital. Is in bedroom now sleep."

    - 2/22/25 @ 9:42PM: Direct care staff, [Shannon Marcum], recorded, “Res wasn’t feeling good today. She stated in bed all day. She took her meds.”
    - 2/23/25 @ 7:05AM: Direct care staff, Myana Collins, recorded, “Says she needed an ambulance because she fell but was in bed when I went in there. She couldn’t tell me when or how she fell either but there is no sign of hurt besides the bruise that I believe has already been there.”
    - 2/23/25 @ 4:52PM: Ms. Gruesbeck recorded, “Resident was upset this morning and demanded to be sent to the hospital. She tried to refuse her medications. I offered them again after she calmed down, and she took them. She said she wanted to go to McLaren because she felt really sick. [Direct care staff, Nicole Holland] called resident’s daughter and her daughter said fine. Ambulance came and picked her up after 9am. Resident’s bed was soiled with BM. I stripped the bed, washed, dried and made her bed.”
    - 2/24/25 @ 1:12PM, direct care staff, Takeyma Rivers, recorded, “Resident bathroom was filled with feces on toilet and floor. I cleaned the toilet and housekeeper cleaned the floor.”
- *Healthcare Provider Plan of Care* for Resident A, dated 8/22/24. Under the section, *Cognitive Status*, “Alert and Oriented” and “Forgetful” are both circled with a narrative that reads, “mild TBI”. Under the section, *Functional Requirements for ADLs/IADLs*, it is noted that Resident A is “Independent” in the areas of grooming, oral hygiene, hair care, and eating. It is recorded that “Assistance Required” in the areas of bathing, toileting, dressing, nail care.
- *Assessment Plan for AFC Residents* document for Resident A, dated 8/30/24. On page two, under section, *II. Self Care Skill Assessment*, subsections, *B. Toileting, D. Grooming, E. Dressing, and F. Personal Hygiene*, all indicate the need for assistance with reminders in these areas. The subsection, *C. Bathing*, indicates a “yes” for needs assistance, with the narrative, “Set up and assist, stand by as fall prevention”.
- *Care Plan,* for Resident A, dated 8/21/24. On page one, under section, *Assurance Checks*, is the goal listed, “Will maintain safety while living in community”. It is noted that this goal was created on 8/21/24. Under the section, *Falls*, the goal reads, “Will reduce chance of falls within the community. This goal was created on 8/21/24. Under the Interventions listed for the goal related to falls, it reads, “Fall interventions are: USE OF ASSISTIVE DEVICES DURING TIMES OF TRANSFERS AS NEEDED. Is at risk for falls due to: HISTORY OF (FREQUENT) FALLS.” These interventions were documented as being created on 8/21/24. On page two, under the sections, *Bathing, Dressing, Grooming, and Toileting*, it reads, “REMINDERS, STAND BY AS A FALL PREVENTION”.
- *University of Michigan Health Sparrow, After Visit Summary,* for Resident A, dated 9/16/24. Under the section, *Reason for Visit*, it reads, “Abdominal Pain, Other”. Under the section, *Diagnoses*, it reads, “Generalized abdominal pain, Yeast infection of the skin”.

- *McLaren Greater Lansing Emergency Department, Discharge Instructions,* for Resident A, dated 12/23/24. Under the section, *Reason for Visit*, it reads, “Nose Bleed Reevaluation”. Under the section, *Final Diagnosis*, it reads, “Chronic pain; Epistaxis”.

On 3/5/25 I sent email correspondence to Ms. Jonzun requesting additional documentation be provided for this investigation. I received and reviewed the following documents:

- Grandhaven Assisted Living and Memory Care, direct care staff schedule, for the month of February 2025.
- *Michigan Workforce Background Check* eligibility letters for every individual identified on the direct care staff schedule for the month of February 2025. Each individual had an available eligibility letter to review.
- All incident reports recorded for Resident A during her time at the facility.
    - Incident Report dated 9/12/24, indicated Resident A stated her stomach hurt and wanted to be transported to the hospital. The document indicates that an ambulance was called and the resident was transported to the hospital on this date.
    - Incident Report dated 9/16/24, identified that Resident A stated her stomach was “filled with fluid” and she wanted to go to the hospital. The document indicates that an ambulance was called and the resident was transported to the hospital on this date.
    - Incident Report dated 9/30/24, identified that Resident A stated she had fallen in her room by tripping over her wheelchair. The report notes she was assessed for injury and not sent to the hospital on this date as no injury was identified.
    - Incident Report dated 1/14/25, identified that Resident A had stated to direct care staff that she was experiencing suicidal ideation. The report indicated that Relative A1, Resident A’s medical provider, and direct care staff/Wellness Leaders, Crystal Barclay & Susan Kuzmanov, were all notified of the occurrence.
    - Incident Report dated 1/24/25, identified that Resident A was having difficulty breathing and direct care staff sent her to the hospital for evaluation.
    - Incident Report dated 2/20/25, identified that Resident A stated she was not feeling well and was sent to the hospital by direct care staff.
    - Incident Report dated 2/22/25, identified that Resident A disclosed an unwitnessed fall to direct care staff. The direct care staff assisted her in completing personal care after the incident as Resident A had an episode of bowel incontinence. Resident A was not sent to the hospital.
    - Incident Report dated 2/23/25, identified that Resident A stated she was not feeling well and was sent to the emergency department by direct care staff.

On 3/27/25 I interviewed Relative A1, via telephone, regarding the allegations. Relative A1 reported that Resident A was admitted to the facility near the end of August 2024 and her last day at the facility was 2/23/25 when she was sent to the hospital. Relative A1 reported that during Resident A's hospital stay she was diagnosed with two spinal fractures and a brain bleed. She reported that Resident A was admitted to the Intensive Care Unit (ICU) as a result of the condition she was in upon arrival at the hospital. Relative A1 reported that the hospital staff had concerns that Resident A might have been sexually assaulted as she had swelling and signs of trauma near her vagina. Relative A1 reported that she spoke with Resident A about this and Resident A denied any possibility of being sexually assaulted at the facility. Relative A1 reported that Resident A did have complaints about the facility and noted that Resident A frequently complained that the direct care staff were "mean" to her and treated her rudely. Relative A1 reported that she did not directly observe the direct care staff acting in this manner toward Resident A. Relative A1 reported that Resident A is now living with her and will not be returning to the facility. I inquired if Relative A1 could share the medical documentation received from Resident A's recent hospitalization and whether Resident A would be willing to be interviewed. Relative A1 requested a telephone call on 3/28/25 with the possibility of interviewing Resident A. She also advised that this licensing consultant could email her to request the medical records.

On 3/27/25 I received email correspondence from Ms. Jonzun. She sent copies of the *Medication Administration Records* (MAR) for Resident A for the months of January 2025 and February 2025, for my review. I observed the following information in reviewing these documents:

- January 2025 *MAR* for Resident A:
    - Supervision Monitoring. Observe location of resident. Document location in note. These checks were completed on each scheduled time, except for when Resident A was documented as being away from the facility.
    - Shower. "Resident is independent with shower. She wants to take it when she wants it. Change sheets on Mondays and pull laundry. Pull Laundry other days if needed". There was never more than a four day period in between documentation of completed showers for Resident A.
    - Estradiol CRE 0.01%. Place 2 grams vaginally nightly. This medication was ordered on 1/31/25.
- February 2025 *MAR* for Resident A:
    - Supervision Monitoring: Observe location of resident. Document location in note. These checks were documented as being completed on each date and time, except for 2/15/25, 2/19/25, and 2/20/25 all at the 10:45pm time.
    - Shower. "Resident is independent with shower. She wants to take it when she wants it. Change sheets on Mondays and pull laundry. Pull Laundry other days if needed". There was never more than a four-day

period in between documentation of completed showers for Resident A.
- Estradiol CRE 0.01%. Place 2 grams vaginally nightly. Documented as being administered by direct care staff from 2/1/25 – 2/19/25.

On 3/28/25 I attempted to interview Resident A, via telephone. I made a telephone call to Relative A1, as requested. There was no answer. I left a voicemail message requesting a returned call. There has been no response to this request.

On 3/28/25 I sent email correspondence to Relative A1 requesting any medical documentation from Resident A's recent hospitalization. I have not received a response to this inquiry.

On 4/4/25 I interviewed Ms. Jonzun and direct care staff/Wellness Director, Susan Kuzmanov, via telephone. I inquired about the order for the Estradiol CRE medication regarding the administration protocol for this medication. Ms. Jonzun reported that she was not familiar with this medication being ordered for Resident A. Ms. Kuzmanov reported that the medication is documented as being administered by direct care staff. She reported that there is not any notation of Resident A self-administering this medication. Ms. Kuzmanov reported that this medication was ordered because Resident A had been experiencing vaginal bleeding, but the source of the bleeding was not identified to Ms. Kuzmanov.

On 4/4/25 I conducted an interview with direct care staff, Shannon Marcum, regarding the allegation. Ms. Marcum reported that she has worked at the facility for about two years, and she works the 3pm to 11pm shift. She reported that she is familiar with Resident A. She reported that she had administered Resident A's Estradiol CRE on several occasions. She reported that Resident A did not want direct care staff to administer the cream as it was a sensitive area. She reported that the cream came in a tube that resembled a tampon. Ms. Marcum reported that the direct care staff would prepare the medication for Resident A and Resident A would self-administer the medication. Ms. Marcum reported direct care staff would stand just outside her bedroom door to give her privacy and wait for the resident to indicate she was done applying the medication. Ms. Marcum reported that she has no reason to believe that any of the direct care staff would have physically or sexually assaulted Resident A.

On 4/7/25 I had a telephone conversation with Ms. Jonzun. Ms. Jonzun reported that she did not have an order for Resident A to self-administer her Estradiol CRE medication. Consultation was provided to Ms. Jonzun that direct care staff must obtain an order from a physician for a resident to self-administer a medication including medications administered to private areas. Ms. Jonzun verbalized understanding of this requirement.

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 upon interviews conducted with Mr. Joyner, Ms. Jonzun, Ms. Gruesbeck, Ms. Husband, Ms. Marcum, & Relative A1 as well as review of Resident A's resident record, it can be determined that there is not adequate evidence to suggest that Resident A had been sexually assaulted while residing at the facility. Mr. Joyner and Relative A1 reported that Resident A denied the allegation that she might have been sexually assaulted. Mr. Joyner and Relative A1 reported that the SANE test was declined by Resident A and Relative A1. The direct care staff interviewed had no knowledge of any physical/sexual abuse perpetrated towards Resident A. It was identified, during the investigation, that Resident A was prescribed a medication to be administered vaginally. In interviewing Ms. Marcum, she reported that the direct care staff did not administer this medication to Resident A. She reported that the medication was prepared and brought to Resident A, who then administered the medication herself. Without substantial evidence, there is not a case to conclude that Resident A had been sexually assaulted at the facility. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Resident A's medications were not administered as ordered.**
- **Direct care staff did not complete entries on Resident A's Medication Administration Record.**

INVESTIGATION:

On 3/27/25 I interviewed Relative A1, via telephone. Relative A1 reported that she wanted to add to the current complaint that Resident A's medications were not being administered as prescribed by her physician. Relative A1 reported that Resident A made complaints that she was not receiving her scheduled medications, and that her insulin medication was being administered prior to direct care staff checking Resident A's blood sugar. Relative A1 reported that Lactulose medication has been ordered for Resident A due to Liver Cirrhosis. Relative A1 reported that she was told

by Resident A on numerous occasions that the Lactulose was not being properly administered due to the facility running out of the medication.

On 3/27/25 I received email correspondence from Ms. Jonzun. She sent copies of the *Medication Administration Records* (MAR) for Resident A for the months of January 2025 and February 2025, for my review. I observed the following information in reviewing these documents:

- January 2025 MAR
    - Enulose (Lactulose) Sol 10GM/15, Take 30ML by mouth twice a day. This medication is charted as not being administered on multiple dates and times during the month of January. There are entries for each missed administered dose which indicate that the resident was “Out of facility”, “Refused”, or “Hospital”.
    - Enulose (Lactulose) Sol 10GM/15, give 30ML by mouth three times a day for 5 days. This order was written on 1/10/25 and discontinued on 1/13/25. This medication is charted as being administered as ordered except on 1/11/25 at 2pm. There is an entry on this date which reads, “Out of facility”.
    - Furosemide Tab 20 mg. Take 2 tablets (40mg) by mouth every day. This medication is marked as not being administered from 1/11/25 – 1/16/25, 1/19/25-1/20/25, 1/24/25-1/31/25. There are notations on the MAR noting Resident A was out of the facility on the following dates, 1/15/25-1/16/25, 1/19/25-1/20/25, 1/24/25-2/1/25, and the order was suspended per doctor’s orders 1/11/25-1/16/25.
    - Insulin Lisp Inj 100/ML. Inject 4 units subcutaneously four times a day before meals and every night at bedtime. This medication is recorded as being administered during each scheduled time except for when Resident A is noted to be absent from the facility.
    - Lactulose Sol 10GM/15 was ordered on 1/10/25 and discontinued on 1/15/25. The instructions read, “Give 30ML by mouth three times a day for 5 days”. This medication is documented as only being administered two times during this five-day period. This medication is noted as being discontinued on 1/15/25.
    - Lantus Solos Inj 100/ML. Inject 20 units subcutaneously every night at bedtime. This medication is documented as being administered as prescribed on each date Resident A was present in the facility.
    - Blood Glucose Monitoring. Check blood glucose levels three times daily (Before Meals). These glucose tests were documented as being performed during each scheduled time, except for times when Resident A was documented as being away from the facility.
    - Blood Glucose Monitoring. Check blood glucose levels nightly. These checks were documented as being performed nightly, except for times when Resident A was documented as being away from the facility.
- February 2025 MAR:

- Atorvastatin Tab 40mg. Take 1 tablet by mouth every night at bedtime. This medication is documented as being administered routinely except for 2/20/25 at 10pm.
- Diclofenac Gel 1%. Apply 4 grams topically to the affected areas four times a day using the medication dosing card provided by your pharmacy. This medication is documented as being administered routinely except for 2/20/25 at 10pm.
- Enulose (Lactulose) Sol 10GM/15. Take 30ML by mouth twice a day. This medication was ordered on 8/22/25 with a stop date of 2/10/25. This medication is recorded as being administered routinely by direct care staff.
- Estradiol CRE 0.01%. Place 2 grams vaginally nightly. This medication is documented as being administered routinely every day the resident was present in the facility, except for 2/20/25 at 8pm.
- Insulin Lisp Inj 100/ML. Inject 4 units subcutaneously four times a day before meals and every night at bedtime. This order was written on 12/4/24 with a stop date of 3/7/25. This medication is not documented as being administered from 2/1/25-2/13/25. There were not any notations as to why this medication was not administered on these dates.
- Lactulose Sol 10GM/15. Take 30ML by mouth twice a day. This medication was ordered on 2/10/25 with a stop date of 3/7/25. This medication is documented as being administered, or offered to Resident A on all dates and times except 2/20/25 at 8pm. There is not available documentation to determine why this dose was not recorded on the MAR.
- Lantus Solos Inj 100/ML. Inject 20 units subcutaneously every night at bedtime. This medication is charted as being administered every day except for the date, 2/20/25 at 7:55pm. There is not available documentation to determine why this dose was not recorded on the MAR.
- Metoprol TAR TAB 25mg. Take ½ tablet by mouth twice a day. This medication is documented as being administered routinely, except for 2/20/25 at 10pm. There is not documentation to determine why this dose was not recorded on the MAR.
- Xifaxan Tab 550mg. Take 1 tablet by mouth twice a day. This medication is documented as being administered/offered routinely to Resident A except on 2/20/25 at 10pm. There is no documentation to determine why this dose was not recorded on the MAR.
- Blood Glucose Monitoring. Check blood glucose levels three times daily (before meals). These checks are documented as being completed on a routine basis by direct care staff.
- Blood Glucose Monitoring. Check blood glucose levels nightly. These checks are documented as being completed on a routine basis by direct care staff except for on 2/20/25 at 8pm.

On 3/5/25, Ms. Jonzun emailed copies of Resident A's incident reports for my review. I reviewed the following incident report. Incident Report dated 2/20/25, identified that Resident A stated she was not feeling well and was sent to the hospital by direct care staff.

On 4/7/25 I had a telephone conversation with Ms. Jonzun regarding Resident A's medications. I inquired if Ms. Jonzun could identify why Resident A's Insulin Lisp Inj 100/ML was not documented as being administered from 2/1/25 through 2/13/25. Ms. Jonzun reported that Resident A had just returned to the facility from a hospital stay and that a new order for Resident A's insulin had not been sent with the updated medication list. Ms. Jonzun reported that on 2/2/25, Ms. Kuzmanov, sent an email communication to Resident A's medical provider, Rachel Seavolt, with Careline Health Group, to address the missing order for this medication. It was noted that Resident A's insulin required review by the primary care provider. Ms. Jonzun reported that the direct care staff were awaiting Ms. Seavolt's review, and this is the reasoning for the missed doses on the February 2025 MAR.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon review of Resident A's MARs for the months of January 2025 and February 2025, it can be determined that from 2/1/25-2/13/25 it is not documented that Resident A received her prescribed Insulin Lisp Inj 100/ML medication on these dates. There were also several medications that were not signed off as being administered on 2/20/25 during the evening shift, however the incident report dated 2/20/25 does indicate that Resident A was sent to the hospital on this date. Ms. Jonzun also provided information regarding Resident A's insulin being placed on hold pending the review from the primary care provider. Based upon this information, there is not adequate evidence to suggest that the direct care staff were not administering Resident A's medications as prescribed.
CONCLUSION:	**VIOLATION NOT 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:

	(i) The medication. **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based upon review of Resident A's MAR's for the months of January 2025 and February 2025 it can be concluded that the direct care staff did not initial the MAR for the month of February 2025 to document Resident A's hospitalization on 2/20/25 and did not document their inability to administer Resident A's Insulin Lisp Inj 100/ML medication from 2/1/25 – 2/13/25. As a result, a violation has been established for failing to provide complete documentation on Resident A's MAR for the month of February 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

4/7/25

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Jana Lipps Date
Licensing Consultant

Approved By:

04/16/2025

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Dawn N. Timm Date
Area Manager