GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2025

Heather Iuni
GESHER HUMAN SERVICES, LLC
15999 W Twelve Mile Rd
Southfield, MI 48076

RE: License #: AS630383361
Investigation #: 2025A0991013
Charach 1

Dear Heather Iuni:

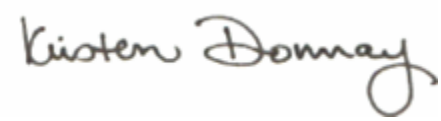
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 972-9136.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630383361
Investigation #:	2025A0991013
Complaint Receipt Date:	03/12/2025
Investigation Initiation Date:	03/12/2025
Report Due Date:	05/11/2025
Licensee Name:	GESHER HUMAN SERVICES, LLC
Licensee Address:	15999 W Twelve Mile Rd Southfield, MI 48076
Licensee Telephone #:	(248) 559-8235
Administrator:	Clifton Phillips
Licensee Designee:	Heather Iuni
Name of Facility:	Charach 1
Facility Address:	33884 Yorkridge Street Farmington Hills, MI 48331
Facility Telephone #:	(248) 559-5000
Original Issuance Date:	04/26/2018
License Status:	REGULAR
Effective Date:	10/26/2024
Expiration Date:	10/25/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the home and was taken to the hospital where she reported that she was sexually assaulted by a male resident in the home. She also reported that she was hit in the face by a female resident.	No
Resident C was not receiving her medications as prescribed. Staff initialed the medication administration record, but did not pass her medication.	Yes

III. METHODOLOGY

03/12/2025	Special Investigation Intake 2025A0991013
03/12/2025	Special Investigation Initiated - Letter Sent email to Office of Recipient Rights (ORR)
03/12/2025	APS Referral Received from Adult Protective Services (APS)- denied for investigation
03/12/2025	Referral - Recipient Rights Sent to ORR- received email from Rachel Moore- not opening for investigation
03/13/2025	Contact - Document Received Received plan of service and behavioral assessment
03/17/2025	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and residents
04/01/2025	Contact - Document Received Received additional allegations
04/03/2025	Contact - Telephone call made Left message for Resident C's relative
04/17/2025	Contact - Telephone call received Interviewed Relative 1C

04/24/2025	Inspection Completed On-site Unannounced onsite inspection- interviewed Resident C and reviewed medication records
04/24/2025	Contact - Document Received Medication administration records
04/29/2025	Contact - Telephone call made Interviewed home manager, Aaliyah Black
04/29/2025	Contact - Document Received Resident C's medication administration records
05/01/2025	Contact - Telephone call made Interviewed Resident A's case manager
05/01/2025	Contact - Telephone call made To home manager, Aaliyah Black
05/02/2025	Exit Conference Via telephone with licensee designee, Heather Iuni

ALLEGATION:

Resident A eloped from the home and was taken to the hospital where she reported that she was sexually assaulted by a male resident in the home. She also reported that she was hit in the face by a female resident.

INVESTIGATION:

On 03/12/25, I received a complaint from Adult Protective Services (APS), alleging that Resident A stated that she was sexually assaulted by Resident B, a male resident at the Charach 1 home. Resident A stated that Resident B hit her on the butt and touched her in other areas around her bottom. It is unknown if the touching was over or under her clothing. Resident A could not recall when this occurred. Resident A also stated that another female resident hit her in the face on 03/09/25 because she asked to cut off the light. Resident A did not have any marks or bruises. She eloped from the group home and did not want to return to the home following her discharge from the hospital. The complaint was denied for investigation by APS. I initiated my investigation on 03/12/25 by referring the complaint to the Office of Recipient Rights (ORR). On 03/13/25, I received an email from the ORR worker, Rachel Moore. Ms. Moore stated that Resident A told her that Resident B touched her butt twice with her clothes on while passing her

in the hallway, and that her roommate slapped her. Rachel Moore stated that ORR would not be opening the complaint for investigation, as the incidents involved peers and there were no allegations made against staff.

On 03/17/25, I conducted an unannounced onsite inspection at Charach 1. I interviewed direct care worker Sharrise Small. Ms. Small stated that she has worked in the home for eight years. Ms. Small stated that Resident A never reported to her or any other staff that she was sexually assaulted in the home. She stated that Resident A was taken to the hospital after eloping from the home. Resident A did not want to come home when it was time for her to be discharged from the hospital, so she told someone at the hospital that she was sexually assaulted. Resident A stated that Resident B touched her inappropriately. Ms. Small stated that she never witnessed Resident B being sexually inappropriate towards Resident A. Resident B does not have any history of acting out sexually. She stated that Resident B “wouldn’t hurt a fly.” Resident B is extremely anxious and would be upset by the allegations.

Ms. Small stated that Resident A has only lived at Charach 1 for approximately one month. She came from a supervised independent living home and was upset that she lost community access and could no longer leave the home or have company. There were more restrictions in the adult foster care home, and she did not want to live there. Ms. Small stated that Resident A never reported that anyone hit her in the face. She stated that Resident A’s roommate is Resident C, and they typically get along well. Ms. Small never saw any marks on Resident A. She stated that Resident A does have a history of making up allegations. Ms. Small felt that Resident A knew that if she made allegations against other residents in the home, she would not have to come back. Ms. Small stated that there are always two or three staff on shift at the home. She did not have any concerns about any of the residents in the home being physically or sexually aggressive towards Resident A.

On 03/17/25, I interviewed direct care worker, Vorica Porter. Ms. Porter stated that she has worked at the home for twelve and a half years. She stated that on the day Resident A was being discharged from the hospital, Resident A told someone at the hospital that Resident B “popped her on the butt.” Ms. Porter stated that Resident A never reported this to her or any other staff as far as she knows. Ms. Porter stated that it would not be in Resident B’s character to touch anyone on the butt. Ms. Porter stated that Resident A never reported that anyone hit her in the face. She stated that Resident A shares a room with Resident C, who likes to sleep with the lights on. Resident A would complain about this, but she was not aware of Resident A and Resident C ever having a physical altercation. Ms. Porter stated that Resident A is not the type to let things go, so she would have told staff or would have “gotten into it” with Resident C if Resident C had hit her. Ms. Porter stated that Resident A has a history of making up allegations and this is stated in her individual plan of service (IPOS). She stated that

something similar happened at her previous placement. Ms. Porter stated that if Resident A had reported these incidents to another staff, then it would have been documented in the staff communication log. There was no documentation regarding either incident. She did not believe any of the residents were physically or sexually aggressive towards Resident A.

On 03/17/25, I interviewed direct care worker, Roslyn Howard. Ms. Howard stated that she has worked in the home for eleven years. She stated that she never heard about the allegations until after Resident A was in the hospital. She stated that Resident A never reported to her or anybody else that someone touched her inappropriately or hit her. She stated that Resident A was a “slick one” and staff always kept a close eye on her. Resident A would try to have random men come to the home and would be on the phone with people late at night. Ms. Howard stated that Resident A jumped out of the window to run away from the home. Ms. Howard never saw anyone touch Resident A. Ms. Howard stated that if Resident A said that someone touched her or hit her, it was a lie. Ms. Howard stated that all of the staff in the home are pretty good, and they keep a close eye on the residents.

On 03/17/25, I interviewed Resident B. Resident B stated that he remembered Resident A, but she never talked to him. He stated that Resident A would not talk to anybody in the house. She was trying to be violent towards everybody, but nobody was violent towards her. Resident B stated that he never touched Resident A on the butt. He stated that he never touched her at all. He was not aware of anybody touching Resident A in a sexual way or hitting her in the face. Resident B stated that there are always two or three staff in the home. The staff are nice and help the residents. He did not have any concerns about the home.

On 03/17/25, I interviewed Resident C. Resident C stated that she got along okay with her roommate, Resident A. She stated that they never got into fights. Resident C stated that she never hit Resident A. Resident C stated that Resident A never said anyone touched her inappropriately. Resident A would call her boyfriend and her brother on the phone and would listen to loud music. Resident C stated that she never saw anyone hit or touch Resident A.

On 03/17/25, I interviewed Resident D. Resident D stated that he does not remember Resident A. He stated that he keeps to himself and does not pay attention to the other people in the home. He never saw anyone hitting or touching anybody. He stated that he has never touched or hit anybody. He did not have any concerns about the home.

During the investigation, I received additional allegations that Resident A told Resident C that she was going to slice her up for unplugging the television. The home manager told Resident C that they have to get along. Resident C moved out of the home due to not feeling safe.

On 04/17/25, I interviewed Relative 1C via telephone. She stated that Resident C moved out of the home at the end of March, because she no longer felt safe in the home. Resident A would watch scary movies in the bedroom that she shared with Resident C. Resident C is very sensitive to movies and would ask Resident A to turn the tv off. She told one of the staff about the issue, and the staff told Resident C to unplug the tv. Resident A then got into Resident C's face and was yelling at her. She threated Resident C by saying, "I will cut you up."

On 04/24/25, I conducted a follow-up unannounced onsite inspection, and I interviewed Resident A. Resident A stated that Resident C recently moved out. She did not get along well with Resident C, because Resident C liked to have the lights on all night, and she did not like that. Resident C was also touching her TV when she told her not to do that. Resident A stated that Resident C slapped her on her face. Resident A stated that she did not want to touch Resident C, so she ran away. She did not recall when this happened. Resident A did not tell any staff what happened. Resident A stated that Resident B also touched her butt. She stated that she did not know if it was on purpose or if it was an accident. He touched her over her clothes. She did not remember when this happened. She stated that she did not tell any staff about this until after she ran away. Resident A was resting in bed and did not want to answer any additional questions.

On 04/29/25, I interviewed the home manager, Aaliyah Black. Ms. Black stated that Resident A made allegations that Resident B touched her butt, and that Resident C hit her in the face after she ran away from the home and was hospitalized. Ms. Black stated that Resident A never reported these allegations to any staff at Charach 1. None of the staff in the home witnessed any residents being physically or sexually aggressive towards Resident A. Ms. Black stated that Resident B does not have any history of acting out sexually. She stated that he typically keeps to himself and has been getting along well with Resident A since she returned home. Ms. Black stated that Resident A and Resident C shared a room until Resident C recently moved out. She stated that she was not aware of Resident C ever hitting Resident A in the face. When Resident A returned to the home, she did "get into it" with Resident C, because Resident C was unplugging her TV. Resident A and Resident C were arguing back and forth, but there was no physical contact as far as Ms. Black knew. Resident C told staff that Resident A was watching "demonic things" on her TV. Ms. Black stated that Resident C admitted that she did unplug Resident A's television a few times. Ms. Black was not aware of any staff telling Resident C to unplug the television. Resident C never told staff that Resident A said, "I'm going to cut you." Ms. Black stated that Resident C later reported this to her sister, but she never told staff. Ms. Black stated that Resident A was also irritated because Resident C likes to sleep with the lights on at night. She stated that

this issue was never really resolved, but Resident A got used to it or would sleep with her head under a blanket.

On 05/01/25, I interviewed Resident A's case manager, April McCullum, via telephone. Ms. McCullum stated that Resident A never directly reported to her that she was sexually or physically assaulted at the home. She stated that Resident A made these allegations at the hospital after she eloped from the home. Ms. McCullum stated that Resident A has a history of stating that she was touched inappropriately when she thinks she is in trouble, such as after she has eloped. She often returns with elaborate stories of how she was victimized. Ms. McCullum stated that she could not say whether or not the stories are true. Ms. McCullum stated that Resident A never expressed complaints about her roommate, Resident C, to her, but she had some issues with Resident C's guardian asking her too many questions. Resident A never told Ms. McCullum that Resident C hit her. Ms. McCullum stated that she did not have concerns about the home or the staff. She felt that staff were appropriately supervising Resident A and following her plan of service. She stated that Resident A is not being compliant with her plan, and may eventually need a higher level of care, but this is not due to any issues with the staff. She felt that the staff were doing their best to ensure Resident A's safety.

I received and reviewed a copy of Resident A's individual plan of service (IPOS) dated 11/09/24 and behavioral assessment plan dated 03/05/25. Resident A's behavior plan notes that the plan was completed due to concerns of verbal aggression, elopement, and safety for herself and others in the community. The plan was updated on 03/05/25 due to Resident A having random men come to the home to bring her substances and engage in sexual relations. The plan notes that Resident A should remain within eyesight of staff while accessing the community and should remain within eyesight for 20 minutes after medication passing due to suspicions of Resident A disposing of her medications. The behavior plan notes that staff should follow Resident A if she elopes from the home but should allow her some distance. Staff should contact law enforcement if they do not observe Resident A eloping from the home, but they later notice that she is missing. The behavior plan also notes that if Resident A's verbal aggression is directed towards a housemate, staff should attempt to separate Resident A and the housemate. Resident A's IPOS and behavioral assessment plan did not contain any additional information regarding requirements for staff to monitor or check on her while in the home.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff did not attend to Resident A's safety and protection at all times. While Resident A stated that Resident B touched her butt, and Resident C slapped her in the face, Resident B and Resident C denied these allegations. The staff at Charach 1 did not have any knowledge of Resident A being sexually or physically assaulted by other residents in the home. They stated that Resident A did not report this to staff, and they did not witness anyone touching Resident A. Resident A made these allegations to staff at the hospital after she eloped from the home. Resident A's case manager stated that Resident A has a history of stating she was assaulted if she perceives that she is going to be in trouble, such as when she has eloped from the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident C was not receiving her medications as prescribed. Staff initialed the medication administration record, but did not pass her medication.

INVESTIGATION:

On 04/01/25, I received additional allegations that Resident C was running low on her blood pressure chews. The home manager told Resident C's relative that she had seven left, but she did not have any left. This happened on more than one occasion. Staff initialed the medication log indicating that the medication was given, but it was not. The staff stated that she just signs the medication log every day, but did not pass the medication.

On 04/17/25, I interviewed Resident C's relative, Relative 1C, via telephone. Relative 1C stated that Resident C moved out of the home on 03/28/25. Prior to Resident C moving out of the home, Relative 1C received a text message from the home manager, Aaliyah Black, on 03/26/25, stating that Resident C was running low on her Super Beet

Heart Chews. The home manager stated that Resident C had seven left. The following day, on 03/27/25, Relative 1C spoke with staff, Samantha, who told her that Resident C was out of her beet chews and had not received it that morning. Samantha told Relative 1C that she signed Resident C's medication log indicating that the medication was administered, but it was not. Relative 1C texted the home manager, Aaliyah Black, to follow up regarding the Super Beet Heart Chews. Ms. Black indicated that there was a typo when she sent the previous text, and there were two left and not seven. Ms. Black told Relative 1C that Samantha did not give the blood pressure chew to Resident C that morning. Samantha assumed they were gone, because Ms. Black threw the packaging away, as there was only one left in the bag. The last chew was placed inside Resident C's medication basket. Ms. Black stated that she gave Resident C the blood pressure chew herself when she came in that morning. Relative 1C also expressed concern that Resident C's medications had not been administered properly. She stated that she received a phone call from the pharmacy that Resident C's medications were ready to be refilled. She stated that Resident C still had four whole packs of medications remaining. The pharmacy stated that she should only have two pills left. Relative 1C stated that when Resident C moved out, she still had medications left in bubble packs that were filled on 02/21/25 and 03/14/25, which should have been administered prior to Resident C moving out of the home. Relative 1C provided screenshots of the text messages received from the home manager, which confirmed the information provided regarding Resident C's Super Beet Heart Chews. She also provided pictures of Resident C's medication bubble packs, but it could not be determined when the medications were supposed to have been administered, as the date the medications are filled does not always correspond to the date that they are administered.

On 04/24/25, I conducted an unannounced onsite inspection at Charach 1. Direct care worker, Vorica Porter stated that she did not have access to Resident C's medication administration records (MARs). The MARs for the other residents in the home are maintained electronically, but Resident C had a paper MAR, as she used a different pharmacy, and her sister picked up and delivered her medications to the home. The paper MARs were filed after Resident C moved out of the home, and only the home manager had access to them. I reviewed the medications and electronic MARs for the other residents in the home. I noted the following:

- Resident A's April 2025 MAR was not initialed for the 8:00pm dose of Oxcarbazepine 150mg- take one tablet by mouth twice daily on 04/23/25. The pill was not in bubble pack, indicating it had been passed but the MAR was not initialed.
- Resident A's April 2025 MAR showed that she had been refusing to take Polyethylene Glycol (3350) 17grams/dose once daily for the entire month of April. The home manager provided documentation from the doctor that the medication

was changed to an as needed (PRN) medication as of 04/23/25, but there was no documentation showing that a health care professional was contacted regarding the refusals prior to that date.

- Resident A's March 2025 MAR showed that she was consistently refusing to take all of her medications or that medications were missed due to her being out of the home. There was no documentation showing that a health care professional was contacted regarding the refusals or missed medications.
- Resident D's April 2025 MAR showed that his Multivitamin- take one daily was not available in the home and was not passed from 04/14/25-04/24/25. There was no documentation showing that a health care professional was contacted regarding the missed medication.
- Resident E's April 2025 MAR showed that her Vitamin B12 100mcg- take one tablet Monday, Wednesday, and Friday was not delivered and was not available in home. It was not administered on 04/02/25, 04/04/25, 04/07/25, 04/09/25, 04/11/25, 04/14/25, 04/16/25, 04/18/25, 04/20/25, or 04/23/25. There was no documentation showing that a health care professional was contacted regarding the missed medication.
- Resident E's April 2025 MAR was not initialed on 04/11/25 for Haloperidol 5mg- take two tablets by mouth at bedtime. The pill was not in the bubble pack, indicating that it had been passed, but the MAR was not initialed.
- Resident F's March 2025 MAR showed that the 6:00pm dose of Famotidine 40mg- take one tablet by mouth daily at dinner was not administered on 03/31/25, as the medication was not available in the home. There was no documentation showing that a health care professional was contacted regarding the missed medication.
- Resident F's April 2025 MAR showed that the 8:00pm dose of Divalproex (Depakote 500mg)- take one tablet by mouth twice daily was not administered on 04/01/25 due to the medication not being available in home. There was no documentation showing that a health care professional was contacted regarding the missed medication.
- Resident F's April 2025 MAR was not initialed on 04/12/25 for the 8:00pm dose of Divalproex (Depakote 500mg)- take one tablet by mouth twice daily. The pill was not in the bubble pack, indicating that it had been passed, but the MAR was not initialed.

On 04/29/25, I interviewed the home manager, Aaliyah Black. Ms. Black stated that Resident C did not use the same pharmacy as the other residents in the home. She stated that Resident C's sister would pick up her medications and deliver them to the home. When Resident C was running low on medications, Ms. Black would text Resident C's sister to let her know. Ms. Black stated that she did make an error when

she texted Resident C's sister that there were seven Super Beet Heart Chews left, when there were only two remaining. She stated that the medication is purchased over the counter by Resident C's sister. When there was only one chew left in the bag for the morning dose on 03/27/25, Ms. Black took it out and placed it in Resident C's medication basket, throwing away the resealable bag that the chews come in. Ms. Black stated that staff, Samantha Williams, initialed Resident A's MAR indicating that she passed the medication on 03/27/25; however, Ms. Williams did not pass the medication, because she did not see the individually wrapped single chew in the medication basket. Ms. Black stated that she personally gave the chew to Resident C when she came in for her shift that morning. I received and reviewed copies of Resident C's MARs. I noted that Resident C's March 2025 MAR was initialed by "SW" on 03/27/25 for the 8:00am dose of Super Beet Heart Chews- take 1 chew by mouth daily in the morning. The code sheet notes that "SW" is staff Samantha Williams.

Ms. Black stated that Resident C received all of her medications as prescribed. She stated that Resident C's sister would sometimes bring extra bubble packs to the home when she picked up Resident C's medications from the pharmacy, as they were filled earlier than needed. Ms. Black did not have any documentation to show when the medications were brought to the home or the quantities that were provided.

Ms. Black stated that there has recently been an issue with the pharmacy not filling prescriptions that can be purchased over the counter, such as the Vitamin B12 or multivitamins. She stated that insurance is no longer covering these prescriptions, and it is expected that the residents or their family members will purchase them. Ms. Black stated that the pharmacy reached out to the doctor and guardians about this, but she did not have any documentation regarding her conversation with the pharmacy or health care providers. Ms. Black stated that Resident A was also consistently refusing medications throughout the month of March. She stated that staff wrote incident reports and sent them to the main office. She did not have any documentation that a health care professional was contacted regarding the medication refusals.

On 05/02/25, I conducted an exit conference via telephone with the licensee designee, Heather Iuni. Ms. Iuni stated that she would submit a corrective action plan to address the violations identified during the investigation.

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

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that medications were not being given as prescribed, due to medications not being available in the home. During a review of the residents' MARs and medications on 04/24/25, the following medication issues were identified: • Resident D's April 2025 MAR showed that his Multivitamin- take one daily was not available in the home and was not passed from 04/14/25-04/24/25. • Resident E's April 2025 MAR showed that her Vitamin B12 100mcg- take one tablet Monday, Wednesday, and Friday was not delivered and was not available in home. It was not administered on 04/02/25, 04/04/25, 04/07/25, 04/09/25, 04/11/25, 04/14/25, 04/16/25, 04/18/25, 04/20/25, or 04/23/25. • Resident F's March 2025 MAR showed that the 6:00pm dose of Famotidine 40mg- take one tablet by mouth daily at dinner was not administered on 03/31/25, as the medication was not available in the home. • Resident F's April 2025 MAR showed that the 8:00pm dose of Divalproex (Depakote 500mg)- take one tablet by mouth twice daily was not administered on 04/01/25 due to the medication not being available in home. The home manager, Aaliyah Black, stated that there has recently been an issue with the pharmacy not filling prescriptions that can be purchased over the counter, such as vitamins and supplements. She stated that insurance is no longer covering these prescriptions, and it is expected that the residents or their family members will purchase them. There was no documentation on file showing that staff contacted the pharmacy or a medical professional regarding the missing medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

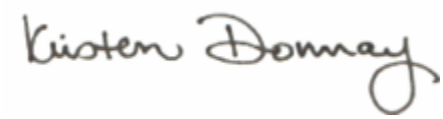
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff, Samantha Williams, initialed Resident C's medication administration record (MAR) on 03/27/25 for the 8:00am dose of Super Beet Heart Chews- take 1 chew by mouth daily in the morning, when she did not pass the medication. The home manager, Aaliyah Black, stated that she administered the chew to Resident C that morning. Ms. Williams thought Resident C was out of the medication, as she did not see the individual chew in Resident C's medication basket, but she initialed the MAR showing it was passed. During a review of the residents' MARs and medications on 04/24/25, the following medication documentation errors were also identified: • Resident A's April 2025 MAR was not initialed for the 8:00pm dose of Oxcarbazepine 150mg- take one tablet by mouth twice daily on 04/23/25. The pill was not in bubble pack, indicating it had been passed but the MAR was not initialed. • Resident E's April 2025 MAR was not initialed on 04/11/25 for Haloperidol 5mg- take two tablets by mouth at bedtime. The pill was not in the bubble pack, indicating that it had been passed, but the MAR was not initialed. • Resident F's April 2025 MAR was not initialed on 04/12/25 for the 8:00pm dose of Divalproex (Depakote 500mg)- take one tablet by mouth twice daily. The pill was not in the bubble pack, indicating that it had been passed, but the MAR was not initialed.
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 of the following provisions: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that a health care professional was not contacted when Resident A refused her medication and when medications were not available in the home. Resident A's March 2025 MAR showed that she was consistently refusing to take all of her medications or that medications were missed due to her being out of the home. There was no documentation on file showing that a health care professional was contacted or what instructions were given. Resident A was also refusing to take Polyethylene Glycol for the entire month of April. The home manager provided documentation from the doctor that the medication was changed to an as needed (PRN) medication as of 04/23/25, but there was no documentation showing that a health care professional was contacted regarding the refusals prior to that date. The residents' MARs also showed that medications had been missed due to medications not being delivered on time or not being available in the home. There was no documentation on file showing that staff contacted the pharmacy or a medical professional regarding the missing medications. The home manager, Aaliyah Black, stated that there has recently been an issue with the pharmacy not filling prescriptions that can be purchased over the counter, such as vitamins and supplements. She stated that insurance is no longer covering these prescriptions, and it is expected that the residents or their family members will purchase them.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

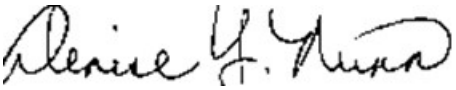
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



05/02/2025

Kristen Donnay Date
Licensing Consultant

Approved By:



05/20/2025

Denise Y. Nunn Date
Area Manager