



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 30, 2026

Mary North  
Brookdale Adrian  
1200 Corporate Drive  
Adrian, MI 49221

RE: License #: AH460264382  
Investigation #: 2026A1027036  
Brookdale Adrian

Dear Licensee:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 authorized representative 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 877-458-2757.

Sincerely,

A handwritten signature in cursive script that reads "Jessica Rogers".

Jessica Rogers, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
Lansing, MI 48909  
(517) 285-7433  
enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AH460264382
<b>Investigation #:</b>	2026A1027036
<b>Complaint Receipt Date:</b>	04/06/2026
<b>Investigation Initiation Date:</b>	04/07/2026
<b>Report Due Date:</b>	06/05/2026
<b>Licensee Name:</b>	BLC Adrian-GC, LLC
<b>Licensee Address:</b>	105 Westwood Place Brentwood, TN 37027
<b>Licensee Telephone #:</b>	(312) 977-3648
<b>Administrator:</b>	Christopher Lender
<b>Authorized Representative:</b>	Mary North
<b>Name of Facility:</b>	Brookdale Adrian
<b>Facility Address:</b>	1200 Corporate Drive Adrian, MI 49221
<b>Facility Telephone #:</b>	(517) 263-8199
<b>Original Issuance Date:</b>	06/04/2004
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/01/2025
<b>Expiration Date:</b>	07/31/2026
<b>Capacity:</b>	65
<b>Program Type:</b>	AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
The home was short staffed.	Yes
Medications were administered late.	No
Medications were not administered according to physician orders.	Yes
Narcotic count logs were incomplete. Narcotic medications were being placed back in the blister packs.	Yes
Food was being removed from residents' meals prior to being completed.	No
Residents were being charged for vitals signs that were not completed.	No
Staff lack medication training.	Yes
Resident L had falls and incident reports were not completed.	No
Additional Findings	Yes

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

## III. METHODOLOGY

04/06/2026	Special Investigation Intake 2026A1027036
04/07/2026	Special Investigation Initiated - Letter Email sent to complainant requesting additional information
04/10/2026	Inspection Completed On-site
04/10/2026	Contact - Telephone call received Telephone interview completed with complainant
04/13/2026	Contact - Document Received Email received from complainant with additional allegations

04/21/2026	Inspection Completed On-site A 2nd on-site inspection was completed due to additional allegations received
04/27/2026	Contact - Document Received Email received from Employee #1 with requested information and documentation
04/29/2026	Contact - Document Sent Additional documentation requested
04/29/2026	Contact - Document Received Additional documentation received
04/29/2026	Inspection Completed-BCAL Sub. Compliance
04/30/2026	Exit Conference Conducted via email and telephone with Mary North and Christopher Lender

**ALLEGATION:**

**The home was short staffed.**

**INVESTIGATION:**

On April 6, 2026, the Department received a complaint alleging that the home was short-staffed. On April 7, 2026, I contacted the complainant via email to request additional information; however, no response was received.

On April 10, 2026, I conducted an on-site inspection and interviewed staff.

The Administrator, Chris Lender, reported that the home utilizes a staffing program called Service Alignment, which adjusts staffing levels based on residents' care needs. Documentation provided indicated a resident census of 45.

Employee #1 stated that staff work eight-hour shifts from 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM, and 10:00 PM to 6:00 AM, with additional partial shifts from 6:00 AM to 12:00 PM and 6:00 PM to 9:00 PM. She reported that three staff members were typically assigned to the first and second shifts with two medication technicians and one caregiver, along with one caregiver assigned to the morning partial shift. She further stated that two medication technicians were assigned to the third shift, along with one caregiver assigned to the evening

partial shift. Employee #1 indicated that she frequently picked up additional shifts, which were not reflected on the schedule.

Employee #1 also reported that resident care needs included one resident requiring a Hoyer lift with two-person assistance, one resident requiring a sit-to-stand with two-person assistance, and three residents requiring two-person assistance. She added that an additional resident would likely require a Hoyer lift upon returning to the home.

During the on-site inspection, I interviewed Resident A, who stated that staff responded to her call pendant and were courteous. I also observed approximately 25 residents who appeared well-groomed and dressed in clean clothing.

A review of staff schedules from March 15, 2026, through April 11, 2026, revealed inconsistencies with Employee #1's statements. For example, the schedule on March 17, 2026, indicated only one staff member on duty for both the afternoon and evening shifts. The March 21, 2026, schedule showed one staff member on the day shift, with two additional staff listed but crossed out, and one staff member on the midnight shift, along with a partial shift from 2:00 AM to 6:00 AM. The March 22, 2026, schedule reflected a similar pattern for the day and midnight shifts. The schedules for March 25 and 26, 2026 indicated one staff member on duty for the afternoon shifts, along with another working a partial shift from 6:00 PM to 9:00 PM. The March 27, 2026 schedule showed one staff member on the midnight shift, with another scheduled staff member crossed out.

On April 27, 2026, email correspondence with the Administrator and Employee #1 indicated that Employee #1 worked on the following dates and times that were not on the staff schedule:

3/15/2026: 6:00 AM – 2:00 PM

3/16/2026: 2:00 PM – 10:00 PM

3/17/2026: 2:00 PM – 10:00 PM

3/18/2026: 10:00 PM – 6:00 AM

3/19/2026: 2:00 PM – 10:00 PM

3/20/2026: 2:00 PM – 10:00 PM

3/21/2026: 6:00 AM – 2:00 PM

3/22/2026: 6:00 AM – 2:00 PM

3/24/2026: 6:00 AM – 2:00 PM

3/25/2026: 6:00 AM – 2:00 PM

3/26/2026: 6:00 AM – 2:00 PM

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.</b>
<b>ANALYSIS:</b>	Based on discrepancies between staff interviews and the schedules reviewed, the omission of staff who reportedly worked, and documentation indicating instances on afternoon and midnight shifts in which only one staff member was on duty, there was insufficient staffing to meet residents' care needs. Therefore, the allegation of short staffing was substantiated.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Medications were administered late.**

**Medications were not administered according to physician orders.**

**INVESTIGATION:**

On April 6, 2026, the Department received a complaint alleging that medications were not administered in a timely manner and that medications ordered to be given separately were instead administered together.

On April 7, 2026, the Department contacted the complainant via email to request specific resident information; however, no response was received.

On April 10, 2026, I conducted an on-site inspection and interviewed staff.

Employee #1 stated that staff have a one-hour window before and after the scheduled administration time to administer medications. She reported that some residents request medications early. For example, Resident D preferred her Levothyroxine to be administered at 5:00 AM, instead of 6:00 AM. Employee #1 stated that Residents B, C, and D had medications such as Levothyroxine ordered to be administered prior to breakfast; however, Resident C self-administered her medications.

While on-site, Employee #1 demonstrated in Resident B's electronic medication administration record (eMAR) that Levothyroxine was scheduled for 6:00 AM with directions to administer before breakfast. Resident D's Levothyroxine was ordered to be administered at 5:00 AM, which was her preference.

Additionally, a review of Levothyroxine administration on Employee #1's computer for Residents B and D from March 4, 2026, through April 1, 2026, showed that medications were administered within the one-hour window before or after the scheduled time. Additionally, Resident B had Furosemide scheduled at 6:00 AM, which was also documented as administered within the allowable timeframe. Comparison of the Levothyroxine administration for Residents B on the computer compared to the March 2026 medication administration record (MAR) indicated that medications were administered by different staff members, suggesting administration occurred on separate shifts.

During the inspection, I interviewed Resident A, who stated that staff administered her medications on time.

A review of Residents A, B, and E's March 2026 MARs showed that staff initialed medications as administered for Residents A and B; however, Resident E's medication administration left blank on March 22, 2026, for the morning doses. Resident A's Ibandronate Sodium was ordered to be administered once monthly on the 28th, with instructions to take it alone with 6 ounces of water and to remain upright for 60 minutes. It was scheduled for 9:00 AM; however, Resident A also had Lactase scheduled at the same time. A review of Resident A's Medication Audit Report for March 28, 2026, read her Ibandronate Sodium was administered at 9:29 AM, and all other morning medications were administered at 8:11 AM, 9:18 AM, and 11:05 AM.

A review of Medication Administration Audit reports for Residents B and D from March 24, 2026, through March 31, 2026, supported medications were administered within the one-hour window of the scheduled time.

Following the inspection on April 10, 2026, a telephone interview was conducted with the complainant, who alleged that Resident F was prescribed Amlodipine and, on six occasions, staff initialed it as administered despite it not being available in the medication cart.

Review of Resident F's March and April 2026 MARs indicated that staff initialed Amlodipine as administered from March 1 through March 5, 2026, after which it was documented as not available on March 6, 2026. The MAR further reflected that Resident F was hospitalized from March 8 through March 18, 2026, and that the medication was administered on March 19 and March 20, 2026. It was then

documented as not administered on March 21 and March 22, 2026, followed by administration from March 23 through March 26, 2026. The medication was again noted as not available from March 27 through March 30, 2026, and then documented as administered on March 31, 2026.

The April 2026 MAR indicated the medication was not available on April 1 and April 2, 2026, administered from April 3 through April 19, 2026, not available from April 20 through April 25, 2026, and then initialed as administered from April 26 through April 29, 2026.

Telephone correspondence with staff at Guardian Pharmacy on April 29, 2026, confirmed that a 30-day supply was delivered on January 7, 2026, followed by a 15-day supply delivered at midnight on April 2, 2026, and another 15-day supply delivered at midnight on April 25, 2026. Based on this information, staff documented Amlodipine as administered during periods in March 2026 and on two occasions in April 2026 when there was no medication available in the home.

On April 13, 2026, the complainant provided additional allegations via email, including:

- Resident A's Ibandronate was administered with other medications despite physician orders indicating it must be taken alone, specifically on March 28, 2026.
- Insulin pens were not dated when opened.
- Resident G, a newly admitted diabetic resident, did not have assigned supplies (auto shields, lancets, or test strips), and staff were reportedly directed to borrow supplies from other residents.
- Resident G's MAR included medications documented as administered that had not yet been received in the facility.
- Resident H did not receive medications for approximately two weeks after moving into the assisted living due to not being entered into the system.
- Resident J reported being given Tylenol from Employee #2 during a meal despite self-administering medications, and staff did not verify her identity.
- Employee #3 reportedly administered Hydrocodone-Acetaminophen (Norco) to Resident K (who has since passed away) from another resident medication supply without proper documentation.

On April 21, 2026, I conducted a second on-site inspection.

Observations of medication cart #3 revealed that insulin pens for Residents F and M showed evidence of use but were not dated when opened.

Observation of medication cart #1 revealed that Resident G did not have auto shields or test strips. Employee #4 stated these items were obtained from another resident's supply. Review of Resident G's April 2026 MAR indicated he moved into the home on April 2, 2026; however, not all prescribed medications were present in the medication cart, including calcium carbonate, cholecalciferol, melatonin, saxagliptin, and docusate. Despite this, staff initialed some of these medications as administered on April 11, 2026.

A review of Resident H's MAR indicated an admission date of February 24, 2026; however, staff reported she transitioned from independent living to assisted living on March 6, 2026. From March 6 through March 15, 2026, her medications were documented as on hold per physician order. After this period, some medications were documented as administered, while others were marked as not available or "see note." Notably, on March 22, 2026, ascorbic acid was documented as administered despite other entries indicating it was unavailable for the remainder of the month.

During the second inspection, I interviewed Resident J, whose statements were consistent with the complaint. She reported that a "newer" staff member attempted to administer Tylenol to her during breakfast without verifying her identity, and she informed the staff member that she self-administers her medications.

Observation of medication cart #1 confirmed that Resident K's medications were no longer present after her passing. A review of her March 2026 MAR indicated she had been prescribed Hydrocodone-Acetaminophen (Norco) beginning March 16, 2026, which was discontinued on April 3, 2026. There was no documentation indicating administration of Norco.

Email correspondence with Employee #1 indicated, in part, that Resident G arrived with auto-shields that were unsafe and a nonfunctioning glucometer. Additionally, the test strips he brought were not compatible with the facility's glucometer. Employee #1 reported making multiple attempts to contact the Veterans Administration (VA) regarding Resident G's diabetic monitoring needs and medications that were sent from Adrian Bay Rehabilitation, the facility from which he was admitted; however, no response was received. As a result, the facility's in-house provider was utilized to obtain new orders, and all medications were reordered through the in-house provider due to the lack of response and receipt from the VA.

The correspondence further indicated that Resident H had been entered into the system; however, her family was not prepared for her to move into her apartment, and she remained in the independent living where she managed her medications with family assistance. As a result, her medications were placed on hold. Upon her return to the facility, staff awaited provider approval to adjust certain medications to align with those supplied by Guardian Pharmacy. The provider was notified by the pharmacy regarding the medication needs.

A review of the facility’s policy titled “Medication & Treatment – General Guidelines for Medication Administration/Assistance” (dated September 2025) read in part trained associates administering medications should follow the “7 Rights of Medication Administration: right medication, right dose, right time, right route, right resident, right documentation, and right to refuse.” They should follow the medication label, pharmacy, and manufacturer directions for each individual medication prescribed. Expiration dates should be checked on medications or treatments before administration. Medications and treatments should be administered within one hour before or one hour after the prescribed frequency and time/range unless ordered by the physician/healthcare provider or according to state regulations. The administration/assistance of medications or treatments should occur outside of the Dining Room area unless the specific physician/primary care provider order is “with meal(s)” or per resident request. Medication and/or treatment errors should be reported promptly and according to the Brookdale Reportable Events Policy and Grid.

A review of the facility’s policy titled “Medication & Treatment – Administration/Assistance” (dated July 2024) indicated that staff are required to verify a resident’s identity prior to medication administration, check expiration dates, and document the date when multi-dose containers are opened.

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident’s medications.</b>
	<b>(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions,</b>

	<p>orders and by the prescribing licensed healthcare professional.</p> <p><b>(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:</b></p> <p style="padding-left: 40px;"><b>(a) Be trained in the proper handling and administration of the prescribed medication.</b></p> <p style="padding-left: 40px;"><b>(b) Complete an individual medication log that contains all of the following information:</b></p> <p style="padding-left: 80px;"><b>(v) The initials of the individual who administered the prescribed medication.</b></p>
<b>ANALYSIS:</b>	<p>The investigation identified multiple concerns related to medication management, documentation, and adherence to facility medication policies. While some records indicated medications were administered within the allowable one-hour timeframe, there were significant discrepancies in the documentation, including documentation indicating medications were initialed as administered when medications were not available in the medication cart and blank MAR entries.</p> <p>Additional concerns included failure to date insulin pens when opened, and reports of borrowing diabetic supplies between residents.</p> <p>Resident interview findings supported concerns related to improper medication administration practices, including failure to verify resident identity prior to administration. Additionally, documentation related to controlled substances lacked required entries, raising concerns regarding medication accountability. Overall, the findings demonstrate systemic issues with medication administration practices, documentation accuracy, medication availability, and compliance with established policies, supporting the allegations reviewed during the investigation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Narcotic count logs were incomplete. Narcotic medications were being placed back in the blister packs.**

**Food was being removed from residents' meals prior to being completed.**

## **Residents were being charged for vitals signs that were not completed.**

### **INVESTIGATION:**

On April 6, 2026, the Department received a complaint alleging that narcotic count logs were incomplete, that narcotics were removed from and returned to blister packs when not used, that residents were being charged for monthly vital signs that were not completed, and that food was being removed from residents before they finished eating or were offered additional servings.

On April 10, 2026, I conducted an on-site inspection and interviewed staff.

Observation of medication cart #1 and the controlled substance/MAR change-of-shift audit log revealed that both off-going and oncoming staff were required to sign to verify completion of narcotic counts. However, the log was incomplete, with missing staff signatures on one or more shifts on the following dates: March 21, March 24, March 25, March 31, April 1, April 4, April 5, and April 6, 2026.

Additionally, observation of Resident N's Haloperidol (a controlled substance) indicated it expired on April 3, 2026. The blister pack showed signs of tampering, with tape applied to the back where pills appeared to have been removed and replaced. During interview, Employee #1 stated that if a narcotic is removed and not administered, it must be properly wasted with another staff member and should not be returned to the blister pack.

Interviews with the Administrator and Employee #1 indicated that vital signs are taken when ordered by a physician and are included in the cost of medication administration. They also reported that monthly vital signs are completed for all residents as part of routine care. Employee #1 stated that Resident A requires vital signs to be taken prior to medication administration.

During the inspection, I interviewed Resident A, who reported that the food was satisfactory, that residents are given sufficient time to eat, and that staff routinely offer additional food or dessert. She also stated that staff check her blood pressure prior to administering her medication and withhold it if parameters are not met.

Observations in the dining room showed staff serving approximately 14 residents, assisting with meal selections, offering desserts, and clearing plates after residents had finished eating. Residents appeared satisfied with the dining experience.

A review of the facility's policy titled "Medication & Treatment – Administration/Assistance" (dated July 2024) indicated that staff were to complete

proper documentation in the narcotic log, including staff signature, date, and time of administration.

A review of Resident A's March 2026 MAR confirmed that her blood pressure was documented in conjunction with medication administration. Additionally, a review of the facility's fee schedule indicated that monthly charges for medication services include monitoring of blood pressure, pulse, and weight.

<b>APPLICABLE RULE</b>	
<b>R 325.1921</b>	<b>Governing bodies, administrators, and supervisors.</b>
	<p><b>(1) The owner, operator, and governing body of a home shall do all of the following:</b></p> <p><b>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</b></p>
<b>ANALYSIS:</b>	<p>Based on observations and staff interviews, the narcotic count logs were incomplete, and there was evidence suggesting improper handling of controlled substances. Therefore, this portion of the allegation was substantiated.</p> <p>The allegations related to food being removed prior to residents finishing meals and failure to complete vital signs were not substantiated based on observations, interviews, and documentation reviewed.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Staff lack medication training.**

**INVESTIGATION:**

On April 13, 2026, the Department received additional allegations via email from the complainant, which read that many medication technicians had not completed required hiring or medication cart training packets. It was further alleged that Employee #4 had been operating a medication cart for approximately seven months without completing required training and had been doing so for four months prior to being formally checked off by the Administrator.

On April 21, 2026, I conducted a second on-site inspection at the home.

During an interview, Employee #5 stated that Employee #1 was responsible for maintaining staff medication administration competency checkoffs; however, she was able to provide Relias training records for review. Employee #5 reported that employees receive a pay increase upon assuming medication technician responsibilities. She stated that Employee #2 was hired on March 20, 2026, already at a higher pay level, and therefore did not have a change in pay. Employee #4 was hired on October 16, 2025, with a pay increase reflecting medication technician duty beginning November 9, 2025. Employee #6 was hired on December 29, 2025, with a pay increase effective March 22, 2026.

On April 27, 2026, email correspondence with the Administrator and Employee #1 read that the previous Director of Health and Wellness notified the Administrator on November 14, 2025, that Employee #4 was signed off on medication administration but could not locate her sign-off form.

Review of Employee #2's records revealed that a Medication Management Competency Checklist was completed on March 28, 2026, and Medication Observation/Administration Signoffs were completed on April 2 and April 3, 2026.

Review of Employee #6's records revealed that a Medication Management Competency Checklist was completed on March 17, 2026, and Medication Observation/Administration Signoffs were completed on March 6, March 9, March 13, March 17, March 18, and March 21, 2026.

A review of Relias training records for Employees #2, #4, and #6 indicated that each completed 10 medication-related training modules, including a medication management final exam. Employee #2 completed her medication training on April 2 and April 8, 2026. Employee #4 completed her training between October 20 through October 22, 2025. Employee #6 completed her training between December 30, 2025, through January 3, 2026.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(6) The home shall establish and implement a staff training program based on the home's program statement, the</b>

	<p><b>residents service plans, and the needs of employees, such as any of the following:</b></p> <ul style="list-style-type: none"> <li><b>(a) Reporting requirements and documentation.</b></li> <li><b>(b) First aid and/or medication, if any.</b></li> <li><b>(c) Personal care.</b></li> <li><b>(d) Resident rights and responsibilities.</b></li> <li><b>(e) Safety and fire prevention.</b></li> <li><b>(f) Containment of infectious disease and standard precautions.</b></li> <li><b>(g) Medication administration, if applicable.</b></li> </ul>
<b>ANALYSIS:</b>	<p>Review of employee files indicated that the home's medication training process included completion of Relias training, a Medication Management Competency Checklist, and a Medication Observation/Administration Sign-Off. However, Employee #4's file did not contain a Medication Management Competency Checklist or a Medication Observation/Administration Sign-Off. Based on this information, the allegation was substantiated.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Resident L had falls and incident reports were not completed.**

**INVESTIGATION:**

On April 13, 2026, the complainant provided additional allegations via email stating that Resident L had fallen from the sling of the sit-to-stand device on multiple occasions, reportedly occurring during the second shift. The complainant indicated uncertainty as to whether incident reports were completed for each occurrence.

Review of Resident L's incident reports revealed that on March 29, 2026, at 9:15 PM, she slipped out of a stand-up lift sling while being seated in her wheelchair in the bathroom. The report indicated there were no injuries; however, lift assistance was required. Emergency services were contacted, and she was assessed for injuries. Her authorized representative and physician were notified at 9:35 PM and 9:40 PM, respectively. The report did not include any follow-up information or interventions to prevent recurrence.

Review of the home's "BAIRS Incident Reporting Policy," dated January 2024, was consistent with the actions taken by the home.

<b>APPLICABLE RULE</b>	
<b>R 325.1924</b>	<b>Reporting of incidents, quality review program.</b>
	<b>(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.</b>
<b>ANALYSIS:</b>	The home followed their own incident report policy along with this rule; therefore, this violation was not substantiated.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Interview with Resident J revealed that staff were not consistently conducting routine checks and were not regularly providing water. She stated that staff no longer check on her and that, although water was previously provided each shift, she is now required to obtain her own.

Review of Resident J's service plan, dated April 17, 2026, indicated that she self-administers her medications and has been assessed and approved to do so. The plan noted she takes 40 mg of Lasix each morning and that staff are to ensure she maintains adequate fluid intake while taking her medications. It also indicated she is prescribed Eliquis and is at risk for falls. Additionally, the plan stated she requires staff assistance with dressing, showering, and toileting. However, the service plan did not specify the frequency or parameters for staff checks.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.</b>

<b>ANALYSIS:</b>	Interview with Resident J revealed staff did not always provide care consistent with her service plan; therefore, a violation was substantiated.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

*Jessica Rogers*

04/29/2026

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Jessica Rogers  
Licensing Staff

Date

Approved By:

*Andrea Moore*

04/30/2026

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Andrea L. Moore, Manager  
Long-Term-Care State Licensing Section

Date