GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2026

Jordan Houston
Hawthorn Landing
600 Golden Drive
Kalamazoo, MI 49001

RE: License #: AH390236775
Investigation #: 2026A1028045
Hawthorn Landing

Dear Jordan Houston:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH390236775
Investigation #:	2026A1028045
Complaint Receipt Date:	03/31/2026
Investigation Initiation Date:	03/31/2026
Report Due Date:	05/30/2026
Licensee Name:	Heritage Community of Kalamazoo
Licensee Address:	2400 Portage St. Kalamazoo, MI 49001
Licensee Telephone #:	(269) 343-5345
Authorized Representative:	Jordan Houston
Administrator:	Martila Sanders
Name of Facility:	Hawthorn Landing
Facility Address:	600 Golden Drive Kalamazoo, MI 49001
Facility Telephone #:	(269) 349-8694
Original Issuance Date:	03/01/1974
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	89
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility staff did not follow Resident A's service plan.	No
Resident A's call light would be pulled, and staff would not arrive or would not assist in a timely manner.	No
The facility did not administer medications in accordance with physician orders.	Yes
Additional Findings	No

III. METHODOLOGY

03/31/2026	Special Investigation Intake 2026A1028045
03/31/2026	Special Investigation Initiated - Letter
03/31/2026	APS Referral No APS referral. Resident A is deceased.
04/01/2026	Contact – Document Sent Emailed the complainant to inform [them] the complaint was forwarded from the Healthcare Fraud Department and received by the Homes for the Aged department for investigation.
04/01/2026	Contact – Document Received Received confirmation email from the complainant.
04/29/2026	Contact - Face to Face Interviewed the facility authorized representative at the facility.
04/29/2026	Contact - Face to Face Interviewed Employee A at the facility.
04/29/2026	Contact - Face to Face Interviewed Employee B at the facility.
04/29/2026	Contact - Document Received Received requested documentation from the facility authorized representative.

05/13/2026	Contact – Document Sent Emailed the facility administrator requesting additional information.
05/13/2026	Contact – Document Received Received the requested information from the facility administrator via email.

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA). Please note that HFA facilities do not provide skilled care and are not licensed to provide skilled care. Please note that the HFA department will not address the allegations or conflicts pertaining to the third-party service providers because the HFA department does not regulate third-party service providers. However, the complaint allegations pertaining to the third-party service providers were referred to the appropriate department for review.

ALLEGATION:

Facility staff did not follow Resident A's service plan.

INVESTIGATION:

On 3/31/2026, the Bureau received the allegations through the online complaint system.

On 4/29/2026, I interviewed the facility authorized representative (AR) at the facility who reported Resident A had Parkinsons disease and had progressed quickly towards the end-of-life stage once beginning hospice services. The facility AR reported that facility staff followed the service plan, hospice recommendations, and physician orders, but there was an incident with staff on 1/6/2026. The facility AR reported that staff member 1 did not administer morphine to Resident A due to Resident A peacefully sleeping and not demonstrating signs of pain, discomfort, or shortness of breath. Staff member 1 documented this in the record, but family member 1 became upset after learning the medication was not provided and staff member 1 proceeded to be defensive and unprofessional in [their] interaction with family member 1. Due to this incident, staff member 1 was terminated immediately. The facility AR reported that while staff member 1 performed [their] duties very well, the facility would not tolerate unprofessional behavior from a staff member towards anyone. The facility AR reported the family struggled with Resident A's progressive decline because Resident A was modified independent when initialing moving into the facility. However, Resident A's Parkinsons disease progressed so quickly, Resident A became very thin, was often not responsive to verbal or tactile stimulation, or began to demonstrate lethargy more frequently. The facility AR reported Resident A's family communicated with facility staff often and the facility attempted to reasonably accommodate the family's requests while remaining compliant with the service plan and physician orders. The facility AR reported that

family members were informed that the facility will attempt to accommodate [their] requests, but the facility must follow physician orders as prescribed. Education and training were provided to facility staff by facility management and the hospice team routinely as Resident A's condition changed and/or continued to decline to ensure care. The facility AR reported that as Resident A continued to decline, Resident A could no longer use the bathroom and required to be changed in bed. Staff monitored Resident A and while it was alleged that Resident A was found wet in bed, there was no evidence to support this when investigated by management. Resident A was observed to sweat a lot and at times, required changing and/or linens required changing, but Resident A was never left in urine soaked or soiled clothing or bedding if an accident occurred. Facility staff were also provided with routine education on the importance of ensuring service plan routines, monitoring Resident A, and the importance of skin integrity as well. The facility AR also reported that Resident A was very thin and when re-positioning Resident A, pressure marks could occur. Hospice and the physician were aware of Resident A's skin integrity. The facility AR provided me with the requested documentation for my review.

On 4/29/2026, I interviewed Employee A at the facility who confirmed that facility staff followed Resident A's service plan, hospice recommendations, and physician orders. Employee A also confirmed that staff member 1 was terminated due to the unprofessional interaction [they] had with Resident A's family.

On 4/29/2026, I interviewed Employee B at the facility whose statement was consistent with the facility AR and Employee A's statement.

On 4/29/2026, I reviewed the requested documentation which revealed the following:
Review of Resident A's facility service plan:

- Admission date: 12/5/2025
- Service Plan date: 12/5/2025
- Resident A had memory loss and was initially modified-independent with mobility and transfers at admission to the facility but required reminders or cues to use walker or cane.
- Resident A required assistance with bathing, dressing, grooming,
- Resident A required assistance with toileting and was on a 2-hour toileting check.
- The facility managed Resident A's laundry, housekeeping, meals, and medication administration.

Review of Hospice Service Plan

- Service Plan date: 11/20/2025 – 2/17/2026
- Resident A was diagnosed with Parkinson's disease w/o dyskinesia, w/o mention of fluctuations, mild cognitive impairment unknown, bulimia nervosa in remission, malignant neoplasm of ascending colon related to terminal prognosis etc.
- Resident A required assistance with activities of daily living (ADLs).

- The hospice team managed/supervised Resident A's pain, physician and medication orders, respiratory interventions, functional limitations of bowel and bladder, functional limitations of speech, nutrition, musculoskeletal interventions, integumentary interventions, psycho/mental/emotional/behavioral interventions, medical social services, personal care, patient care and functional needs.
- There is evidence that Resident A was actively declining and progressed to requiring total assistance for ADLs, mobility/bed mobility, and integumentary goals, and personal care.

Review of Resident A's record:

- Resident A required assistance with all care due to progressive Parkinsons disease.
- There is evidence of 2-hour checks for repositioning and oral care.
- There is evidence of facility communication with Resident A's AR and family, the physician, and hospice team.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(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.
ANALYSIS:	It was alleged that facility staff did not follow Resident A's service plan. Interviews, onsite investigation, and review of documentation revealed there is no evidence to support this allegation. The facility demonstrated care in accordance with the service plan and physician orders as Resident A continued to demonstrate a significant decline in condition due to disease progression. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's call light would be pulled, and staff would not arrive or would not assist in a timely manner.

INVESTIGATION:

On 4/29/2026, the facility AR reported that the facility staff responded in a timely manner. The facility AR reported that Resident A or Resident A's family would pull

the call-light staff would arrive in a timely manner, but sometimes the family's expectations were that staff were to immediately attend to Resident A even though staff may be assisting other residents. The facility AR reported Resident A's call-lights were answered in a timely manner and that facility staff checked on Resident A at minimum every 2-hours. The facility AR reported that Resident A passed in their room on 1/9/2026 and that facility staff had completed the required checks. However, family member 1 arrived at the facility after 6am to visit with Resident A and later reported to [them/the facility AR] that [they/family member 1] had pulled the call-light and no one came, so family member 1 went to look for staff and found staff in the hallway, reportedly at 6:37am. The facility AR reported that family member 1 texted [them] at 6:29am to let [them] know Resident A had passed and that [they] couldn't find any staff to assist with pronouncing Resident A. The facility AR called facility staff immediately and hospice team as well to notify [them] of Resident A's passing. The facility AR reported that family member 1 was upset and wanted staff to assess Resident A immediately, but then subsequently asked facility staff not to touch Resident A until after hospice arrived and assessed. The facility AR reported that the hospice team was alerted immediately by facility staff after family member 1's first phone call to [them] that morning. Also, the facility AR reported that the hospice team was already aware of Resident A's death when the facility called to notify the hospice team and that hospice is the appropriate authority to confirm death. However, the facility AR reported staff did attempt to clean Resident A, but the family declined until after the hospice team arrived. The facility AR provided me with the requested documentation for my review.

On 4/29/2026, Employee A's statement and Employee B's statement were consistent with the facility AR's statement.

On 4/29/2026, I reviewed the working staff schedules for January 2026 and had no concerns.

On 4/29/2026, I reviewed the information that the complainant had provided when filing the initial complaint and it read as follows:

- Friday, January 9th, 2026 at 6:23am – *I arrived at [the facility] and went directly to Resident A's room. Upon opening [the] door, it was apparent that [Resident A] was deceased. [Sic] I walked out of [Resident A's] room and [sic] I was unable to locate any staff. I then went back to [Resident A's] room and pulled the emergency cord [sic]. After one minute and with no response to the emergency cord being pulled in the room, I pulled the cord in [the] bathroom.*
    - *6:23am – I texted [family member 2] and said I found [Resident A] and think [they] had passed.*
    - *6:26am – I called [family member 2] and told [them] that I have pulled both cords and can't find staff and need help.*
    - *6:27am – I started to walk the halls again, even going down other resident halls but still found no one.*

- *6:29am – I texted [the facility AR], "I just walked in and [Resident A] has clearly passed. I pulled both emergency cords at 6:24am and can't find anyone on the floor."*
- *6:29am – I called [the hospice team] and reported the death and told them no one is here to help.*
- *6:29am – [the facility AR] replied, "I am calling now".*
- *6:30am – [Family member 2] arrived [at Resident A's room].*
- *6:31am – As I was checking [Resident A], an aide appeared and was heading into another resident's room. I walked out and told her I had pulled both cords almost ten minutes ago and [Resident A] had clearly passed. [The aide] [sic] went to find more people.*
- *6:33am – [Family member 2] called [sic] and I told [them] we need him now, that Resident A has passed and no one is here.*
- *6:34am – I felt [Resident A's] feet and they were ice cold and appeared blue. I took a picture.*
- *6:36am – [The facility AR] called and said the med tech [sic] was on the way down. [sic]*
- *6:37am – The [med tech] walks into the unit on the phone and past our room to the med cart.*
- *6:37am – [Sic] called [family member 2] and told us to get an external temperature reading now.*
- *6:38am – [Family member 1] and I walked down to the med cart and asked the [med tech] for a temperature reading now.*
- *6:40am – The [med tech] arrived [sic] and [Resident A's] temporal temperature was 97.0 degrees Fahrenheit. The [med tech] was unable to provide me with a definitive answer on the last time [they] checked on [Resident A] when asked.*
- *6:41am – [Staff member 2] came [sic] on shift, and I told [them] what was happening.*
- *6:45am – [Staff member 2] came down to clean up [Resident A.] We ask that [Resident A] not be touched until Hospice arrives.*
- *6:52am – [Sic] arrived.*
- *7:23am – The [hospice team] arrived and pronounced [Resident A] dead at 7:25am [sic.]*

On 5/13/2026, I emailed the facility administrator requesting additional information and received the requested information.

On 5/13/2026, I reviewed the call-light log for December 2025 and January 2026 for Resident A and had no concerns.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(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.
ANALYSIS:	It was alleged that Resident A's call light would be pulled, and staff would not arrive or would not assist in a timely manner. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. The January 2026 working staff schedules along with the December 2025 and January 2026 call-light logs demonstrated there was an appropriate number of staff working in the facility and that Resident A's call-lights were answered in a timely manner. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not administer medications in accordance with physician orders.

INVESTIGATION:

On 4/29/2026, the facility AR reported that Resident A had a lot of medication changes, particularly from as needed medication administration to scheduled medication administration. The facility AR reported that during the weekend of 1/2/2026 to 1/4/2026, Resident A received changes to the morphine orders and that the changes were received late and the pharmacy was already closed to process the orders. The facility AR reported that the pharmacy will not take anymore orders for processing after 4:30pm on Friday(s) and that the facility was not able to get Resident A's new medication orders until Monday. Resident A's family made several requests concerning the administration of the new medication orders, particularly for morphine, but the facility informed the family that they cannot take verbal orders and that the facility has to follow the physician orders in place until the new orders are received. The hospice team was alerted that the new medication orders were not available to the facility over the weekend and the hospice team attempted to get the orders filled but were not able to until Monday as well. Due to the family's concerns, the facility AR reported they reviewed Resident A's medication administration record (MAR) to ensure accurate medication administration for Resident A and to direct staff accordingly to physician orders. The facility AR reported that a medication review was completed by the hospice team and the facility as well. The facility AR

reported knowledge of a medication error discovered on 1/8/2026 and that it was documented in the record. The facility AR provided me with the requested documentation for my review.

On 4/29/2026, Employee A's statement and Employee B's statement was consistent with the facility AR statement.

On 4/29/2026, I reviewed the requested documentation which revealed the following:
Resident A's January MAR:

- The following medications were prescribed as needed (PRN) during the date ranges of 12/5/2025 to 1/9/2026: Acetaminophen, Clonazepam, Docusate Sodium, Hyoscyamine, Lorazepam, Excedrin Migraine Caplet, Morphine, and Prochlorperazine Maleate.

The following medications were scheduled:

- Resident A was to *take 1 tablet of Carbidopa-Levodopa 25-100mg (Sinemet 25-100mg) by mouth four times daily (Indications for use: Parkinson Disease). Start date: 12/5/2025 at 09:00; Hold Date: 1/3/2026 at 15:13 to 1/6/2026 at 07:27; Discharge Date: 1/6/2026 at 07:27.*
- Resident A was to *take 1 tablet of Clonazepam 0.125mg DIS TAB by mouth three times daily (Indications for use: Anxiety). Start date: 1/2/2026 at 08:48; Discharge Date: 1/8/2026 at 10:03.*
- Resident A was to *take 1 tablet of Clonazepam 0.25mg ODT TABL by mouth three times daily (Indications for use: Anxiety). Start date: 1/1/2026 at 09:00; Discharge Date: 1/2/2026 at 17:19.*
- Resident A was to *take Lorazepam 2MG/ML ORAL CONC 0.25ML (0.5MG) by mouth every 2 hours (Indications for use: Anxiety/restlessness). Start date: 1/5/2026 at 11:56; Discharge Date: 1/5/2026 at 2045.*
- Resident A was to *take Lorazepam Concentrate 2MG/ML Give 0.25ml by mouth every 4 hours for agitation. Start date: 1/6/2026 at 08:00; Discharge Date: 1/9/2026 at 12:03.*
- Resident A was to *take 1 tablet of Mirtazapine 30mg TABLET by mouth at bedtime (Indications for use: Antidepressant). Start date: 1/2/2026 at 20:00; Hold Date from 1/3/2026 at 15:12 to 1/6/2026 at 07:27; Discharge Date: 1/6/2026 at 07:27.*
- *Resident A was to take Morphine 20MG/ML Solution (Morphine Sulfate) 0.25ML (5MG) every 4 hours (Indications for use: Pain/SOB). Start date: 1/2/2026 at 15:33; Hold Date from 1/3/2026 at 15:20 to 1/6/2026 at 07:27; Discharge Date: 1/6/2026 at 07:27.*
- *Resident A was to take Morphine 20MG/ML Solution (Morphine Sulfate) 0.5ML (10MG) every 4 hours (Indications for use: Pain and/or shortness of breath). Start date: 1/3/2026 at 16:00; Discharge Date: 1/9/2026 at 12:03.*
- *Resident A was to take Morphine (Concentrate) Solution 20MG/ML Give 0.5ML every 4 hours (Indications for use: Pain or shortness of breath). Start date: 1/3/2026 at 16:00; Discharge Date: 1/4/2026 at 14:11.*

- *Resident A was to take 1 capsule of Omerprazole 40MG by mouth once daily (Indications for use: GERD). Start date: 12/5/2025 at 0900; Hold Date from 1/3/2026 at 15:11 to 1/6/2026 at 07:27; Discharge Date: 1/6/2026 at 07:27.*
- *Resident A was to take 2 tablets of Quetiapine 50MG (Quetiapine Furmarate) by bedtime (Indications for use: Anxiety). Start date: 12/23/2025 at 15:06; Hold Date from 1/3/2026 at 15:10 to 1/6/2026 at 07:27; Discharge Date: 1/6/2026 at 07:27.*
- *Resident A was to take 1 tablet of Quetiapine 50MG (Quetiapine Furmarate) by mouth daily (Indications for use: Anxiety). Start date: 12/23/2025 at 15:06; Hold Date from 1/3/2026 at 15:10 to 1/6/2026 at 07:27; Discharge Date: 1/6/2026 at 07:27.*
- *Resident A was to take 1 capsule of Venlafaxine ER 150MG CAP (EFFEXOR XR 150MG CAPSULE SA) by mouth once daily (Indications for use: Antidepressant). Start date: 12/5/2025 at 09:00; Hold Date from 1/3/2026 at 15:11 to 1/6/2026 at 07:27; Discharge Date: 1/6/2026 at 07:27.*

Chart Notes:

- On 1/2/2026 at 06:57 [entered by care staff], [Resident A] unable to stay awake, very drowsy. Morning 6am or 9pm medication from last night not given due to [Resident A] not responding to wake up and take medication.
- On 1/3/2026 at 14:45 [entered by care staff], *[Resident A] is having difficulty taking [sic] medications due to not swallowing, no fluid intake or eating soft food. [Resident A] is also having breathing APNEA, [sic] will take breath and then 10 seconds [sic] stops breathing. [Sic] vitals as follows BP 74/54; Pulse 102; Resp 12-16; Temp 99.6; POX 92. [Hospice] was notified and instruction was to give Morphine PRN, and a nurse will be sent out for further assessment. Will continue to monitor [Resident A].*
- On 1/3/2026 at 17:58 [entered by care staff]*, [Hospice] nurse [sic] visit and put new order for Morphine 0.50 every four hours scheduled. All other medication [sic] discontinued. Family was updated by nurse. Order was faxed to [pharmacy] and clinical manager was also notified of all meds changes. [Resident A] to be checked and reposition every 2 hours and mouth swab. DO NOT SWAB MOUTH AFTER PASSING MORPHINE. Will continue to monitor [Resident A].*
- On 1/4/2026 at 14:35 [entered by care staff], [Resident A] has been very restless. Anxiety/agitation was given. Given prn Clonazepam along with schedule dose due to anxiety reaching up frighten every 45-60 minutes. Crying out, clench fist and eyes shut. [Sic] was given PRN morphine. Family raises concerns about frequent scare reaction, ask if [Resident A] can be on other meds for anxiety. Clonazepam was not effective. Try Haloperidol [hospice] response with instruction NO due to [Resident A] having Parkinson. [Resident A] cannot be on Haloperidol. Will discuss Monday 1/5/2026 with PCP about increase dose on clonazepam. For now, continue with morphine as needed PRN. Will continue to monitor [Resident A].
- On 1/5/2026 at 14:35 [entered by care staff], *Spoke with [pharmacy], RE: Lorazepam [sic] is on its way to be delivered.*

- On 1/5/2026 at 15:43 [entered by care staff]*, received clarification on Lorazepam from [hospice] – Lorazepam instensol 2mg/ML; Give 0.25ML (0.5MG) Q2H; Give 0.25ML (0.5ML) Q2H PRN Anxiety/Restlessness.*
- On 1/7/2026 at 08:01 [entered by care staff], *hourly checks, 2-hour change, repositioning and oral care are being implemented. Follow the medications as prescribed by provider. Requested by family to administer comfort medications prior to being repositioned.*
- On 1/7/2026 at 23:43 [entered by care staff], *morphine was given 0.5ml as shown in system. Lorazepam was also given. 3 Narcos for [Resident A] was added to cart. [Resident A] is sleeping and doing fine at this time.*
- On 1/8/2026 at 00:00 [entered by hospice nurse], [Sic] *Family present throughout visit. [Sic] concerns about patient receiving smaller dose of comfort medications than ordered [sic] and concerns about bruising on patient [reported by family.] Family member reports [they] are currently very happy with the level of care that the patient is receiving and with current symptom management efforts. Med recon performed. Confirmed Lorazepam and morphine concentrate orders are consistent with expectation and justified to hospice med list. Patient [sic] does not respond (with the exception of slight changes in breathing rate/rhythm) during gentle physical assmt. Full skin assmt. provided. Areas of blanchable erythema (left heel; sacrum) [sic] and faded yellow/green bruising (right mid-thigh) [sic] noted and documented. Patient continues in active dying phase. [sic] Status reviewed with [care staff member]. Reviewed medications/doses as written. Reviewed standard q2 and oral care protocols for bed bound actively/dying patient. [Sic] Full report provided to community manager [sic], wellness director [sic], and hospice RN manager. Voice mail left for facility administrator [sic].*
- On 1/8/2026 at 07:00; LATE ENTRY; [entered by facility AR], *received call prior evening regarding resident medication from onsite medication assistance. Medication assistant seeking understanding concerning resident medication orders related to morphine. Aide requested clarification regarding dosage of morphine between 0.5ml to 0.25ml. Write reviewed order as written with medication assistant and discussed routine order dosage to be 0.5ml and any subsequent as needed dosage to be 0.25ml. Medication assistant reported additional confusion with the dosages administered as represented on the narcotic count sheet. Writer arrived to community at 06:55 and reviewed the narcotic count sheet. Dosage administered is noted to be incorrect. Provider notified, [Resident A's AR] notified.*
- On 1/8/2026 at 07:35 LATE ENTRY; [entered by facility AR], [Sic] *met with [family member 1] this AM. Family reporting several bruises observed on resident that appear to be old in nature. Hospice provider in and spoke with family as well. Hospice RN noted one bruise in right mid-thigh. No other bruising noted.*
- On 1/9/2026 at 10:35 {entered by facility AR], [Sic] received text from family at 06:29 informing writer that resident appeared without life. [Sic] Per hospice RN, resident pronounced at 07:25. [Sic].

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.
ANALYSIS:	It was alleged that the facility did not administer medications in accordance with physician orders. Interviews, onsite investigation, and review of documentation revealed the following: • Resident A had multiple PRN and scheduled medications prescribed by the physician with ongoing changes to the medication orders from December 2025 to January 2026. • On 1/7/2026, it was documented in the chart notes that "*3 Narcos for [Resident A] was added to cart."* However, after reviewing the January 2026 Medication Administration Record (MAR) along with Resident A's medication order list, it was discovered there is not a physician order prescribed for Narcos for Resident A. • On 1/8/2026, a medication discrepancy related to Resident A's morphine dosage(s) was found on the January 2026 narcotic count sheet and documented by facility staff in Resident A's chart record. Due to the discrepancies found between the January 2026 narcotic count sheet and the January MAR along with the documented medication error on 1/8/2026, it cannot be determined if Resident A received medication in accordance with the physician orders. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remains the same.

Julie Viviano

5/11/2026

_____

Julie Viviano Date
Licensing Staff

Approved By:

07/30/2026

_____

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