GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 21, 2021

Suzy Hunter, Licensee Designee
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #:	AS700297560
Investigation #:	2021A0356022
	Beacon Home at Trolley Center

Dear Ms. Hunter:

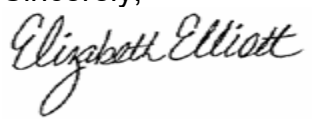
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

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

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700297560
Investigation #:	2021A0356022
Complaint Receipt Date:	02/23/2021
Investigation Initiation Date:	02/23/2021
Report Due Date:	04/24/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Suzy Hunter
Licensee Designee:	Suzy Hunter
Name of Facility:	Beacon Home at Trolley Center
Facility Address:	320 64th Ave. North Coopersville, MI 49404
Facility Telephone #:	(616) 384-3141
Original Issuance Date:	02/25/2009
License Status:	REGULAR
Effective Date:	08/25/2019
Expiration Date:	08/24/2021
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A's prescribed medications and special medical procedures are not administered as prescribed by Resident A's physicians.	No
Resident A's medication label instructions for Clobazam are not included on the Medication Administration Record.	Yes

III. METHODOLOGY

02/23/2021	Special Investigation Intake 2021A0356022
02/23/2021	APS Referral Special Investigation Initiated - Telephone Lorena Fredrick, Ottawa County DHHS, APS worker assigned.
03/09/2021	Contact - Face to Face Melissa Dyke, Lorena Fredrick, APS, Suzy Hunter, Felisha Battice, Ella Philander, Sara Paxton, Roxane Goldammer, Beacon, Lynne Doyle, Jill Oosterhout, Pamela TenBrink, Ottawa County CMH.
03/10/2021	Contact - Face to Face Relative #1, Ottawa County CMH and APS.
03/16/2021	Contact - Document Sent Suzy Hunter and Felisha Battice.
03/23/2021	Contact - Telephone call received. CMH nurse, Bonnie Evans.
03/26/2021	Contact - Face to Face Felisha Battice.
03/29/2021	Contact - Document Received Facility Documents received from F. Battice.
04/02/2021	Contact - Telephone call received. Suzy Hunter, Program Director and Felisha Battice, review of documents.
04/13/2021	Contact-Telephone call made. Kelly Blanchard, direct care worker.

04/13/2021	Telephone call made. Dr. Samantha McBee, primary care physician.
04/15/2021	Telephone call made. Interviewed Brittney Risselada, medical assistant, Dr. McBee's office. Bonnie Evans, CMH nurse.
04/19/2021	Contact-Documents Received Assessment plan and IPOS plan/reviewed.
04/21/2021	Exit Conference-Licensee Designee, Suzy Hunter.

ALLEGATION: Resident A's prescribed medications and special medical procedures are not administered as prescribed by Resident A's physicians.

INVESTIGATION: On 02/23/2021, I received a complaint via email from Relative #1. Relative #1 reported there is an issue with insurance covering birth control pills for (Resident A) because the pills will not cover the time needed to make it until the insurance will cover the next prescription. Relative #1 reported that 11 packs of pills were dispensed from Tasker's Pharmacy since 09/08/2020, the script is written to skip placebo pills and according to Relative #1, the first insurance override was done on 10/01/2020 because the number of pills dispensed on 09/08/2020 should have lasted until November 2020 but they did not. According to Relative #1's calculations from 09/08/2020 until 02/22/2021, there are 64 pills unaccounted for, hence, Tasker's computer and insurance flagged the script as too soon to fill.

Relative #1 reported that Dr. Haykal wrote an order to wear a smart watch and documented in Resident A's IPOS (Individual Plan of Service) are instructions to charge the smart watch weekly. Relative #1 reported the smart watch monitors blood pressure, O2, sleep, steps, and HCG. Relative #1 reported at Resident A's last appointment, the smart watch was uncharged.

Relative #1 reported on 01/19/2021, she received a voicemail from staff at the facility that COVID-19 was in the home and the following day, 01/20/2021, Resident A went out to a dental appointment. Relative #1 stated she had concerns about Resident A being exposed to the virus while in the home and then being taken into the community after exposure. Relative #1 stated on 01/29/2021, there were only 2 residents in the facility, Resident A, and another resident. Relative #1 stated she speculated that 2 residents were out for treatment of Covid, yet Resident A was taken out for medical appointments which was not safe for Resident A or others in the community and there was no need to keep a dental appointment.

Relative #1 reported the MAR (medication administration record) for Resident A indicated staff did not administer PRN (as needed) Klonopin prior to a 01/07/2021 & 01/12/2021 doctor's appointment, then prior to a 01/20/2021 dental appointment

PRN Haldol was administered when Klonopin is the prescribed PRN for appointments.

On 02/23/2021, I reviewed the complaint allegations with Lorena Fredricks, APS (Adult Protective Services) for Ottawa County Department of Health and Human Services (DHHS). Ms. Fredricks stated this is an open, ongoing APS case.

Resident A is nonverbal and unable to provide information that is pertinent to this investigation.

On 03/09/2021, I participated in a face-to-face zoom meeting regarding the complainant's concerns about Resident A's birth control medication. In attendance at the meeting were, Melissa Dyke, APS worker and Lorena Fredrick, APS supervisor, Ottawa County DHHS, Suzy Hunter, Program Manager, Felisha Battice, Home Manager, Ella Philander, Sara Paxton, Roxane Goldammer (Beacon Homes management), Lynne Doyle, Jill Oosterhout, Pamela TenBrink, Ottawa County CMH (Community Mental Health). Ms. Battice stated Resident A's birth control pills are administered as prescribed. Ms. Battice stated the pills come in a pack as a 28-day supply, 7 of those 28 pills are placebo pills leaving 21 usable pills/doses. Ms. Battice stated Resident A's doctor has instructed that Resident A skip the 7 placebo pills each month and continue on to the next pack of pills so she does not have a menstrual period. This will create a shortage of the pills due to the continuous use of the actual pill and starting a new pack prior to the end of each month. Ms. Battice stated according to her calculations, on 05/18/2021 they will be out of pills and will have to pay for 2 packs of pills before another prescription can be covered by Resident A's insurance. Again, Ms. Battice stated this is due to the continual use of the actual pill and skipping the 7 days of placebo pills and continuing on to a new pack of pills. Ms. Battice and Ms. Hunter explained the pills are packaged all together and there is no way for the pharmacy to separate out the placebo pills from the regular birth control pills so they will always come with the 7 days of placebo pills in the pack. Ms. Battice stated, bottom line, Resident A is getting the medication daily as prescribed by the doctor.

On 03/23/2021, I interviewed Bonnie Evans, Ottawa County CMH Nurse via telephone. Ms. Evans stated she received a chart from the facility that showed the dates Resident A's prescription was filled, the total amount of pills, placebos, and usable doses for dates in question of 09/08/2020, 10/01/2020, 11/30/2020 and 02/09/2021. Ms. Evans stated the facility documented 3 packs delivered each time totaling 315 usable doses (not counting the placebos). Ms. Evans stated she also reviewed with Scott Karasinski, head pharmacist at Tasker's Pharmacy the number of pills provided to the facility and while the pharmacist gave her the run down as 09/08/2020, 4 packs delivered (112 pills), 10/01/2020, 3 packs (84 pills), 11/30/2020, 4 packs (112 pills), and 02/09/2021, 4 packs (112 pills) minus the placebos each month came out to 315 usable doses. Ms. Evans stated it appeared as though what was dispensed vs. the number of pills received at the facility from the pharmacy is correct.

On 03/24/2021, Ms. Evans and I spoke again, and she stated a meeting occurred today between CMH and the facility and Resident A's birth control medication was discussed, and numbers were found to be inaccurate. Ms. Evans stated what she reported on 03/23/2021 was not correct and at the end of this prescription, the facility will be two months short of pills for Resident A and someone will have to buy the medication out of pocket.

On 03/24/2021, Ms. Evans forwarded an IR (Incident Report) she wrote on 02/25/2021 regarding information discovered on 02/23/2021. Ms. Evans documented the following information on the IR, '*Consumer prescribed by Dr. McBee, Levonor-Eth Estrad 0.1-0.02, take one tablet by mouth once daily continuously-no menses. In the packs are 21 days of treatment dosage and 7 days of placebos. The placebos are disregarded so she does not have a menstrual cycle. There has been a discrepancy as to the amount of medications dispensed via Tasker's Pharmacy in Coopersville, MI per request of AFC home to the number of treatment doses she has received since September 2020. Consumer's insurance has denied two refills which had to be overridden in order to continue med as ordered. On 02/23/2021, Scott, pharmacist, reviewed history of med filled. On 09/08/2020 84 treatment doses dispensed, 10/01/2020, 63 doses, 11/30/2020 84 doses and on 02/09/2021 84 doses dispensed for total of 315 days of medication. According to the pharmacist consumer should have enough tablets until 05/04/2021 when home will need a refill but will be short by two packs and he doubts insurance will allow another override. Insurance will not pick up again until 06/28/2021. Action Taken: Discussed with Felisha, home manager, as to possible cause of discrepancy. She is unsure why this is occurring. She did report she usually calls for a refill when (*Resident A*) has sixteen or so pills left in last pack so as to not run out. Reviewed home's procedure/protocol when medications are delivered/picked up. Medications are signed in by two people, home manager and another staff person and locked in med cabinet until needed to administer to consumer as ordered.'*

On 03/26/2021, I conducted a face-to-face zoom meeting with Ms. Battice for additional information and clarification regarding the complaint allegations. Ms. Battice stated she started as the facility manager on 10/06/2020 so it was after Resident A had been prescribed birth control pills. Ms. Battice stated all medications that come into the facility are checked in by two staff and documented on a Beacon form where all residents' names and medication information is maintained. Ms. Battice stated staff administer one birth control pill each day to Resident A and when they get to the placebo pills at the end of the pack, they have been instructed by the doctor to skip the placebos and move on to the next pack of pills so Resident A does not have a menstrual period. Ms. Battice stated the pills are administered as prescribed and from her calculations, the medication will be out on 05/18/2021 and will be short by 2 months before a new prescription can be filled. Ms. Battice stated there will be 2 months that the prescription will need to be paid for out of pocket. Ms. Battice stated Tasker's Pharmacy reported there was a month where 4 packs of pills were delivered but Ms. Battice stated she never received 4 packs of pills, the prescription is written out for a quantity of 3 packs (84 pills) and not for 4 packs (112

pills). Ms. Battice stated that the chart she has submitted are the number of packs of pills delivered, the number of pills administered to Resident A and the number of placebos not administered. Again, Ms. Battice stated they are administering Resident A's birth control pills as prescribed by her doctor.

On 03/29/2021, I received and reviewed the medication chart for Resident A's medication Levonor Estradiol birth control pills sent by Ms. Battice. The chart documents the delivery of 3 packs of pills on 09/08/2020, 10/01/2020, 11/30/2020 and 02/09/2021 for a total of 12 packs of pills, 336 total pills, 84 placebo pills and 252 usable doses of the pill. The chart shows that 252 days from 09/08/2021 is 05/19/2021 when the pills will run out. Ms. Battice documented the actual date the pill will run out is 05/18/2021 because one pill was dropped and destroyed per Beacon protocol.

On 03/29/2021, I received and reviewed Resident A's MARs for the months of August 2020 through the end of February 2021. Resident A was prescribed Levonor ETH Estradiol, birth control pills that began on 08/12/2020 to be administered 0.1-0, 02, Frequency 8:00PM. This prescribed medication is administered every day and the MAR is initialed by staff that administers the medication. The only time this medication was not administered was on 09/30/2021, when staff KB (Kelly Blanchard) documented that the medication was not administered because the '*medication was not delivered.'*

On 03/29/2021, I received and reviewed Resident A's patient prescription summaries, one dated 02/09/2021 covering 09/01/2020-02/09/2021 that shows one refill of Levonor-Eth Estrad as a transfer with no mention of skipping the placebo tablets. The next prescription profile was dated 03/19/2021 covering 09/01/2020-03/19/2021. This summary showed no refills of the Levonor-Eth Estrad pills and a different script for Vienva 0.1-20mg-mcg tabs, take one tablet by mouth daily, skip placebo tablets as directed with 4 refills total and 3 refills left. I reviewed a refill e-script prescription for Resident A dated 11/30/2020 written by Dr. McBee for 5 fills (expires on 04/30/2021) of Aviane tab 0.1-20 tablet, quantity 84 tablets, take one by mouth once daily, skip placebo tablets as directed.

On 04/13/2021, I interviewed direct care worker (DCW) Kelly Blanchard via telephone. Ms. Blanchard stated staff were administering Resident A's birth control pills beginning on 08/12/2020 and were administering the placebo pill at that time. Ms. Blanchard stated at a doctor's appointment on 09/29/2021, Dr. McBee ordered that the placebo pill not be administered to Resident A so on 09/30/2020 when it came time to administer Resident A's birth control medication, all Ms. Blanchard had at the facility were the 7 days of placebo pills, a new pack of the medication was not at the facility yet. Ms. Blanchard stated the following day, 10/01/2020, a new pack of pills was available and Resident A's birth control pill was administered, not the placebo pill. Ms. Blanchard stated she documented the MAR and did exactly what the doctor had ordered based on Resident A's appointment on 09/29/2020.

On 04/16/2021, I interviewed Brittney Risselada, Medical Assistant at Dr. McBee's office. Ms. Risselada explained that upon prescribing birth control pills for Resident A, Dr. McBee wrote the script as "take one tablet by mouth daily, continuous without menses," then, at a doctor's appointment for Resident A on 09/29/2021, Dr. McBee re-wrote the script as "take one tablet by mouth daily, skip placebo pills." Ms. Risselada stated it was at that point, that staff began to skip the 7 daily placebo pills each month for Resident A. Ms. Risselada stated Dr. McBee meant for staff to skip the placebo pills each month right from the beginning of the script in August 2020 but realized that her wording on the script was ambiguous and staff may not have realized what she meant. So, during the appointment on 09/29/2020, Dr. McBee changed the wording on the script to direct staff to skip the placebo pill. Ms. Risselada stated it makes sense that Ms. Blanchard then began to skip Resident A's placebo pills on 09/30/2020 and documented the MAR reflecting that. Ms. Risselada stated the scripts were written for 84 pills which is a 90-day supply, 3 months and the prescriptions are not usually for more than that number of pills so a script for 112 pills is not typical. Ms. Risselada stated the first prescription for birth control pills for Resident A in August 2020 was sent to Rite Aid in Coopersville with one refill, the facility staff called the doctor's office and stated they were told there was no refill so Dr. McBee's nurse called Rite Aid pharmacy to let them know there should be another refill. Ms. Risselada stated on 11/30/2021, a prescription for 1 years' worth of pills for Resident A was sent to Gull Point pharmacy in Kalamazoo and the only mention of Tasker's pharmacy in Dr. McBee's system is when Ms. Evans from Ottawa County CMH called on 02/08/2021 asking questions about Resident A's birth control pills. Ms. Risselada stated often when changing from one pharmacy to another, the pharmacies do not transfer refills. Ms. Risselada stated there is nothing documented that indicates Dr. McBee is concerned with the administration of this medication to Resident A by staff at the facility.

This concludes the information received regarding Resident A's birth control medication.

On 03/26/2021, I interviewed Ms. Battice face-to-face via zoom. Ms. Battice stated Resident A's fit bit is not on the MAR. The fit bit is also not a prescribed special medical procedure but rather a device suggested by Relative #1 to assist with following patterns of sleep and activity for Resident A. Ms. Battice stated Dr. Haykal has written a letter stating Resident A should be allowed to wear a smart watch, which they do allow. Ms. Battice stated she charges Resident A's watch every Monday or Tuesday but the watch charge does not last an entire week so it may be dead on certain days during the week. Ms. Battice stated Resident A wears the watch and while staff try to keep it charged, Resident A is not always cooperative in allowing staff to remove the watch and/or putting the watch back on. Ms. Battice stated staff cannot force Resident A to remove or put the watch on, but they do make attempts to keep the device charged and working properly.

On 03/29/2021, I received documentation in the form of a letter written by Dr. Mohamad Haykal, MD, Spectrum Health Medical Group dated 10/09/2020 that

states, '*This is to certify that* (Resident A) *was seen in the office on 05/21/2020. She is requesting to wear a smartwatch to monitor sleep, etc. She should be allowed to wear this. Please feel free to contact my office if you have any questions or concerns. Thank you for this assistance in this matter.*'

On 04/15/2021, I received and reviewed Resident A's MARs from August 2021 through March 2021 and there is no documentation on the MAR that a smart watch or fit bit was ordered by the doctor.

On 04/19/2021, I reviewed Resident A's assessment plan for AFC residents dated 10/12/2020 and signed by Relative #1 on 01/15/2021 and Kevin Kalinowski on 10/12/2020. The assessment plan does not document any information regarding the use of a smart watch or fit bit for Resident A.

On 04/19/2021, I reviewed Resident A's IPOS (Individual Plan of Service) for Resident A written by Stephanie Van Harn, LBSW, signed on 02/23/2021 by Ms. Van Harn, LBSW and signed on 02/28/2021 by Relative #1. The plan start date is 11/29/2020 with the next review date of 11/27/2021. On page 2 of the IPOS is '*interventions*' and one being, '*wearing/charging smartwatch (at least weekly, this tracks steps sleep, O2, blood pressure and heart rate), and up at night needs (see nursing support plan for good sleep hygiene) etc.'*

On 04/19/2021*,* I received and reviewed signature pages for varying dates in December 2020 signed by facility staff including Ms. Battice and documenting that Sara Paxton, LMSW, CAADC, CCS, Ottawa County CMH staff conducted in-service trainings for staff on Resident A's IPOS plan.

This concludes the information received regarding Resident A's smartwatch/Fitbit.

On 03/10/2021, I received from Relative #1 a copy of a recorded voicemail message from Ms. Battice to Relative #1. Ms. Battice left a message stating there was a confirmed case of COVID in the home and she was informing Relative #1 per Beacon protocol and invited Relative #1 to call her with any questions or concerns.

On 03/26/2021, I interviewed Ms. Battice face-to-face via zoom. Ms. Battice stated a staff at the facility was diagnosed with COVID-19 and was isolating at home. Ms. Battice stated she notified Relative #1 per Beacon's policy. Ms. Battice stated the staff member with COVID was not working and was not around the residents, all of the residents were in the home and none of the residents were out of the facility being treated for COVID as reported by Relative #1. Ms. Battice stated she was following protocol by having staff at home in isolation, the residents did not exhibit any symptoms of COVID and there was no reason to miss Resident A's appointment. Ms. Battice stated she notified Relative #1 just to keep her informed and up to date on what was going on at the facility. Ms. Battice stated Relative #1 did not call her to inquire or to gather more information about this. Ms. Battice stated

they want to keep up on all of Resident A's medical care needs including dental appointments and did not see it necessary to cancel this appointment.

This concludes the information received regarding Resident A's scheduled dental appointment with Miles of Smiles that was kept despite a case of COVID with a staff at the facility.

On 03/26/2021, I interviewed Ms. Battice face-to-face via zoom. Ms. Battice stated Resident A's Klonopin, and Haldol medications are not prescribed for any appointments specifically, the medications are prescribed as PRN (as needed) medications for agitation and anxiety and are administered as determined necessary by staff and documented on the MAR.

On 03/29/2021, I received and reviewed a script written by Dr. Petrovic dated 11/13/2020. The script shows a prescription for Haldol 5mg, PRN for agitation, the script does not specify that the medication Haldol should be administered prior to Resident A's medical appointments.

On 03/29/2021, I received and reviewed Resident A's MARs for August 2020 to March 2021 including attached documents showing what the PRN's were used for. On the dates Relative #1 reported that Resident A did not receive a PRN medication Klonopin before an appointment, 01/07/2021, 01/12/2021 and 01/20/2021 it appears as though Resident A did not receive PRN Klonopin. On 01/20/2021, the MAR documents that Resident A was given PRN Haldol but states the medication was given for pain rather than for an appointment. Resident A received PRN Klonopin prior to medical appointments as documented on the PRN log on 01/13/2021, 01/19/2021 and 01/29/2021 and on varying other dates for agitation and anxiety.

On 03/29/2021, I reviewed Resident A's medication narrative from 07/22/2020-current. The medication Klonopin (Clonazepam) 1mg tablet by mouth, take as needed, take ½ tablet by mouth twice daily PRN (as needed) for anxiety or agitation and 1 tablet before appointments was documented on 8 dates from July 2020 to October 2020 in the notes. On the medical notes from October 2020 forward the Klonopin medication does not state take 1 tablet before appointments.

On 04/20/2021, I reviewed the label on Resident A's Klonopin medication, written by Dr. Marija Petrovic, take 1mg, 1 tablet by mouth twice daily as needed (PRN) and on the eMAR as take 1mg, 1 tablet by mouth twice daily as needed (PRN).

On 04/21/2021, I conducted an Exit Conference with Licensee Designee, Suzy Hunter via telephone. Ms. Hunter stated she agrees with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on investigative findings, a preponderance of evidence is not established to substantiate that Resident A's birth control pills are not being administered as prescribed. While the reason behind the shortage is not clearly established, Resident A is currently receiving the medication as prescribed by the physician. On 09/30/2020 staff did not administer the placebo pill as instructed by Resident A's doctor but began the regular cycle of pills on 10/01/2020 as instructed by the doctor. Resident A's smart watch is not prescribed as a special medical procedure. While the smart watch is documented in Resident A's IPOS plan, there is no documentation that shows Dr. Haykal prescribed the use of this watch as a necessary medical procedure. The smart watch's use or need to be charged on a regular basis is not documented on the resident MARs as a special medical procedure however, staff at the facility charge the smartwatch weekly as documented in the IPOS. Staff at the facility maintained Resident A's Dental appointment despite a staff member testing positive for COVID but this staff member was quarantined at home and residents did not show signs or symptoms of the virus. Resident A's prescription medication PRN Klonopin does not have physician instructions directing staff to administer the medication prior to medical appointments.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATIONS: Resident A's medication label instructions for Clobazam are not included on the Medication Administration Record.

INVESTIGATION: On 02/23/2021, Relative #1 reported the MAR given to staff at Mary Free Bed on 02/18/2021, showed the 8:00PM Clobazam medication as 10mg, the prescribed amount by Dr. VanTil is 20mg or 2 tablets at 8:00PM.

On 03/26/2021, I interviewed Ms. Battice face-to-face via zoom. Ms. Battice stated the MAR shows Resident A is to get Clobazam 10Mg at 8:00AM and 10Mg at 8:00PM but staff are administering that medication as prescribed and according to the label that appears on the medication bottle and on the eMAR (electronic medication administration) system at the facility which is one 10mg tablet by mouth in the morning and 2, 10mg tablets by mouth at bedtime.

On 03/29/2021, I received and reviewed Resident A's MARs for August 2020 to March 2021. The MAR for Clobazam shows 10mg dose at 8:00AM and a 10mg dose at 8:00PM with no label instructions included.

On 04/19/2021, I reviewed the label on Resident A's Clobazam medication, written by Dr. Mohamad, MD, the label documents '*Clobazam 10mg tablet, take 1 tablet by mouth in the morning and take 2 tablets by mouth at bedtime*.' I also reviewed the eMAR system that shows '*Clobazam 10 mg tablet, take twice daily, take 1 tablet by mouth every morning and take 2 tablets at bedtime.*' Ms. Battice stated staff are directed by what is documented on the eMAR system rather than by what prints off and shows on the paper MARs that we are viewing.

On 04/21/2021, I conducted an Exit Conference with Licensee Designee, Suzy Hunter via telephone. Ms. Hunter stated she will review the eMAR and the printed-out version of the MAR and see if they can get the label instructions to show up on the MAR. Ms. Hunter will submit an acceptable corrective action plan.

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: (iii) Label instructions for use.
ANALYSIS:	On all of the MARs reviewed, the medications including Clobazam do not have the label instructions for use as required by licensing rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

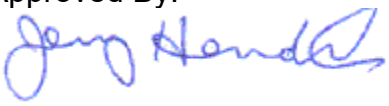
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the current status of the license remain unchanged.

04/21/2021

Elizabeth Elliott Date
Licensing Consultant

Approved By:



04/21/2021

Jerry Hendrick Date
Area Manager