GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 14, 2021

Nichole VanNiman
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS390394306
Investigation #: 2021A1024033
Beacon Home At Kalamazoo

Dear Ms. VanNiman:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On June 25, 2021, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390394306
Investigation #:	2021A1024033
Complaint Receipt Date:	05/21/2021
Investigation Initiation Date:	05/21/2021
Report Due Date:	07/20/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At Kalamazoo
Facility Address:	2710 West Main Street Kalamazoo, MI 49006
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/23/2018
License Status:	REGULAR
Effective Date:	04/22/2021
Expiration Date:	04/21/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Medications prescribed from psychiatric hospital were not implemented by direct care staff at the facility.	Yes

III. METHODOLOGY

05/21/2021	Special Investigation Intake 2021A1024033
05/21/2021	Special Investigation Initiated – Telephone with Resident A's primary nurse practitioner Debra Klinger
05/21/2021	Contact - Face to Face with home manager at Woodland Danyell Lacer
05/24/2021	Contact - Telephone call made with supervisor Jill Mullins from InterAct of Michigan, Inc
05/24/2021	Contact - Telephone call made with Relative A1
05/24/2021	Inspection Completed On-site with home manager Heather Juan
05/26/2021	Contact - Telephone call made with case manager Elandra Zarice from InterAct of Michigan Inc
06/14/2021	Contact - Face to Face with Resident A
06/16/2021	Contact - Telephone call made with district director Kimberly Howard
06/24/2021	Exit Conference with licensee designee Nichole VanNiman
06/24/2021	Corrective Action Plan Requested and Due on 07/13/2021
06/24/2021	Inspection Completed-BCAL Sub. Compliance
06/25/2021	Corrective Action Plan Received
06/25/2021	Corrective Action Plan Approved

ALLEGATION:

Medications prescribed from the psychiatric hospital were not implemented by direct care staff at the facility.

INVESTIGATION:

On 5/21/2021, I received this complaint through the Bureau of Community and Health Systems online complaint system. This complaint alleged medications prescribed to Resident A from the psychiatric hospital were not implemented by direct care staff at the AFC facility after her discharge from the hospital.

On 5/21/2021, I conducted an interview with Resident A's primary care nurse practitioner Debra Klinger who stated that Resident A was discharged from an involuntary stay at a psychiatric hospital on 5/4/2021 to her residence at Beacon at Kalamazoo and was transferred to another Beacon Corporation owned facility, Beacon at Woodland, the next following day on 5/5/2021. Ms. Klinger stated Resident A came into her office on 5/21/2021 for a follow up visit and during this time Ms. Klinger discovered that Resident A had not been taking all her medications from her current medication list that was adjusted upon discharge at the psychiatric hospital on 5/4/2021. Ms. Klinger stated the medication changes were important because the medication Klonopin 1 mg was discontinued and medication Latuda 120 mg was added which controlled Resident A's seizures and suicidal ideation. Ms. Klinger stated the direct care staff members at Beacon at Kalamazoo failed to follow the medication orders and failed to coordinate with the pharmacy and direct care staff members at Resident A's next AFC placement to ensure Resident A received the correct medications.

On 5/21/2021, I conducted an interview with home manager Danyell Lacer at Beacon at Woodland adult foster care (AFC) facility. Ms. Lacer stated Resident A was relocated to the new facility on 5/5/2021. Ms. Lacer stated at the time of admission she was provided with discharge paperwork for Resident A from a psychiatric hospital however was not informed that there were any medication instructions that needed to be implemented and assumed she was provided with Resident A's current medication list. Ms. Lacer stated she eventually discovered by speaking to Resident A's primary nurse practitioner that Resident A had medication changes made by the psychiatric hospital that were not reflected on the medication list from Beacon Home at Kalamazoo that was provided to her at admission therefore Resident A had not been administered all her prescribed medications while she has been residing in the home.

On 5/24/2021, I conducted an interview with supervisor Jill Mullins with InterAct of Michigan, Inc. Ms. Mullins stated Resident A has been receiving mental health services for the past 3 years with her agency. Ms. Mullins stated she was recently made aware that Resident A had not been taking the correct medications that were prescribed to her by the psychiatric hospital and Resident A's pharmacy was never

provided with the correct medication list. Ms. Mullins further stated she has not had any contact with any staff members from Beacon at Kalamazoo regarding Resident A's medications at any given time.

On 5/24/2021, I conducted an interview with Relative A1 regarding this allegation. Relative A1 stated Resident A was discharged from Crown Point Psychiatric Hospital in Indiana back to her residence at Beacon Home at Kalamazoo on 5/4/2021. Relative A1 stated the psychiatric hospital made two medication changes and medication scripts to reflect these changes were included in Resident A's discharge paperwork which was given to the staff at Beacon Home at Kalamazoo. Relative A1 stated the direct care staff members did not implement the medication orders from the psychiatric hospital therefore Resident A did not take the correct medications for 10 days.

On 5/24/2021, I conducted an onsite investigation at the facility with home manager Heather Juan. Ms. Juan stated on 05/04/2021 Resident A was discharged from a psychiatric hospital in Indiana and dropped off by ambulance at 11:45pm to Beacon at Kalamazoo AFC where she has been residing. Ms. Juan stated prior to Resident A being dropped off Ms. Juan spoke with a physician at Crown Point Psychiatric Hospital who informed Ms. Juan that Resident A had Klonopin 1 mg medication discontinued and Latuda 120 mg medication added to her medication regimen. Ms. Juan further stated the physician instructed her to begin the administration of Resident A's new medication Latuda on 5/5/2021 at 9am. Ms. Juan stated unfortunately she was not able to administer Resident A's new medication because she did not get the new medication from the pharmacy prior to Resident A being transferred to another Beacon Corporation owned facility at 11am on 5/5/2021. Ms. Juan stated she did not contact the pharmacy, mental health case manager or physician when she realized that she did not have the new medication that was added to Resident A's medication regimen. Ms. Juan stated when Resident A was relocated, she gave Resident A's discharge paperwork to the home manager, Danyell Lacer, at the other Beacon Corporation owned facility however did not inform Ms. Lacer of the new medication changes that were made by the psychiatric hospital or speak to any other direct care staff members at this facility to make sure the new physician instructions for Resident A's new medication would be followed. Ms. Juan stated the new medication orders were included in the discharge paperwork for Ms. Lacer to review at the time of admission at Beacon Home at Woodland. Ms. Juan stated she assumed everything was worked out because she saw an email on 5/5/2021 at 1:24pm from Resident A's pharmacist, Gull Point Pharmacy, that the new medication scripts were sent to Resident A's new pharmacy therefore Ms. Juan did not feel there was any further action she needed to take regarding Resident A's medications.

While at the facility, I reviewed the discharge paperwork that included the medication orders which listed Lurasidone HCL (Latuda) to be given by mouth in the morning.

On 5/26/2021, I conducted an interview with mental health case manager Elandra Zarice from InterAct of Michigan, Inc regarding this allegation. Ms. Zarice stated the direct care staff members were provided with discharge paperwork which included the medication changes for Resident A. Ms. Elandra stated there has been times in the past where staff members have contacted her when they did not have the correct medications for Resident A or needed physician scripts to be sent out to the pharmacy however Ms. Zarice did not receive any communication from any staff members at Beacon at Kalamazoo or Beacon at Woodland regarding Resident A not having her correct medications.

On 6/14/2021, I conducted an interview with Resident A who stated when she was discharged from the psychiatric hospital on 5/4/2021, she was supposed to take a new medication that she did not take for 10 days which was supposed to help with her seizures. Resident A stated her nurse practitioner learned on 5/21/2021 that she was taking mediations from an old medication list that was never updated after she was discharged from the psychiatric hospital.

On 6/16/2021, I conducted an interview with district director Kimberly Howard who stated she spoke with Ms. Juan regarding Resident A at the time of admission to Beacon at Woodland and Ms. Juan did not inform her of any physician instructions made to her regarding Resident A's medications that needed to be implemented therefore the direct care staff administered medications based on Resident A's old medication list and had no knowledge of any medication changes.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**

ANALYSIS:	Based on my investigation which included interviews with nurse practitioner Debra Klinger, Relative A1, mental health case manager Elandra, mental health supervisor Jill Mullins, home managers Heather Juan, Danyell Lacer, district director Kimberly Howard there is evidence to support the allegation medications prescribed from the psychiatric hospital were not implemented by staff at the facility. Ms. Klinger stated Resident A had medication changes made when she was hospitalized at a psychiatric hospital however the staff did not follow the new medication orders that were included in Resident A's discharge paperwork that were provided to staff when Resident A returned to the facility. Ms. Juan stated she was notified by Resident A's physician from the psychiatric hospital prior to Resident A being dropped off to the facility, that Resident A needed to discontinue taking Klonopin medication and began taking Latuda medication beginning on 5/52021 at 9am. Ms. Juan stated she was not able to administer Resident A her new medication on 5/5/2021 because she did not have the new medication from Resident A's pharmacist however did not follow up with Resident A's physician or mental health case manager to obtain the medications needed. Ms. Zarice stated she has helped staff in the past with getting the correct medications for Resident A from the pharmacist however Ms. Zarice never received a phone call from any staff members regarding Resident A's medications. Ms. Lacer stated she spoke with Ms. Juan regarding Resident A and Ms. Juan never informed her that Resident A had medication changes that needed to be implemented. Ms. Juan did not follow the physician's instructions regarding Resident A's medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/25/2021, I conducted an exit conference with licensee designee Nichole VanNiman. I informed Ms. VanNiman of my findings and allowed her an opportunity to make comments and ask questions.

IV. RECOMMENDATION

An acceptable corrective action plan was approved; therefore, I recommend the current license status remain unchanged.

_____ 7/13/2021

Ondrea Johnson Date
Licensing Consultant

Approved By:

07/14/2021

_____

Dawn N. Timm Date
Area Manager