GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 22, 2021

Ramon Beltran, II
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS390396198
Investigation #: 2021A0462036
Beacon Home At Augusta

Dear Mr. Beltran, II:

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

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390396198
Investigation #:	2021A0462036
Complaint Receipt Date:	06/02/2021
Investigation Initiation Date:	06/03/2021
Report Due Date:	08/01/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Navi Kaur
Licensee Designee:	Ramon Beltran, II
Name of Facility:	Beacon Home At Augusta
Facility Address:	817 Webster St. Augusta, MI 49012
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/29/2018
License Status:	REGULAR
Effective Date:	05/29/2021
Expiration Date:	05/28/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's medication administration records do not contain all required documentation.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/02/2021	Special Investigation Intake 2021A0462036
06/03/2021	Special Investigation Initiated – Email to Complainant.
06/07/2021	Contact - Telephone interview with Kalamazoo County Recipient Right's Officer Lisa Smith. Unannounced investigation on-site. Face-to-face interview with home manager Marie Ulrich. Requested and received documentation.
06/11/2021	Second Unannounced investigation on-site.
07/14/2021	Contact- Telephone interview with chief compliance officer Melissa Williams.
07/22/2021	Contact- Exit conference with licensee designee Ramon Beltran via telephone.

ALLEGATION: Resident A's medication administration records do not contain all required documentation.

INVESTIGATION: On 06/02/2021 the Bureau of Community and Health Systems (BCHS) received the above complaint via the BCHS' online complaint system. The written compliant indicated Resident B's medication administration records (MARs) also did not contain all required documentation.

On 06/03, via email, I informed Complainant I was assigned to investigate this allegation.

On 06/07 I conducted a telephone interview with Kalamazoo County Recipient Rights Officer Lisa Smith who confirmed that during a recent "site review" a Kalamazoo County Recipient Right Officer (RRO) discovered "blanks" on Resident

A's and Resident B's medication administration records. According to Ms. Smith, the facility reported frequent issues with their internet going "down." When this occurred, facility staff members were unable to document the administration of medications to residents using their electronic medication administration software system (EMAR). According to Ms. Smith, due to significant missing documentation on Resident A's and Resident B's EMARs, it was difficult for RROs to verify whether or not Residents A and B received all of their medications as prescribed.

I conducted an unannounced investigation at the facility and interviewed home manager Marie Ulrich. According to Ms. Ulrich, Resident B was discharged approximately one year ago and no longer resided at the facility. Ms. Ulrich stated Resident B was transferred to a non-licensed residential facility, also operated by the licensee.

Ms. Ulrich confirmed that all facilities operated by the licensee began utilizing a cloud-based EMAR system called NextStep to document the administration of medication to residents for "a little over a year now." Ms. Ulrich confirmed the facility occasionally experienced internet outages, and during this time facility staff members were unable to access NextStep. However, according to Ms. Ulrich, in addition to this issue "there was something wrong with the system." Ms. Ulrich explained that immediately following each medication pass, facility staff members called Med Passers "inputted" the administration of residents' medications into NextStep. According to Ms. Ulrich, medication administration documentation could be reviewed by then generating a MAR for each resident in NextStep. However, when the MARs were generated, several of the "inputted" medication passes were missing. Ms. Ulrich stated they were unable to figure out why this was occurring and the facility's management team was aware of this issue. Ms. Ulrich stated that as a "workaround", on the first day of every month she generated blank MARs in NextStep for every resident, printed them, and kept them in each residents' record. According to Ms. Ulrich, Med Passers, via their handwritten initials, documented all medications administered to residents on their paper MARs during an internet outage. Ms. Ulrich stated that at the end of every month she generated MARs for that month in NextStep for each resident and identified all missing documentation due to a "glitch" in their system. According to Ms. Ulrich, she then went back and completed the missed documentation, via handwritten initials, on each residents' blank paper MAR.

Ms. Ulrich stated that although Med Passers' documentation on residents' EMARs did not always confirm this, she was confident residents were receiving all of their medications as prescribed. When asked how Ms. Ulrich was certain that all the missed documentation on the residents' monthly MARs generated from NextStep was due to a systems error, and how she was certain residents actually received their medications, Ms. Ulrich stated she always received verbal confirmation from each Med Passer prior to going back and completing the missed documentation on the paper MARs. Ms. Ulrich stated she also utilized the surveillance camera located in the medication room to confirm residents' medication was administered. According to Ms. Ulrich, facility staff members were instructed to conduct an inventory of every

residents' medications by counting each medication weekly, and then documenting this on a facility form titled, *Medication Weekly Count.* Ms. Ulrich stated that since the weekly resident medication counts appeared to be accurate, she had no reason to believe residents were not receiving their medication as prescribed. Ms. Ulrich stated she had the ability to generate a report for Resident A on NextStep, called a *Pass History Report*. According to Ms. Ulrich, documentation on Resident A's *Past History Report* would confirm that all medication administered to Resident A was "inputting" into NextStep by the Med Passer who administered the medication following each medication pass.

I requested, received, and reviewed a copy of Resident A's generated MAR from NextStep for the month of May, a copy of Resident A's paper MAR for the month of May, a copy of Resident A's *Pass History Report* for the month of May, and a copy of all completed *Medication Weekly Count* forms for Resident A for the month of May.

Both Resident A's generated MAR from NextStep for the month of May and Resident A's May paper MAR included the name and dose of all Resident A's prescribed medications, their instructions for use, and the times these medications were to be administered.

According to documentation on both Resident A's generated MAR from NextStep for the month of May and Resident A's paper MAR for the month of May, Resident A was prescribed the medication Propranolol 40mg, to be administered three times daily. Missing Med Passers' initials on Resident A's generated MAR from NextStep indicated Resident A did not receive one dose of this medication on 05/01, 05/04, 05/05, 05/09, and 05/31. Missing Med Passers' initials on Resident A's generated MAR from NextStep indicated Resident A did not receive two doses of this medication on 05/19 and 05/20. Med Passers' initials on Resident A's paper MAR verified Resident A was administered two doses of this medication on 05/19 and 05/31. However, there were no Med Passers' initials on Resident A's paper MAR verifying Resident A received one dose of this medication on 05/01, 05/04, 05/05, 05/09, and 05/31. In addition to this, documentation on Resident A's *Pass History Report* for the month of May did not confirm Med Passers inputted the administration of one dose of this medication to Resident A on 05/01, 05/04, 05/05, 05/09, and 05/31 into NextStep.

According to documentation on both Resident A's generated MAR from NextStep for the month of May and Resident A's paper MAR for the month of May, Resident A was prescribed the medication Oxcarbazepine 300mg, to be administered twice daily. Missing Med Passers' initials on Resident A's generated MAR from NextStep indicated Resident A did not receive one dose of this medication on 05/01, 05/02, 05/04, 05/05, 05/09, 05/20, and 05/31. Missing documentation on Resident A's generated MAR from NextStep indicated Resident A did not receive two doses of this medication on 05/19. Med Passers' initials on Resident A's paper MAR verified Resident A was administered one dose of this medication on 05/19 and 05/20. There were no Med Passers' initials on Resident A's paper MAR verifying Resident A

received his second dose of this medication on 05/19. There were no Med Passers' initials on Resident A's paper MAR verifying Resident A received one dose of this medication on 05/01, 05/02, 05/04, 05/05, 05/09, and 05/31. Documentation on Resident A's *Pass History Report* for the month of May did not confirm Med Passers inputted the administration of one dose of this medication to Resident A on 05/01, 05/02, 05/04, 05/05, 05/09, 05/19, 05/20, and 05/31 into NextStep.

According to documentation on both Resident A's generated MAR from NextStep for the month of May and Resident A's paper MAR for the month of May, Resident A was prescribed the medication Valproic 20ml, to be administered twice daily. Missing Med Passers' initials on Resident A's generated MAR from NextStep indicated Resident A did not receive one dose of this medication on 05/01, 05/02, 05/04, 05/05, 05/09, 05/20, and 05/31. Missing Med Passers' initials on Resident A's generated MAR from NextStep indicated Resident A did not receive two doses of this medication on 05/19. Med Passers' initials on Resident A's paper MAR verified Resident A was administered two doses of this medication on 05/19. However, there were no Med Passers' initials on Resident A's paper MAR verifying Resident A received one dose of this medication on 05/01, 05/02, 05/04, 05/05, 05/09, 05/20, and 05/31. In addition to this, documentation on Resident A's *Pass History Report* for the month of May did not confirm Med Passers inputted the administration of one dose of this medication to Resident A on 05/01, 05/02, 05/04, 05/05, 05/09, 05/20, and 05/31 into NextStep.

According to documentation on both Resident A's generated MAR from NextStep for the month of May and Resident A's paper MAR for the month of May, Resident A was prescribed the medication Fluoxetine 20mg, to be administered twice daily in the morning. Missing Med Passers' initials on Resident A's generated MAR from NextStep indicated Resident A did not receive both doses of this medication on 05/01, 05/02, 05/05, 05/09, 05/19, 05/20, and 05/31. Med Passers' initials on Resident A's paper MAR verified Resident A was administered both doses of this medication on 05/20. However, there were no Med Passers' initials on Resident A's paper MAR verifying Resident A received both doses of this medication on 05/01, 05/02, 05/05, 05/09, 05/19, and 05/31. In addition to this, documentation on Resident A's *Pass History Report* for the month of May did not confirm Med Passers inputted the administration of both doses of this medication to Resident A on 05/01, 05/02, 05/05, 05/09, 05/19, and 05/31 into NextStep.

According to documentation on both Resident A's generated MAR from NextStep for the month of May and Resident A's paper MAR for the month of May, Resident A was prescribed the medication Loxapine 10mg, to be administered once daily at bedtime. Missing Med Passers' initials on Resident A's generated MAR from NextStep indicated Resident A did not receive this medication on 05/04 and 05/19. Med Passers' initials on Resident A's paper MAR verified Resident A was administered this medication on 05/19. However, there were no Med Passers' initials on Resident A's paper MAR verifying Resident A received this medication on 05/04. In addition to this, documentation on Resident A's *Pass History Report* for the month

of May did not confirm Med Passers inputted the administration of this medication to Resident A on 05/04 into NextStep.

Ms. Ulrich was only able to locate one of Resident A's *Medication Weekly Count* forms for the month of May. Documentation on this form indicated a facility staff member counted all of Resident A's medication on 05/03 and again on 05/23. While documentation on this form indicated the available number of pills and/or tablets of each medication prescribed to Resident A, there was no clear way to determine how many of these pills and/or tablets should have been available when they were counted on 05/03 and 05/23.

On 07/14 I conducted a telephone interview with the facility's chief compliance officer Melissa Williams, who confirmed the facility started using the EMAR function of NextStep approximately one year ago. Ms. Williams confirmed Ms. Ulrich's statements regarding the facility's "workaround" policy regarding documenting the administration of residents' medication during an internet outage. Ms. Williams statements regarding a "glitch" within the system were also consistent with the statements Ms. Ulrich provided to me. According to Ms. Williams, she worked with the NextStep systems administrator, who identified that the problem was caused by an update to the EMAR function of the system. Subsequently, the issue had since been corrected.

Ms. Williams stated that prior to identifying this issue in NextStep, Ms. Ulrich and other facility supervisory staff members were instructed to generate a MAR in NextStep for each resident at the end of every shift to determine if there was missing medication administration documentation due to a system error. If missing documentation was established, Ms. Ulrich and/or other facility supervisor staff members would verify residents' medications were in fact administered. The Med Passer who administered the medication would then complete the missing documentation, via their written initials, on the paper MARs prior to leaving their shift. According to Ms. Williams, it appeared Ms. Ulrich and/or other facility supervisory staff were not following this "workaround" protocol. Ms. Williams stated that at the beginning of each month, Ms. Ulrich and/or other facility supervisory staff members were instructed to generate a MAR in NextStep for each resident for the previous month. According to Ms. Williams, Ms. Ulrich and/or other facility supervisory staff members were to compare the documentation on the residents' generated MARs from NextStep to the documentation on the residents' paper MARs to ensure accuracy and to address any possible medication errors and/or documentation errors made by Med Passers.

Ms. Williams confirmed that to prevent resident medications from being lost or stolen, facility staff members were instructed to count all residents' medications weekly and document this on a *Medication Weekly Count* form. According to Ms. Williams, these forms were to be submitted to the residents' pharmacy every Monday. Ms. Williams stated it appeared facility staff members were also not following this facility protocol.

Ms. Williams acknowledged that since Ms. Ulrich and/or other facility supervisory staff members were not following the correct facility protocol to address missing documentation on residents' MARs generated from NextStep due to a systems error, there was no way to determine whether all the missing documentation on Resident A's generated MAR from NextStep for the month of May was due to a systems error, if Med Passers failed to document the administration of some medications to Resident A via "inputting" this into NextStep, or if Resident A was not administered some of his medications as prescribed throughout the month of May. According to Ms. Williams, she and/or other members of the facility's management team would address the issue of facility staff members not following the correct facility protocols with Ms. Ulrich and other facility staff members. Ms. Williams stated she and other members of the facility's management team were also in the process of working with the Kalamazoo County ORR regarding these issues.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	According to home manager Marie Ulrich, she created a "workaround" to address Med Passers restricted access to the residents' EMAR in NextStep due to occasional internet outages, as well as for the missing documentation on residents' MARs generated from NextStep due to a systems error. Upon reviewing Resident A's generated MAR from NextStep for the month of the May and Resident A's paper MAR for the month of May, I established Ms. Ulrich and other facility staff members did not follow the "workaround" protocols as described by Ms. Ulrich. Subsequently, it was established both records were missing the initials of the Med Passers who administered medications to Resident A on several occasions throughout the month of May. A review of Resident A's *Pass History Report* for the month of May also did not provide proof that the missing documentation on Resident A's generated MAR from NextStep for the month of May was due to a systems error. Ms. Ulrich was unable to provide any evidence to support her claim that the missing documentation was due to a system's error. The facility's chief compliance officer Melissa Williams confirmed the "workaround" protocol described by Ms. Ulrich to address Med Passers restricted access to the residents' EMAR

	in NextStep due to occasional internet outages was correct. Ms. Williams also confirmed there was a “glitch” in the EMAR function of NextStep, which had since been corrected. However, the “workaround” protocol described by Ms. Williams to address Med Passers’ missing documentation on residents’ MARs generated from NextStep due to a systems error was different than the protocol described by Ms. Ulrich. According to Ms. Williams, facility staff members should not have waited until the end of the month to identify missing documentation on residents’ MARs generated from NextStep and/or to verify whether or not residents were administered their medications as prescribed. It has been established Resident A’s generated MAR from NextStep for the month of the May and paper MAR for the month of May did not contain all required documentation. It has also been established that per Ms. Ulrich, Med Passers’ initials were sometimes entered in residents’ MARs at the end of the month instead of at the time they were administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: During an onsite licensing renewal inspection conducted at the facility on 05/12, it was established the facility’s entire back yard was enclosed by a fence. Residents were able to exit the facility’s sliding glass door on the main floor into the facility’s enclosed backyard. Residents could also enter the enclosed backyard from inside the facility from an egress located in the basement. The fence was equipped with an unlocked gate to ensure the residents’ right to their freedom of movement. During the onsite renewal inspection on 05/12, it was discovered a large rock was placed in front of the outside gate leading into the enclosed backyard to prevent residents from being able to exit through the gate from inside the enclosed backyard. Administrator Navi Kaur informed me she was unaware the rock had been placed there and believed the lawn care company contracted by the facility had placed the rock there while mowing the lawn. Ms. Kaur acknowledged the rock should not have been there and immediately removed the rock, allowing for unobstructed egress through the gate from inside the enclosed the fence, and subsequently allowing for the freedom of residents’ movement.

During my unannounced investigation on 06/07, I discovered the large rock had once again been placed in front of the outside gate leading into the enclosed backyard, thus again preventing residents from being able to exit through the gate from inside the enclosed backyard.

On 06/11 I conducted a second unannounced investigation onsite and established the rock was still located in front of the outside gate leading into the enclosed backyard.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	During an onsite licensing renewal inspection conducted at the facility on 05/12, administrator Navi Kaur acknowledged that a large rock placed in front of the outside gate leading into the enclosed backyard should not have been there, as it prevented residents from being able to exit through the gate from inside the enclosed backyard. Subsequently, on 05/12 Ms. Kaur removed the rock, allowing for unobstructed egress through the gate from inside the enclosed the fence, and for the freedom of residents' movement. During two separate unannounced investigations on 06/07 and 06/11, it was discovered the large rock had once again been placed in front of the outside gate leading into the enclosed backyard, which prevented residents from being able to exit through the gate from inside the enclosed backyard.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/22 I conducted an exit conference with licensee designee Ramon Beltran via telephone and shared with him the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

07/20/2021

Michele Streeter — Date
Licensing Consultant

Approved By:

07/21/2021

Dawn N. Timm — Date
Area Manager