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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 9, 2021

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

RE: License #: AS380396667
Investigation #: 2021A0007017
Beacon Home At Cascades

Dear Mr. Kalinowski:

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.

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380396667
Investigation #:	2021A0007017
Complaint Receipt Date:	07/12/2021
Investigation Initiation Date:	07/14/2021
Report Due Date:	09/10/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Matthew Owens
Licensee Designee:	Kevin Kalinowski
Name of Facility:	Beacon Home At Cascades
Facility Address:	1920 Herkimer Dr. Jackson, MI 49203
Facility Telephone #:	(517) 888-5137
Original Issuance Date:	06/12/2019
License Status:	REGULAR
Effective Date:	12/12/2019
Expiration Date:	12/11/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's medication was not given as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/12/2021	Special Investigation Intake - 2021A0007017
07/14/2021	Special Investigation Initiated - Letter
07/14/2021	APS Referral
07/22/2021	Inspection Completed On-site - Unannounced- Face to face contact with Ms. Krutsch, Home Manager, Resident A, Resident B, Resident C and Resident D.
07/26/2021	Contact - Document Received- Information regarding Resident A's medications.
09/07/2021	Contact - Telephone call made to the facility, Message left for Ms. Krutsch, additional information needed regarding Resident B.
09/07/2021	Contact - Telephone call made - Message left for Ms. Haynesworth, Direct Care Staff. I requested a returned phone call.
09/07/2021	Contact - Telephone call received - From Ms. Haynesworth, missed call.
09/07/2021	Contact - Telephone call made to Ms. Haynesworth X2, no answer.
09/07/2021	Contact - Telephone call made to Ms. Krutsch. Resident B had his teeth pulled today. He’s doing okay. Case discussion.
09/07/2021	Contact - Document Received - Additional information regarding Resident B.
09/08/2021	Contact - Telephone call made to Ms. Krutsch. I was unable to speak with her due to phone connectivity issues.
09/08/2021	Contact - Telephone call made - Interview with Ms. Lemar, Lead Worker.

09/08/2021	Contact - Telephone call made – Discussion with Ms. Krutsch.
09/08/2021	Contact - Telephone call made to Ms. Haynesworth, no answer.
09/08/2021	Contact - Document Received - Information regarding Resident B's medications.
09/08/2021	Exit Conference conducted with Mr. Kalinowski, Licensee Designee.
09/08/2021	Contact – Telephone call received – from Ms. Haynesworth. Interview.
09/08/2021	Contact - Telephone call made to Ms. Krutsch. Follow-up discussion.

ALLEGATIONS:

Resident A's medication was not given as prescribed.

INVESTIGATION:

As a part of this investigation, I reviewed the incident report authored by Ms. Fairchild, Direct Care Staff, and noted the following: Ms. Fairchild documented that when she arrived for her work shift at 7:40 p.m., on July 4, 2021, she observed Resident A in a behavior. Ms. Fairchild asked Ms. Haynesworth, Direct Care Staff, about Resident A's Diazepam 5 mg. Ms. Haynesworth informed Ms. Fairchild that she had already passed his (Resident A) PRN medication twice. It was noted that Resident A was prescribed the PRN medication every twelve hours and Ms. Haynesworth had administered it at 1:45 p.m. and 3:35 p.m.

It was also noted on the incident report that the health care official was notified on July 5, 2021, at 4:30 p.m. According to the incident report, the corrective measures and actions taken to remedy and to prevent recurrence included the following: Ms. Fairchild contacted her manager and on-call medical. The staff member (Ms. Haynesworth) would be given a Progressive Action and PRN protocols would be discussed with her. The staff would also be signed up for hands on medication training with a Beacon Nurse.

On July 22, 2021, I conducted an unannounced on-site investigation and made face-to-face contact with Ms. Krutsch, Home Manager, Resident A, Resident B, Resident C and Resident D.

Resident A is diagnosed with Cerebral Palsy and Autism. I was not able to interview Resident A, due to his current diagnoses.

On July 22, 2021, I spoke with Ms. Krutsch, Home Manager, and informed her of the investigation. She was aware of the medication error that had occurred. She informed me that Resident A did not have any adverse side effects, as a result of not receiving his PRN medications, as prescribed. Ms. Krutsch then informed me that there had recently been another medication error and Ms. Haynesworth did not give Resident B his medication as prescribed. I observed Resident A, Resident B, Resident C, and Resident D in the home.

While at the home, Ms. Krutsch provided me with a copy of the incident report regarding Resident B. I requested that Ms. Krutsch send me the contact information for Ms. Haynesworth, along with some other documents.

During this investigation, I reviewed the prescription medication for Resident A and noted that he is prescribed Diazepam 5 mg, once by mouth every twelve hours, as needed, for anxiety and behavior problems.

I also reviewed the *Daily Controlled Medication* chart and noted that on July 4, 2021, Ms. Haynesworth, Direct Care Staff, gave Resident A Diazepam 5 mg, at 1:00 p.m. and 4:30 p.m.

On September 7, 2021, I spoke with Ms. Krutsch on the phone. Ms. Haynesworth did receive additional training on medications after the first incident ; however, they were waiting to see what would happen after the second incident and the investigation was completed. Ms. Krutsch informed me that Ms. Haynesworth is no longer employed at the home.

On September 8, 2021, I had a follow-up conversation with Ms. Krutsch. According to Ms. Krutsch, on July 4, 2021, Resident A received too much medication.

On September 8, 2021, I conducted the exit conference with Mr. Kalinowski. I informed him of the conclusion of the investigation and my findings. He inquired about what the staff said about the medication error. I informed him that I called her (Ms. Haynesworth) leaving a message, then I missed her call, and I attempted to return her call again a couple times, without success.

On September 8, 2021, I received a phone call from Ms. Haynesworth. It was difficult to understand what she was saying, due to phone connectivity issues and background noise. However, Ms. Haynesworth did confirm that Resident A was in a behavior that day. She stated that he had bitten her and another staff member (full name unknown to Ms. Haynesworth). Ms. Haynesworth confirmed that Resident A received the medication at 1:45 p.m. and 3:35 p.m. After this occurred, Ms. Haynesworth stated that she called her manager, other management, and the nurse. The nurse instructed her to monitor Resident A. I inquired about the *Daily Controlled Medication* chart, which Ms. Haynesworth documented two medication passes, and she informed me that “the other girl didn’t sign, so that meant I had to.”

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during this investigation and provided above, it's concluded that Resident A did not receive his PRN medication (Diazepam 5 mg), as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the course of this investigation, a subsequent incident report was received, and the following was noted:

I reviewed the incident report authored by Ms. Lemar, Direct Care Staff. She documented that on July 21, 2021, at shift change, the staff (Ms. Haynesworth and Ms. Wilson) completed the controlled substance count for Resident B's medications. Ms. Haynesworth and Ms. Wilson noticed that the 8:00 a.m. medication for Clonazepam 0.5 mg was wrong. Ms. Haynesworth passed two of the Clonazepam 0.5 mgs to Resident B at 8:00 a.m.; however, he was prescribed one 0.5 mg of Clonazepam at 8:00 a.m. Ms. Lemar also documented in the incident report that Ms. Haynesworth did not follow the six rights to passing medications. The home manager brought this to her attention and Ms. Haynesworth admitted that she did not pay attention when she was passing the medication. Ms. Lemar counted the medication and confirmed that the count was off. In addition, it was documented on the incident report that staff notified Resident B's physician on July 21, 2021, at 8:20 a.m.

The corrective measures taken to remedy and to prevent recurrence included one-on-one hands-on medication administration training with a Beacon Nurse, along with a Progressive Action regarding the facility medication key protocols.

I reviewed the prescription medication for Resident B and noted that he is prescribed Clonazepam 0.5 mgs (1 tablet by mouth, twice a day, with the 1 mg Clonazepam tablet). He is also prescribed 1 mg of Clonazepam (take 1 tablet by mouth, twice a day).

I reviewed the *Daily Controlled Medication* Chart for Resident B and noted that on July 20, 2021, Ms. Haynesworth administered two of the Clonazepam 0.5 mgs to Resident B.

On September 8, 2021, I interviewed Ms. Lemar, Lead Worker. She informed me that Resident B is diagnosed with Autism. Her reporting was consistent to what she had documented in the incident report. Ms. Lemar informed me that Resident B did not suffer any adverse effects from not receiving his medications as prescribed. After the incident, Ms. Haynesworth received additional medication training. According to Ms. Lemar, Ms. Haynesworth is no longer employed at the home.

On September 8, 2021, I spoke with Ms. Krutsch, as I had some additional questions after reviewing the documents submitted. She stated that Resident B was prescribed 0.5 mgs and 1.0 mgs of Clonazepam at 8:00 a.m. Resident B received two of the 0.5 mgs tablets (instead of one); he did not receive the 1.0 mgs tablet at all. According to Ms. Krutsch, Resident A received too much medication and Resident B did not receive enough medication.

On September 8, 2021, I conducted the exit conference with Mr. Kalinowski, Licensee Designee. I informed him of the conclusion of the investigation and my recommendations. I also informed him that I would be requesting a written corrective action plan.

On September 8, 2021, I spoke with Ms. Haynesworth. While she could not recall the specific milligrams for each tablet, Ms. Haynesworth stated that Resident B received one pill in the morning and one at 5:30 p.m. It was difficult to hear Ms. Haynesworth, so I specifically asked her if based on her understanding of the situation (and what was documented in the incident report), did she concur that the medication was not administered as prescribed. Ms. Haynesworth stated that she did not agree. She informed me that she would show up to work late, on a regular basis, and Resident B's medications would already be administered. Ms. Haynesworth stated that she was told by her manager (name unknown) to put it in the "drugs box."

On September 8, 2021, I spoke with Ms. Krutsch, Home Manager, as I had some follow-up questions after speaking with Ms. Haynesworth. I inquired about the "drugs box," and Ms. Krutsch informed me that it is a box for narcotics. These medications have either been dropped, refused, or need to be destroyed. The Beacon Nurse will check the drug box. They also keep documentation (on a different sheets) of the medications that need to be destroyed and the reason why they are to be disposed of.

I inquired about her attendance, and Ms. Krutsch stated that Ms. Haynesworth was tardy often. The shift started at 7:00 a.m. and she (Ms. Haynesworth) would arrive between 7:10 a.m. and 7:30 a.m. I inquired what would happen if it was time to pass the medications and Ms. Haynesworth was not there. Ms. Krutsch stated that medications are not passed until 8:00 a.m. and Ms. Haynesworth would be there prior to when medications were to be administered. Ms. Krustsh stated that Ms. Haynesworth is no longer on the schedule to work in the home.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during this investigation and provided above, it's concluded that Resident B did not receive his medication (Clonazepam), as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.

Mahtina Rubritius 9/08/2021

Mahtina Rubritius Date
Licensing Consultant

Approved By:

Mary Holton 09/09/2021

Mary E. Holton Date
Area Manager