GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 19, 2022

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

RE: License #: AS380396667
Investigation #: 2022A0007007
Beacon Home At Cascades

Dear Ms. Rawlings:

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 (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

Enclosures

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

I. IDENTIFYING INFORMATION

License #:	AS380396667
Investigation #:	2022A0007007
Complaint Receipt Date:	11/19/2021
Investigation Initiation Date:	11/23/2021
Report Due Date:	01/18/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Shelly Keinath
Licensee Designee:	Kimberly Rawlings
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?
Allegations that Resident A did not receive his medications as prescribed.	Yes

III. METHODOLOGY

11/19/2021	Special Investigation Intake - 2022A0007007
11/23/2021	Special Investigation Initiated – Letter to APS.
11/23/2021	APS Referral made.
12/07/2021	Contact - Telephone call received from Home Manager #1.
12/07/2021	Contact - Document Received - Medication Logs.
12/09/2021	Contact - Face to Face contact with Home Manager #1, Administrative Staff #1, Resident A, three residents and three staff via Microsoft Teams.
01/14/2022	Contact - Telephone call made to Home Manager #1. Discussion.
01/14/2022	Contact - Telephone call made to Employee #2. Message left. I requested a returned phone call.
01/14/2022	Contact - Telephone call received - Employee #2, Interview.
01/18/2022	Contact - Telephone call made to Ms. Rawlings, Licensee Designee. I called to conduct the exit conference. I left a message regarding the findings and requested a returned phone call if she had any additional questions.
01/18/2022	Exit Conference conducted with Ms. Rawlings.

ALLEGATIONS:

Allegations that Resident A did not receive his medications as prescribed.

INVESTIGATION:

As a part of this investigation, I reviewed an incident report and noted the following: On November 17, 2021, while passing medications, Employee #1 noticed that the wrong medication dosage was in Resident A's folder on November 16, 2021. Third shift staff passed the wrong medication dosage. Employee #1 contacted on call medical and Home Manager #1 to inform them of what she had discovered.

The corrective measures included the home manager and on call medical being contacted, an incident report was completed, and the home manager would be mentoring third shift staff regarding the medication error.

On December 7, 2021, I spoke with Home Manager #1 regarding the medication error. She stated that staff was not paying attention when the error occurred. Home Manager #1 agreed to send me a copy of the medication log.

Home Manager #1 informed me that the medication that was in the wrong slot was the Lamotrigine 150 mg. Resident A also takes Lamotrigine 100 mg (two times a day) with the 150 mg.

Home Manager #1 also informed me that they were taking precautions due staff having colds and one staff member was out due to possible exposure to COVID-19.

An on-site inspection was not completed due to the on-going health pandemic.

On December 9, 2021, I completed a virtual licensing renewal inspection. During that inspection, I made face to face contact with Home Manager #1, Administrative Staff #1, Resident A, three residents and three staff.

During the inspection, we discussed how medication errors were addressed. Home Manager #1 and Administrative Staff #1 informed me that the staff member (Employee #2) received a write up. In addition, that depending on the situation, staff may be required to complete medication training again or receive 1:1 training with a nurse and are monitored for three medication passes before being allowed to pass medications again. They reported that the staff member was not following the 6 rights, which resulted in the medication error.

I reviewed the medication log and Resident A was prescribed 100 mg of Lamotrigine at 8:00 a.m. and 8:00 p.m. (Instructions: take one tablet by mouth twice a day). He was also prescribed 150 mg of Lamotrigine at 8:00 a.m. and 8:00 p.m. (Instructions: take one tablet by mouth twice a day with 100 mg tablet for a total of 250 mg).

On January 14, 2022, I spoke with Home Manager #1. She stated that when Employee #2 did the medication count, she put both of the 100 mg bubble packs of (Lamotrigine) into the 8:00 a.m. folder and both of the 150 mg bubble packs of (Lamotrigine) into the 8:00 p.m. folder. However, it should have been one 100 mg and 150 mg bubble pack of (Lamotrigine) in the 8:00 a.m. and one 100 mg and 150 mg bubble pack of (Lamotrigine) in the 8:00 p.m.; a total of 250 mg of Lamotrigine for each medication pass. Therefore, Resident A did not receive the correct dosage for the medication of (Lamotrigine) on 11/16 at 8:00p.m., as he received 300 mg of the medication of Lamotrigine instead of 250 mg, as prescribed.

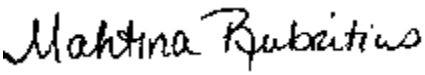
On January 14, 2022, I interviewed Employee #2. She informed that this occurred a while ago, and she could not recall the specific details of the medication error. She did confirm that there was an issue with Resident A's medications being in the wrong slot (medications grouped together by times to be administered). She also confirmed that she was written up for an error and was retrained to pass medications.

On January 18, 2022, I conducted the exit conference with Ms. Rawlings. I informed her of the findings and the recommendations. I also informed her that this was a repeat violation. Ms. Rawlings reported that the matter would be addressed, and she agreed to submit a written corrective action plan to address the established violation.

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 there is a preponderance of the evidence to support the allegations that Resident A did not receive his medication as prescribed. **THIS IS A REPEAT VIOLATION - Please see SIR #2021A0007017**
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.



1/18/2022

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Mahtina Rubritius — Date
Licensing Consultant

Approved By:

1/19/2022

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Ardra Hunter — Date
Area Manager