GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 7, 2022

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

RE: License #: AM800299049
Investigation #: 2022A1030022
Beacon Home at Woodland

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 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 (616) 356-0183.

Sincerely,

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM800299049
Investigation #:	2022A1030022
Complaint Receipt Date:	02/10/2022
Investigation Initiation Date:	02/14/2022
Report Due Date:	04/11/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Woodland
Facility Address:	56832 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	09/12/2016
License Status:	REGULAR
Effective Date:	03/12/2021
Expiration Date:	03/11/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A medication error occurred for two residents.	Yes
Additional Findings	No

III. METHODOLOGY

02/10/2022	Special Investigation Intake 2022A1030022
02/14/2022	Special Investigation Initiated - On Site Interview with Resident A
02/14/2022	Contact - Face to Face Interview with Sabrina Loehr
02/14/2022	Contact - Face to Face Interview with Danyell Lacer
02/14/2022	Contact - Face to Face Interview with Brittani Smith
02/14/2022	Contact - Document Received Received and reviewed Resident A MAR
02/15/2022	Contact - Face to Face Interview with Resident B
02/15/2022	Contact - Document Received Received and reviewed Resident B's MAR
02/24/2022	Exit Conference Exit conference by phone

ALLEGATION:

A medication error occurred for two residents.

INVESTIGATION:

On 2/14/2022, I interviewed Resident A at the home. Resident A reported she has lived at the home for one year. Resident A reported she was unaware that a medication error occurred on 2/4/2022. Resident A reported she does not believe the medication error affected her in in an adverse manner.

On 2/14/2022, I interviewed direct care staff member (DCSM) Sabrina Loehr at the home. Ms. Loehr reported she was the staff that made the medication error on 2/4/2022. Ms. Loehr reported she dispensed medications on 2/4/2022 and realized the mistake after she was going through the medication files for the residents. Ms. Loehr reported the resident's medications books were right next to each other's and was passing medications "too quickly." Ms. Loehr reported she informed her direct supervisor, Danyell Lacer who called Beacon's medical person, the office of recipient rights and filed an incident report with LARA. Ms. Loehr admitted she made the comment "I guess Resident B will sleep a little longer" after she discovered her mistake.

On 2/14/2022, I interviewed DCSM Danyell Lacer at the home. Ms. Lacer reported she is the home manager and was informed of the medication error on 2/4/2022. Ms. Lacer reported DCSM Sabrina Loehr was on duty and made the error. Ms. Lacer reported she ensured an incident report was filed with LARA and contacted the Office of Recipient Right and their medical department. Ms. Lacer reported she pulled Ms. Loehr's ability to dispense medication until she was retrained on passing medication. Ms. Lacer reported Resident B was moved to another Beacon Facility in Kalamazoo, River Run and can be interviewed at the home.

Ms. Lacer reported Beacon uses a policy for passing medications called the "Six Rights." Right Resident, Right Documentation, Right Dose, Right Time and Right Medication. Ms. Lacer reported Ms. Loehr violated the Right Resident and Right Dosage parts of the policy. Ms. Lacer also reported that Ms. Loehr attitude about the medication error was problematic.

On 2/14/2022, I interviewed DSCM Brittani Smith at the home. Ms. Smith reported she was working on 2/2/2022 and was aware of the medication error by Ms. Loehr. Ms. Smith confirmed that Ms. Loehr made the comment "I guess Resident B will sleep a little longer." Ms. Smith reported Ms. Loehr had been retrained on passing medication because of what happened. Ms. Smith reported the error did not negatively affect either resident.

On 2/14/2022, I received and reviewed Resident A's medication administration record (MAR) and noted she was prescribed 1MG Lorazepam three time daily

0n 2/15/2022, I interviewed Resident B at the home. Resident B denied knowing that a medication error occurred on 2/4/2022.

On 2/15/2022, I received and reviewed Resident B's MAR and noted she was prescribed .5mg of Lorazepam three times per day.

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:	Ms. Loehr passed the wrong dosage of medication to both Resident A and Resident B. These two errors occurred because Ms. Loehr did not follow the homes required "Six Rights" policy that ensures safe medication administration.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/24/2022, I shared the findings of this report with Licensee Designee, Nichole VanNiman by phone. Ms. VanNiman acknowledged and agreed with the findings.

IV. RECOMMENDATION

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

Nele Khabeny, LMSW 3/7/2022

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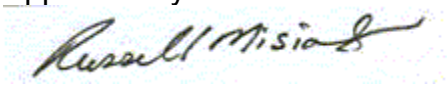
Nile Khabeiry Date
Licensing Consultant

Approved By:



3/7/2022

Russell B. Misiak Date
Area Manager