GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 20, 2022

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

RE: License #: AS250395771
Investigation #: 2022A0569036
Beacon Home at Linden

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 (517) 284-9730.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250395771
Investigation #:	2022A0569036
Complaint Receipt Date:	05/26/2022
Investigation Initiation Date:	05/26/2022
Report Due Date:	07/25/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Rawlings
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Linden
Facility Address:	14180 N. Hogan Road Linden, MI 48451
Facility Telephone #:	(269) 214-4341
Original Issuance Date:	10/09/2018
License Status:	REGULAR
Effective Date:	04/09/2021
Expiration Date:	04/08/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• **Staff let several residents go on community outings unsupervised.**	Yes
• **Resident B was given an incorrect dose of Clozaril on 6/15/22.**	Yes

III. METHODOLOGY

05/26/2022	Special Investigation Intake 2022A0569036
05/26/2022	Special Investigation Initiated - Letter Email received from Kim Nguyen-Forbes, RRO.
05/31/2022	APS Referral Referral sent to APS.
07/12/2022	Inspection Completed On-site
07/14/2022	Contact - Telephone call made Contact with Kim Nguyen-Forbes, RRO.
07/14/2022	Contact- Telephone call made Attempted contact with Lavan Whiteside. Left voicemail to return call.
07/14/2022	Contact- Telephone call made. Attempted contact with Leandria Berry. Left voicemail.
07/14/2022	Inspection Completed-BCAL Sub. Compliance
07/14/2022	Exit Conference Exit conference with Kim Rawlings, licensee designee.

ALLEGATION:

Staff let several residents go on community outings unsupervised.

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that staff Levan Whiteside allowed Resident A to go on an outing unsupervised on 5/21/22. The complainant reported that Resident A, Resident B, and Resident C were also allowed by staff Leandria Berry to enter a mall without staff supervision on 6/16/22.

An unannounced inspection of this facility was conducted on 7/12/22. Resident A, Resident B, and Resident C's plan of service were reviewed. Resident A, Resident B, and Resident C all require direct supervision by staff while in the community documented in their plan of service.

Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A stated that he was admitted to this facility in May 2022 after being released from a court ordered placement. Resident A stated that he does not have "community access" without being directly supervised by staff. Resident A stated that on 5/21/22 he asked Levan Whiteside, staff person, if he could go to his son's birthday party. Resident A stated that Mr. Whiteside told Resident A that he would not take Resident A to the party, so Resident A would have to "find a ride". Resident A stated that he then called his cousin, and she came to the facility and picked him up. Resident A stated that Mr. Whiteside allowed Resident A to leave with his cousin. Resident A stated that when he left the party, he observed Mr. Whiteside sitting in his car, and Mr. Whiteside then transported Resident A back to the facility. Resident A stated that Mr. Whiteside had said that he followed Resident A to the party and then waiting for him outside, but Resident A stated that he never saw Mr. Whiteside until he was leaving the party. Resident A stated that another incident occurred on 6/16/22. Resident A stated that on that date, the residents were taken to a mall by Leandria Berry, staff person. Resident A stated that he, Resident B and Resident C were all allowed to exit the facility van and entered the mall without staff supervision. Resident A asked Ms. Berry if she was going to come with the residents and she responded, "I don't need to".

Resident B was alert and oriented to person, place, and time. Resident B was appropriately dressed and groomed with no visible injuries. Resident B stated that he does require staff supervision when in the community. Resident B stated that he used to be able to move independently in the community, but he "got into some trouble" and now requires staff supervision. Resident B stated that Ms. Berry did allow he, Resident A and Resident C to go into the mall without staff supervision on 6/16/22.

Resident C was oriented to person and place but was not oriented to time when interviewed on 7/12/22. Resident C was appropriately dressed and groomed with no

visible injuries. Resident C stated that he does require staff supervision in the community but did not recall going into a mall without supervision.

An attempted phone call with Mr. Whiteside and Ms. Berry was made on 7/14/22. Mr. Whiteside and Ms. Berry have not returned the phone call to give a statement. Kim Nguyen-Forbes, recipient rights officer, stated on 7/14/22 that she has interviewed Mr. Whiteside, and Mr. Whiteside reported that he followed Resident A to the party, and waited for him outside of the party until Resident A was leaving the party. Ms. Nguyen-Forbes stated that even if Mr. Whiteside is telling the truth, it did not meet the supervision requirements in Resident A's plan of service. Ms. Nguyen- Forbes stated that she is citing a recipient rights violation for lack of supervision.

Katherine Blackburn, facility manager, stated on 7/12/22 that she witnessed Ms. Berry allow the residents to enter the mall without staff supervision on 6/16/22. Ms. Blackburn stated that she was in a fast-food drive through next to the mall when she observed the facility van park in the mall parking lot. Ms. Blackburn stated that she was going to take something to Ms. Berry, so she called Ms. Berry to tell her that she could see the van and would be there as soon as she was through the drive through. Ms. Blackburn stated that when she arrived at the van, Ms. Berry was waiting in the van and all of the residents were gone. Ms. Blackburn stated that Ms. Berry admitted that she had allowed all of the residents to go into the mall without supervision. Ms. Blackburn stated that the staff had all been in a training a week prior to this incident and were all told that the residents could not be left unsupervised in the community. Ms. Blackburn stated that Ms. Berry was "written up" for this incident. Ms. Blackburn stated that Mr. Whiteside was also written up for allowing Resident A to go to his son's birthday party unsupervised.

In SIR# 2022A0569003 dated 12/13/21, a violation of Rule 400.14303(2) was cited due to a former staff person who was terminated from employment allowed a resident to enter a store unsupervised by staff. The corrective action plan (CAP) was received and approved on 12/14/21. The CAP documented that all of the staff would be retrained on proper supervision of the residents and all of the resident behavior plans would be reviewed. This was signed by Kimberly Rawlings, licensee designee.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Resident A, Resident B, and Resident C all require staff supervision when in the community per their plans of service. Resident A was allowed to be in the community unsupervised on two occasions, and Resident B and Resident C were also allowed unsupervised community access. Statements from Resident A, Resident B, and Ms. Blackburn all confirm that the residents were allowed to be in the community unsupervised. Based on the statements given, it is determined that there has been a violation of this rule. This is a repeat violation cited in SIR# 2022A0569003 dated 12/13/21. The corrective action plan was received and approved on 12/14/21. The CAP documented that all of the staff would be retrained on proper supervision of the residents and all of the resident behavior plans would be reviewed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SIR#2022A0569003 dated 12/13/21**

ALLEGATION:

Resident C was given an incorrect dose of Clozaril on 6/15/22.

INVESTIGATION:

The complainant reported that Resident C was given an incorrect dosage of Clozaril on 6/15/22. The complainant reported that Resident C had been in the hospital and the dosage was reduced from 700mg to 400mg, but when Resident C had returned from the hospital, he was given 700mg on 6/15/22.

Resident C's medication administration record (MAR) was reviewed during the inspection on 7/12/22. Resident C's June MAR documents that he was given 700mg of Clozaril on 6/15/22. Resident C's file contains a physician's order dated 6/15/22, the date that Resident C was released from the hospital, changing the dose of Clozaril from 700mg to 400mg to begin on 6/15/22. Resident C's MAR does not reflect the change in dose to take effect until 6/16/22. Resident C stated that he did not know if he received an incorrect dose of medication.

Ms. Blackburn stated on 7/12/22, that she received a "write up" for this error. Ms. Blackburn stated that she had transported Resident C back to the facility from the hospital on 6/15/22. Ms. Blackburn stated that she had the new prescription and physician's order to change the dose of Clozaril, but forgot to inform the staff of the change, so Resident C was given the higher dose on 6/15/22.

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:	Resident C's file contains a physician order and prescription changing the dose of Clozaril from 700mg to 400mg effective 6/15/22. Resident C's MAR documents that he was given 700mg on 6/15/22 and the change was not documented until 6/16/22. Ms. Blackburn stated that she had received the new order and prescription on 6/15/22 but forgot to inform the staff and Resident A was given 700mg on 6/15/22. Based on the documentation reviewed and statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted via telephone with Kimberly Rawlings on 7/14/22. The findings in this report were reviewed and a corrective action plan was requested.

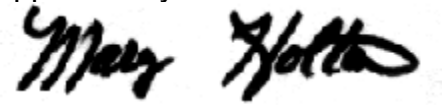
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

7/20/2022

Kent W Gieselman Date
Licensing Consultant

Approved By:



07/20/2022

Mary E Holton Date
Area Manager