GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 28, 2022

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

RE: License #: AS380396667
Investigation #: 2022A0007022
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

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380396667
Investigation #:	2022A0007022
Complaint Receipt Date:	05/31/2022
Investigation Initiation Date:	06/01/2022
Report Due Date:	07/30/2022
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:	12/12/2021
Expiration Date:	12/11/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Allegations that on May 28, 2022, a medication error was discovered regarding Resident A s' Clonazepam .5 mg.	Yes

III. METHODOLOGY

05/31/2022	Special Investigation Intake - 2022A0007022
06/01/2022	Special Investigation Initiated – Telephone to Guardian A.
06/01/2022	Referral - Recipient Rights
06/13/2022	Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #1 and Resident A.
07/26/2022	Contact - Telephone call made - Home Manager #1. Message left and phone call returned.
07/26/2022	Contact - Document Sent - Email - I requested the contact information for Employee #1.
07/26/2022	Contact - Document Received from Administrative Staff #1. The contact information for Employee #1 was provided. According to Administrative Staff #1, Employee #1 no longer works for Beacon.
07/27/2022	Contact - Telephone call made to Employee #1 - Message received: The number dialed has been changed or disconnected.
07/27/2022	Exit Conference conducted with Mr. Ramon Beltran, Vice President of Operations.

ALLEGATIONS:

Allegations that on May 28, 2022, a medication error was discovered regarding Resident A s' Clonazepam .5 mg.

INVESTIGATION:

As a part of this investigation, I reviewed an incident report authored by Employee #1. In summary, Employee #1 documented the following:

> On May 28, 2022, during the 7:00 a.m. medication count, a medication error was found regarding Resident A's 8:00 p.m. medications. It was documented in the medication book that there were 30 pills (of Clonazepam); however, when the actual medications were counted, there were only 29 pills. Employee #1 documented that she called the home manager and was instructed to contact on-call medical. Staff was then instructed to inform the house manager to call on-call medical for further instructions.
>
> The action taken by staff/ treatment given included that the medication error was documented in the Med book with the correct number of pills (29).
>
> The corrective measures taken to remedy and/or prevent recurrence included that the home manager contacted on-call medical and was told to review the medication cameras to observe what happened. The medication error was documented on the count sheet. Staff was to give PA to out-going staff. Staff were instructed to keep an eye on Resident A in case he received a double dosage.

On June 1, 2022, I interviewed Guardian A and her staff, Staff A. They informed that the last incident information they received was regarding the resident testing positive for COVID-19, and they were not made aware of this incident.

On this same day, I spoke with Staff A, and she called the case manager, who contacted Administrative Staff #1, to let them know that the guardian was not notified of the incident regarding the medications. Administrative Staff #1 apologized for them not be notified. Staff A was then informed that every staff member was being written up (all but one), as when they reviewed the information, the cameras showed that Resident A received a double dosage of the medication. The staff were told to monitor Resident A for any adverse effects.

On July 13, 2022, I made face to face contact with Home Manager #1 and Resident A. Home Manager #1 reported that he did not have any adverse effects from receiving the double dosage of medication (Clonazepam). Home Manager #1 also provided me with a copy of the *Daily Controlled Medication Chart* for the file, which included the documented medication error.

On July 26, 2022, I followed up with Home Manager #1. I inquired how she knew that Resident A received a double dosage of the medication. She stated that the narc count was off, and they began to investigate, including watching the cameras. It was discovered that Employee #1 made the error. I inquired about the contact information for Employee #1; and Home Manager #1 informed me that her last

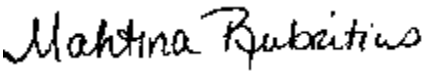
phone number was not in service, as others have also been trying to get a hold of her regarding another matter. Home Manager #1 stated that Employee #1 had been suspended pending an investigation regarding another matter. Home Manager #1 stated that Employee #1 is no longer working for Beacon Services.

On July 27, 2022, I conducted the exit conference with Mr. Ramon Beltran, Vice President of Operations, as Ms. Rawlings was out of the office until August 8, 2022. He agreed to submit a written corrective action plan to address the established violation. I also informed him of the repeat violations.

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 (Clonazepam), as prescribed. **THIS IS A REPEAT VIOLATION** – Please see: • SIR #2021A0007017 & • SIR #2022A0007007
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

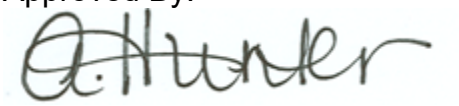
Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.



07/27/2022

Mahtina Rubritius Date
Licensing Consultant

Approved By:



07/28/2022

Ardra Hunter Date
Area Manager