GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 7, 2022

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

RE: License #: AS250395771
Investigation #: 2022A0569046
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.
Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 #:	2022A0569046
Complaint Receipt Date:	08/02/2022
Investigation Initiation Date:	08/02/2022
Report Due Date:	10/01/2022
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?
Resident A and Resident B were given incorrect medications.	Yes

III. METHODOLOGY

08/02/2022	Special Investigation Intake 2022A0569046
08/02/2022	APS Referral
08/02/2022	Special Investigation Initiated - Letter Email to RRO.
09/06/2022	Contact - Telephone call made Contact with Kim Nguyen- Forbes, recipient rights officer.
09/06/2022	Inspection Completed On-site
09/06/2022	Inspection Completed-BCAL Sub. Compliance
09/07/2022	Exit Conference Exit conference with Kim Rawlings, licensee designee.
09/07/2022	Corrective Action Plan Requested and Due on 09/30/2022

ALLEGATION:

Resident A and Resident B were given incorrect medications.

INVESTIGATION:

This complaint was received via the on-line complaint portal. The complainant reported that Resident A had his prescription of Paliperidone discontinued by Genesee Health System (GHS) psychologist Marcus McKee on 7/5/22 and changed to an injection of Invega that would be administered at GHS. The complainant reported that Resident A continued to be administered Paliperidone through 7/25/22. The complainant reported that Resident B has been administered two of his medications only one time per day instead of the prescribed amount to be given two times a day.

An unannounced inspection of this facility was conducted on 9/6/22. Resident A and Resident B were both alert and oriented to person, place, and time. Resident A and Resident B were observed to be appropriately dressed and groomed with no visible injuries. Resident A stated that he is unaware of any medication changes he has had, and simply takes what the staff administer to him at the medication times. Resident A stated that he does not know if he has been administered any medications that were not supposed to be administered. Resident B stated that he is also unaware of any medication errors, and trusts staff to administer the medication as prescribed.

The resident files were reviewed. Resident A's medication administration record (MAR) documents that Resident A was administered Paliperidone 9mg through 7/24/22, then discontinued on 7/25/22. Resident A's file contains a prescription discontinuation for Paliperidone dated 7/5/22, following a medication review by GHS psychologist Marcus McKee.

Resident B's MAR was reviewed during the inspection on 9/6/22. Resident B's MAR documents that Resident B was to be administered Haloperidol 10mg three times a day until 7/13/22. Resident B's MAR documents that the Haloperidol was changed to 10mg two times a day on 7/13/22, but Resident B was not administered the medication at all on 7/13/22, and only one time on 7/14/22. Resident B's MAR documents that Resident B is currently prescribed Benztropine 1mg, to be administered two times a day. Resident B's MAR documents that Resident B was only administered the medication one time per day for the entire month of July 2022.

Katherine Blackburn, facility manager, stated on 9/6/22 that she found the medication errors while completing a medication audit. Ms. Blackburn stated that while she was completing the audit, she noticed that the current prescriptions for Resident A and Resident B did not match the instructions on the MAR for each resident. Ms. Blackburn stated that this facility utilizes an electronic MAR system, and that the changes that are made by physicians or psychologist are automatically entered onto the MAR. Ms. Blackburn stated that the medication errors for both Resident A and Resident B did

occur. Ms. Blackburn stated that she did not now about the medication changes. Ms. Blackburn stated that when a staff person takes a resident for a medication review or any other medical appointment, they are supposed to take a “provider contact sheet” so that the changes will be documented. Ms. Blackburn stated that staff have not been taking the contact sheets, so she was unaware of the changes. Ms. Blackburn stated that GHS will send the prescriptions to the pharmacy, and then she will pick the prescriptions up from the pharmacy, but that she did not notice the changes on the labels of the medications.

The violation to R 400.14312(1) was cited in SIR #2022A0569036 dated 7/20/22. A resident’s prescription of Clozaril was lowered from 700 to 400 mg on 6/15/22, by his physician. Ms. Blackburn stated that she had received the new order and prescription on 6/15/22 but forgot to inform the staff and the resident was given 700mg on 6/15/22. The resident was administered 700 mg of Clozaril an additional day versus the prescribed lower dosage of 400 mg. An acceptable corrective action plan (CAP) was submitted on 8/15/22 and signed by Kimberly Rawlings, licensee designee. The CAP documents that the staff were retrained in medication administration and that Ms. Blackburn received a written discipline.

An exit conference was conducted via telephone with Kimberly Rawlings, licensee designee on 9/7/22. The findings in this report were reviewed. Ms. Rawlings stated that Ms. Blackburn is currently in a retraining plan and is being closely monitored and evaluated regarding her administrative responsibilities as the facility manager.

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:	The complainant reported that Resident A and Resident B were administered medications incorrectly. Resident A and Resident B's MAR document that Resident A was given a medication that had been discontinued for an additional three weeks, and that Resident B had not been administered the dosage prescribed of two of his medications. Ms. Blackburn admitted to finding the errors when she conducted a medication audit recently. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule. This is a repeat violation also cited in SIR#2022A0569036, however, the errors cited in this report also occurred in the same time period as the medication error cited in the previous investigation. It is determined that there has not been a willful and substantial violation of this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2022A0569036 dated 7/20/22.**

IV. RECOMMENDATION

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

9/7/22

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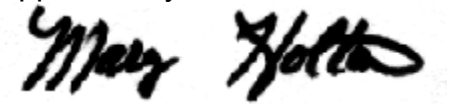
Kent W Gieselman Date
Licensing Consultant

Approved By:



9/7/22

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Mary E Holton Date
Area Manager