GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 3, 2022

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

RE: License #: AS370405093
Investigation #: 2022A0790040
Beacon Home At Mt Pleasant

Dear Ms. Goldammer:

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,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370405093
Investigation #:	2022A0790040
Complaint Receipt Date:	09/21/2022
Investigation Initiation Date:	09/22/2022
Report Due Date:	11/20/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Matthew Owens
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home At Mt Pleasant
Facility Address:	4659 S Leaton Rd Mt Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/16/2020
License Status:	REGULAR
Effective Date:	05/16/2021
Expiration Date:	05/15/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct Care Worker (DCW) Dana Sprague, who functions as home manager, did not order medications for Resident A in a timely manner which resulted in Resident A missing his doses of Risperidone, Olanzapine, and Trazodone on 9/19/22.	Yes

III. METHODOLOGY

09/21/2022	Special Investigation Intake 2022A0790040
09/22/2022	Special Investigation Initiated - On Site
09/22/2022	Inspection Completed On-site- I interviewed Direct Care Workers (DCWs) Ashlee McEwen, Kendra Pannill, and Gage Lynch.
09/22/2022	Contact - Telephone call received- DCW Dana Sprague who functions as the home manager called to speak to me.
09/22/2022	Contact - Document Received- DCW Dana Sprague emailed me the documentation I requested.
09/23/2022	Contact - Document Sent- I emailed DCW Dana Sprague and requested additional information and documentation.
09/23/2022	Contact - Document Received- DCW Naomi Voorhees who functions as the assistant home manager emailed me the additional information and documentation I requested.
09/26/2022	Corrective Action Plan Requested and Due on 10/11/2022.
09/26/2022	Inspection Completed-BCAL Sub. Compliance
09/26/2022	Exit Conference with licensee designee Roxanne Goldammer.
09/27/2022	Contact – Telephone call received from Licensee designee Roxanne Goldammer.

ALLEGATION:

Direct Care Worker (DCW) Dana Sprague who functions as home manager did not order medications for Resident A in a timely manner which resulted in Resident A missing his doses of Risperidone, Olanzapine, and Trazodone on 9/19/22.

INVESTIGATION:

I conducted an unannounced onsite investigation on 09/22/2022. I interviewed direct care workers (DCWs) Ashlee McEwen, Kendra Pannill, and Gage Lynch.

Ms. McEwen was asked for Resident A's resident records, however she stated being unsure of the location of resident records. Ms. McEwen explained she is employed at the facility through a temp service and does not have a lot of knowledge pertaining to where things are kept at the facility. Ms. McEwen also did not have any knowledge if Resident A received his doses of Risperidone, Olanzapine, and Trazodone on 09/19/2022 because she did not work on 09/19/2022.

Resident A came out of his room and into the kitchen where I was interviewing the DCWs. I observed Resident A to have an open wound on his forehead. The wound was red in color and shiny. It appeared some type of ointment or salve had been applied to the wound.

DCW Kendra Pannill explained Resident A had a behavior at school today and was sent home early. Ms. Pannill said DCWs were informed Resident A was hitting his head on something at the park. She said Resident A displays this type of behavior often. Ms. Pannill stated Resident A suffers from autism spectrum disorder (ASD) and has demonstrated extreme self-harming behaviors at the facility, school, and other venues. She said the main form of self-harm Resident A displays is head-butting things. She said Resident A has broken windows out of both DCWs' and facility vehicles by head-butting them and caused a tremendous amount of property damage. Ms. Pannill stated Resident A has been suspended from school for threatening to harm others.

I observed three DCWs currently working with the three residents during the unannounced onsite investigation. Ms. Pannill explained both Resident A and another resident at the facility have one-to-one supervision services 16 hours a day, so it is necessary to have three DCWs to meet all supervision requirements. She said Ms. McEwen is providing one-to-one supervision to Resident A and she is providing one-to-one supervision to the other resident.

I attempted to interview Resident A, but he would not speak to me. Ms. Pannill explained Resident A often ignores, becomes highly agitated, and/or aggressive when attempting to engage him in conversation.

DCW Dana Sprague who functions as the home manager called to speak to me. I asked to see Resident A's *Resident Record* and Mr. Sprague explained all their residents' *Resident Records* are kept in digital form and stored on the facility computer. Mr. Sprague said he has access to the residents' electronic documents and can email me whatever documents I need for Resident A. I requested Resident A's electronic *Medication Administration Record* (MAR), *Assessment Plan for AFC Residents, Health Care Appraisal, and AFC Resident Information Identification Record.*

I interviewed Kendra Pannill who indicated she did not work on 09/19/2022. Ms. Pannill said she did work on 09/20/2022 and was informed upon her arrival Resident A did not receive his medications on 09/19/2022. She stated Resident A did not receive his medications on 09/19/2022 because they were not ordered timely. Ms. Pannill stated DCW Naomi Voorhees, who functions as the assistant home manager, is responsible for counting the residents' medications on a weekly basis. Ms. Pannill said Ms. Voorhees completes medication counts on Mondays and if there are only seven pills left, Ms. Voorhees is to order a refill from the pharmacy.

Ms. Pannill stated Ms. Voorhees called in sick for work on 09/20/2022 so the facility nurse Jessica DeRuiter came in to count in the medications received from the pharmacy. Ms. Pannill said counting the medications in from the pharmacy is normally Ms. Voorhees' responsibility but since she called in Ms. DeRuiter came to count in the medication.

Ms. Pannill said Resident A always has facial injuries. She said she is unaware of Resident A sustaining any major injuries but often head-butts hard objects at the facility such as windows, doors, walls, and furniture. Ms. Pannill stated Resident A often threatens to harm himself and others as well. She said Resident A is calm, cooperative, quiet, and kind to other residents and DCWs when he is not escalated and having behaviors. Ms. Pannill said she did not notice a change in Resident A's behavior on 09/20/2022.

I interviewed DCW Gage Lynch and he indicated he worked from 9:00 a.m. to 8:00 p.m. on 09/19/2022. Mr. Lynch stated he did not pass medication and was unaware Resident A ran out of his routine prescriptions until receiving a call from the third shift DCW Jaimee Osmolinski after arriving home. Mr. Lynch said assistant home manager Naomi Voorhees is responsible for counting and ordering the residents medications every Monday. He stated Ms. Voorhees called off sick on 09/20/2022 but cannot remember if she called off on 09/19/2022. Mr. Lynch stated he did not notice a change in Resident A's behavior on 09/19/2022 despite not receiving medication.

I called DCW Dana Sprague back after leaving the facility. Mr. Sprague said Resident A failed to receive his routine medications Risperidone, Olanzapine, and Trazodone on 9/19/22 because of an error made by the pharmacy. He explained Beacon Specialized Living began the process of changing pharmacies approximately a month ago which played a part in causing the error.

Mr. Sprague said assistance home manger Naomi Voorhees is responsible for counting and ordering the residents' medications every Monday. Mr. Sprague explained Ms. Voorhees ordered Resident A's routine medications Risperidone, Olanzapine, and Trazodone on 09/06/2022. He said Ms. Voorhees emailed their original pharmacist Chris Rousch from Gull Pointe Pharmacy because Resident A's medications were not received. Mr. Sprague said Mr. Rousch failed to respond to the email. Mr. Sprague said Ms. Voorhees ordered Resident A's medications again on 09/12/2022 and on 09/17/2022 it was brought to his attention Resident A only had a few pills left of his routine medications.

Mr. Sprague said he found out the new pharmacy Alternatives had the wrong doctor's name and information and denied the refill. Mr. Sprague did not provide the date and/or time he found this information out. He indicated the facility nurse Jessica DeRuiter then contacted their old pharmacist Chris Rousch, ordered Resident A's routine medications, and they arrived on 09/20/2022. Mr. Sprague said he would email me the medication timeline he sent to his supervisor Matthew Owens and other requested documentation for review.

Mr. Sprague emailed me the following timeline on 09/22/2022:

- On 9/6 the medication was ordered
- On 9/8 an email was sent to Chris (original pharmacist) because we did not receive them, there was no response.

- On 9/12 the medication was ordered again

- On 9/17 it was brought to my attention that there were only a few left. Pharmacy alternatives had the wrong doctor's information and denied the refill. Jessica then contacted Chris and got the medication into the home.

I reviewed Resident A's *Medication Administrative Record (MAR)* and found the following documentation for September 19, 2022:

- *"ja *1 – 0"* was documented for Resident A's Risperidone, Olanzapine, and Trazodone*:* ja stands for DCW Jaime Osmolinski, *1 stands for none – no medication remaining, and 0 stands for zero medications administered.

I emailed and requested additional information and documentation from Mr. Sprague. Mr. Sprague informed me he would have the assistant home manager email the requested information and documentation.

DCW Naomi Voorhees who functions as the assistant home manager provided the following information and documentation via email on 09/23/2022:

- The old pharmacy was Gull Pointe Pharmacy, the new one Pharmacy Alternative. Jessica DeRuiter is the facility nurse.

- An email was provided sent on 09/06/2022 requesting the following medication refill for [Resident A] from Ms. Voorhees to Chris Rousch (Gull Pointe Pharmacy). Mt. Pleasant: [Resident A] - Risperdal 1mg - 13 days, Trazodone 150mg - 13 days, Olanzapine 5mg - 13 days.

- An email sent on 09/08/2022 from Ms. Voorhees to Chris Rousch (Gull Pointe Pharmacy) stating, "Did not receive [Resident A's] Risperdal 1mg, Trazodone 150mg, Olanzapine 5mg, nor have we received his new zinc oxide yet."

- An email sent on 09/12/2022 from Ms. Voorhees to Chris Rousch (Gull Pointe Pharmacy) stating, "Here is the medication order for Mt. Pleasant – [Resident A] – Risperdal 1mg – 6 days, Trazodone 150mg – 6 days, and Olanzapine 5mg – 6 days."

- A PDF copy of an E-Rx Renewal Prescription Response was received from Ms. Voorhees showing [Resident A's] prescription for Trazodone TAB 150mg was denied with a response message and additional notes dated 09/18/2022 and indicating the following: "Patient unknown to the provider and patient unknown to the prescriber." This PDF was forwarded by Mr. Sprague to Ms. Voorhees on 09/19/2022 and originally received from an Otega Luningning from Palrx on 09/19/2022.

- Ms. Voorhees provided a copy of [Resident A's] Weekly Count and Medication Needs Lists dated 09/05/2022 and 09/12/2022 showing the following information: "Medication: Risperdal 1MG – Frequency: 2X day – Days on Hand Week #1 - 12, Days on Hand Week #2 – 4, and Date Ordered - 09/06/2022; Medication: Risperdal 1MG – Frequency: 2X day – Days on Hand Week #1 – 15, Days on Hand Week #2 – 10, and Date Ordered - 09/06/2022; Medication: Trazodone 150MG – Frequency: 1X day, Days on Hand Week #1 - 13, Days on Hand Week #2 - 7, Date Ordered 09/06/2022; and Medication: Olanzapine 5MG, Frequency: 1X day, Days on Hand Week #1 - 13, Days on Hand Week #2 – 7.

I called and left a voicemail message with licensee designee Roxanne Goldammer on 09/26/2022 informing her a violation was established during this special investigation. Ms. Goldammer was instructed to provide an acceptable Corrective Action Plan (CAP) on or before 10/11/2022.

Ms. Goldammer called on 09/27/2022 to request clarification and discuss the findings with me directly. She agreed to provide a CAP.

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 special investigation through review of documentation found in Resident A's electronic *Resident Record,* emails, pharmaceutical and facility documents, and interviews and email communication with DCWs Ashlee McEwen, Kendra Pannill, Gage Lynch, Dana Sprague who functions as the home manager, and Naomi Voorhees who functions as the assistant home manager there is evidence Resident A was not given his prescribed medication doses of Risperidone, Olanzapine, and Trazodone on 09/19/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

09/26/2022

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Rodney Gill Date
Licensing Consultant

Approved By:

10/03/2022

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Dawn N. Timm Date
Area Manager