GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 7, 2022

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

RE: License #: AS130408635
Investigation #: 2022A1034003
Beacon Home at East Ave

Dear Mr. Beltran:

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,

Kevin L. Sellers

Kevin Sellers, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-3704

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130408635
Investigation #:	2022A1034003
Complaint Receipt Date:	09/09/2022
Investigation Initiation Date:	09/09/2022
Report Due Date:	11/08/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Navpreet Kaur
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at East Ave
Facility Address:	20271 East Ave N Battle Creek, MI 49017
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/04/2021
License **Status:**	REGULAR
Effective Date:	04/04/2022
Expiration Date:	04/03/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
An unknown direct care staff grabbed medication from Resident A, refused to give it back, and shoved Resident A onto the bed.	No
Medication room was not secured and loose medication was observed.	No
Unknown direct care staff member refused to give Resident A her Norco and sleeping medication, Resident A was administered inaccurate medication and medication is missing.	No
Resident A's medication administration paperwork was not completed daily.	Yes
Bug spray and cleaning supplies were observed not secured in the appropriate locations	No

III. METHODOLOGY

09/09/2022	Special Investigation Intake 2022A1034003
09/09/2022	Special Investigation Initiated – Telephone contact with recipient rights officer, Suzie Suchyta
09/09/2022	Contact - Documents received from Suzie Suchyta
09/12/2022	Inspection Completed On-site
09/12/2022	Contact - Face to Face interviews with direct care staff members D-Nasia Wilson, Krystal Walterhouse, Seabreeann Johnson, Resident A, house manager Heather Cortes, registered nurse-Amy Zapf, and administrator Aubry Napier.
09/12/2022	Contact - Document Received copies of Resident A's prescribed medications scripts and weekly medication counts.
09/12/2022	Contact - Document Received additional pictures taken by AFC consultant at the facility.
09/15/2022	Contact - Document Received online complaint Intake 190201/AS130408635-reject for APS Investigation.
09/20/2022	Contact - Face to Face onsite visit with Heather Cortes and Resident A.
09/20/2022	Contact - Telephone call made with DCW-Brittany Labadie

09/20/2022	Contact - Telephone call made leaving voice message for DCW-Brittany Shepard
09/20/2022	Contact - Telephone call made leaving voice message for DCW-Whitney Powell
09/21/2022	Contact - Telephone call received from Suzie Suchyta
09/22/2022	Contact – Telephone call received from recipient rights officer-Linda Wagner
10/05/2022	Contact - Document received with an email pertaining to additional information
10/05/2022	Contact - Telephone call made leaving message for APS specialist-Jennifer Stockford
10/11/2022	Contact – Telephone call received from Jennifer Stockford.
10/12/2022	Exit Conference with licensee designee Ramon Beltran.
~~10~~/17/2022	Contact - Telephone call made with direct care worker, Brittany Shepard.
10/18/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: An unknown direct care staff grabbed medication from Resident A, refused to give back, and shoved Resident A onto the bed.

INVESTIGATION:

On 09/09/2022, Complainant reported several direct care staff members grabbed medication out of Resident A's hand, refused to give Resident A the medication back, and then shoved Resident A onto the bed.

On 09/12/2022, I conducted an unannounced onsite investigation at the facility and interviewed direct care worker (DCW) Seabreeanna Johnson who reported working with Resident A but denied ever taking any medication away from Resident A or shoving her at any time. DCW Johnson reported DCW Brittany Shepard and DCW Whitney Powell work second shift (evenings) with the residents.

I interviewed home manager Heather Cortes who reported that today, 09/12/2022, was her first day as the new home manager. Ms. Cortes denied having any knowledge about DCW(s) grabbing medication out of Resident A's hand, not giving

the medication back to Resident A and/or allegedly shoving Resident A onto the bed.

On 09/12/2022, I interviewed Resident A who reported approximately three weeks ago she was physically assaulted by two DCWs named Brittany Shepard and Whitney Powell. Resident A reported DCW Brittany Shepard administered her nighttime medication and when she questioned DCW Shepard about the medication, DCW Shepard grabbed the medication out of her hand and would not give the medication back to her. Resident A reported DCW Whitney Powell was also there and shoved her onto the bed. During my interview with Resident A, I observed Resident A changed the details of when the alleged assault occurred, changed the names of the DCWs involved and changed how many DCWs were involved in the alleged incident. Additionally, Resident A reported having a verbal altercation with Resident A's roommate but Resident A indicated direct care staff members intervened appropriately and separated the two residents. Resident A stated she reported this same information to an adult protective services specialist.

On 09/12/2022, I interviewed administrator, Aubry Napier who denied having any knowledge about a physical altercation incident at any time between Resident A and DCW Shepard and DCW Powell.

On 10/05/2022, I interviewed APS specialist Jennifer Stockford via telephone who reported investigating allegations of adult abuse at the facility between DCWs Shepard and Powell and Resident A. Ms. Stockford denied finding any evidence Resident A was abused at the facility by any staff members.

On 09/13/2022, I reviewed the facility's Incident/Accident Report (IR), which was identified as "*East Ave South Incident Report*", dated 09/13/2022. What was written in the IR was consistent with what was reported by Resident A and Ms. Stockford. The IR indicated Resident A got into a verbal altercation with her roommate where Resident A and her roommate physically hit each other, and the action taken by staff was to "remove one resident from the room and provide support." The action taken to prevent the incident from reoccurring was indicated as "staff will continue to do their daily monitoring on residents, staff will report all incidents to the appropriate parties as needed, staff will monitor any injuries and report to appropriate staff."

On 10/17/2022, I interviewed DCW Brittany Shepard via telephone who reported working 2nd shift at the facility and providing care to Resident A since being employed at the facility. DCW Shepard denied ever grabbing medication out of Resident A's hand, refusing to give Resident A's medication back and/or ever shoving Resident A onto the bed. DCW Shepard described an incident during an evening medication administration when Resident A was sitting at the dining room table during the time she administered Resident A's prescribed nighttime medication. DCW Shepard stated after administering Resident A's medication, Resident A became agitated because Resident A wanted more of her nighttime pain medication (Norco). DCW Shepard stated Resident A also refused to take her sleep

medication claiming the sleep medication she administered to Resident A was not her prescribed sleep medication. DCW Shepard reported Resident A placed her medications on the dining room table while she stood next to Resident A. DCW Shepard reported telling Resident A she needed to take all her prescribed nighttime medication and not leave it sitting on the table. DCW Shepard reported after a few minutes when Resident A did not follow the instructions, she reached out and removed the medication from the table. DCW Shepard stated Resident A then grabbed her right wrist, did not let go, and so she forcibly pulled her right arm back away from Resident A. DCW Shepard reported Resident A then took her medication along with a glass of water. DCW Shepard reported filing an incident report regarding the situation between her and Resident A and passing it along to the former home manger, Ms. Lewis. DCW Shepard denied there was any other DCWs working at the time of the incident. DCW Shepard reported knowing DCW Whitney Powell but denied DCW Powell was present during the time of the incident. DCW Shepard reported filing the incident report sometime around the end of August 2022. DCW Shepard stated Resident A has repeatedly requested more pain medication during regular medication administration times as well as asking for pain medication outside of the prescribed times.

On 09/20/2022, I completed a follow up onsite investigation at the facility, where I briefly interviewed Resident A who denied having any issues.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my interviews with Resident A, DCWs Seabreeanna and Shepard, APS specialist Stockford and reviewing Resident A MARs, there was no evidence direct care staff grabbed medication from Resident A, refused to give Resident A's medication back and/or shoved Resident A onto the bed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The medication room was not secured and a loose pill was observed sitting on the counter.

INVESTIGATION:

On 09/09/2022, Complainant reported the medication room was not secured and medication was observed loosely on the counter which allowed residents easy access to the medications.

On 09/09/2022, I received several pictures from Complainant taken from inside the medication room. Complainant reported observing the resident medication room in the basement which was not locked. Complainant provided two separate pictures with the first picture displaying resident medication laying on a desk in the medication room which were not secured. The second picture provided was one unknown medication pill inside a dixie cup not secured.

On 09/12/2022, during my unannounced onsite investigation, I interviewed nurse, Amy Zapf who denied having any knowledge of the medication room at the facility ever being kept unsecured or that there has been loose medication left lying about in the facility.

I interviewed home manager, Ms. Cortes who denied knowing the medication room was not secured or that there was unsecured medication inside the medication room. Ms. Cortes reported the medication room is supposed to be always locked. Ms. Cortes stated herself and DCWs are the only personnel who have keys to the medication room and upper basement doors leading to the medication room.

I interviewed administrator, Aubry Napier who denied knowing anything about either the medication room and/or resident medications being unsecured.

During the unannounced onsite inspection, I observed the medication room door was open due to nurse Zapf working in the room. I did not observe any unsecured resident medications as the resident medications were held in locked filing cabinets. I also observed a lock on the door handle leading into the medication room and individual locks on each filing drawer that held resident medication.

On 10/17/2022, I interviewed DCW Shepard who denied ever witnessing the medication room or resident medications being left open or unsecured.

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:	My investigation did not find the medication room unlocked nor did I find loose medications lying about the facility. I interviewed multiple staff members who denied observing the medication room being left unsecured at any time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Unknown direct care staff member refused to give Resident A her Norco and sleeping medication, Resident A was administered inaccurate medication and medication is missing.

INVESTIGATION:

On 09/09/2022, Complainant reported direct care worker (DCW) Brittany Shepard refused to give Resident A her evening Norco and sleep medication. Complainant reported Resident A was passed the wrong dosage of medication and the medication is now missing.

On 09/12/2022, I interviewed Resident A who reported nighttime DCWs have refused several times to give her prescribed nighttime pain medication (Norco) and sleeping medication. Resident A was not able to provide the name of a specific direct care staff member who did not provide her the medications nor was she able to give any specific dates when this occurred.

I interviewed home manager and administrator, Ms. Cortes and Mrs. Napier who both denied having any knowledge of DCWs refusing to give Resident A her prescribed Norco or sleep medication. Ms. Cortes and Mrs. Napier both reported resident medications are handled correctly and documented in the residents' MARs. Ms. Cortes denied also having any knowledge that there have been medication errors or any missing medications with Resident A's medications. Ms. Cortes stated Resident A is constantly requesting more of her prescribed narcotic medication Norco, however, DCWs are not administering more pain medication than what the medication label instructions allow per Resident A's physician.

During my unannounced onsite investigation, I reviewed Resident A's September 2022 medication administration record (MAR) and did not observe any time Resident A was not administered the narcotic medication Norco or sleep medication as prescribed. I also did not observe any inaccurate medication administrations nor was there evidence of any missing medications.

On 10/05/2022, I interviewed APS specialist, Ms. Stockford who reported investigating allegations of Resident A was being abused at the facility by staff members. Ms. Stockford denied finding any evidence Resident A was being abused or that Resident A was not being administered her prescribed medication or was missing medication.

On 10/17/2022, I interviewed DCW Shepard who denied she has ever refused to give Resident A her prescribed Norco and/or sleep medication. DCW Shepard reported continually struggling with Resident A about her Norco medication as Resident A often requests more than what is prescribed by her physician. DCW Shepard reported having repeated conversations with Resident A that she can only be administered the amount prescribed by her physician. DCW Shepard reported Resident A's medication is being handled correctly and MARs are kept electronically.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Through my investigation, based on interviews with Resident A, DCW Shepard, home manager Cortez, administrator Napier, APS specialist Stockford, and my review of Resident A's medication administration records, I did not observe any time Resident A's medications were not administered as prescribed, including Resident A's narcotic medication Norco or sleep medication, or that any of Resident A's medications were missing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's medication administration paperwork was not completed daily.

INVESTIGATION:

On 09/09/2022, Complainant reported observing medication administration paperwork was not completed daily and Norco counts were not signed off and counted at shift changes. **Please note it is not an administrative rule requirement to count medication, so this will not be investigated.*

On 09/12/2022, I interviewed nurse, Amy Zapf who reported the reason she was there today at the facility was to straighten out the medication room and ensure resident medication administration records (MAR)s are in order. Ms. Zapf reported finding discrepancies with missing resident MARs. Ms. Zapf reported finding missing medical documentation and was unsure if it had to do with the former home manager, Ms. Lewis, having poor recording keeping.

I interviewed home manager and administrator, Ms. Cortes and Mrs. Napier all of whom denied having any knowledge there were missing MARs for residents. Ms.

Cortes and Mrs. Napier reported being aware of the situation but did not have current contact information for the previous home manager Margo Lewis.

During my unannounced onsite investigation, I was only able to review Resident A's Medication Administration Records (MAR) for the month of September 1- 30 2022. I was not able to review any July or August 2022 MARs due to staff not being able to locate those records. I was able to observe Resident A's MARs for September 1-12 2022 and did not observe any errors. Additionally, I reviewed copies of Resident A's medication scripts provided by her medical physician.

On 10/05/2022, I interviewed APS specialist, Ms. Stockford who reported finding no discrepancies in Resident A's MARs during her investigation.

On 10/17/2022, I interviewed DCW Shepard who reported when she administered resident medications, she always initialed the MARs book which was kept in the medication room.

On 09/20/2022, I completed a follow up onsite investigation at the facility, where I observed Resident A's *Medication Administration Record* (MAR) observing no discrepancies.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	Based on interviews with complainant, home manager Cortes, nurse Zapf, administrator Napier, DCW Shepard and my observations during an unannounced onsite investigation, there was only the September 2022 MAR for Resident A available for review. There were no MARs for Resident A for July and August 2022 available for review as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Bug spray and cleaning supplies were observed not secured in the appropriate locations

INVESTIGATION:
On 09/09/2022, I received several pictures from Complainant who stated the pictures were taken inside the facility. One of the pictures showed a can of Hot Shot Fly Insect repellent sitting on the dining room table next to a plate of food. Several other pictures showed bottles of bleach cleaner sitting openly outside the locked chemical storage cabinet and a mop and wash bucket container containing bleach water sitting adjacence outside the chemical cabinet.

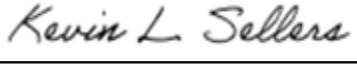
On 09/12/2022, during my unannounced onsite investigation, I did not observe any insect repellent spray, bottles of bleach and/or any other cleaning supplies unsecured outside of their appropriate locked or safeguarded locations.

During the unannounced onsite investigation, I interviewed home manager and administrator Ms. Cortes and Mrs. Napier who denied having knowledge there were chemicals like insect repellent, bottles of bleach and a mop bucket containing bleach water left out exposed to the residents. Mrs. Napier reported becoming aware of such concerns after having a conversation with a recipient right officer and learning there were pictures of these items.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	Based on my investigation, I did not observe any insect repellant sprays or chemical cleaning supplies unsecured inside the facility. Although I received photographs of the items unsured in the facility from the complainant, I observed all cleaning materials to be safeguarded at the time of my unannounced investigation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in license is recommended.



11/07/2022

Kevin Sellers — Date
Licensing Consultant

Approved By:

11/07/2022

Dawn N. Timm — Date
Area Manager