GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 6, 2022

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

RE: License #: AS130411523
Investigation #: 2023A1034002
Beacon Home At East Ave South

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 #:	AS130411523
Investigation #:	2023A1034002
Complaint Receipt Date:	10/21/2022
Investigation Initiation Date:	10/21/2022
Report Due Date:	12/20/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At East Ave South
Facility Address:	20271 East Ave N Battle Creek, MI 49017
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	04/13/2022
License **Status:**	TEMPORARY
Effective Date:	04/13/2022
Expiration Date:	10/12/2022
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Whitney Powell gave Resident A an extra dose of prescribed Ativan medication.	Yes

III. METHODOLOGY

10/21/2022	Special Investigation Intake 2023A1034002
10/21/2022	Special Investigation Initiated – Telephone call with Complainant, Complainant interviewed.
10/24/2022	Inspection Completed On-site interviewed home manager- Heather Cortes, direct care workers- Whitney Powell, Maria Granado, Gillian Johnston and Residents A
10/24/2022	Contact - Document received copies of Beacon Daily Controlled Medication Charts for Resident A
10/27/2022	Contact - Telephone call made interviewing direct care workers- Brittany Labadie and Jamie Anderson
11/02/2022	Inspection Completed-BCAL Sub. Compliance
11/07/2022	Exit Conference with licensee designee Ramon Beltran

ALLEGATION: Direct care staff member Whitney Powell gave Resident A an extra dose of prescribed Ativan medication.

INVESTIGATION:

On 10/20/2022, Complainant reported direct care staff member Whitney Powell gave Resident A an extra dose of Ativan during the overnight shift.

On 10/21/2022, I interviewed Complainant who reported morning staff members noticed Resident A was unable to stay awake, had glassy eyes, Resident A's oxygen level dropped and Resident A's behaviors were odd. Complainant reported direct care staff member Whitney Powell gave Resident A an extra dose of prescribed Ativan during the overnight shift, DCW Powell did so in hopes of not dealing with Resident A's behaviors. Complainant stated daytime shift had to call 911 for Resident A.

On 10/24/2022, I conducted an unannounced onsite investigation and interviewed home manager Heather Cortes who reported already being aware of a recent incident involving Resident A and direct care worker (DCW) Whitney Powell where DCW Powell administered an additional dosage of Ativan (1 mg) to Resident A. Ms. Cortes reported on the morning of 10/18/2022 herself and day shift DCW Maria Granado observed odd behaviors from Resident A like being unable to stay awake, falling asleep at the dining room table and having glassy eyes. Ms. Cortes reported while trying to assess what was going on with Resident A, she spoke with DCW Granado who informed her of DCW Powell's statement to DCW Granado from the previous shift. Ms. Cortes reported DCW Granado told her DCW Powell made the statement "I'm going to give [Resident A] an extra dosage of Ativan so I don't have to deal with [Resident A's] behaviors all night long." Ms. Cortes reported asking Resident A if she would like to be transported to an urgent care to get medically checked out and Resident A agreed to go to an urgent care for further medical assistance. Ms. Cortes reported she asked DCW Granado to check Resident A's oxygen level while she went to retrieve Resident A's medical paperwork and DCW Granado told her Resident A's oxygen level was low. Ms. Cortes stated Resident A was observed at this point lying on the couch and unresponsive. Ms. Cortes stated DCW Granado tried to get a response from Resident A but was unsuccessful. Ms. Cortes reported contacting the visiting nurse, informing the nurse of what was happening with Resident A, their plan to take Resident A to an urgent care and what medical steps staff have done for Resident A thus far. Ms. Cortes reported the visiting nurse suggested staff call 911 for an ambulance at the home to transport Resident A to the hospital. Ms. Cortes stated the visiting nurse was en route to the facility to assist with Resident A prior to EMTs arriving. Ms. Cortes reported contacting administrator Aubry Napier about Resident A's current condition and the plan for Resident A to be medically evaluated. Ms. Cortes reported Resident A remained unresponsive even after staff and the nurse made attempts to get a response out of Resident A while waiting for EMTs. Ms. Cortes reported EMTS arrived at the home, began performing medical assistance for Resident A, made attempts to get a response from Resident A and not until several minutes later were paramedics were able to get a response from Resident A. Ms. Cortes stated Resident A began to talk, Resident A jumped off the couch and began walking Around the living room. Ms. Cortes reported Resident A's oxygen levels were checked by EMTs and had increased helping Resident A look much better. Ms. Cortes reported paramedics denied having any immediate concerns transporting Resident A to the hospital due to Resident A's current responses, Resident A's current oxygen levels, so suggested Resident A remain at the home, staff continue to monitor Resident A, and if Resident A's health declines, then staff should transport Resident A to the hospital.

Ms. Cortes reported after receiving the information from DCW Granado about Resident A potentially receiving more medication than what is prescribed, she stated she reviewed Resident A's daily controlled medication charts from September 2022 through October 2022 and observed several discrepancies involving DCW Powell's administration of Resident A's prescribed medication Ativan. Ms. Cortes reported

following up with administrator Aubry Napier about the discrepancies she observed in the administration of Resident A's Ativan medication by DCW Powell. Ms. Cortes also stated she sought direction on how to address DCW Powell's actions. Ms. Cortes advising DCW Powell she would be suspended until further authorized by management. Ms. Cortes reported as a normal course of practice when direct care workers administer medications to residents they are required to use paper medication administration record (MARs) and electronic MARs when cross-referencing resident medications. Ms. Cortes reported every direct care worker who administers medications are trained in this process and DCW Powell was trained to administer medications. Ms. Cortes denied there have been any computer issues with electronic MARs that would explain the discrepancies noted.

On 10/24/2022, I reviewed Resident A's *Daily Controlled Medication Charts* dated September 21, 2022, through October 20, 2022 and observed discrepancies in Resident A's prescribed Ativan (1 mg) on 09/29/2022, 10/12/2022, 10/13/2022 and 10/17/2022 indicating DCW Powell administered one extra 1 mg dosage to Resident A. The extra dosage administrations were initialed by DCW Powell on each occasion. Resident A is prescribed Lorazepam (Ativan) 1 mg 1X daily per Resident A's prescribing physician.

On 10/24/2022, I interviewed direct care worker (DCW) Whitney Powell who reported being aware of concerns she has administered additional doses of Resident A's prescribed Ativan. DCW Powell admitted she might have "accidentally" administered an extra dosage of Resident A's prescribed Ativan but denied this happened more than one time. DCW Powell reported administering Resident A's prescribed medication during the night shift on 10/17/2022 where she accidentally administered an extra dose of Resident A's Ativan 1mg. DCW Powell reported remembering she placed Resident A's paper medication administration record (MAR) in front of her while she was dispensing all Resident A's medication. DCW Powell denied she ever cross-referenced Resident A's medication to the paper MAR. DCW Powell reported she would cross reference Resident A's medication in the past but she was familiar with Resident A's medication she stopped cross-referencing the medication. DCW Powell reported always using the paper MAR because the electronic MAR does not work all the time. DCW Powell reported once she has gone through the resident medications, she will initial each medication she administers. DCW Powell reported she believes what happened on 10/17/2022 was she accidentally "popped" too many of the bubbles on Resident A's Ativan (1 mg) pill. DCW Powell admitted dispensing medications too fast but emphasized it was an accident. DCW Powell denied ever making a statement to DCW Granado she was going to administer an extra Ativan to Resident A so she would not have to deal with Resident A's behaviors. DCW Powell denied ever wanting to harm any of the residents. DCW Powell was not able to provide an explanation why she administered extra doses of Ativan to Resident A on 09/29/2022, 10/12/2022 and 10/13/2022. DCW Powell reported due to what happened she was suspended until further authorized by her employer.

On 10/24/2022, I interviewed Resident A who reported direct care staff members administer her prescribed medication. During my interview with Resident A, I observed Resident A was having difficulty identifying what medications she is prescribed, difficulty explaining if she was administered too much medication, and difficulty remaining on task in answering the questions asked by this AFC licensing consultant.

On 10/24/2022, I interviewed direct care worker (DCW) Maria Granado who reported having knowledge about Resident A being administered extra doses of Ativan (1 mg). DCW Granado reported the same information as home manager Heather Cortes observed regarding Resident A's unusual behaviors on the morning of 10/18/2022. Ms. Granado confirmed Resident A was not able to stay awake, kept wanting to fall asleep, had glassy eyes, was unresponsive on the couch, Resident A's oxygen levels were low, the visiting nurse was contacted and came to the home, and 911 was called and paramedics came to the home for Resident A. DCW Granado confirmed the statement DCW Powell made to her about DCW Powell giving Resident A an extra dosage of Ativan so she did not have to deal with Resident A's behaviors during the night shift. DCW Granado reported she gave this information to Ms. Cortes following Resident A's odd behaviors on the morning of 10/18/2022.

During my unannounced onsite investigation, I reviewed DCW Whitney Powell's employee file. Ms. Powell has been employed at the facility since January 2022 and there were no identified disciplinary actions taken against Ms. Powell observed in her file. Additionally, I observed Ms. Powell has completed the required number of trainings to administer resident medications.

On 10/19/2022, I reviewed the facility's Incident/Accident Report (IR), which was identified as "*East Ave South Incident Report*", dated 10/18/2022. What was written in the IR was consistent with what was reported by home manager Heather Cortes and DCW Maria Granado. The IR indicated on the morning of 10/18/2022 Resident A was observed having unstable balance, not being able to stay awake, falling asleep, having glassy eyes, laying on the couch becoming unresponsive. The action taken by staff was calling the nurse, staff possibly transporting Resident A to an urgent care, multiple staff attempting to wake Resident A with no success, calling 911 for further medical assistance for Resident A. Action taken to prevent the incident from reoccurring was indicated as "staff will monitor [Resident A] and transport [Resident A] to the hospital if anything changes with [Resident A]."

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on interviews with home manager Cortes, DCW Powell, DCW Granado, reviewing Resident A's Daily Controlled Medication Charts dated 09/21/2022 through 10/20/2022 and East Ave South Incident Report dated 10/18/2022, direct care staff member Whitney Powell gave Resident A an extra dose of her prescribed Ativan medication during the night shift of 10/17/2022 and on 09/29/2022, 10/12/2022 and 10/13/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kevin L. Sellers 12/06/2022

Kevin Sellers Date
Licensing Consultant

Approved By:

Dawn Timm 12/06/2022

Dawn N. Timm Date
Area Manager