GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 31, 2023

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

RE: License #: AS630387842
Investigation #: 2023A0602006
Beacon Home at Dilley

Dear Ms. Howard:

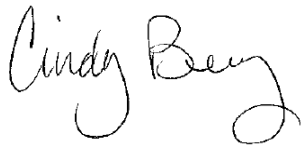
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630387842
Investigation #:	2023A0602006
Complaint Receipt Date:	11/02/2022
Investigation Initiation Date:	11/03/2022
Report Due Date:	01/01/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St., Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Rawlings
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Dilley
Facility Address:	7570 Dilley Road Davisburg, MI 48350
Facility Telephone #:	(248) 382-5648
Original Issuance Date:	08/13/2018
License Status:	REGULAR
Effective Date:	02/13/2021
Expiration Date:	02/12/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Per incident report, on 10/28/2022, Resident A found medications outside that were delivered to the home. Resident A stated he took two pills from the box because dayshift staff would not give him a PRN.	Yes

III. METHODOLOGY

11/02/2022	Special Investigation Intake 2023A0602006
11/03/2022	Special Investigation Initiated - Telephone Call made to the group home.
11/22/2022	Inspection Completed On-site Interviewed home manager, Jordan Eldridge, staff member Zanaria Collins, Resident A, and Resident B.
11/23/2022	Contact – Telephone call made Message left for staff member, Alizhae White-Blackwell.
12/01/2022	Contact – Telephone call made Message left for staff member, Kiyana Harrison.
01/10/2023	Contact – Telephone call made Message left for staff member, Kiyana Harrison.
01/30/2023	Exit Conference Held with the licensee designee, Kimberly Rawlings.

ALLEGATION:

Per incident report, on 10/28/2022, Resident A found medications outside that were delivered to the home. Resident A stated he took two pills from the box because dayshift staff would not give him a PRN.

INVESTIGATION:

On 11/02/2022, a complaint was received and assigned for investigation alleging that on 10/28/2022, Resident A found medications outside that were delivered to the home. Resident A stated he took two pills from the box because dayshift staff would not give him a PRN.

On 11/22/2022, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Jordan Eldridge, staff member Zanaria Collins, Resident A and Resident B. Ms. Eldridge stated she has worked for the company since 2019 but was not on shift at the time the incident occurred. She said there are two companies who deliver supplies to the home, Granger and Gull Pointe Pharmacy. Granger does not require a signature at the time of delivery and will usually leave deliveries on the front porch or in the garage. Gull Pointe Pharmacy requires a signature for deliveries.

Ms. Collins stated she is a direct care worker and has worked in the home since May 2022. On 10/28/2022, she worked the day shift between the hours of 7 am and 7 pm. Later that evening (after her shift) she received a call from staff member, Kiyana Harrison, who was working the second shift (7 pm – 7 am). Ms. Harrison informed her that Resident B gave her some pills and said he found them in the garage. She then asked her if she had signed for any medication deliveries during her shift. Ms. Collins said she did not receive any deliveries during her shift and had no knowledge of any resident having any medication. She advised Ms. Harrison to complete an incident report.

Resident A stated Resident B gave him two boxes of aspirin and said he found them by the fence. Resident A told Resident B he did not want the boxes and gave them back after he took one pack from the box (each pack contained two pills). Resident A said he is prescribed the same medication on an as needed basis every six hours and did not see the harm in taking the pills. Once staff was informed that he took the pills, he was taken to Genesis Urgent Care where he was examined and released. There were no issues found and he was allowed to return to the home.

Resident B stated he found a box that contained two smaller boxes of medication by the back door. He thought they belonged to Resident A but when he asked, Resident A said they did not belong to him. Resident B stated he then gave both boxes to staff member Kiyana Harrison. Resident B denied taking any of the pills and said he had no knowledge if Resident A took any of the pills.

On 11/22/2022, I observed the box of medication that was delivered to the home, retrieved by Resident B and consumed by Resident A. The medication, non-aspirin

Acetaminophen 325 mg, 125 packs of two tablets (250 tablets total). The medication was not prescribed for any specific resident.

On 1/30/2023, I conducted an exit conference with the licensee designee, Kimberly Rawlings by telephone. Ms. Rawlings was informed of the investigative findings and recommendation documented in this report. Ms. Rawlings stated Advantage Pharmacy delivered the non-aspirin medication to the home without notifying staff or requesting a staff signature. The home now uses Gull Pointe for all their pharmacy needs as they require a signature for all medication deliveries. Ms. Rawlings agreed to submit a corrective action plan upon receipt of this report.

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:	Based on the information obtained during the investigation, there is sufficient information to determine that medication was delivered to the home without notifying staff of the delivery. Therefore, the medication was not stored in a locked cabinet or drawer making it easily accessible to the residents. Resident B found the medication outside and gave it to Resident A because he thought it belonged to him. Resident A stated Resident B gave him the medication and he took two pills before it was given to staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

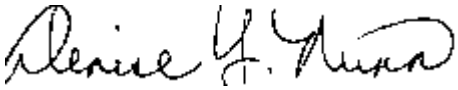
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remain unchanged.

01/30/2023

Cindy Berry Date
Licensing Consultant

Approved By:



01/31/2023

Denise Y. Nunn Date
Area Manager