GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 8, 2023

Ramon Beltran
Galesburg Retirement Home LLC
Suite #110
890 North 10th Street
Kalamazoo, MI 49009

RE: License #: AM390337021
Investigation #: 2023A1024025
Beacon Home at Stagecoach

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 (616) 356-0183.

Sincerely,

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM390337021
Investigation #:	2023A1024025
Complaint Receipt Date:	03/16/2023
Investigation Initiation Date:	03/16/2023
Report Due Date:	05/15/2023
Licensee Name:	Galesburg Retirement Home LLC
Licensee Address:	11218 Miller Dr. Galesburg, MI 49053
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Stagecoach
Facility Address:	11218 Miller Dr. Galesburg, MI 49053
Facility Telephone #:	(269) 200-5174
Original Issuance Date:	01/23/2013
License Status:	REGULAR
Effective Date:	07/23/2021
Expiration Date:	07/22/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his medication inhaler upon his request because direct care staff failed to obtain the new prescription in a timely a manner.	Yes

III. METHODOLOGY

03/16/2023	Special Investigation Intake 2023A1024025
03/16/2023	APS Referral made via email
03/16/2023	Special Investigation Initiated – Letter email sent to Recipient Rights Officer Tasha Stewart regarding allegations
03/16/2023	Contact - Telephone call made with direct care staff member Suzanne Street
03/16/2023	Contact - Document Received Resident A's Incident Report
03/16/2023	Contact - Telephone call made with direct care staff member Sarah Badditt and La'Nay White
04/17/2023	Inspection Completed On-site with direct care staff Amanda Hale, Amanda Wilson and Resident A
04/25/2023	Contact - Face to Face with home manage Melissa Carlson
05/02/2023	Exit Conference with licensee designee Ramon Beltran

ALLEGATION:

Resident A did not receive his medication inhaler upon his request because direct care staff failed to obtain the new prescription in a timely a manner.

INVESTIGATION:

On 3/16/2023, I received this complaint though the Bureau of Community and Health Systems BCHS) online complaint system. This complaint alleged Resident A did not receive his medication inhaler upon his request because direct care staff failed to obtain the new prescription in a timely manner.

On 3/16/2023, I conducted an interview with direct care staff member Suzanne Street whose role is assistant home manager. Ms. Street stated on 3/6/2023 she arrived to work during the morning shift and direct care staff informed her that Resident A requested his Albuterol Sulfate inhaler during the overnight shift on 03/06/2023 however the direct care staff member was not able to give the medication to Resident A because the medication was expired. Ms. Street stated she is responsible for monitoring all resident medications and must request a refill prescription with the physician prior to the medication expiring. Ms. Street stated she did not request a refill for a new prescription for Resident A's inhaler medication accidentally as Resident A does not take this medication often as it is prescribed as an as needed medication. Ms. Street stated it was reported to her that when the direct care staff member was not able to give Resident A his inhaler medication, he became upset and began to demonstrate aggressive behaviors by displaying property destruction and threatening to harm staff with kitchen silverware. Ms. Street stated when she was informed Resident A's inhaler medication was expired, she immediately contacted Resident A's psychiatrist, who was able to write a new prescription the next day on 3/7/2023. Ms. Street Resident A smokes cigarettes often therefore is prescribed to take an inhaler as needed however Resident A rarely requests his inhaler.

On 3/16/2023, I reviewed the facility's *AFC Licensing Division-Accident/Incident Report* dated 3/6/2023 written by La'Nay White. According to this report Resident A came to staff and stated that it was hard for him to breathe and that he would like his PRN inhaler which was found to be out of date and expired. The report stated Resident A then called his family and stated that he was calling Recipient Rights because no one cared that he could not breathe. The report stated Ms. White then explained to Resident A direct care staff was waiting on a new prescription from the doctor at which time Resident A then punched a hole in the wall and walked into the kitchen, grabbed a fork and started to stab the counter/sink area. Resident A then began to walk towards staff with the fork, kicked the fireplace and punched a hole in the dining room wall. The report stated Resident A then called 911 and stated that he needed his inhaler and when EMS arrived at the home, Resident A requested to be taken to the hospital. The report stated Resident A was given an IV and after 2 hours of waiting at the hospital with staff, Resident A requested to leave the hospital to return to the facility without being medically seen or getting his inhaler.

On 3/16/2023, I conducted an interview with direct care staff members Sarah Badditt and La'Nay White. Ms. Badditt stated while working with Resident A on 3/6/2023, he stated he was having breathing issues and requested to have his inhaler medication which is prescribed to be taken as needed. Ms. Badditt stated she was not able to administer this medication as the medication was expired which made Resident A upset and become physically aggressive. Ms. Street stated before she could call Resident A's pharmacist to see about getting a current inhaler, Resident A had already called 911 and requested to be taken to the hospital. Ms. Street stated while at the hospital, Resident A refused to wait to be seen by a physician and left the hospital without receiving inhaler medication or being seen by a physician. Ms. Badditt stated she notified Ms. Street regarding Resident A's expired medication and was informed that the

request for a new prescription for Resident A's inhaler had not yet been requested from his physician and this will be taken care of as soon as possible. Ms. Badditt stated Ms. Street handles all of the medications in the home and ensures that all medications are current and stored in the facility.

Ms. White stated on 3/6/2023, Resident A became upset and violent because he was not able to get his Albuterol Sulfate inhaler as it was expired. Ms. White stated Resident A hardly ever requested his inhaler therefore the assistant manager missed getting this medication refilled by a physician which is a normal task that she does for all resident medications. Ms. White stated although Resident A requested to have his inhaler, he did not appear to be in any distress nor have any issues with breathing. Ms. White stated Resident A erupted very quickly after being informed that his inhaler had expired and called EMS who then transported him to be hospital. Ms. White stated the assistant manager was able to contact Resident A's physician right away when she was notified that the medication had expired and had the inhaler medication delivered by the following day.

On 4/17/2023, I conducted an onsite investigation at the facility with direct care staff members Amanda Hale and Amanda Wilson and Resident A. Ms. Hale stated she was working on 3/6/2023, when she observed Resident A on the phone upset about not being able to take his inhaler because it was expired. Ms. Hale stated she has never heard Resident A request his inhaler in the past although he was prescribed to Albuterol Sulfate to take as needed. Ms. Hale further stated usually the managers in the home ensure that all resident medications are current and request for prescription refills as needed.

Ms. Wilson stated on 3/6/2023 she was the on-call manager on shift and was informed that Resident A was demonstrating violent behaviors because he was not able to receive his inhaler medication due to this medication being expired. Ms. Wilson stated she contacted the on-call nurse Kaitlynn Taylor, who contacted Resident A's physician, Dr. Elami who had the medication refilled on 3/7/2023. Ms. Wilson stated she believe Ms. Street also contacted Dr. Elami and the pharmacist to request for Resident A to have his inhaler medication refilled. Ms. Wilson stated the inhaler medication was delivered by the pharmacy on 3/7/2023.

Resident A stated on 3/6/2023 he requested his inhaler because he was having issues with breathing and staff informed him that his medication prescription had expired, and they would have to talk to the home manager to get a new prescription filled. Resident A stated he gets anxiety and wanted his inhaler to help him calm down. Resident A stated he believes he did not get his inhaler until weeks later after his request on 3/6/2023.

While at the facility I reviewed Resident A's Medication Administration Record (MAR) for the months of January 2023, February 2023 and March 2023. According to these MARs, Resident A was to be given Pro-Air Inhaler 108 mcg/1ACT IH, to be inhaled by mouth every six hours as needed for wheezing or cough.

I also reviewed Resident A's physician prescription for Albuterol Sulfate 90 mcg/actuation inhaler with a start date of 3/18/2022. The direction states the medication should be inhaled 2 puffs into the lungs every six hours as needed for wheezing or cough.

I also reviewed Resident A's physician script with a start date of 3/6/2023 for medication Ventolin HFA to be sprayed 2 pumps into the lungs as needed for wheezing or coughing and this prescription can be refilled six times.

I also reviewed the facility's delivery log dated 3/7/2023 which states Resident A's medication Ventolin HFA 108 mcg spray was filled and delivered on 3/7/2023 and signed by direct care staff member La'Nay White.

On 4/25/2023, I conducted an interview with direct care staff member whose role is home manager Melissa Carlson. Ms. Carlson stated she was made aware by Ms. Street that when Resident A had an expired inhaler medication that was not able to be given to Resident A upon his request. Ms. Carlson stated Ms. Street was responsible for making sure medications are current and refiled in the timely manner, therefore this was an oversight, and this mistake usually does not occur. Ms. Carlson stated she is also going to start assisting Ms. Street in making sure all resident medications are readily available for residents.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Suzanne Street, La'Nay White, Sarah Badditt, Melissa Carlson, Amanda Hale, and Amanda Wilson, Resident A, and my review of Resident A's MAR, incident report, physician prescription, and pharmacy delivery log, Resident A did not receive his medication inhaler upon his request because the prescription had expired and a new one had to be ordered. All staff members interviewed stated Ms. Street did not assure Resident A's Albuterol Sulfate 90 mcg/actuation inhaler prescription was refilled by Resident A's physician before the current medication expired therefore Resident A was not given his inhaler medication upon his request on 3/6/2023. The facility's incident report also stated staff was not able to give Resident A his inhaler medication upon his request due to the medication being expired which resulted in Resident A calling 911 and requesting to go to the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/2/2023, I conducted an exit conference with licensee designee Ramon Beltran. I informed Mr. Beltran of my findings and allowed him an opportunity to ask questions or make comments.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the current license status remain unchanged.

Ondrea Johnson

5/8/2023

Ondrea Johnson
Licensing Consultant

Date

Approved By:

Dawn Timm

05/08/2023

Dawn N. Timm
Area Manager

Date