GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 23, 2023

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

RE: License #: AS250395771
Investigation #: 2023A0569054
Beacon Home at Linden

Dear Kimberly Rawlings:

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) 643-7960.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250395771
Investigation #:	2023A0569054
Complaint Receipt Date:	06/30/2023
Investigation Initiation Date:	06/30/2023
Report Due Date:	08/29/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Rawlings
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Linden
Facility Address:	14180 N. Hogan Road Linden, MI 48451
Facility Telephone #:	(248) 286-6900
Original Issuance Date:	10/09/2018
License Status:	REGULAR
Effective Date:	04/09/2023
Expiration Date:	04/08/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was left, unattended by staff in the emergency room on 6/24/23.	Yes
Resident A ingested another resident's medication on 7/15/23.	Yes

III. METHODOLOGY

06/30/2023	Special Investigation Intake 2023A0569054
06/30/2023	Special Investigation Initiated - Telephone Contact with Kim Nguyen-Forbes, RRO.
06/30/2023	APS Referral Complaint received from APS.
08/08/2023	Contact - Telephone call made Contact with Cynthia Badour, APS worker.
08/08/2023	Contact - Telephone call made Attempted contact with Destiny Wiley, staff person.
08/21/2023	Contact - Telephone call made Contact with Kim Nguyen-Forbes, RRO.
08/22/2023	Inspection Completed On-site
08/22/2023	Contact - Telephone call made Contact with Katherine Blackburn, former home manager.
08/22/2023	Contact - Face to Face Contact with Marcus McKee, GHS psychologist.
08/22/2023	Inspection Completed-BCAL Sub. Compliance
08/22/2023	Exit Conference Exit conference with Melissa Williams, executive vice president of operations.

ALLEGATION:

Resident A was left, unattended by staff in the emergency room on 6/24/23.

INVESTIGATION:

This complaint was received from the adult protective services central intake department. The complainant reported that Resident A was taken to the emergency room on 6/24/23 for psychiatric treatment. The complainant reported that Resident A was being supervised by Destiny Wiley, staff person. The complainant reported that Destiny Wiley then left Resident A, unattended, in the emergency room at 9:00pm and did not return until midnight.

Kim Nguyen-Forbes, recipient rights officer, stated on 8/21/23 that she investigated this complaint. Kim Nguyen-Forbes stated that Resident A was taken to the emergency room by Destiny Wiley on 6/24/23 and was supposed to continue supervising Resident A until relieved by another staff person. Kim Nguyen-Forbes stated that Resident A's plan of service requires that Resident A be supervised by staff while in the community. Kim Nguyen-Forbes stated that Destiny Wiley then left Resident A at the emergency room when a relief staff did not come to the emergency room. Kim Nguyen-Forbes stated that Destiny Wiley then returned to the emergency room around midnight, leaving Resident A unsupervised for three hours. Kim Nguyen-Forbes stated that she is citing a recipient rights violation for improper supervision of Resident A.

An unannounced inspection of this facility was conducted on 8/22/23. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A stated that he was taken to the hospital "a few weeks ago" but did not recall the staff person that went with him. Resident A stated that he had to wait in the emergency room for "a long time" and fell asleep. Resident A stated that he did not know if the staff person left him or not. Resident A stated that a staff person was present when he woke up and was released from the hospital. Resident A's plan of service was reviewed. Resident A's plan of service documents that staff are to maintain a "line of sight" level of supervision when Resident A is in the community, and the only exception is when a physician or medical staff release the staff person from supervision while treating Resident A for privacy issues.

Katherine Blackburn, former facility manager, stated on 8/22/23 that Resident A was sent to the emergency room on 6/24/23 for psychiatric treatment. Katherine Blackburn stated that a staff person must supervise Resident A when ever he leaves the facility, so Destiny Wiley was sent with Resident A to the hospital. Katherine Blackburn stated that Destiny Wiley called Katherine Blackburn at around 7:30pm and stated that the staff person who was supposed to relieve her at the hospital had not arrived, and that it was then end of Destiny Wiley's shift. Katherine Blackburn stated that she told Destiny Wiley that she would call other staff to get someone to relieve her, but that she needed to stay with Resident A until Katherine Blackburn could get another staff person to cover for the

absent staff person. Katherine Blackburn stated that she called Destiny Wiley back just before 9:00pm on 6/24/23 to update Destiny on when another staff person could relieve her, and Destiny reported that she had already left the hospital and was going home to take a shower. Katherine Blackburn stated that she told Destiny that she needed to return to the emergency room because Resident A could not be left unsupervised, but Destiny Wiley did not return to the hospital until 12:00am on 6/25/23. Katherine Blackburn stated that Destiney Wiley was then terminated from employment the following day for leaving Resident A unsupervised at the emergency room.

Several attempts were made to contact Destiny Wiley for a statement. Destiny Wiley has not returned the phone calls to give a statement.

Marcus McKee, Genesee Health System psychologist, stated on 8/22/23 that a staff person did go with Resident A to the hospital on 6/24/23 due to Resident A having a psychotic episode. Marcus McKee stated that the staff person did leave Resident A unsupervised for about three hours from 9:00pm to 12:00am on 6/25/23 because a relief staff did not come to the emergency room.

Melissa Williams, executive vice president for operations, stated on 8/22/23 that she is aware of this incident. Melissa Williams stated that Destiny Wiley and other staff have been terminated for poor performance and other issues. Melissa Williams stated that new staff are being hired and current staff retrained to address some of the supervision issues within this facility.

This is a repeat violation of R 400.14303 (2) for the following three Special Investigation Reports (SIRs). SIR #2022A0569003 dated 12/13/21 documents that Residents from this facility were allowed by staff to enter a store without staff supervising the residents as required by the residents' plans of service. The CAP was approved on 12/14/21 and documented that the staff involved were terminated and the remaining staff were re-trained regarding the residents' plans of service. This incident did not include Resident A or Destiny Wiley. SIR #2022A0569036 dated 7/20/22 documents that three residents were allowed by staff to go to a mall, unsupervised when their plans of service required staff supervision in the community. The CAP is dated 8/15/22 and documented that the staff who allowed the residents to be unsupervised received disciplinary action and were retrained regarding the residents' plans of service. Destiny Wiley was not one of the staff included in the report. SIR #2022A0569059 dated 11/7/22 documents that Resident A returned from a visit with marijuana and smoked it in his bedroom. Resident A's plan of service documents that staff are to search Resident A for any drugs or alcohol when he returns from a visit with his family, and Resident A was not searched by staff. The CAP was approved on 2/9/23 and documented that all staff were re-trained regarding all of the residents' plans of service and new binders were being used to make the plans of service easily accessible to all of the staff for frequent review. This violation did not include Destiny Wiley.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A's plan of service documents that staff must maintain a "line of sight" level of supervision when Resident A is in the community. Resident A was taken to the emergency room on 6/24/23 under the supervision of Destiny Wiley, staff person. Katherine Blackburn and Marcus McKee stated that Destiny Wiley left Resident A at the emergency room unsupervised for a period of three hours when a relief staff person did not come to the emergency room. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR#2022A0569003 dated 12/13/21, CAP approved 12/14/21.** **SIR#2022A0569036 dated 7/20/22, CAP approved 8/16/22.** **SIR#2022A0569059 dated 11/7/22, CAP approved 2/9/23**

ALLEGATION:

Resident A ingested another resident's medication on 7/15/23.

INVESTIGATION:

The complainant reported that several resident medications were delivered to this facility on 7/15/23 via Fed-Ex. The complainant reported that Resident A was able to sign for the medications, and then took the box to his room. The Complainant reported that Resident A then crushed several Trazadone pills that were prescribed to another resident and ingested them by "snorting" the pills.

Cynthia Badour, APS worker, stated on 8/8/23 that she investigated this complaint. Cynthia Badour stated that Resident A admitted that he did get the medication and did crush some pills and snorted them. Cynthia Badour stated that she is substantiating neglect of Resident A by staff.

Katherine Blackburn stated on 8/22/23 that Resident A did get the medications, and crushed four Trazadone pills, then snorted them. Katherine Blackburn stated that the pharmacy that was used, would contract with Fed-Ex to deliver the medications, and several times previous to this incident the delivery driver would simply leave the box of

medications on the front porch with no notification. Katherine Blackburn stated that there were several times when staff would be leaving or arriving at the facility and there was a box of medications just sitting on the porch. Katherine Blackburn stated that Fed-Ex drivers do not require anyone to sign for a package, so Resident A may have received the delivery, or just found it when he went out onto the porch to smoke a cigarette. Katherine Blackburn stated that Resident A does not receive an elevated level of supervision while at the facility, and frequently goes out onto the front porch to smoke. Katherine Blackburn stated that she did order a refill of several medications on 7/12/23 but was never informed when they would be delivered. Katherine Blackburn stated that the box was then delivered on 7/15/23 and Resident A got the box, then took it to his bedroom and ingested the Trazadone pills. Katherine Blackburn stated that she found the box in Resident A's bedroom shortly after Resident A had taken it into his room, and immediately took him to the hospital for treatment. Katherine Blackburn stated that Resident A was not injured from ingesting the medication. Katherine Blackburn stated that she then called the pharmacy to inform them of what had happened, and that the delivery of medications could not just be left on the front porch.

Marcus McKee, psychologist, stated on 8/22/23 that Resident A did get the medication and crushed four pills of Trazadone prescribed for another resident. Marcus McKee stated that this was reported, and the pills were replaced by the pharmacy so that the other resident did not miss any doses of his medication. Marcus McKee stated that Resident A was not physically injured from this incident.

Resident A stated on 8/22/23 that he went out onto the porch to smoke a cigarette. Resident A stated that a Fed-Ex truck pulled not the driveway, and the driver brought a box to the front porch. Resident A stated that the driver didn't say anything or have him sign anything. Resident A stated that he opened the box and saw the medications. Resident A stated that he "wanted to get high" so he took the box to his room. Resident A stated that he opened the bottle of Trazadone and "crushed some pills" then "snorted the dust" to "get high". Resident A stated that Katherine Blackburn then went into his bedroom and found the box and took him to the hospital. Resident A stated that he was not injured and did not get sick.

Melissa Williams stated on 8/22/23 that she is aware of this issue. Melissa Williams stated that she has already contacted the pharmacy to inform them of the situation, and that the method of delivery has to change. Melissa Williams stated that she has informed the pharmacy that vulnerable adults live in the facility, and that a staff person with identification must sign for the medications when delivered.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Resident A stated that he took a box of medications that was delivered to the front porch of the facility on 7/15/23 to his room because he wanted to “get high”. Resident A then crushed four Trazadone pills prescribed to another resident and “snorted” the pills. Katherine Blackburn stated that the pharmacy that was used by this facility would contract with Fed-Ex to deliver the medication and that the delivery driver never had anyone sign for the package. Katherine Blackburn stated that a box of medications had been simply left on the porch by the driver several times prior to this incident but had always been recovered by staff. Because the medications had been left on the porch prior to this incident, it is determined that reasonable precautions were not taken to ensure that the medications were delivered to staff and not just left on the porch. Based on the statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted on 8/22/23 with Melissa Williams, executive vice president of operations. The findings in this report were reviewed.

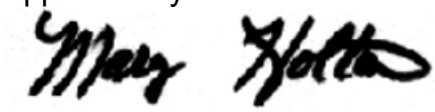
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

8/22/23

Kent W Gieselman — Date
Licensing Consultant

Approved By:



8/23/23

Mary E. Holton — Date
Area Manager