GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 13, 2024

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

RE: License #: AS390396198
Investigation #: 2025A0581006
Beacon Home At Augusta

Dear Nichole VanNiman:

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390396198
Investigation #:	2025A0581006
Complaint Receipt Date:	10/21/2024
Investigation Initiation Date:	10/22/2024
Report Due Date:	12/20/2024
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:	Nichole VanNiman
Name of Facility:	Beacon Home At Augusta
Facility Address:	817 Webster St. Augusta, MI 49012
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/29/2018
License Status:	REGULAR
Effective Date:	04/03/2023
Expiration Date:	04/02/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
Resident A had a medication change; however, the facility's home manager, Kelly Fox, did not update Resident A's Medication Administration Record to reflect the changes.	Yes
The facility's home manager, Kelly Fox, gave Resident A the wrong medication, despite receiving updated medication orders from Resident A's psychiatrist.	Yes

III. METHODOLOGY

10/21/2024	Special Investigation Intake 2025A0581006
10/22/2024	Special Investigation Initiated – Telephone - Interview with Suzy Suchyta, Integrated Services of Kalamazoo (ISK), Recipient Rights Officer (RRO)
10/22/2024	APS Referral - Confirmed Adult Protective Services (APS) is investigating.
10/23/2024	Contact - Telephone call received - Interviewed direct care staff via MiTeams.
11/12/2024	Inspection Completed On-site - Observed Resident A.
12/10/2024	Contact - Document Sent - Email to Lauren Crock, Kalamazoo Adult Protective Services (APS) specialist
12/10/2024	Contact - Document Sent - Email to Suzie Suchyta, RRO
12/10/2024	Inspection Completed-BCAL Sub. Compliance
12/11/2024	Exit conference with licensee designee, Nichole VanNiman. Left message. Contact with Administrator, Aubry Napier.

ALLEGATION:

- **Resident A had a medication change; however, the facility's home manager, Kelly Fox, did not update Resident A's Medication Administration Record to reflect the changes.**

- **The facility's home manager, Kelly Fox, gave Resident A the wrong medication, despite receiving updated medication orders from Resident A's psychiatrist.**

INVESTIGATION: On 10/21/2024, I received this complaint through the Bureau of Community Health System (BCHS) online complaint system. The complaint alleged Resident A had a medication review appointment with his psychiatrist on or around 10/11/2024 at 11 am. It was determined by the psychiatrist during the appointment Resident A needed multiple medications reduced because Resident A was overly sedated. Resident A was observed struggling to stay awake, unable to answer questions and was drooling excessively.

The complaint alleged the facility's identified home manager, Kelly Fox, did not update Resident A's Medication Administration Record (MAR) or change any of his medications to reflect the new physician's order until 10/15/2014 or 10/16/2024. The complaint alleged Kelly Fox reported the medication change did not occur because she "…didn't want to bury one of [her] staff because [Resident A] kills them." Consequently, the complaint alleged Resident A was overdosed for 4-5 days and was at a risk of physical harm, which included falling and choking due to being overly sedated.

On 10/22/2024, I received additional information relating to the complaint, which documented Resident A is diagnosed with an "intellectual disability, Autism, separation anxiety and intermittent explosive disorder." The additional information documented Resident A walks independently; however, due to his extreme sedation at his 10/11/2024 medication review his medication was reduced by his psychiatrist. The additional information documented it was the licensee's policy for all medication changes to occur within 24 hours; however, the home manager, Kelly Fox, took it upon herself to continue overmedicating Resident A for an additional five days, which was against Resident A's psychiatrist's recommendation. The additional information documented Kelly Fox did not want her staff overwhelmed over the weekend with Resident A.

On 10/22/2024, I contacted Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Suzie Suchyta, via telephone. Suzie Suchyta stated she received the same allegations and was investigating. She confirmed an Adult Protective Services (APS) referral was completed and APS specialist, Lauren Crock, was investigating, as well. Suzie Suchyta's statement was consistent with the allegations. She stated she reviewed notes relating to the new medication orders in the electronic note system, NextStep, which ISK shares with the licensee, confirming the allegations.

Additionally, Suzie Suchyta identified Resident A's psychiatrist, Jennifer Richardson, as the physician who made Resident A's medication changes on 10/11/2024.

On 10/22/2024, I reviewed several ISK documents relating to Resident A provided by Suzie Suchyta. Integrated Services of Kalamazoo's "Psychiatric E&M Note", dated 10/11/2024, documented Resident A's visit started at approximately 11:30 am, ended at approximately 12 pm and identified those in attendance of the meeting as Jennifer Richardson PA-C, Resident A, two facility staff, Relative A1, and home manager, Kelly Fox, who attended by listening via telephone. The note established Resident A was experiencing side effects from his medications such as drooling, severe sedation, increased sleepiness, and severely decreased agitation with no reports of physical aggression. The note determined Resident A's medications would be continued; however, they would be decreased. The note documented the following medication changes:

- Decrease Klonopin 0.5 mg from three times a day to twice a day due to sedation and challenges with breathing and sleep apnea
- Decrease Clozaril from 50 mg twice daily to one tab in the morning and two tabs at night – meds to be taken twice daily
- Decrease Propranolol from 50 mg 3 times daily to 40 mg 3 times daily in the hopes of lessening sedation, helping with unsteady gait to alertness

The note documented inconsistency with Resident A's Clozaril medication as it was also documented in the note that Resident A was prescribed Clozaril 25 mg tablet with the instruction to take 1 tablet by mouth three time a day with further instruction to decrease to one tab in the AM and two tabs during hours of sleep.

The note documented the information was provided to the facility's staff and was faxed to Gull Point pharmacy. Additionally, the note also documented Resident A had 89 days left of his Clozaril medication, 116 days left of his Klonopin medication and 116 days left of his Propranolol medication.

I reviewed Resident A's October 2024 electronic Medication Administration Record (eMAR), which documented Resident A received the following medications on 10/11, 10/12, 10/13, and 10/14 after his medication review appointment until the new and updated orders prescribed at his 10/11 medication review were implemented on the evening of 10/15/2024:

- Clozaril 25 mg with the instruction of take 2 tablets by mouth twice a day (9 am and 8 pm)
- Klonopin 0.5 mg with the instruction of take 1 tablet by mouth every morning
- Klonopin 0.5 mg with the instruction of take 2 tablets by mouth at bedtime
- Propranolol 10 mg with the instruction of take 1 tablet by mouth three times a day (9am, 3 pm and 8 pm) Notes: Take one tablet by mouth three times daily (take along with a 40 mg tablet to total 50 mg)

I also reviewed a NextStep nurse note, dated 10/13/2024 completed by Kelly Fox. The nurse note documented the same medication changes as identified in Resident A's Psychiatric E&M Note.

On 10/22/2024, I was contacted by APS specialist, Lauren Crock, via text. She confirmed she was visiting Resident A at the facility with law enforcement. She texted after her visit with Resident A documenting Resident A was sleepy, would only look at her and would not talk.

On 10/23/2024, in conjunction with ISK RRO, Suzie Suchyta, and APS specialist, Lauren Crock, we conducted MiTeams interviews with direct care staff, Alezhah Newell and Ashley Gibson, and the facility's home manager, Kelly Fox. Both Alezhah Newell and Ashley Gibson stated Resident A had been more tired and drowsy over the last month due to medication changes. Alezhah Newell stated home manager, Kelly Fox, was in charge of making any medication changes for residents. Neither Alzhah Newell nor Ashley Gibson had any concerns Resident A was not receiving his medications as prescribed or that staff were over medicating him. They both stated they administer Resident A's medications per Resident A's MAR instructions.

Ashley Gibson stated she transported Resident A to his medication review appointment on 10/11/2024. She stated Resident A's symptoms of lethargy were discussed with his psychiatrist who was concerned Resident A's Clozaril medication needed to be decreased. Ashley Gibson stated Resident A's psychiatrist also lowered Resident A's Klonopin medication from two pills at night to one pill. Ashley Gibson stated a physician contact sheet was not completed from the medication review appointment because she forgot to bring a contact sheet; however, she stated Kelly Fox faxed a contact sheet over to the medication clinic to complete and send back. Ashley Gibson stated she did obtain a print off of the medication changes, which she gave to Kelly Fox. Ashley Gibson stated she recalled the medication changes would start that Monday and recalled it being at the instruction of Resident A's psychiatrist.

Kelly Fox's statement was consistent with the allegations. She stated Resident A went to the ISK medication clinic on 10/11/2024. She stated she received his updated medication changes from Resident A's guardian, Guardian A1, upon Resident A's return to the facility and staff returned with his updated medication list. Kelly Fox stated Resident A received a change to three of his medications, including Clozaril, Klonopin, and Propranolol. She stated she had enough medication in the facility to implement the changes for all three of Resident A's medication changes; however, she stated she needed a new label for the Klonopin prescription. Kelly Fox stated the medication changes were made around 12 pm; however, she received an email from Gull Pointe Pharmacy later in the day documenting the pharmacy staff needed clarification from Resident A's psychiatrist regarding the Clozaril changes, which she received on Monday. Kelly Fox stated due to Resident A's behavior changing she wanted to have all three new prescriptions in the facility prior to

implementing any changes in Resident A's medications. She stated she waited until Monday before implementing these changes because that is when she received clarification on Resident A's Clozaril. Kelly Fox stated she wanted to make the changes to Resident A's medication "all at once."

On 10/23/2024, Kelly Fox forwarded emails between herself and the licensee's other management staff, as well as Chris Rousch from Gull Pointe Pharmacy. According to my review of these emails, Kelly Fox informed Chris Rousch on 10/11/2024 at 4:52 pm Resident A had a medication review that day, that there were several medication changes, and she requested updated prescriptions and medications. Chris Rousch emailed Kelly Fox back at 4:55 pm and documented he contacted the Resident A's physician because she put two sets of instructions on the Clozaril prescription. Chris Rousch responded to Kelly Fox on 10/14/2024 at 12 pm documenting he spoke to Resident A's physician and the change would be sent to the facility that day.

Kelly Fox also forwarded a picture of the updated prescription orders from Resident A's medication review for Clozaril, Klonopin, and Propranolol, which was dated 10/11/2024. These prescriptions were consistent with the information provided in the Psychiatric E&M Note, dated 10/11/2024.

On 10/29/2024, Suzie Suchyta emailed me a copy of the licensee's "Prescription Policy", dated 10/16/2023, which documents the facility's home manager "shall make every effort to have the prescription filled and available the same, but within no more than twenty-four(24) hours from the date/time the prescription was written".

On 11/12/2204, I conducted an unannounced inspection at the facility. I attempted to interview Resident A; however, he would not engage with me or answer any of my questions. Resident A was awake and alert during my inspection. He appeared well cared for and content.

On 12/10/2024, I emailed APS specialist, Lauren Crock. She documented in her email to me she substantiated her complaint for neglect. Lauren Crock included her closing summary report, which documented home manager, Kelly Fox, did not implement Resident A's medication changes according to Beacon's Prescription Policy claiming she could not make the changes without a new prescription from the pharmacy; despite having physician's orders to do so.

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 a review of Resident A's October 2024 electronic Medication Administration Record (eMAR), the licensee's NextStep notes, dated 10/13/2024, Integrated Services of Kalamazoo's "Psychiatric E&M Note", dated 10/11/2024, emails from the facility's home manager, Kelly Fox, the licensee's Prescription Policy, and interviews with home manager, Kelly Fox, and direct care staff, Alezhah Newell and Ashley Gibson, there is substantial supporting evidence Resident A's psychiatrist, Jennifer Richardson, changed Resident A's Clozaril, Klonopin, and Propranolol dosages and/or instructions after his medication review on 10/11/2024; however, the facility's home manager did not update Resident A's MAR or instruct staff to administer the medications with the new dosages and/or instructions, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**

ANALYSIS:	On 10/11/2024, the facility's home manager, Kelly Fox, was aware of the changes in Resident A's medications to decrease the dosages and alter the instructions after concerns in Resident A's demeanor and behavior from his medication review that day. Despite Resident A's psychiatrist recommending a decrease in Resident A's Clozaril, Klonopin, and Propranolol dosages and/or instructions, the home manager, Kelly Fox, continued following the previous medication dosages and/or instructions. Consequently, Resident A continued receiving higher dosages of medications that continued causing significant sedation, excessive drooling, and increased sleepiness until approximately 10/15/2024 when Kelly Fox implemented the updated medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/11/2024, I attempted to conduct the exit conference with the licensee designee, Nichole VanNiman, via telephone; however, I was unable to reach her. I contacted the facility's Administrator, Aubry Napier, and explained my findings. She stated once the report was reviewed, she and the licensee designee would determine an appropriate plan of correction.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman

12/11/2024

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Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm

12/13/2024

_____

Dawn N. Timm Date
Area Manager