GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 22, 2025

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

RE: License #: AM030402102
Investigation #: 2025A0340011
Beacon Home at Bridge Street

Dear Ms. 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 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,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030402102
Investigation #:	2025A0340011
Complaint Receipt Date:	12/06/2024
Investigation Initiation Date:	12/09/2024
Report Due Date:	02/04/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Bridge Street
Facility Address:	691 West Bridge Street Plainwell, MI 49080
Facility Telephone #:	(269) 204-6493
Original Issuance Date:	07/16/2020
License Status:	REGULAR
Effective Date:	01/16/2025
Expiration Date:	01/15/2027
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was given Resident B's medication by mistake.	Yes

III. METHODOLOGY

12/06/2024	Special Investigation Intake 2025A0340011
12/09/2024	APS Referral
12/09/2024	Special Investigation Initiated - Telephone Suzy Hunter-Beacon Designee
01/07/2025	Inspection Completed On-site
01/21/2025	Contact – Telephone Call Made Staff Keyaria Johnson
01/21/2025	Exit Conference Nicole VanNiman Designee

ALLEGATION: Resident A was given Resident B's medication by mistake.

INVESTIGATION: On December 6, 2024, a complaint was filed with BCHS online complaints. It stated that staff KeyArlya administered the wrong medication to Resident A. He was given medication prescribed to Resident B.

On December 9, 2024, I reported the allegations to Adult Protective Services which they had already been made aware.

On December 9, 2024, I contacted Suzy Hunter, whom is the Designee for this Consultant's Beacon Home. She advised me that Nicole VanNiman is the Designee for Bridge St. Home and Kaitlyn Taylor is administrator. I emailed back to Ms. Taylor and Ms. VanNiman but did not hear back from either one.

On January 7, 2025, I conducted an unannounced home inspection. Ms. Taylor was present during my inspection. She confirmed that Resident A was given Resident B's medication by Ms. Johnson and Ms. Johnson was written-up and given a corrective action for the error and was retrained in medication administration. Ms. Taylor provided me with Ms. Johnson's contact information.

Ms. Taylor showed me the Medication Administration Record (MAR) and the medications which were given in error. The medications given to Resident A in error were the following:

- Glycopyrrolate 1 mg
- Meloxicam 15 mg
- Naltrexone 50 mg

Ms. Taylor also showed me the Incident Report (IR) regarding the error. The IR was completed by Ms. Johnson on 11/25/2024 and stated that she had passed medication to Resident A that was prescribed for Resident B. The IR further stated that Resident B was asking her questions not related to medication and she grabbed Resident B's morning medication and gave it to Resident A, instead of Resident A's evening medications. She immediately realized the mistake she had made and called poison control, as well as management. Resident A was monitored the rest of the evening.

I was able to interview Resident A during my inspection. He did not have any knowledge of the medication error. Resident A did not know what medications he takes or what they look like. Resident stated he is happy that someone else takes care of him and gives him his medications.

On January 21, 2024, I interviewed Keyaria Johnson. I informed her of the reason for my call. She acknowledged that she had gotten distracted and gave Resident A the morning medications that are prescribed for Resident B instead of Resident A's evening medications. She stated that she passed Resident B his evening medications and saw Resident A in the kitchen. She called to him and asked if he was ready to take his medications. Resident B remained in the "med room" talking to her. Ms. Johnson stated she must have been thinking of Resident B and grabbed his morning medication and gave it to Resident A. Ms. Johnson acknowledged that she did not follow the established medication passing protocol. More specifically, she did not check the name on the medication nor the label with the MAR for Resident A. She said she called 911 for poison control and was instructed by poison control to give Resident A his normal medications except his Amantadine, which she did. She monitored Resident A for the rest of her shift and there were no further issues. I asked Ms. Johnson if other staff were made aware of the error so that they could also monitor Resident A and she stated that they were. She also worked the following shift as well, so she was able to continue monitoring him until morning.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The allegation states that Resident A was given the incorrect medications. Ms. Johnson gave him Resident B's medication instead.

	The IR confirms that the mistake was made by Ms. Johnson and poison control was called. Ms. Johnson acknowledged making the mistake of giving Resident A Resident B's medications. A rule violation is found due to the medication error.
CONCLUSION:	**VIOLATION ESTABLISHED**

On January 21, 2025, I conducted an exit conference with Designee Nicole VanNiman. She was aware of the medication error and stated Ms. Johnson has already been retrained. I requested a Corrective Action Plan which Ms. VanNiman understood and had no further questions.

IV. RECOMMENDATION:

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the current license status.

Rebecca Piccard January 22, 2025

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Rebecca Piccard Date
Licensing Consultant

Approved By:

January 22, 2025

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Jerry Hendrick Date
Area Manager