GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 17, 2024

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

RE: License #: AS630393369
Investigation #: 2024A0465023
Beacon Home at Clarkston

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 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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630393369
Investigation #:	2024A0465023
Complaint Receipt Date:	05/23/2024
Investigation Initiation Date:	05/28/2024
Report Due Date:	07/22/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Clarkston
Facility Address:	10358 Horseshoe Circle Clarkston, MI 48348
Facility Telephone #:	(248) 922-7413
Original Issuance Date:	10/16/2018
License Status:	REGULAR
Effective Date:	11/24/2023
Expiration Date:	11/23/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
In April 2024, staff administered expired medication to Resident A.	Yes

III. METHODOLOGY

05/23/2024	Special Investigation Intake 2024A0465023
05/28/2024	Special Investigation Initiated - Letter I spoke to Complainant via email
05/31/2024	Inspection Completed On-site I attempted to conduct an onsite investigation, however, no one was home
06/03/2024	Contact - Document Received I spoke to ORR Officer, Sarah Rupkus, via email exchange
06/05/2024	Contact - Document Sent Email exchange with ORR Officer, Sarah Rupkus
06/12/2024	Inspection Completed On-site I completed a walk-through of the facility, reviewed resident files, observed residents, interviewed Resident A, Resident B, Resident C, Resident D, and staff, Andrea Lapp
06/24/2024	Contact – Telephone call made I spoke to Guardian A1 via telephone
06/27/2024	Contact - Document Received Email exchange with Ms. Rupkus
07/14/2024	Exit Conference I conducted an exit conference with Licensee Designee, Nichole VanNiman, via telephone

ALLEGATION:

In April 2024, staff administered expired medication to Resident A.

INVESTIGATION:

On 5/23/2024, a complaint was received, alleging that during the month of April 2024, direct care staff administered expired medication to Resident A. The complaint stated that direct care staff, Tamerah Stokes, Janiya Towner, Brittany Rogers, and Sierra McNeil administered two expired medications, Lantus Insulin and Humalog Insulin, to Resident A between the dates of 4/22/2024 – 4/30/2024.

On 5/28/2024, I spoke to Complainant via email exchange. Complainant confirmed the information contained in the complaint is accurate.

On 6/3/2024, 6/5/2024 and 6/27/2024, I spoke to Office of Recipient Rights Officer, Sarah Rupkus, via email exchange. Ms. Rupkus stated that she has completed an investigation of this complaint. Ms. Rupkus stated that she did substantiate a rights violation against the facility for administration of expired medication to Resident A. Ms. Rupkus stated that her investigation is now closed.

On 6/12/2024, I conducted an onsite investigation. I completed a walk-through of the facility, reviewed resident files, observed residents, interviewed Resident A, Resident B, Resident C, Resident D, and direct care staff, Andrea Lapp.

I reviewed Resident A's file. The *Face Sheet* stated that she moved into the facility on 12/7/2021 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Depressive Disorder. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, independently completes self-care tasks and does not require use of assistive devices. The *Medication Administration Record* (MAR) for the month of April documented that Resident A was prescribed Humalog KwikPen Insulin 100 unit/ml to be injected once daily and Lantus Solostar U-100 Insulin to be injected every night at bedtime. The MAR documented that staff did administer Humalog and Lantus to Resident A the entire month of April 2024. The *Incident/Accident Report*, dated 4/30/2024, stated the following:

4/30/2024 at 1:00am; Completed by Andrea Lapp: On 4/30/2024, it was discovered that Lantus and Humalog insulin were being administered to Resident A although both opened insulin pens had ben expired for eight days (Humalog and seven days (Lantus). The pens expire after 28 days of being opened. The expiration dates on the packaging for both pens was incorrect – for the Humalog, the opened date was noted as 3/25/2024 (expiration date was 4/25/2024) and the Lantus was noted as 3/26/2024 (expiration date was 4/26/2024). The actual expiration date for Humalog would have been 4/22/2024 and for the Lantus, it should have been 4/23/2024. The expired insulin pens were immediately disposed of. New pens were opened and correctly labeled with the opened dates and expiration dates (28 days after the opened date). Recipient Rights contacted. The home manager (Quayanna Norris) was educated on proper insulin protocol and procedure. Home manager was instructed to educate the staff members on proper

insulin protocol and procedure. Follow-up was done with the home nurse to ensure no harm was caused to Resident A. Senior vice president was contacted.

I interviewed direct care staff, Andrea Lapp, who stated that she has worked at the facility for eight months. Ms. Lapp stated, "This complaint is true. Direct care staff did administer two expired insulin medications to Resident A from 4/22/2024 – 4/30/2024. Our protocol is to write down the date we open the insulin pens, and to date them for 28 days out from the open date, as this is what defines the expiration date. However, staff did not properly date the expiration date and so staff continued to use the medication thinking it was not expired. I was working on 4/30/2024, and while I was completing a medication review, I found this error. I immediately discarded the expired medications and replaced them with new insulin pens. I also notified management and completed an incident report. Since this incident, we have been focused on refresher medication training to ensure this does not happen again. We consulted with our medical nurse and there was no harm or medical care needed for Resident A related to this incident. The staff involved were reprimanded. Ms. McNeal. Ms. Rogers and Ms. Stokes are no longer employed by the facility. Ms. Towner was given a written reprimand and refresher training. We have taken all appropriate steps to rectify this issue." Ms. Lapp acknowledged this allegation is true.

I interviewed Resident A, who stated that she likes living at the facility. Resident A stated, "I like it here. Staff do a good job at helping me and giving me my medication." Resident A did not vocalize any concerns related to this complaint.

On 6/24/2024, I spoke to Guardian A1 via telephone. Guardian A1 stated, "I do not have any concerns related to the staff's administration of Resident A's medication. I do have concerns that some of Resident A's medications should be modified but I am working with the primary care doctor to address this issue."

On 7/14/2024, I conducted an exit conference with licensee designee/administrator, Nichole VanNiman, via telephone. Ms. VanNiman stated that she is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	According to the *Medication Administration Record* (MAR) for April 2024, staff administered Humalog and Lantus to Resident A the entire month of April 2024. According to the *Incident/Accident Report*, dated 4/30/2024, between the dates of 4/22/2024 – 4/30/2024, staff administered

	expired Humalog KwikPen Insulin 100 unit/ml and Lantus Solostar U-100 Insulin to Resident A. This medication error was due to an incorrect expiration date being written on each insulin pen and was not discovered until 4/30/2024. According to Ms. Lapp, she completed a medication cart review on 4/30/2024 and discovered that staff had been administering expired Humalog and Lantus to Resident A for approximately eight days. Ms. Lapp acknowledge that this complaint is true. Based on the information above, from 4/22/2024 – 4/30/2024, the facility failed to properly discontinue and dispose of Resident A's expired prescribed medications, Humalog KwikPen Insulin 100 unit/ml and Lantus Solostar U-100, which led to continued administration of these expired medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend this special investigation be closed with no change to the status of the license.

Stephanie Gonzalez 7/17/2024

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Denise Y. Nunn 07/17/2024

Denise Y. Nunn Date
Area Manager