GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR


July 28, 2021

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

RE: License #: AM800299049
Investigation #: 2021A1024036
Beacon Home at Woodland

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 was required. On June 25, 2021, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 #:** | AM800299049 |
| | |
| **Investigation #:** | 2021A1024036 |
| | |
| **Complaint Receipt Date:** | 06/08/2021 |
| | |
| **Investigation Initiation Date:** | 06/08/2021 |
| | |
| **Report Due Date:** | 08/07/2021 |
| | |
| **Licensee Name:** | Beacon Specialized Living Services, Inc. |
| | |
| **Licensee Address:** | Suite 110<br>890 N. 10th St.<br>Kalamazoo, MI 49009 |
| | |
| **Licensee Telephone #:** | (269) 427-8400 |
| | |
| **Administrator:** | Nichole VanNiman |
| | |
| **Licensee Designee:** | Nichole VanNiman |
| | |
| **Name of Facility:** | Beacon Home at Woodland |
| | |
| **Facility Address:** | 56832 48th Avenue<br>Lawrence, MI 49064 |
| | |
| **Facility Telephone #:** | (269) 427-8400 |
| | |
| **Original Issuance Date:** | 09/12/2016 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 03/12/2021 |
| | |
| **Expiration Date:** | 03/11/2023 |
| | |
| **Capacity:** | 12 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED |

| | MENTALLY ILL |
|---|---|

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Medications prescribed by the psychiatric hospital were not implemented by the direct care staff at the facility. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 06/08/2021 | Special Investigation Intake 2021A1024036 |
| 06/08/2021 | Special Investigation Initiated – Telephone with Relative A1 |
| 06/08/2021 | Contact - Telephone call made with nurse practitioner Debra Klinger |
| 06/14/2021 | Inspection Completed On-site with Resident A, direct care staff members Colleen Stewart, Jessica Lee, home manager Danyell Lacer |
| 06/14/2021 | Contact - Document Received Resident A's *Discharge Paperwork*, *Medication List* |
| 06/16/2021 | Contact - Telephone call made with district director Kimberly Howard |
| 06/24/2021 | Exit Conference with licensee designee Nichole VanNiman |
| 06/24/2021 | Corrective Action Plan Requested and Due on 07/26/2021 |
| 06/24/2021 | Inspection Completed-BCAL Sub. Compliance |
| 06/25/2021 | Corrective Action Plan Received |
| 06/25/2021 | Corrective Action Plan Approved |

**ALLEGATION:**

**Medications prescribed by psychiatric hospital were not implemented by direct care staff at the facility.**

## INVESTIGATION:

On 6/8/2021, I received this complaint through the Bureau of Community and Health Systems online complaint system. This complaint alleged medications prescribed by a psychiatric hospital were not implemented by direct care staff at the facility.

On 6/8/2021, I conducted an interview with Relative A1 regarding this allegation. Relative A1 stated Resident A was discharged from Crown Point Psychiatric Hospital in Indiana back to her residence at Beacon Home at Kalamazoo on 5/4/2021. Relative A1 stated the psychiatric hospital made two medication changes and medication scripts to reflect these changes were included in Resident A's discharge paperwork which was given to the staff at Beacon Home at Kalamazoo. Relative A1 stated Resident A transferred to Beacon at Woodland, another Beacon Specialized Living Services Corporation owned facility, the next day on 5/5/2021 and the discharge paperwork which included the new medication list was also provided to direct care staff at Beacon at Woodland. Relative A1 stated on 5/21/2021, Resident A went to see her primary care physician and the nurse practitioner, Debra Klinger, discovered that Resident A was not taking medications from the correct medication list that was modified by the psychiatric hospital to Beacon Home at Woodland. Therefore, Resident A missed taking the correct medications for approximately three weeks because neither direct care staff from Beacon at Woodland checked the discharge paperwork which included the new medication list and prescriptions. Relative A1 stated the direct care staff members did not implement the medication orders from the psychiatric hospital which put Resident A at risk.

On 6/8/2021, I conducted an interview with nurse practitioner Debra Klinger who stated that Resident A was discharged from an involuntary stay at a psychiatric hospital on 5/4/2021 to her residence at Beacon at Kalamazoo. Ms. Klinger stated Resident A was then transferred to another Beacon Specialized Living Corporation owned facility, Beacon at Woodland, the next following day on 5/5/2021. Ms. Klinger stated Resident A came into her office on 5/21/2021 for a follow up visit and during this time Ms. Klinger discovered that Resident A had not been taking all her medications from her current medication list that was adjusted upon discharge from the psychiatric hospital on 5/4/2021. Ms. Klinger stated the medication changes were important because the medication Klonopin 1 mg was discontinued and medication Latuda 120 mg was added which controlled Resident A's seizures and suicidal ideation. Ms. Klinger stated the direct care staff members at Beacon Home at Woodland failed to follow the medication orders by not checking Resident A's discharge paperwork from the psychiatric hospital and failed to coordinate with Resident A's pharmacist to ensure Resident A had the correct medications.

On 6/14/2021, I conducted an onsite investigation at the facility and interviewed home manager Danyell Lacer, direct care staff members Colleen Stewart and Jessica Lee. Ms. Lacer stated Resident A was relocated to Beacon at Woodland on 5/5/2021. Ms. Lacer stated at the time of admission she was provided with discharge

paperwork for Resident A from a psychiatric hospital however was not informed that there were any medication instructions that needed to be implemented and assumed she was provided with Resident A's current medication list. Ms. Lacer further stated she failed to look at Resident A's discharge paperwork that included Resident A's correct medication list which was provided to her at admission. Ms. Lacer stated she eventually discovered by speaking to Resident A's primary nurse practitioner that Resident A had medication changes made by the psychiatric hospital that were not reflected on the medication list from Beacon Home at Kalamazoo that was provided to her at admission therefore Resident A had not been administered all her prescribed medications while she has been residing in the home.

Ms. Stewart and Ms. Lee both stated Resident A went to see her nurse practitioner on 5/21/2021 and learned that she has not been taking the correct medications since admission at Beacon Home at Woodland and they have no knowledge of Resident A being prescribed Latuda or having any medication changes made when she was discharged from the psychiatric hospital prior to her admission at Beacon Home at Woodland.

While at the facility, I also interviewed Resident A. Resident A stated when she was discharged from the psychiatric hospital on 5/4/2021, she was supposed to take a new medication that she did not take for 10 days which was supposed to help with her seizures. Resident A stated her nurse practitioner learned on 5/21/2021 that she was taking mediations from an old medication list that was never updated after she was discharged from the psychiatric hospital.

On 6/14/2021, I reviewed Resident A's *Discharge Paperwork* and *Medication List.* I reviewed the discharge paperwork that included the medication orders which listed Lurasidone HCL (Latuda) to be given by mouth in the morning.

On 6/16/2021, I conducted an interview with district director Kimberly Howard who stated she spoke with home manager Ms. Juan, from Beacon Home at Kalamazoo, regarding Resident A at the time of admission to Beacon Home at Woodland. Ms. Howard stated Ms. Juan did not inform her of any physician instructions made regarding Resident A's medications that needed to be implemented therefore the direct care staff administered medications based on Resident A's old medication list and had no knowledge of any medication changes. Ms. Howard further stated the home manager at Beacon Home at Woodland, Ms. Lacer, was provided with Resident A's discharge paperwork which included Resident A's correct medication list and prescriptions, however Ms. Lacer failed to look at the discharge paperwork to check for any further physician instructions.

| **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:**<br>**(a) Medications.** |
| **ANALYSIS:** | Based on this investigation which included interviews with home manager Danyell Lacer, district director Kimberly Howard, direct care staff members Colleen Stewart, Jessica Lee, nurse practitioner Debra Klinger, Resident A, and review of Resident A's discharge paperwork and medication list there is evidence to support the allegation that medications prescribed by psychiatric hospital were not implement by direct care staff at the facility. Ms. Klinger stated Resident A had medication changes made when she was hospitalized at a psychiatric hospital however the staff did not follow the new medication orders that were included in Resident A's discharge paperwork that were provided to staff when Resident A was admitted to Beacon Home at Woodland. Ms. Lacer stated at the time Resident A was admitted to the facility, she assumed she had Resident A's correct medication list and failed to check Resident A's discharge paperwork for any further physician instructions therefore Resident A was not administered her correct medications until 5/21/2021 when it was brought to their attention by Resident A's nurse practitioner. Ms. Howard also stated staff was provided with discharge paperwork at admission which included the correct medication list and staff failed to check the paperwork to ensure Resident A's medication list was current and followed therefore the direct care staff did not implement the medications prescribed by the psychiatric hospital. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 6/24/2021, I conducted an exit conference with licensee designee Nichole VanNiman. I informed Ms. VanNiman of my findings and allowed her an opportunity to ask questions and make comments.

On 6/25/2021, I received an acceptable corrective action plan.

## IV. RECOMMENDATION

An acceptable corrective action plan was approved; therefore, I recommend the current license status remain unchanged.

7/26/2021

Ondrea Johnson — Date
Licensing Consultant

Approved By:

07/28/2021

Dawn N. Timm — Date
Area Manager