GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 30, 2021

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

RE: License #: AS230404895
Investigation #: 2021A0577037
Beacon Home at Arlene

Dear Ms. Rawling:

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 (231) 922-5309.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230404895
Investigation #:	2021A0577037
Complaint Receipt Date:	07/07/2021
Investigation Initiation Date:	07/07/2021
Report Due Date:	09/05/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator/Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Arlene
Facility Address:	4219 Arlene Drive Lansing, MI 48917
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/02/2020
License **Status:**	REGULAR
Effective Date:	04/02/2021
Expiration Date:	04/01/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident B stated that her heart hurt and medical attention was not provided.	No
Resident A and Resident B went without medications for several days.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/07/2021	Special Investigation Intake 2021A0577037
07/07/2021	Special Investigation Initiated - Letter Email to Phyllis Kchodl, ORR-CMCMH.
07/07/2021	Referral - Recipient Rights- Phyllis Kchodl, CMH-ORR.
07/08/2021	Contact-Document Received Email from Leslie Herrguth with IR attached.
07/13/2021	APS Referral Complainant completed APS referral-Denied for investigation.
07/14/2021	Contact - Telephone call made Interview with Amanda Norton, RN-BSL.
07/16/2021	Contact - Telephone call made Alyssa Colburn-Caring Hearts Guardianship
07/19/2021	Contact - Document Received Phyllis Kchodl emailed, IR"s Assessment Plans, MAR's.
07/21/2021	Inspection Completed On-site Review of medications and interview with Rachel Gould, HM.
07/21/2021	Inspection Completed-BCAL Sub. Compliance
07/23/2021	Contact - Telephone call made Dan Rippinger, Maintenance with BSL.
07/27/2021	Contact - Document Sent- Kim Rawlings.
07/30/2021	Contact - Telephone call made

	Interview with Wendy Blanton, LPN with BSL.
08/09/2021	Exit Conference conducted with Kimberly Rawlings, LD/Admin.

ALLEGATION: Resident B stated that her heart hurt and medical attention was not provided.

INVESTIGATION:

On July 07, 2021, the complaint stated Resident B was found to be without her medication for heart and liver diagnosis for at least seven days. During this time, Resident B reported her heart hurt and staff did not take Resident B to the hospital because Resident B did not want to go. Complainant did not believe Resident B had the ability to make that decision.

On July 08, 2021, I contacted Phyllis Kchodl, Office of Recipient Rights with Community Mental Health Central Michigan (ORR-CMHCM) who reported she does not have any additional information at this time regarding the complaint but will be opening an investigation.

On July 08, 2021, I received an email from Licensing Consultant Leslie Herrguth with an *AFC Licensing Division-Incident/Accident Report* (IR) attached regarding Resident B and the ambulance being called to the facility on June 05, 2021. The IR reported staff member Vicki Williams was in Resident B's bedroom when Resident B reported her heart was hurting and direct care staff called 9-1-1 while another staff tried to get a blood pressure read. According to the IR, when the ambulance arrived, Resident B began laughing and giggling and told the paramedics she would not go to the hospital. The IR stated Resident B's guardian, Guardian B1 was contacted to determine the best course of action. Guardian B1 stated that Resident B did not have to go if she did not want to.

On July 13, 2021, I received an email with additional information from Adult Protective Service Centralized Intake reporting an ambulance was contacted but Resident B was never sent to the hospital for chest pains.

On July 16, 2021, I interviewed Guardian B1 with Caring Hearts Guardianship. Guardian B1 reported she is the public guardian for Resident B and has not been to the facility since Resident B moved to the facility in May of 2021. Guardian B1 reported she was notified of the ambulance being called due to Resident B reporting her heart hurt. Guardian B1 reported Resident B did not want to go to the hospital so she advised direct care staff that they could not make Resident B go to the hospital. Guardian B1 reported she was not aware of Resident B being out of medications at the time of the ambulance was called.

On July 21, 2021, Rachel Gould, direct care staff member and home manager reported that on June 05, 2021, Resident B was telling staff she was pregnant and was having her baby and acting like she was having a seizure. Ms. Gould reported she had contacted Beacon Specialized Living medical regarding the altered mental status and while on the phone Resident B started saying her heart was hurting. Ms. Gould reported she hung up with medical and contacted 911, the ambulance arrived but Resident B then refused to go to the hospital. Ms. Gould reported she contacted Resident B's guardian and explained the events and the guardian said, "if [Resident B] does not want to go to the hospital that is her right to refuse treatment and no one can make her go to the hospital." Ms. Gould reported she was not certain if she told Guardian B1 that Resident B had been without her prescribed heart medication called Propranolol. Ms. Gould reported Resident B did not go to the hospital, based on her choice, but was closing monitored by staff.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the information gathered during the investigation, it has been found the direct care staff did seek medical attention immediately, by calling 9-1-1 and requesting an ambulance when Resident B reported her heart was hurting. Consequently, needed care was obtained immediately for Resident B.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A and Resident B went without medications for several days.

INVESTIGATION:

On July 7, 2021, a complaint was received reporting that on July 02, 2021, Amanda Norton, Registered Nurse (RN) with Beacon Specialized Living Services discovered that Resident A went without psychiatric medications for several days.

On July 13, 2021, I received an email with additional information from Adult Protective Service Centralized Intake reporting Wendy Blanton, LPN is responsible for handling resident medication needs and did not order medications for Resident A and Resident B in a timely manner causing Resident A to go three days without her cardiac medication as well as some psychotropic medications. Resident B also went seven days without her blood pressure medication.

On July 14, 2021, I interviewed Amanda Norton, Registered Nurse with Beacon Specialized Living Services (BSLS). Ms. Norton reported she was at the facility on June 01, 2021, to complete her weekly checks on residents and resident medications. Ms. Norton reported when reviewing the electronic Medication Administration Record (e-Mar) she noted Resident A and Resident B were going without medications due to the medications running out and not being reordered timely. Ms. Norton reported she did not remember the specific medications for Resident A, only that they were psychotropic medications, but did recall that the medication Resident B went without was propranolol. Ms. Norton stated this medication addresses Resident B's heart issues and she cannot go without it. Ms. Norton reported she spoke with home manager Rachel Gould about Resident A and Resident B going without their medications and Ms. Gould stated, "I did not know I was supposed to order the medications for the residents." Ms. Norton reported she contacted Marci Villeneuve, Nurse Manager with BSLS. Ms. Norton reported Ms. Villenueve explained to her there was an issue with getting Resident A's medications and that Wendy Blanton, Licensed Practical Nurse with BSLS was supposed to be handling the medication concerns for Resident A and Resident B. Ms. Norton reported Resident B did not have a primary care physician in the area so Ms. Blanton was trying to get new prescriptions ordered by Dr. Elami, Physician with BSLS and had been unsuccessful getting the medications filled.

On July 16, 2021, I interviewed Guardian B1 with Caring Hearts Guardianship. Guardian B1 reported she is the public guardian for Resident B and has not been to the facility since Resident B moved to the facility in May of 2021, all communication has been completed through telecommunications. Guardian B1 reported Resident B had a primary care physician (PCP) in Midland who Resident B is no longer able to see since moving to a new facility. Guardian B1 reported the facility is trying to find a PCP in the area for Resident B and has recently connected Resident B with Visiting Physicians Association. Guardian B1 reported she has been involved with Resident B's psychiatric doctor appointments with Community Mental Health Central Michigan (CMHCM) Psychiatrist. Guardian B1 reported Resident B's last medication review with CMHCM was on June 23, 2021 and was only for Resident B psychiatric medications. Guardian B1 reported she was not aware of Resident B running out of Lactulose and Propranolol in June of 2021.

On July 19, 2021, Phyllis Kchodl, CMHCM-ORR provided me with copies of *Medication Administration Record (MAR)* from May and June 2021 for Resident A and Resident B, *AFC Licensing Division-Incident/Accident Reports* (IR), email exchanges between Beacon Specialized Living Services employees, prescriptions, and file notes. The following information is from documents received:

- Resident A:
    - MAR: Prescribed Trazodone (Desyrel), 50mg, 1 tablet by mouth twice daily. MAR documents Resident A receiving two doses of Trazodone at 8:00pm. On June 6 and June 7, 2021, Resident A's MAR documented Resident A was not given her Trazadone due to the medication not delivered/not in stock.

- IR was completed on July 08, 2021, by Amanda Norton, Registered Nurse with Beacon Specialized Living Services reported on June 01, 2021, at 12:20pm Resident A had prescriptions for Risperdal and Trazadone lapse and went several days without receiving prescribed doses of each. Staff were trained in the correct process of ordering medications, monitoring prescription dates, and renewing prescriptions when necessary. Reviewed during regional meeting in June 2021. Persons Notified-left blank.
- Email from Amanda Norton to Marci Villeneuve, Wendy Blanton, and Rachel Gould dated June 08, 2021, at 12:28pm reporting [Resident A] is out of Trazadone and has been since yesterday. This is the same resident who has been out of Synthroid, Lamictal and Briviact (for seizures) within the last few weeks.
- Copy of order-prescription for Briviact 50mg, take 1 tablet by mouth twice daily. May and June 2021 MAR's logged Briviact, 50mg at 8:00am and 8:00pm as a medication to be administered, but no doses were administered in May 2021 until June 14. 2021 at 8:00pm was the first dose administered.

- Resident B:
  - MAR: Prescribed Ammonium Lactate Cream 12%, apply topically to feet twice daily. On June 8, 2021, the MAR documented Resident B did not receive the 8:00 pm of the cream.
  - MAR: Prescribed Lactulose (Enulose), 10G/15ML, take 45ML by mouth three times daily. MAR documents on June 8, 2021, at 8:00pm not given, MAR left blank and on June 09, 2021, MAR documented medication not available.
  - MAR: Prescribed Propranolol HCL Dosage, 10mg, Notes: Take ½ tablet by mouth daily (hold for heart rate less than 50 or SBO less than 90). Medication administered at 8:00am. Per MAR, medication was not administered on June 01-7, 2021, due to medication not being delivered.
  - MAR: Prescribed Xifaxan, 550mg, take 1 tabled by mouth twice daily, MAR shows administrations at 8:00am and 8:00pm. On June 01-07, 2021, Resident B was not administered her Xifaxan at 8:00am due to medication not being delivered. Resident B was not administered her Xifaxan at 8:00pm from June 01-03, 2021, due to medication not being delivered. June 08, 2021, MAR is left blank, not administered-no documentation for reason medication not administered.
  - MAR: Prescribed Prozac, 20mg, Notes: Take 2 capsules by mouth every morning, medication administered at 8:00am. On June 12 and 13, 2021 medication was not administered due to medication not being delivered.
  - MAR: Prescribed Risperdal (Risperidone), 2mg, take 1 tablet by mouth twice daily. On June 8, 2021, at 8:00pm MAR is left blank, not administered.

- IR was completed on July 08, 2021, by Amanda Norton, Registered Nurse with Beacon Specialized Living Services reported on June 01, 2021, at 11.54am, Resident B had prescriptions that lapsed and staff were unaware of how to order, refill, or what to do in the event medications ran out. During period of going without medications. Resident had an incident of angina and was not treated in the ER due to staff reporting guardian had stated Resident didn't have to go to ER if she chose not to. Guardian was inaccessible since Resident's admission and probably unaware of Resident going without medications or complaining of angina while going without medications. Home manager was trained in the process for ordering medications and trained in alerting the correct nursing staff if the normal processes were ineffectual. Process for ordering medications was reviewed in the regional call on June 29, 2021. Persons Notified-Left Blank.
- Email from Wendy Blanton, LPN-BSL to Heather Weber, Rachel Gould, and Marci Villeneuve, dated June 1, 2021, at 4:15pm stating, "we are in the need of some prescription refills for a client at Arlene home that is in between PCP and is due to be seen on 6/14/21 but is running out of medications. She is in need of gap script of her Xifaxan 550mg 1 PO BID and Propranolol 10mg, take ½ tablet daily."
- Email from Marci Villeneuve to Amanda Norton and Wendy Blanton, dated June 01, 2021, at 4:08pm notifying them of [Resident B] being out of Xifaxan and Propranolol, both need new scripts. Requesting Amanda Norton to work on these today/tomorrow, may need to ask Dr. Elami for a gap script. Wendy Blanton replied, got it handled, spoke to the office and it will be called into afterhours pharmacy so staff can go get it tonight.
- Email from Amanda Norton to Marci Villeneuve, Wendy Blanton, and Rachel Gould dated June 08, 2021, at 12:28pm reporting [Resident B] is out of Lactulose, took last does this morning.

On July 21, 2021, I completed on unannounced onsite investigation at the facility and learned Resident A is currently the only resident living at the facility as Resident B recently moved out. Resident A is not able to be interviewed due to her cognitive disabilities. I completed a medication reconciliation for Resident A and found no discrepancies between the original written prescription, the E-MAR, and Resident A's current medications for the month of July 2021. While at the facility I interviewed home manager Rachel Gould who reported she did not have the knowledge and training regarding the expectations of being a home manager and medications. Ms. Gould reported their first resident's parents did all off the appointment making, provided transportation, and kept track of medications. Ms. Gould reported the facility had a licensed practical nurse and a registered nurse in May and June of 2021 and was under the understanding it was their responsibility to order medications when needed. Ms. Gould acknowledged both Resident A and Resident B went without medications for various periods of time in June 2021. Ms. Gould reported she was not confident on how medications were logged into the E-MAR so when the pharmacy would deliver a

medication, Ms. Gould would go into the medication and edit the E-MAR with a new start date, which in-turn would clear out the previous medication administrations from that date back to the beginning of the month. Ms. Gould reported May and June 2021 E-MARs were not accurate documentation of medications being administered due to the error of using the edit button. Ms. Gould reported Resident A did run out of her Briviact in June 2021 because Ms. Gould called the pharmacy a week before the medication ran out and left a message requesting a refill and did not hear back from the pharmacy. Ms. Gould reported Resident B ran out of her Lactulose, Xifaxan and Propranolol due to not having a primary care physician to fill the prescription. Ms. Gould reported she contacted Amanda Norton, RN with BSL regarding Resident B running out of her Lactulose asking if Resident B's psychiatrist could fill the prescription and was advised the prescription would need to be filled by a primary care physician. Ms. Gould reported Resident B's first appointment with her new primary care physician was not until June 14, 2021. Ms. Gould reported Wendy Blanton, Licensing Practical Nurse (LPN) with BSLS contacted Dr. Elami, Medical Director with BSL and requested a gap prescription be written for Resident B's Lactulose. Ms. Gould reported Dr. Elami was not comfortable with writing a prescription because he did not know why Resident B was on the medication or what it was being used to treat and initially refused to write the gap prescription, but then wrote only for the days until Resident B was seen by her PCP.

On July 30, 2021, I interviewed Wendy Blanton, Licensed Practical Nurse with BSLS. Ms. Blanton acknowledged Resident A and Resident B went without medications in June 2021. Ms. Blanton reported Resident B was in between primary care physicians at the time and could not get new prescriptions written to refill medications. Ms. Blanton reported they were in the process of finding a new physician for Resident B but had not yet found one. Ms. Blanton reported Rachel Gould, Home Manager reached out to Ms. Blanton to report B was getting low on medications and Ms. Blanton reached out to Marci Villeneuve, Nurse Manager who instructed Ms. Blanton to contact Dr. Elami, BSLS medical director to see if he could prescribe a gap prescription. Ms. Balton reported she contacted Dr. Elami and requested a gap prescription but Dr. Elami wanted additional information such as why the resident was taking the medication, what is the medication being used to treat, and what other medications was Resident B taking. Ms. Blanton reported Dr. Elami agreed to write a gap script but it was a couple of days until Resident B could be seen by her new physician. Ms. Blanton reported she was trying to get the prescriptions called into a pharmacy closer to facility instead of Gull Point Pharmacy in Kalamazoo and Dr. Elami had already called the prescriptions into Gull Point Pharmacy and it took the pharmacy 3 or 4 days to get the medication filled and delivered. With regard to Resident A's missing medication doses, Ms. Blanton reported Resident A was without her Briviact in June 2021 also and Ms. Blanton was able to get Dr. Elami to write a gap prescription until Resident A could be seen by Visiting Physicians Association for a new prescription to be filled. Ms. Blanton reported Dr. Elami had the prescription sent to Rite Aid by the facility but the Rite Aid did not have the medication in stock, said they will order it and have it in the following day. Ms. Blanton reported the medication was not delivered to Rite Aid the following day, that it took another day for the medication to be delivered and filled by Rite Aid.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during the investigation, Resident A and Resident B were not given their medications as prescribed. The medication administration record for the months of May and June 2021 documented that Resident A went without her Synthroid, Lamictal and Briviact and Trazadone on various dates/times and Resident B was not administered Prozac, Risperdal due to not having the medication in the facility, then ran out of her Lactulose, Xifaxan and Propranolol due to not having a primary care physician to write a new prescription.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On July 21, 2021, during the onsite inspection the facility I observed holes in the walls throughout the facility. Some of the holes had been patched but needed to be painted and some of the holes had not been patched.

On July 23, 2021, I spoke reported to Dan Rippinger, head of maintenance with BSLS about the holes in the walls and the importance of repairing the holes as soon as possible to ensure the safety of staff and residents. We discussed options of wall coverings to prevent the residents from putting holes in the walls when having a behavior.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	On July 21, 2021, during the onsite inspection I observed holes in the walls in different stages of being patched. These walls are not easily cleanable due to not being painted and not being patched.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite investigation on July 21, 2021, the toilet located in the full resident bathroom off of the front living room was found in non-working order. The toilet was found lying in the middle of the bathroom floor. The home manager Rachel Gould reported maintenance had been notified but reported to Ms. Gould it would be too much money to fix and advised Ms. Gould to keep the door locked. Consequently, residents are not able to use this bathroom.

On July 23, 2021, I spoke with Dan Rippinger, head of maintenance with BSLS and he will ensure the toilet gets repaired as soon as possible and will discuss with his maintenance the importance of repairing items immediately.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(7) All water closet compartments, bathrooms, and kitchen floor surfaces shall be constructed and maintained so as to be reasonably impervious to water and to permit the floor to be easily kept in a clean condition.
ANALYSIS:	Based on the information found during the onsite inspection, the toilet in the resident bathroom off of the front living room was found lying on the floor in the bathroom and not in working order. The water closet has not been maintained as to be reasonably impervious to water and to permit the floor to be easily kept clean.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the current status of the license remains unchanged.

08/26/2021

Bridget Vermeesch — Date
Licensing Consultant

Approved By:

08/30/2021

Dawn N. Timm — Date
Area Manager