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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 3, 2022

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

RE: License #: AS390406165
Investigation #: 2022A0462010
Beacon Home at Richland

Dear Mr. Beltran:

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,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406165
Investigation #:	2022A0462010
Complaint Receipt Date:	12/06/2021
Investigation Initiation Date:	12/07/2021
Report Due Date:	02/04/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Ramon Beltran
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Richland
Facility Address:	9445 N. 24th St. Richland, MI 49083
Facility Telephone #:	(269) 488-0024
Original Issuance Date:	01/11/2021
License Status:	REGULAR
Effective Date:	07/11/2021
Expiration Date:	07/10/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
During the months of September and October 2021, Resident A and Resident B's Medication Administration Records were missing the initials of the persons who administered medications to them on several occasions.	Yes
Additional finding	Yes

III. METHODOLOGY

12/06/2021	Special Investigation Intake 2022A0462010
12/07/2021	Special Investigation Initiated – Email to Complainant.
12/20/2021	Unannounced investigation onsite. Face-to-face interview with DCW Aamani Spivey. Requested and received documentation from BSLS employee Jamara White.
01/10/2022	Contact- Email exchange with Chief Administrative Officer Melissa Williams.
02/03/2022	Exit conference with licensee designee Ramon Beltran via telephone.

ALLEGATION: During the months of September and October 2021, Resident A and Resident B's Medicationication Administration Records were missing the initials of the persons who administered medications to them on several occasions.

INVESTIGATION: On 12/06/2021 the Bureau of Community and Health Systems (BCHS) received is allegation, via a written complaint, through the BCHS on-line compliant system.

On 12/07, via email, I informed Complainant I was assigned to investigate this allegation.

On 12/20 AFC Licensing Consultant Rodney Gill and I conducted an unannounced investigation at the facility and interviewed facility direct care staff member Aamani Spivey, who was the only facility staff member present in the facility. According to Ms. Spivey, while she had previously worked at other facilities owned and operated by the licensee, she had only worked at Beacon Home at Richland for approximately

one and ½ weeks. Ms. Spivey stated she was trained on how to administer medication cation to residents. According to Ms. Spivey, she, and other facility employees, called “medication passers”, documented the administration of resident medication via an “easy to use” cloud-based electronic medication administration record system (EMAR) called NextStep. Ms. Spivey stated she did not know the facility’s policy regarding documenting the administration of resident medications should the facility’s internet connection be disrupted and/or should there be an issue with the NextStep system. When asked if Ms. Spivey was familiar with the facility’s use of a “backup” paper medication administration record (MAR) to document the administration of resident medications, Ms. Spivey answered “no”.

Mr. Gill and I requested a printed copy of Resident A and B’s EMARs for the months of September and October 2021. However, Ms. Spivey did not know how to print this documentation off of the NextStep system for us.

I called home manager Cassandra Pueblo, who was working offsite. Ms. Pueblo informed us she was unable to come to the facility to assist us with our investigation. Subsequently, Ms. Pueblo arranged for Beacon Specialized Living, Inc. (BSLS) employee Jamara White, who worked at another AFC facility owned and operated by the licensee, to report to the facility and provide us with requested documentation.

Upon her arrival, Ms. White provided Mr. Gill and I with a copy of Resident A and B’s September and October 2021 EMARs, which she printed from NextStep. Ms. White confirmed that according to Beacon Specialized Living Services Inc.’s policy, when the facility’s internet connection was disrupted and/or when there were issues with the NextStep system, medication passers were to document the administration of residents’ medication on a backup paper MAR. Subsequently, per our request, Ms. White also provided us with a copy of Resident A and B’s September and October 2021 “paper MAR”.

Mr. Gill and I reviewed Resident A’s September and October 2021 EMAR and paper MAR, and established the following information:

There were no medication passers’ initials on Resident A’s September 2021 EMAR for the administration of his 8:00AM dose of BuSpar (Buspirone) 15mg on 09/02, 09/09, 09/10, 09/13, 09/15, 09/16, 09/18, 09/19, 09/21, 09/22, 09/23, 09/26, and 09/29. However, Resident A’s September 2021 paper MAR did include medication passers’ initials for the administration of the 8:00AM dose of this medication on the above dates.

There were no medication passers’ initials on Resident A’s September 2021 EMAR for the 3:00PM dose of BuSpar (Buspirone) 15mg on 09/02, 09/03, 09/05, 09/06, 09/08, 09/10, 09/13, 09/15, 09/16, 09/17, 09/18, 09/19, 09/21, 09/22, and 09/25. Documentation on Resident A’s September 2021 paper MAR did include medication passers’ initials for the administration of the 3:00PM dose of this medication on

09/02, 09/03, 09/05, 09/06, 09/08, 09/10, 09/13, 09/15, 09/16, 09/17, 09/18, 09/19, 09/21, and 09/22 but not on 09/25.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of Resident A's 8:00PM dose of BuSpar (Buspirone) 15mg on 09/14, 09/15, 09/17, 09/18, 09/19, 09/20, 09/21, and 09/27. However, Resident A's September 2021 paper did include medication passers' initials for the administration of the 8:00PM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of his 8:00AM dose of Docusate Sodium 100mg on 09/02, 09/09, 09/10, 09/13, 09/15, 09/16, 09/19, 09/20, 09/21, 09/22, 09/23, 09/26, and 09/29.

Documentation on Resident A's September 2021 paper MAR did include medication passers' initials for the administration of the 8:00AM dose of this medication on 09/02, 09/09, 09/10, 09/13, 09/15, 09/16, 09/19, 09/21, 09/22, 09/23, 09/26, and 09/29 but not on 09/20.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of his 8:00PM dose of Docusate Sodium 100mg on 09/14, 09/15, 09/17, 09/18, 09/19, 09/20, 09/21, and 09/27. However, Resident A's September 2021 paper MAR did include medication passers' initials for the administration of the 8:00PM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of Resident A's Fluticasone 50mcg nasal spray on 09/02, 09/09, 09/10, 09/13, 09/15, 09/16, 09/18, 09/19, 09/21, 09/22, 09/23, 09/26, and 09/29. However, Resident A's September 2021 paper MAR did include medication passers' initials for the administration of this medication on the above dates.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of Resident A's 8:00AM dose of Fluvoxamine 100mg on 09/02, 09/09, 09/10, 09/13, 09/15, 09/16, 09/18, 09/19, 09/21, 09/22, 09/23, 09/26, and 09/29. However, Resident A's September 2021 paper MAR did include medication passers' initials for the administration of the 8:00AM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of Resident A's 8:00PM dose of Fluvoxamine 100mg on 09/14, 09/15, 09/17, 09/18, 09/19, 09/20, 09/21, and 09/27. However, Resident A's September 2021 paper MAR did include medication passers' initials for the administration of the 8:00PM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of Resident A's Haldol (Haloperidol) 10mg on 09/14, 09/15,

09/17, 09/18, 09/19, 09/20, 09/21, and 09/27. However, Resident A's September 2021 paper MAR did include medication passers' initials for the administration of this medication on the above dates.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of Resident A's Loratadine 10mg on 09/02, 09/09, 09/10, 09/13, 09/15, 09/16, 09/18, 09/19, 09/21, 09/22, 09/23, 09/26, and 09/29. The medication Loratadine 10mg was not included on Resident A's September 2021 paper MAR.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of Resident A's 8:00AM dose of Oxcarbazepine (Trileptal) 300mg on 09/02, 09/09, 09/10, 09/13, 09/15, 09/16, 09/18, 09/19, 09/21, 09/22, 09/23, 09/26, and 09/29. However, Resident A's September 2021 paper MAR did include medication passers' initials for the administration of the 8:00AM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of Resident A's 8:00PM dose of Oxcarbazepine (Trileptal) 300mg on 09/14, 09/15, 09/17, 09/18, 09/19, 09/20, 09/21, and 09/27. However, Resident A's September 2021 paper MAR did include medication passers' initials for the administration of the 8:00PM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of Resident A's 8:00AM dose of Pantoprazole Sod DR 20mg on 09/02, 09/09, 09/10, 09/13, 09/15, 09/16, 09/18, 09/19, 09/21, 09/22, 09/23, 09/26, and 09/29. However, Resident A's September 2021 paper MAR did include medication passers' initials for the administration of the 8:00AM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's September 2021 EMAR for the administration of Resident A's 8:00PM dose of Pantoprazole Sod DR 20mg on 09/14, 09/15, 09/17, 09/18, 09/19, 09/20, 09/21, and 09/27. However, Resident A's September 2021 paper did include medication passers' initials for the administration of the 8:00PM dose of this medication on the above dates.

Mr. Gill and I established Resident A was prescribed Claritin 10mg, to be administered daily. This medication was included on Resident A's September 2021 paper MAR but not indicated on his September 2021 EMAR. There were no medication passers' initials on Resident A's September 2021 paper MAR for the administration of this medication on 09/01, 09/03, 09/04, 09/05, 09/06, 09/07, 09/08, 09/11, 09/14, 09/17, 09/20, 09/24, 09/25, 09/27, 09/28, and 09/30.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of his 8:00AM dose of BuSpar (Buspirone) 15mg on 10/05, 10/23, 10/24, 10/26, and 10/29. However, Resident A's October 2021 paper MAR did

include medication passers' initials for the administration of the 8:00AM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's October 2021 EMAR for the 3:00PM dose of BuSpar (Buspirone) 15mg on 10/01, 10/17, 10/18, 10/23, and 10/24. However, Resident A's October 2021 paper MAR did include medication passers' initials for the administration of the 3:00PM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of Resident A's 8:00PM dose of BuSpar (Buspirone) 15mg on 10/23. However, Resident A's October 2021 paper MAR did include medication passers' initials for the administration of the 8:00PM dose of this medication on the above date.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of his 8:00AM dose of Docusate Sodium 100mg on 10/05, 10/23, 10/24, 10/26, and 10/29. However, Resident A's October 2021 paper MAR did include medication passers' initials for the administration of the 8:00AM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of his 8:00PM dose of Docusate Sodium 100mg on 10/01, and 10/23. Resident A's October 2021 paper MAR included medication passers' initials for the administration of the 8:00PM dose of this medication on 10/23 but not on 10/01.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of Resident A's Fluticasone 50mcg nasal spray on 10/05, 10/23, 10/24, 10/26, and 10/29. However, Resident A's October 2021 paper MAR did include medication passers' initials for the administration of this medication on the above dates.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of Resident A's 8:00AM dose of Fluvoxamine 100mg on 10/05, 10/23, 10/24, 10/26, and 10/29. However, Resident A's October 2021 paper MAR did include medication passers' initials for the administration of the 8:00AM dose of this medication on the above date.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of Resident A's 8:00PM dose of Fluvoxamine 100mg on 10/23. However, Resident A's October 2021 paper MAR did include medication passers' initials for the administration of the 8:00PM dose of this medication on the above date.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of Resident A's Haldol (Haloperidol) 10mg on 10/23. However, Resident A's October 2021 paper MAR did include medication passers' initials for the administration of this medication on the above date.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of Resident A's Loratadine 10mg on 10/05, 10/23, 10/24, 10/26, and 10/29. The medication Loratadine 10mg was not indicated on Resident A's October 2021 paper MAR

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of Resident A's 8:00AM dose of Oxcarbazepine (Trileptal) 300mg on 10/05, 10/23, 10/24, 10/26, and 10/29. However, Resident A's October 2021 paper MAR did include medication passers' initials for the administration of Resident A's 8:00AM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of Resident A's 8:00PM dose of Oxcarbazepine (Trileptal) 300mg on 10/23. However, Resident A's October 2021 paper MAR did include medication passers' initials for the administration of Resident A's 8:00PM dose of this medication on the above date.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of Resident A's 8:00AM dose of Pantoprazole Sod DR 20mg on 10/23, 10/26, and 10/29. However, Resident A's October 2021 paper MAR did include medication passers' initials for the administration of Resident A's 8:00AM dose of this medication on the above dates.

There were no medication passers' initials on Resident A's October 2021 EMAR for the administration of Resident A's 8:00PM dose of Pantoprazole Sod DR 20mg on 10/01, and 10/23. Resident A's October 2021 paper MAR included medication passers' initials for the administration of Resident A's 8:00PM dose of this medication on 10/23 but not on 10/01.

Resident A's prescribed 10mg of Claritin, to be administered daily, was included on Resident A's October 2021 paper MAR but not on his October 2021 EMAR. There were no medication passers' initials on Resident A's October 2021 paper MAR for the administration of this medication on 10/01, 10/02, 10/03, 10/04, 10/06, 10/07, 10/08, 10/09, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/18, 10/19, 10/20, 10/21, 10/22, 10/25, 10/27, 10/29, 10/30, and 10/31.

To verify whether or not the initials of the individuals administering Resident A's medications were documented on his EMARs and/or paper MARs at the time the medications were actually administered and not at a later date, Mr. Gill and I requested a printed copy of Resident A's most current EMAR and paper MAR. Ms.

White provided us with a copy of Resident A's December 2021 EMAR and paper MARs for 12/01 through 12/20 (the date of our unannounced investigation).

Mr. Gill and I reviewed a copy of Resident A's December 2021 EMAR and paper MAR for 12/01 through 12/20, and established the following information:

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of his 8:00AM dose of BuSpar (Buspirone) 15mg on 12/01, 12/05, 12/006, 12/07, 12/08, 12/10, 12/13, 12/15, and 12/20.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the 3:00PM dose of BuSpar (Buspirone) 15mg on 12/02, 12/04, 12/05, 12/06, 12/08, 12/10, 12/11, 12/13, and 12/19.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of Resident A's 8:00PM dose of BuSpar (Buspirone) 15mg on 12/05.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of his 8:00AM dose of Docusate Sodium 100mg on 12/01, 12/05, 12/06, 12/07, 12/08, 12/10, 12/13, 12/15, and 12/20.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of his 8:00PM dose of Docusate Sodium 100mg on 12/06.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of his Fluticasone 50mcg nasal spray on 12/01, 12/05, 12/06, 12/07, 12/08, 12/10, 12/13, and 12/15.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of Resident A's 8:00AM dose of Fluvoxamine 100mg on 12/01, 12/05, 12/06, 12/07, 12/08, 12/10, 12/13, 12/15, and 12/20.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of Resident A's 8:00PM dose of Fluvoxamine 100mg on 12/06.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of Resident A's Haldol (Haloperidol) 10mg on 12/06.

There were no medication passers' initials on Resident A's December 2021 EMAR for the administration of Resident A's Loratadine 10mg on 12/01, 12/05, 12/06, 12/07, 12/08, 12/10, 12/13, 12/15, 12/16, and 12/20. The medication Loratadine 10mg was not indicated on Resident A's December 2021 paper MAR.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of Resident A's 8:00AM dose of Oxcarbazepine (Trileptal) 300mg on 12/01, 12/05, 12/06, 12/07, 12/08, 12/10, 12/13, 12/15, and 12/20.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of Resident A's 8:00PM dose of Oxcarbazepine (Trileptal) 300mg on 12/06.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of Resident A's 8:00AM dose of Pantoprazole Sod DR 20mg on 12/01, 12/05, 12/06, 12/07, 12/08, 12/10, 12/13, 12/15, and 12/20.

There were no medication passers' initials on Resident A's December 2021 EMAR and paper MAR for the administration of Resident A's 8:00PM dose of Pantoprazole Sod DR 20mg on 12/06.

Resident A's prescribed 10mg of Claritin, to be administered daily, was included on Resident A's December 2021 paper MAR but not on his December 2021 EMAR. There were no medication passers' initials on Resident A's December 2021 paper MAR for the administration of this medication from 12/01 through 12/19, with the exception of 12/16.

Mr. Gill and I reviewed Resident B's September and October 2021 EMAR and paper MAR, and established the following information:

There were no medication passers' initials on Resident B's September 2021 EMAR for the administration of his liquid Haloperidol Lactate 2mg on 09/14, 09/15, 09/17, 09/18, 09/19, 09/20, 09/21, and 09/27. However, Resident B's September 2021 paper MAR did include medication passers' initials for the administration of this medication on the above dates.

There were no medication passers' initials on Resident B's September 2021 EMAR for the administration of his Hydralazine 25mg on 09/14, 09/15, 09/17, 09/18, 09/19, 09/20, 09/21, and 09/27. However, Resident B's September 2021 paper MAR did include medication passers' initials for the administration of this medication on the above dates.

There were no medication passers' initials on Resident B's September 2021 EMAR for the administration of his Olanzapine 20mg on 09/14, 09/15, 09/17, 09/18, 09/19, 09/20, 09/21, and 09/27. However, Resident B's September 2021 paper MAR did include medication passers' initials for the administration of this medication on the above dates.

There were no medication passers' initials on Resident B's September 2021 EMAR for the administration of his Olanzapine 5mg on 09/14, 09/15, 09/17, 09/18, 09/19,

09/20, 09/21, and 09/27. However, Resident B's September 2021 paper MAR did include medication passers' initials for the administration of this medication on the above dates.

There were no medication passers' initials on Resident B's September 2021 EMAR for the administration of his Pantoprazole 40mg on 09/02, 09/05, 09/10, 09/12, 09/13, 09/15, 09/16, 09/18, 09/19, 09/21, 09/22, 09/23, 09/26, 09/29. However, Resident B's September 2021 paper MAR did include medication passers' initials for the administration of this medication on the above dates.

There were no medication passers' initials on Resident B's October 2021 EMAR for the administration of his Haloperidol Lactate 2mg on 10/01 and 10/23. Resident B's October 2021 paper MAR did include medication passers' initials for the administration of this medication on 10/01 but not 10/23.

There were no medication passers' initials on Resident B's October 2021 EMAR for the administration of his Hydralazine 25mg on 10/01 and 10/23. However, Resident B's October 2021 paper MAR did include medication passers' initials for the administration of this medication on the above dates.

There were no medication passers' initials on Resident B's October 2021 EMAR for the administration of his Olanzapine 20mg on 10/01 and 10/23. However, Resident B's October 2021 paper MAR did include medication passers' initials for the administration of this medication on the above dates.

There were no medication passers' initials on Resident B's October 2021 EMAR for the administration of his Olanzapine 5mg on 10/01 and 10/23. However, Resident B's October 2021 paper MAR did include medication passers' initials for the administration of this medication on the above dates.

There were no medication passers' initials on Resident B's October 2021 EMAR for the administration of his Pantoprazole 40mg on 10/05, 10/23, 10/24, 1026, and 10/30. However, Resident B's October 2021 paper MAR did include medication passers' initials/documentation for the administration of this medication on the above dates.

To verify whether or not the initials of the individuals administering Resident B's medications were documented on his EMARs and/or paper MARs at the time the medications were actually administered and not at a later date, Mr. Gill and I requested a printed copy of Resident B's most current EMAR and paper MAR. Ms. White provided us with a copy of Resident B's December 2021 EMAR and paper MARs for 12/01 through 12/20 (the date of our unannounced investigation).

There were no medication passers' initials on Resident B's December 2021 EMAR and paper MAR for the administration of his Haloperidol Lactate 2mg on 12/06.

There were no medication passers' initials on Resident B's December 2021 EMAR and paper MAR for the administration of his Hydralazine 25mg on 12/06.

There were no medication passers' initials on Resident B's December 2021 EMAR and paper MAR for the administration of his Olanzapine 20mg on 12/06.

There were no medication passers' initials on Resident B's December 2021 EMAR and paper MAR for the administration of his Olanzapine 5mg on 12/06.

There were no medication passers' initials on Resident B's December 2021 EMAR and paper MAR for the administration of his Pantoprazole 40mg on 12/01, 12/05, 12/06, 12/07, 12/08, 12/10, 12/13, and 12/15.

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: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Based upon our investigation, it has been established Resident A and B's September and October 2021 EMARs and paper MARs were missing the initials of the persons who administered their medications on a few occasions. Subsequently, based upon a comparison of Resident A and B's September and October 2021 EMARs/paper MARs to their most current EMARs/paper MARs, it has been established Resident A and B's current EMARs/paper MARs indicated far more missing medication passers' initials that what was reflected on their September and October 2021 EMARs/paper MARs. Based upon this comparison, it has been established that when medication passers do not document the administration of Resident A and B's medications on their EMARs via NextStep, they are likely not entering their initials on Resident A and B's backup paper MARs at the time they actually administer Resident A and B their medications, but rather, are doing so at a later date.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: According to the written complaint filed with the BCHS on 12/06, Residents A and B were diagnosed with an unidentified mental illness. The written complaint indicated Residents A and B take prescription medications for both physical and mental health conditions.

On 01/10/2022, via email, Beacon Specialized Living, Inc.'s Chief Administrative Officer Melissa Williams informed me resident medication was automatically refilled on a monthly basis, at the facility's preferred pharmacy. According to Ms. Williams, "as a rule of thumb" resident medication was refilled when there was "less than a week-10 days of medication left", to ensure the facility would not run out of medication.

During our onsite investigation on 12/20, Mr. Gill and I reviewed Resident A's most current EMAR (12/01-12/20) and compared it to his individual pharmacy labeled bubble packs of medication. In addition to this, Mr. Gill and I counted all of the medication in each of Resident A's medication bubble packs, and established the following information:

Resident A was to be administered 15mg of BuSpar (Buspirone), three times daily. According to the label on the bubble pack of Resident A's AM dose of this medication, the pharmacy refilled 31 pills of this medication on 11/18. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering Resident A the medication, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/27, the last pill in the bubble pack would be administered on or closely around 12/27. I established there were 7 pills left in the bubble pack of Resident A's AM dose of this medication, which confirmed that if this medication was refilled one week-10 days before running out as indicated by Ms. Williams, Resident A more than likely received the AM dose of this medication as prescribed.

According to the label on the bubble pack of Resident A's PM dose of this medication, the pharmacy refilled 31 pills on 11/02. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering this medication to Resident A, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/11, the last pill in the bubble pack would have been administered on or closely around 12/11. However, upon counting the medication on 12/20, we established there were still 8 pills left in the bubble pack of Resident A's PM dose of this medication.

According to the label on the bubble pack of Resident A's bedtime dose of this medication, the pharmacy refilled 31 pills on 11/18. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently

started administering this medication to Resident A, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/27, the last pill in the bubble pack would be administered on or closely around 12/27. However, upon counting the medication 12/20, we established there were still 14 pills left in Resident A's bubble pack of his bedtime dose of this medication.

Resident A was to be administered 100mg of Docusate Sodium, twice daily. According to the label on the bubble pack of Resident A's AM dose of this medication, the pharmacy refilled 29 pills on 11/02. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering Resident A's this medication, out of this bubble pack. Assuming this medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/12, the last pill in the bubble pack would have been administered on or closely around 12/10. However, upon counting the medication on 12/20, we established that there were still 13 pills left in Resident A's bubble pack of his AM dose of this medication.

According to the label on the bubble pack of Resident A's PM dose of this medication, the pharmacy refilled 31 pills on 11/18. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering this medication to Resident A, out of this bubble pack. Assuming this medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/27, the last pill in the bubble pack would have been administered on or closely around 12/10. However, upon counting the medication on 12/20, there were still 16 pills left in Resident A's bubble pack of his PM dose of this medication.

Resident A was to be administered 100mg of Fluvoxamine, twice daily. According to the label on the bubble pack of Resident A's AM dose of this medication, the pharmacy refilled 27 pills on 11/02. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering Resident A this medication, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/11, the last pill in the bubble pack would have been administered on or closely around 12/07. However, upon counting the medication on 12/20, there were 19 pills left in Resident A's bubble pack of his AM dose of this medication.

According to the label on the bubble pack of Resident A's bedtime dose of this medication, the pharmacy refilled 31 pills on 11/18. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering Resident A this medication, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/27, the last pill in the bubble pack would be administered on 12/27. However, upon counting the

medication on 12/20, there were 14 pills left in Resident A's bubble pack of his bedtime dose of this medication.

Resident A was to be administered 10mg of Haldol (Haloperidol), once daily. According to the label on Resident A's bubble pack of this medication, the pharmacy refilled 31 pills on 11/18. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering this medication to Resident A, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/27, the last pill in the bubble pack would be administered on or closely around 12/27. However, upon counting the medication on 12/20, there were 28 pills left in Resident A's bubble pack of this medication.

Resident A was to be administered 10mg of Loratadine (allergy relief), once daily. According to the label on Resident A's bubble pack of this medication, the pharmacy refilled 31 pills on 11/18. During the onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering this medication to Resident A, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/27, the last pill in the bubble pack would be administered on or closely around 12/27. However, upon counting the medication on 12/20, there were 22 pills left in Resident A's bubble pack of this medication.

Resident A was to be administered 300mg of Oxcarbazepine (Trileptal), twice daily. According to the label on the bubble pack of Resident A's AM dose of this medication, the pharmacy refilled 31 pills five months ago, on 07/19. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering Resident A this medication, out of this bubble pack. Assuming this medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 07/28, the last pill in the bubble pack would have been administered on or closely around 08/27. However, upon counting the medication on 12/20, there were still 21 pills left in Resident A's bubble pack of his AM dose of this medication.

According to the label on the bubble pack of Resident A's PM dose of this medication, the pharmacy refilled 31 pills approximately five months ago, on 07/18. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering this medication to Resident A, out of this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 07/27, the last pill in the bubble pack would have been administered on 08/26. However, upon counting the medication on 12/20, there were 29 pills left in Resident A's bubble pack of his PM dose of this medication.

Resident A was to be administered 20mg of Pantoprazole Sod DR, twice daily. According to the label on the bubble pack of Resident A's AM dose of Pantoprazole Sod DR medication, the pharmacy refilled 31 pills on 11/18. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering this medication to Resident A, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/27, the last pill in the bubble pack would be administered on or closely around 12/27. Upon counting the medication on 12/20, we established there were six pills left in the bubble pack of Resident A's AM dose of this medication, which confirmed that if this medication was refilled one week-10 days before running out, as indicated by Ms. Williams, Resident A more than likely received the AM dose of this medication as prescribed.

According to the label on the bubble pack of Resident A's PM dose of this medication, the pharmacy refilled 31 pills on 11/18. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering this medication to Resident A, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/27, the last pill in the bubble pack would be administered on 12/27. However, upon counting the medication on 12/20, there were still 15 pills left in Resident A's bubble pack of his PM dose of this medication.

According to documentation on Resident A's September and October 2021 EMARs, Resident A refused his AM dose of BuSpar 15mg, Docusate Sodium 100mg, Fluvoxamine 100mg, Oxcarbazepine (Trileptal) 300mg, and Pantoprazole Sod Dr, as well as his Fluticasone 50mg, and Loratadine 10mg on 09/06, 09/20, 09/25, 10/02, 10/06, and 10/11. Per medication passers' initials on Resident A's October 2021 EMAR, on 10/25 Resident A was administered all of his scheduled AM medications. However, handwritten documentation on Resident A's October 2021 paper MAR indicated that on 10/25, Resident A refused all of his AM medications.

Documentation on Resident A's December 2021 EMAR and paper MAR indicated Resident A had not refused any medications from 12/01 through 12/20.

While at the facility on 12/20, Mr. Gill and I also reviewed Resident B's most current EMAR and compared it to his individual pharmacy labeled bubble packs of medication. In addition to this, Mr. Gill and I counted all of the medication in each of Resident B's medication bubble pack, and established the following information:

Resident B was to be administered 25mg of Hydralazine, every night at bedtime. According to the label on Resident A's bubble pack of this medication, the pharmacy refilled 31 pills on 10/19. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering this medication to Resident B, from this bubble pack. Assuming the

medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 10/28, the last pill in the bubble pack would have been administered on or closely around 11/27. However, upon counting the medication on 12/20, there were 27 pills left in Resident A's bubble pack of this medication.

Resident B was to be administered 20mg of Olanzapine, once daily. According to the label on Resident A's bubble pack of this medication, the pharmacy refilled 31 pills on 10/19. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering this medication to Resident B, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 10/28, the last pill in the bubble pack would have been administered on or closely around 11/27. However, upon counting the medication on 12/20, there were 14 pills left in Resident A's bubble pack of this medication.

Resident B was to be administered 5mg of Olanzapine, once daily. According to the label on Resident A's bubble pack of this medication, the pharmacy refilled 31 pills on 10/19. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering this medication to Resident B, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 10/28, the last pill in the bubble pack would have been administered on or closely around 11/27. However, upon counting the medication 12/20, there were 14 pills left in Resident A's bubble pack of this medication.

Resident B was to be administered 40mg of Pantoprazole, once daily. According to the label on Resident A's bubble pack of this medication, the pharmacy refilled 31 pills on 11/18. During our onsite investigation, there was no way to determine when medication passers opened, and subsequently started administering this medication to Resident B, from this bubble pack. Assuming the medication was refilled approximately 10 days before running out, and the bubble pack was opened and started on approximately 11/27, the last pill in the bubble pack would be administered on or closely around 12/27. However, upon counting the medication on 12/20, there were 22 pills left in Resident A's bubble pack of this medication.

According to documentation on Resident B's September and October 2021 EMAR, Resident B refused his Pantoprazole 40mg on 09/08, 09/25, 09/28, 10/02, 10/03, 10/06, 10/10, 10/11, 10/15, 10/19, 10/21, 10/22, and 10/27. Documentation on Resident B's October 2021 paper MAR indicated Resident B also refused his Pantoprazole 40mg on 10/23 and 10/24. Resident B's September 2021 EMAR indicated that on 09/08, Resident B did not receive his Haloperidol Lactate 2mg, Hydralazine 25mg, Olanzapine 20mg, and Olanzapine 5mg because he was not at the facility.

According to documentation on Resident B's December 2021 EMAR, on 12/16 Resident B's Haloperidol Lactate 2mg, Hydralazine 25mg, Olanzapine 20mg, and Olanzapine 5mg were "held per physician's orders". Documentation on Resident B's December 2021 EMAR indicated that Resident B refused his Pantoprazole 40mg on 12/12, 12/14, 12/18, and 12/19.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	According to Beacon Specialized Living, Inc.'s Chief Administrative Officer Melissa Williams, resident medication was automatically refilled on a monthly basis at the facility's preferred pharmacy. To ensure the facility would not run out of medication, resident medication was refilled when there was "less than a week-10 days of medication left." Based upon a comparison of Resident A and B's most current EMAR to the pharmacy labels on each one of their individual bubble packs of medication, as well as an audit of every pill left in each bubble pack, it has been established that even when given a 10-day grace period, upon comparing the dates the medications were refilled to the amount of pills left in each individual bubble pack of medication, it appeared that some of the medication bubble packs contained more pills than they should. On 12/20 it was also discovered that medication passers were currently administering Resident A his AM and PM doses of Oxcarbazepine (Trileptal) 300mg from bubble packs that were filled on 07/18 and 07/19, approximately 5 months ago. Documentation on Resident A and B's September, October, and December 2021 EMARs/paper MARs indicated that Residents A and B occasionally refused their medications. On 09/08 Resident B was not administered some of his medications because he was out of the facility. On 12/12, 12/14, 12/18, and 12/19 Resident B was not administered some medications "per physician's orders". This could account for some of the extra pills in Resident A and B's medication bubble packs. However, there was no clear way to determine this. Due to missing medication passers' documentation and/or inconsistencies in documentation on Resident A and B's EMARs/paper MARs, and because there was no clear way for the department to determine exactly when medication passers opened, and subsequently began administering medications from Resident A and B's medication bubble packs, the facility

	failed to adequately demonstrate to the department that medication passers administered Residents A and B their medication(s) as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: During Mr. Gill and I's unannounced investigation at the facility on 12/20, we waited on the facility's front porch for Ms. White to arrive and assist us with our investigation. While waiting, I leaned on the front porch handrail and discovered the handrail was not sturdy or securely fastened, and subsequently was in need of repair. Mr. Gill and I also discovered multiple empty water bottles, empty cigarette cartons, and miscellaneous pieces of trash on and around the facility's front porch.

According to Special Investigation Report (SIR) 2022A0462003, dated 12/03/2021, the facility was in violation of AFC administrative licensing rule 400.14403(2) when it was established that sometime around 10/16 a resident (identified as Resident C in SIR 2022A0462003) punched another resident's (identified as Resident A in SIR 2022A0462003) bedroom door, creating a large vertical crack to form, large enough to see some light shine through. According to Ms. Pueblo, a "work order" had been placed with the maintenance team to either fix or replace the door. However, as of 11/18, approximately one month after the incident, the door had not been repaired or replaced. The facility's approved corrective action plan, dated 12/21/2021, indicated the door would be repaired or replaced by 12/31/2021.

APPLICABLE RULE	
R 400.14403	**Maintenance of premise.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants. **(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.**
	During an unannounced investigation at the facility on 12/20, it was established the handrail on the facility's front porch was not sturdy or securely fastened, and subsequently pose a safety risk. It was also established that multiple empty water bottles, empty cigarette cartons, and miscellaneous pieces of trash were present on and around the facility's front porch.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR 2022A0462003, DATED 12/03/2021, AND CAP, DATED 12/21/2021]**

ADDITIONAL FINDING:

INVESTIGATION: Before leaving the facility on 12/20, I requested to use the facility's bathroom and was instructed to do so in a resident bathroom, located in the lower level of the facility. Upon washing my hands I discovered there were no individual towels available for residents to dry their hands.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(8) Hand-washing facilities that are provided in both the kitchen and bathroom areas shall include hot and cold water, soap, and individual towels, preferably paper towels.
	During an unannounced investigation at the facility on 12/20, it was established the resident bathroom located in the lower level of the facility did not have individual towels available for residents to dry their hands, and subsequently posed a sanitation issue.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/03 I conducted an exit conference with licensee designee Ramon Beltran via telephone and shared with him the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

Michele Streeter 01/25/2022

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 02/02/2022

Dawn N. Timm Date
Area Manager