GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 16, 2022

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

RE: License #: AS800242668
Investigation #: 2022A1024019
Beacon Home at Highland

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 January 28, 2022, 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

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 #:	AS800242668
Investigation #:	2022A1024019
Complaint Receipt Date:	01/21/2022
Investigation Initiation Date:	01/21/2022
Report Due Date:	03/22/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Highland
Facility Address:	56838 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	01/22/2002
License Status:	REGULAR
Effective Date:	07/08/2021
Expiration Date:	07/07/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A gained access to narcotic medications that were not locked in the home.	Yes

III. METHODOLOGY

01/21/2022	Special Investigation Intake 2022A1024019
01/21/2022	Special Investigation Initiated - Face to Face with home manager Paula Cummins, district director Kimberly Howard, licensee designee Nichole VanNiman, Beacon nurse Kaitlyn Taylor
01/28/2022	Contact - Telephone call made with licensee designee Nichole VanNiman
01/28/2022	Contact - Telephone call made with care manager Shelly Baldwin from Lakeland Hospital
01/28/2022	Corrective Action Plan Received
02/03/2022	Contact - Telephone call made with direct care staff member Brittany Smith and Resident A
03/09/2022	Contact - Telephone call made with direct care staff member Kayla Cummings and Marie Garcia
03/10/2022	Contact - Document Received-*AFC Licensing Division Incident/Accident Report*, *After Visit Summary/Provider Notes*
03/10/2022	Exit Conference with licensee designee Nichole VanNiman
03/10/2022	Inspection Completed-BCAL Sub. Compliance
03/10/2022	Corrective Action Plan Requested and Due on 03/25/2022
03/10/2022	Corrective Action Plan Approved

ALLEGATION:

Resident A gained access to narcotic medications that were not locked in the home.

INVESTIGATION:

On 1/21/2022, I conducted an onsite investigation at the facility with licensee designee Nichole VanNiman, district director Kimberly Howard, home manager Paula Cummins and Beacon nurse Kaitlynn Taylor. Ms. VanNiman stated on 1/19/2022 she was notified by staff that Resident A was found in her bedroom sleeping holding 3 packages of the narcotic medication, Lorazepam 1 mg, that belonged to another resident. Ms. VanNiman stated Resident A was not able to confirm or deny if she swallowed any of the medications therefore direct care staff immediately called 911 and sent Resident A to the hospital as two of the medication packages were empty. Ms. VanNiman further stated a room search was conducted along with a search throughout the entire home, however the missing medications were not found. Ms. VanNiman stated they are awaiting to find out if Resident A consumed any of the medications from the lab results that were conducted by the hospital. Ms. VanNiman stated they are currently investigating how Resident A gained accessed to the medications that were supposed to be locked in a medication cabinet in the medication room. Ms. VanNiman stated based on Beacon's internal investigation the Lorazepam medication was delivered to the home on 1/18/2022 to direct care staff member Kayla Cummins however the other staff member that was working, Brittany Smith, did not observe the Lorazepam medication in the locked cabinet where the other resident medications are stored before leaving her shift at 9pm. Ms. VanNiman stated Ms. Cummins informed her that she retrieved the medications from the pharmaceutical delivery driver at around 6:45pm and placed the medications on top of a cooler next to the locked cabinet in the medication room. Ms. VanNiman stated Ms. Cummins failed to lock the medication in the cabinet with the other resident medications which is their normal standard procedure when storing resident medications. Ms. VanNiman also stated Ms. Cummins failed to sign her name in the medication administration record to verify the delivery of the medications and did not communicate to any other staff member that the Lorazepam medication had been delivered. Ms. VanNiman further stated the medication room is also supposed to be closed shut and locked to restrict residents from entering therefore Ms. VanNiman believes the medication room door was not fully closed shut and locked which allowed Resident A to gain access to the Lorazepam medication that was placed on a shelf.

Ms. Howard stated she was also notified by staff that Resident A was found in her bedroom sleeping and had possession of 3 packages of the narcotic medication Lorazepam 1mg. Ms. Howard stated each package of medication contained 30 tablets and a total of 59 of the 90 tablets were missing. Ms. Howard stated it is unknown how Resident A gained access to the medication at this time. Ms. Howard stated the medications that were in Resident A's possession were delivered by the

pharmacist on 1/18/2022 to the home at around 6:45pm at which time direct care staff member Kayla Cummins signed off to retrieve them. Ms. Howard stated Ms. Cummins reported to her that she placed the medications on an opened shelf in the medication room however no other staff member observed those medications in the medication room at any given time the evening of 1/18/2022 or on the morning of 1/19/2022 before Resident A was found in the bedroom. Ms. Howard stated Ms. Cummins did not communicate to the other staff members that the Lorazepam medication was delivered to the home and was required to lock up the medication upon delivery. Ms. Howard further stated they are currently in the process of searching for the missing medications and are waiting to find out if any of those medications were consumed by Resident A.

Ms. Taylor stated she was the on-call nurse who was notified on the morning of 1/18/2022 that Resident A was found holding 3 packages of narcotic medication while she was sleeping and 2 of the packages were empty. Ms. Taylor stated the staff was able to wake up Resident A however Resident A was unable to articulate if she consumed any of the medications therefore Ms. Taylor advised staff to contact 911 immediately to have Resident A evaluated for suspected overdose. Ms. Taylor stated all medications are required to be kept in a locked cabinet in the medication room where the door is also supposed to be kept locked at all times when staff are not preparing medications to prevent residents from having access to the medications.

Ms. Cummins stated she was notified by staff that Resident A was found sleeping holding narcotic medications that were prescribed to another resident in the facility. Ms. Cummins stated direct care staff members Brittany Smith and Maria Garcia were the staff members that observed Resident A with the narcotic medications. Ms. Cummins stated when medications are delivered, the medications are supposed to be signed in by the designated medication passer and the medications are to be stored in a locked cabinet with the door to the medication room completely shut and locked after the staff member leaves the room. Ms. Cummins stated direct care staff member Brittany Smith was working with Ms. Cummins the night the medications were delivered to the home however Ms. Smith was not made aware that the medications were delivered, nor did she observe the medications in the medication room before leaving her shift at 9pm.

While at the facility I observed three bubble packs of Lorazepam 1 mg with a 30-quantity count prescribed by Kalamazoo LTC Pharmacy to Resident B. I observed 30 tablets missing from 1 bubble pack and 29 tablets missing from another bubble pack.

I also reviewed a Packaging Slip document which provided the name of the medication Lorazepam 1mg and 3 packages of 30 tablets to be delivered to Resident B at Highland AFC home from Kalamazoo LTC Pharmacy dated 1/18/2022.

On 1/28/2022, I spoke with Ms. VanNiman who stated that no drugs were found in Resident A's system per hospital staff however the medications have still yet to be found after a complete search was conducted inside and outside of the home. Ms. VanNiman stated Ms. Cummins has been pulled from any administration of medication duties and all direct care staff members will be retrained on the medication delivery/intake process and designated medication administration policy.

On 1/28/2022, I conducted an interview with care manager Shelly Baldwin from Lakeland Hospital. Ms. Baldwin stated Resident A was seen at the emergency room for suspected overdose on 1/18/2022. Ms. Baldwin stated drug screen and examinations were conducted and no drugs were found in Resident A's system.

On 2/3/2022, I conducted an interview with direct care staff member Brittany Smith. Ms. Smith stated she worked on 1/18/2022 with Ms. Cummins and was not made aware that the medication Lorazepam 1mg was delivered to the home during their shift as required by Beacon policy. Ms. Smith stated she later found out the following day that the Lorazepam 1mg medication was delivered around 6:30pm on 1/18/2022 to Ms. Cummins. Ms. Smith stated she prepared and administered medications around 7:45pm on 1/18/2022 and did not observe the Lorazepam medication in the medication locked cabinet nor did she observe this medication anywhere in the medication room. Ms. Smith stated she observed Resident A before leaving her shift at 9pm and did not observe any unusual behavior by Resident A. Ms. Smith also stated she observed Resident A in her bedroom prior to her leaving and did not see any medications or contraband in Resident A's bedroom. Ms. Smith stated while working on the morning of 1/19/2022, she was notified by direct care staff member Maria Garcia that Resident A was found holding 2 bubble packs of Lorazepam 1mg medication while she was sleeping. Ms. Smith stated Ms. Garcia provided her with the two bubble packs of Lorazepam 1mg prescribed to Resident B. Ms. Smith stated she immediately followed Ms. Garcia back into the bedroom where Ms. Smith observed a third bubble pack under Resident A's arm. Ms. Smith stated 1 bubble pack was empty missing 30 medications, the second bubble pack was missing 29 medications with 1 tablet visible, and the third bubble pack contained the correct amount of 30 tablets unopened. Ms. Smith stated she and Ms. Garcia were able to wake up Resident A who speaks in a mumbling voice regularly and advised them to "leave her alone." Ms. Smith stated they immediately called the on-call nurse who then instructed them to call 911. Ms. Smith stated EMS arrived around 8:30am and transported Resident A to the hospital for suspected drug overdose. Ms. Smith stated they were given permission to conduct a room search for the missing pills however after searching the interior and exterior of the home, no medications were found. Ms. Smith stated she is unsure where Ms. Cummins stored the medications when the medications were delivered since Resident A was able to gain access them.

I attempted to interview with Resident A however Resident A was not able to be interviewed due to Resident A's cognitive impairment.

On 3/9/2022, I conducted interviews with direct care staff members Kayla Cummins and Maria Garcia. Ms. Cummins stated the medication Lorazepam was delivered on 1/18/2022 around 6:30pm from Resident B's pharmacy. Ms. Cummins stated when she retrieved the medications, she signed for them with the delivery driver and placed them on a shelf in the medication room. Ms. Cummins stated she then closed the door which shuts and automatically locks. Ms. Cummins stated she does not recall if she notified Ms. Smith that the medications were delivered and realizes that she did not follow corporate policy by not placing the medication in the designated locked cabinet. Ms. Cummins stated when she retrieved the medications, she observed all 90 pills in the original packaging and did not see any pills missing. Ms. Cummins stated after she put the medications in the medication room, she cleaned and did paperwork prior to leaving her shift. Ms. Cummins stated she took a break outside and smoked a cigarette where Resident A was also observed smoking a cigarette outside. Ms. Cummins stated Resident A did not demonstrate any unusual behaviors while smoking and was observed mumbling in her usual way of speaking.

Ms. Garcia stated on the morning of 1/19/2022 at 8am, while passing medications she observed Resident A sleeping in her bed holding 2 bubble packs of Lorazepam 1 mg medication which is a narcotic medication prescribed to another resident. Ms. Garcia stated she became very concerned because one of the bubble packs were missing 30 tablets, therefore she notified the other staff member Ms. Smith who then found a 3rd bubble pack under Resident A's arm. Ms. Garcia stated she called the on-call nurse after waking Resident A up who was not able to communicate effectively to them. Ms. Garcia stated the on-call nurse instructed them to call 911 who transported Resident A to the hospital for further evaluation. Ms. Garcia stated the staff members searched the entire house for the missing medications however were never able to find the medications that were missing. Ms. Garcia stated Resident A has difficulty communicating and was not able to tell them what she did with the missing medications or explained how she got access to the medications. Ms. Garcia stated she worked the overnight shift on 1/18/2022 and never saw the Lorazepam medication in the medication locked cabinet where all the resident medications are stored, nor did she see this medication anywhere in the medication room.

On 3/10/2022, I reviewed the facility's *AFC Licensing Division Incident/Accident Report* dated 1/19/2022 written by Brittany Smith and Maria Garcia. According to this report, Ms. Garcia noticed that Resident A had bubble packs containing prescribed medications not prescribed to Resident A totally 30, a pharmacy issued narcotics count sheet, and a delivery packaging slip when being prompted to take her morning medication at approximately 8:20am at which time staff immediately took possession of the two bubble packs, the delivery slip, and the narcotic count sheet and informed Ms. Smith who was in the medication room. Both Ms. Smith and Ms. Garcia went back to Resident A's bedroom to wake Resident A and sit her up. While moving Resident A, another bubble pack was found of this same medication underneath's Resident A's arm that contained only 1 tablet. Ms. Smith notified the home manager

and on-call nurse Kaitlynn who instructed staff to obtain a set of vitals which were BP:106/48 with a pulse 146 and SPO2 levels were 90%. The on-call nurse instructed the staff members to contact 911 to have EMS evaluate Resident A further who then transported Resident to Lakeland Hospital in St. Joseph. This report stated staff were then informed that a room search would have to be conducted of every room including all resident bedrooms authorized by Nichole VanNiman. This report stated staff was then interviewed by Deputy Weber to question staff on how Resident A had received the medications that did not belong to her.

I also reviewed Resident A's *After Visit Summary* dated 1/19/2022. According to this summary Resident A was seen at Lakeland Emergency Center center for suspected overdose. According to the *Provider Notes* dated 1/19/2022, no written instruction and orders are needed.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Based on my investigation which included interviews with licensee designee Nichole VanNiman, district director Kimberly Howard, nurse Kaitlin Taylor, home manager Paula Cummins, care manager Shelly Baldwin, direct care staff members Brittany Smith, Kayla Cummins, Maria Garcia, review of the Resident B's bubble pack medications, review of Resident A's *AFC licensing Division-Incident/Accident Report,* and *After Visit Summary/Provider Notes* there is evidence to support the allegation Resident A gained access to narcotic medications that were not locked in the home as required. According to Ms. VanNiman, Ms. Howard, Ms. Taylor and Ms. Paula Cummins, Brittany Smith, Ms. Garcia, and Ms. Kayla Cummins Resident A was found in possession of three bubble packs of the narcotic medication Lorazepam 1mg with 59 of the 90 medications missing. Ms. VanNiman, Ms. Howard, Ms. Taylor, and Ms. Paula Cummins all stated all resident medications are required to be locked in a cabinet in the medication room however no staff member reported that they observed the Lorazepam medication anywhere in the medication room or in the locked cabinet as required on the evening of 1/18/2022 or morning 1/19/2022. Resident A was able to gain access to medications that were not properly locked in the medication room.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/10/2022, 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 3/10/2022, I approved an acceptable corrective action plan.

IV. RECOMMENDATION

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

Ondrea Johnson
Licensing Consultant

3/14/2022
Date

Approved By:

03/16/2022

Dawn N. Timm
Area Manager

Date