GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 25, 2022

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

RE: License #: AS250395771
Investigation #: 2022A0779026
Beacon Home at Linden

Dear Ms. Rawlings:

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 (906) 226-4171.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250395771
Investigation #:	2022A0779026
Complaint Receipt Date:	03/16/2022
Investigation Initiation Date:	03/16/2022
Report Due Date:	05/15/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Rawlings
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Linden
Facility Address:	14180 N. Hogan Road Linden, MI 48451
Facility Telephone #:	(269) 214-4341
Original Issuance Date:	10/09/2018
License **Status:**	REGULAR
Effective Date:	04/09/2021
Expiration Date:	04/08/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/13/2022, Staff Katrina failed to give Resident A his insulin, as required.	No
Additional Findings	Yes

III. METHODOLOGY

03/16/2022	Special Investigation Intake 2022A0779026
03/16/2022	APS Referral Complaint was referred to AFC licensing by APS centralized intake.
03/16/2022	Special Investigation Initiated - Telephone Voicemail message was left for recipient rights advisor, Pat Shepard.
03/17/2022	Inspection Completed On-site
03/22/2022	Contact - Telephone call made Interview conducted with staff person, Katrina Brantley.
03/29/2022	Contact - Telephone call made Interview conducted with home manager, Katherine Blackburn.
04/07/2022	Exit Conference Conducted with licensee designee, Kimberly Rawlings.

ALLEGATION:

On 3/13/2022, Staff Katrina failed to give Resident A his insulin, as required.

INVESTIGATION:

On 3/16/22, a phone conversation took place with recipient rights investigator, Pat Shepard, who confirmed that she was investigating the same allegations. Ms. Shepard stated that she had already spoken to Resident A, who confirmed to her that he did not get his afternoon insulin shot on 3/13/22. She reported that Resident A told her that he and staff person, Katrina Brantley got into a verbal struggle over the procedure of passing his insulin, that Ms. Brantley would not talk to him during the process and that he refused to take the medication.

On 3/17/22, an on-site inspection was conducted. Interviews took place with staff person, Shay Hines and Resident A.

Ms. Hines stated that she worked with Ms. Brantley on 3/13/22 and was aware that Resident A refused to take him insulin shot. Ms. Hines reported that Resident A and Ms. Brantley tend to not get along very well and that she could hear them going back and forth verbally during the medication passing, but could not say exactly what was said. She stated that she did specifically hear Resident A refuse to take his insulin shot. Ms. Hines stated that she is not fully trained to pass medications yet or she would have tried to get Resident A to take it from her.

Resident A admitted that he refused to take his 5:00pm dose of insulin. He stated that he takes his own blood sugar and that the device speaks what the blood sugar level is, as well as, prints it on the device screen. Resident A claims that he asked Ms. Brantley several times if she saw the blood sugar number on the device and she kept saying "You see me getting the needle don't you". Resident A stated that then she said "4, 5, 6" trying to be funny, so he refused to take the medication. Resident A stated that he refused the medication because she would not confirm that she knew how much insulin to give him and that he did not trust her to give him the correct amount.

On 3/22/22, a phone interview was conducted with staff person, Katrina Brantley. She stated that Resident A kept coming to her and wanting to test his blood sugar to early and was getting nasty to her when she told him he had to wait a little while longer. Ms. Brantley reported that Resident A was being disrespectful to her and calling her names, which is normal behavior for him, so she was not responding to him. She stated that the device that is used to test Resident A's blood sugar talks and displays the blood sugar level on the screen. Ms. Brantley claims that she told Resident A she saw the number, but admits that she did not repeat back to him what the number actually was. Ms. Brantley stated that she drew up Resident A's insulin correctly and he simply refused to take it.

On 3/29/22, a phone interview was conducted with home manager, Katherine Blackburn, who stated that Resident A's insulin (Novolog) is administered on a sliding scale, depending on what his blood sugar level at the time. Ms. Blackburn stated that this is not the first time something like this has happened between Resident A and Ms. Brantley and admits that they do not seem to get along. Ms. Blackburn reported that Resident A called her during the afternoon of 3/13/22, saying that Ms. Brantley was refusing to test his blood sugar. She stated that Resident A called her again a little while later saying that Ms. Brantley would not acknowledge that she knew what his blood sugar level was, that he was tired of arguing with her and that he didn't even want to take his insulin anymore. Ms. Blackburn stated that Resident A normally does not refuse his medications and is good about taking his insulin, so there is nothing in his treatment/behavior plans to address this specific issue.

Resident A's written assessment plan states that he is quite independent and is physically able to complete all his activities of daily living on his own. Resident A's medication log for March 2022, confirms that he did not receive his 5:00pm dose of insulin on 3/13/22.

When Resident A tests his blood sugar level, staff document what his level was and how much insulin was required at each passing. A second staff initials this document confirming that the numbers are correct and that the appropriate amount of insulin was drew. On 3/13/22, the document shows that for Resident A's 5:00pm testing, his blood sugar level was 109 and that he should have been given 10 units of insulin.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	It was confirmed that Resident A did not receive his 5:00pm insulin medication on 3/13/22, but only because he refused to take it. Although the situation could have been handled more appropriately by staff person, Katrina Brantley, it appears that the appropriate amount of insulin was prepared and offered to Resident A; therefore, there is no violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When reviewing Resident A's medication logs, it was found that there were multiple spots where staff did initial the log indicating that Resident A's blood sugar was tested and/or that his insulin (Novolog) was administered. Other than on 3/13/22, it appears that Resident A did receive his insulin as prescribed, but that staff simply did not initial the log confirming that fact. There were a few other random spots on Resident A's medication logs where staff appeared to pass the medications but failed to initial the log.

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:	Review of Resident A's medication log showed that there were multiple random times when Resident A was provided his medication, but that the staff did not initial the log confirming that fact.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/7/22, an exit conference was conducted with licensee designee, Kimberly Rawlings. She was informed that a corrective action plan is required to address the above licensing rule violation.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged

Christopher A. Holvey

4/25/2022

Christopher Holvey — Date
Licensing Consultant

Approved By:

Mary Holton

4/25/2022

Mary E Holton — Date
Area Manager