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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 20, 2022

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

RE: License #: AS380398558
Investigation #: 2022A0007021
Beacon Home at Sheffield

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosures

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

I. IDENTIFYING INFORMATION

License #:	AS380398558
Investigation #:	2022A0007021
Complaint Receipt Date:	05/23/2022
Investigation Initiation Date:	05/23/2022
Report Due Date:	07/22/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Shelly Keinath
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Sheffield
Facility Address:	4162 Sheffield Drive Jackson, MI 49203
Facility Telephone #:	(517) 795-2004
Original Issuance Date:	02/05/2020
License Status:	REGULAR
Effective Date:	08/05/2020
Expiration Date:	08/04/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On May 17, 2022, Resident A was given the medication prescribed for Resident B.	Yes
On May 24, 2022, Resident A consumed a cleaning solution, which had been left out by staff.	Yes

III. METHODOLOGY

05/23/2022	Special Investigation Intake- 2022A0007021
05/23/2022	Special Investigation Initiated - Letter
05/23/2022	APS Referral Made.
05/26/2022	APS Referral Made.
05/26/2022	Contact - Telephone call received from Jackson County Guardian A and Staff A.
05/26/2022	Contact - Telephone call received from APS Worker #1.
05/26/2022	Contact - Telephone call received from Jackson County Guardian A.
06/08/2022	Referral - Recipient Rights - Complaint made.
06/09/2022	Inspection Completed On-site - Unannounced - Face to face contact with Employee #2, 3 Direct Care Staff, Resident A and Resident C.
07/12/2022	Contact - Telephone call made - Interview with Employee #3.
07/12/2022	Contact - Telephone call made - Interview with Employee #4.
07/13/2022	Contact - Telephone call made to Employee #1. Message left. I requested a returned phone call.
07/13/2022	Contact - Telephone call received - Interview with Employee #1.
07/13/2022	Contact - Face to Face with APS Worker #1.

07/14/2022	Exit Conference conducted with Ms. Kimberly Rawlings, Licensee Designee.

ALLEGATIONS:

On May 17, 2022, Resident A was given the medication prescribed for Resident B.

INVESTIGATION:

As a part of this investigation, I reviewed the incident report authored by Employee #1.

> It was documented that during the 8:00 p.m. medication passing, "I [Employee #1] as DMA passed [Resident A] another resident's medication." Resident A was given Celexa 20 mg, Trileptal 300 mg, Quetiapine100 mg, and Famotidine 20 mg. This happened "because I was side tracked due to helping a staff with another resident that was going in to an behavior." Employee #1 then contacted Home Manager #1, and she was instructed to call on call medical with a list of the medications that were given to Resident A and to take her vitals. Employee #1 spoke to LPN #1, and she was instructed to take Resident A's vitals every hour. The first vitals were taken at 8:30 p.m. and they were 120/98, the second set of vitals were 120/70, and the third set of vitals were 120/72. Resident A's vitals were taken every hour and she was monitored throughout the night. Resident A's vitals were normal.
>
> The Corrective Measures Taken to Remedy and/or Prevent Recurrence included that Employee #1 would be issued a Progressive Action and taken off medications until DMA class has been retaken. Employee #1 also would be mentored by the regional nurse. In addition, all staff will be mentored on the passing of medications, the importance of not being distracted, and provided with guidance to improve the medication administration process.

On May 26, 2022, I spoke with Jackson County Guardian (Guardian A) and her staff, (Staff A). Guardian A and Staff A reported that Resident A was seen at the emergency room on May 20, 2022, as they were trying to get lab work completed without success. Eventually it was determined that Resident A would be taken to the hospital. Guardian A reported that she was never told about the medication error. She had been in contact with the facility staff regarding Resident A going to the hospital and receiving IV fluids. Resident A is now hydrated.

On June 9, 2022, I conducted and unannounced on-site investigation and made face to face contact with Employee #2, three other direct care staff, Resident A and Resident C. I observed Resident A sitting in the living room. I also reviewed the resident files and medications logs during the on-site investigation. I also obtained the contact information for Employee #1.

On July 13, 2022, I interviewed Employee #1. Employee #1 informed me that she was the Med Passer, and she was preparing medications, when Resident C went running through the house headed to the kitchen. Employee #1 stated that Resident C has Pica, and they must watch him very closely. The staff that was supposed to supervise Resident C was assisting another staff with Resident D, who required a two-person assist into the wheelchair. Resident C got into the refrigerator and was drinking hot sauce, and spilling juice all over the floor. Employee #1 ran from the medication room, with the medications in hand, and was trying to redirect Resident C. He was pushing her away and trying to drink juice from the refrigerator. Employee #1 stated that she was very distracted. Resident A and Resident B were sitting in their recliners next to each other. Employee #1 stated that she put the spoon of medications in Resident A's mouth. She immediately realized that she had given Resident B's medication to Resident A. Employee #1 stated that her heart started beating fast and she felt awful. She called the appropriate officials including poison control, the home manager, and on-call medical. She was instructed to monitor Resident A's vitals. She stated that Resident A appeared to be sleepy.

As a result of the incident, Employee #1 was removed from passing medications, she was in-serviced, and they changed their protocols. Employee #1 stated that the resident receiving the medication is now brought to the door of the medication room. The medication passer remains in the medication room. The staff that brings the resident to the door, must also check the computer, and make sure that it is the correct resident etc. Employee #1 stated that this new process is working. She also stated that at times they are short staffed but that her boss does her best to help in any way possible.

On July 14, 2022, I conducted the Exit Conference with Ms. Kimberly Rawlings, Licensee Designee. We discussed the investigation and findings. She concurred with the recommendations and agreed to submit a written corrective action plan to address the established violations.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Employee #1 informed me that she was the Med Passer, and she was preparing medications, when Resident C went running through the house headed to the kitchen. Resident C got into the refrigerator and was drinking hot sauce, and spilling juice all over the floor. Employee #1 ran from the medication room, with the medications in hand, and was trying to redirect Resident C. Employee #1 stated that she was very distracted. Resident A and Resident B were sitting in their recliners next to each other. Employee #1 stated that she put the spoon of medications in Resident A's mouth. She immediately realized that she had given Resident B's medication to Resident A. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A received the medications prescribed to Resident B. The resident medications were not administered as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

On May 24, 2022, Resident A consumed a cleaning solution, which had been left out by staff.

INVESTIGATION:

As a part of this investigation, I reviewed the incident report authored by Employee #3.

It was noted that Employee #3 was cleaning the home around 4:30 a.m. Employee #3 initially thought it was Employee #4; however, as she turned around, she found Resident C, who had gotten a bottle of floor cleaner that had been left out by the other staff on counter. Resident C managed to take about two sips of the liquid. As soon as Employee #3 realized what was going on, the liquid was removed from him. Resident C was removing his clothing, moving from chair to chair in the living room and going outside to cool down, in an attempt to get comfortable.

The Action Taken by Staff /Treatment Given included that staff immediately got Resident C a glass of water, he went straight to the restroom; however, staff gave him the water anyway to get something in his stomach as soon as possible.

While Resident C was on the toilet he had a medium loose bowel movement, possibly in reaction to the chemical. Employee #1 suggested Resident C be given milk. Staff got a glass of milk for Resident C. When Resident C began wheezing staff immediately took his vitals, called the on-call nurse, home manager and the Jackson County Guardians Office.

Staff were instructed to take Resident C to the hospital. Staff began to get Resident C ready to go and gathered all necessary documentation that should go with him. While gathering his paperwork staff offered Resident C more milk and bread to coat his stomach.

Employee #1 and Employee #6 took Resident C to the hospital, where he was admitted. The staff also kept Guardian A up to date on the situation.

The Corrective Measures Taken to Remedy and/or Prevent Recurrence included: The liquid was removed from Resident C and placed in the proper location to prevent recurrence. Resident C was assisted by staff to make sure he was as comfortable as possible until he was then taken to the hospital. It was also noted that Home Manager #1 would complete a TA with all staff to communicate the importance of following protocol on keeping all cleaning supplies in the locked closet when not in use and not to leave them unattended. Staff will also be re-trained on following directions in situations like this and be informed as to who should be called and when they should be contacted.

I reviewed the medical records for Resident C. It was noted that Resident C was a 59-year-old male, who was non-verbal. Resident C was brought to the emergency department, as he was having trouble breathing after ingesting a cleaning solution. Staff assisted Resident C and brought him to the hospital. Staff reported that around 5:30 a.m., Resident C ingested two gulps of Lysol. About ten minutes later, Resident C had increased work with breathing and coughing. The staff gave Resident C milk and bread to coat his stomach. Staff then contacted poison control who recommended that Resident C be taken to the emergency department.

On May 26, 2022, I spoke with Guardian A and Staff A regarding Resident C. They received information that Resident C ingested “two gulps” of Lysol. Guardian A and Staff A reported that Resident C was still in the hospital.

On May 26, 2022, Guardian A later called to inform me that Resident C would be released from the hospital.

On May 26, 2022, APS Worker #1 contacted me to inform that he would be going out to the home on the following day. In addition, that he would be contacting Office of Recipient Rights.

On June 9, 2022, during the on-site investigation, I observed Resident C sitting in the living room, next to the dedicated staff. I also spoke with Employee #2, who

stated that she heard about Resident C consuming the cleaner, and that Resident C was in the hospital for two days following that incident.

On July 12, 2022, I interviewed Employee #3. Employee #3 informed me that she was assigned as the 1:1 staff for Resident C, she thought he was asleep, so she decided to help-out and clean. She was sweeping and mopping the floors. She saw Employee #4 walk towards the hallway. Then she heard something, thinking it was Employee #4, but as she turned around, she noticed that it was Resident C. She observed Resident C holding the bottle of unlabeled floor cleaner. Employee #3 grabbed the bottle to remove it, as he took his second gulp. Resident C then went to the bathroom and had a BM. She was concerned about his stomach, as she did not know what he had ingested. He was first given water to get something in his stomach. Once Resident C was sitting in his chair, she realized that he had puked. Employee #3 explained that she freaked out and was frustrated. She stated that they monitored the resident (before he was sent to the hospital). She stated she did not know where the cleaner came from or what it was.

On July 12, 2022, I interviewed Employee #4. She informed me that she no longer works for the home. Regarding the incident, Employee #4 stated that she was attending to Resident E and did not know what happened until about 45 minutes later. Employee #4 stated that Resident C's nose was running, he was running back and forth, and she thought he was coming down with a cold. Once she was informed of what happened, she jumped up and said they had to do something. The other staff told her they gave Resident C bread and milk to coat his stomach. Employee #4 stated that she should have called poison control first, but she called the nurse. Employee #4 stated this was her first incident with a situation like this. Employee #4 stated that Resident C was wheezing, and they were instructed to take him to the hospital. Employee #4 stated that the corporation has a protocol that staff must follow, including contacting management first. She stated that she would have just called for an ambulance. Once instructed to take him to the hospital, they had to decide who would accompany him, as it needed to be one staff from 1st shift and one from 3rd shift. Employee #5 wanted to go but Employee #4 told her no. Employee #1 and Employee #6 ended up taking him to the hospital. Employee #4 stated that she was sad that no one told her what happened sooner. She stated that Resident C had a history of picking up glass or pop. The cleaner was in a spray bottle on the kitchen counter. Employee #3 was mopping the floors. Employee #4 stated that the cleaner was brought in because the facility only provides bleach, which was not doing the cleaning job.

During the course of this investigation, I reviewed an Incident Report authored by Home Manager #1.

> Home Manager #1 noted that on May 25, 2022, she received a call at 5:47a.m. from Employee #4, who reported that Resident C drank Pine-Sol. Home Manager #1 immediately directed

Employee #4 to call poison control and then medical on call. A few moments went by, and Home Manager #1 did not hear from any staff, so she called back to the home to see what the plan was. Staff answered the phone and said that on call medical said to call poison control. Home Manager #1 said “that’s who you were directed to call first.” After staff called poison control, they called on call medical back and were directed to take Resident C to the ER for treatment.

Later that day, Home Manager got a report that Pine-Sol was not the cleaner that was used; it was Fabuloso cleaner, that 3rd shift kept in their locker in the garage. It was also reported that 3rd shift staff tried to get him to drink water and milk and to eat bread before they made any calls.

Home Manager #1 also spoke with Employee #3, and she stated that she did not know where the cleaner came from and did not know that it was left on the counter. Employee #3 stated that she was Resident C’s 1:1 but he was sleeping. Employee #3 was sweeping the floor while another staff was sitting on the recliner watching TV, when Resident C came out to the kitchen area, where he consumed the Fabuloso.

On July 13, 2022, I made face to face contact with APS Worker #1 who reported that his investigation is still pending.

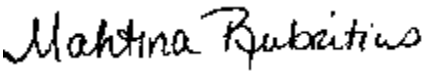
During the Exit Conference with Ms. Kimberly Rawlings, Licensee Designee, we also discussed staff bringing in their own cleaning supplies and the issues regarding those matters. She concurred with the recommendations and agreed to submit a written corrective action plan.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	According to Employee #3 Resident C ingested two gulps of floor cleaner. Employee #4 reported that she learned about the situation 45 minutes after it occurred. Employee #4 stated that Resident C's nose was running, he was running back and forth, and she thought he was coming down with a cold. Once she was informed of what happened, she jumped up and said they had to do something. The other staff told her they gave Resident C bread and milk to coat his stomach. Guardian A and Staff A reported that they received information that Resident C ingested "two gulps" of Lysol. The medical records for Resident C reflected that Resident C was brought to the emergency department, as he was having trouble breathing after ingesting a cleaning solution. Staff reported that around 5:30 a.m., Resident C ingested two gulps of Lysol. About ten minutes later, Resident C had increased work with breathing and coughing. The staff gave Resident C milk and bread to coat his stomach. Staff then contacted poison control who recommended that Resident C be taken to the emergency department. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident C was not treated with dignity and his personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

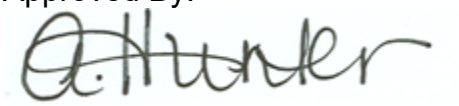
Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.



7/14/2022

Mahtina Rubritius Date
Licensing Consultant

Approved By:



7/18/2022

Ardra Hunter Date
Area Manager