GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 8, 2022

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

RE: License #: AS390406162
Investigation #: 2022A0581033
Beacon Home at Sprinkle

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406162
Investigation #:	2022A0581033
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:	Aubry Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Sprinkle
Facility Address:	6457 N. Sprinkle Rd. Kalamazoo, MI 49004
Facility Telephone #:	(269) 488-8118
Original Issuance Date:	02/18/2021
License Status:	REGULAR
Effective Date:	08/18/2021
Expiration Date:	08/17/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Tashia Doubley, passed the incorrect medication to Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/23/2022	Special Investigation Intake 2022A0581033
05/23/2022	Referral - Recipient Rights Integrated Services of Kalamazoo received the complaint and is investigating.
05/23/2022	Special Investigation Initiated - Letter Email with ISK RRO, Suzie Suchyta.
05/24/2022	Inspection Completed On-site Interviewed staff and residents.
05/24/2022	Contact - Document Sent Email to Administrator, Aubry Napier, requesting documents.
05/24/2022	Contact - Document Received Received staff schedules, Resident A's health care appraisal, Incident/Accident reports, assessment plans.
05/27/2022	Contact - Telephone call made Left voicemail with direct care staff, Tashia Doubley.
05/27/2022	Contact - Telephone call made Interview with direct care staff, Artillla White.
05/27/2022	Contact - Telephone call made Interview with home manager, Amanda Wilson.
05/27/2022	Contact - Document Sent Email to Ms. Suchyta. Requested Resident A's and Resident B's plans through ISK
05/27/2022	Inspection Completed-BCAL Sub. Compliance

06/09/2022	Exit conference with Ramon Beltran, licensee designee.

ALLEGATION:

Direct care staff, Tashia Doubley, passed incorrect medication to Resident A.

INVESTIGATION:

On 05/23/2022, I received this complaint through the Bureau of Community Health Systems (BCHS') online complaint system. The complaint alleged on 05/18/2022, direct care staff, Tashia Doubley, passed Resident B's medications to Resident A.

On 05/23/2022, I confirmed with Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Suzie Suchyta, she had received the allegations and was investigating. She indicated she had scheduled an on-site at the facility for 05/24/2022, which I informed her I would be attending. Ms. Suchyta stated Resident A consumed Resident B's medications, which included Pravastatin 40 mg, Quetiapine 400 mg, Quetiapine 100 mg, and Oxybutynin 5 mg.

Ms. Suchyta forwarded me the Incident / Accident Report (IR) she received relating to the medication error, which was dated 05/19/2022. According to this IR on 05/18/2022 around 8 pm, direct care staff, Tashia Doubley, "didn't double check" while passing medications to Resident A. Ms. Doubley indicated by the time she realized the error, Resident A had already taken the wrong medications. She indicated in the IR the facility's on-call nurse was contacted and poison control. The IR indicated poison control informed Ms. Doubley Resident A would be "fine" but could be "a little sleepy" compared to normal. The corrective measures on the IR indicated "management has taken this staff off of DMA shifts and instructed her to attend DMA training".

On 05/24/2022, I conducted an announced on-site investigation at the facility in conjunction with Ms. Suchyta and interviewed Resident A. Resident A confirmed receiving Resident B's medications after Ms. Doubley prepared and put them out for him to take. He stated after he took them, he became drowsy, so he went to bed.

During the on-site investigation, I also interviewed direct care staff, Alicia Burns and Jackie Baldwin. Both staff reported appropriate methods for administering resident medication such as checking the medication for right medication, right dose, right person, right time, and right method. Both Ms. Burns and Ms. Baldwin indicated only one resident is administered medications at a time to prevent too much going on in the medication room, indicating distractions could lead to medication errors.

I also reviewed Resident B's electronic and paper Medication Administration Records (MARs), which confirmed he is prescribed the medications that were administered to Resident A.

On 05/27/2022, I interviewed the facility's home manager, Amanda Wilson, via telephone. Ms. Wilson stated Ms. Doubley took a "refresher" medication training and one of the licensee's nurses went over the medication process again, as well. Ms. Wilson stated she also did a training with Ms. Doubley in the facility's medication room and discussed how she needs to keep the medication room door shut to create a calm environment and indicated that if there is a distraction for Ms. Doubley to stop what she is doing, handle the distraction and then put all her attention on the medications. Ms. Wilson confirmed all direct care staff, who are trained to administer medications, are taught to make sure they have the right resident, the right medications, the right time, the right dose, and right method for administering the medications. She indicated once medications are administered, direct care staff are to document in the facility's computer eMAR and paper MAR.

On 05/27/2022, I interviewed direct care staff, Artilla White, via telephone. Ms. White stated she was not working when Ms. Doubley administered the wrong medications to Resident A; however, the process in which she administers medications was consistent with the process described by Ms. Wilson.

On 05/31/2022, I Interviewed direct care staff, Tashia Doubley, via telephone. Ms. Doubley acknowledged she gave Resident B's medications to Resident A on 05/18/2022. She stated she was the only direct care staff working that evening and was having a "rough day", but also "got distracted" from having the medication room window open and residents were "asking for cigarettes." She acknowledged she was supposed to check the medication "three times" prior to administering it and that she should ensure the medication is to the "right person, right route, and right time." She acknowledged she did not complete these steps and made an error. Ms. Doubley stated she contacted on-call medical and poison control who advised Resident A could become sleepy, which she stated did occur. She stated Resident B received his correct medication on the night of the medication error, but Ms. Doubley was advised by poison control to not administer Resident A's correct medications. She stated as a result of the medication error, she had been retrained in medications.

This is a repeat violation of Adult Foster Care Rule 400.14312(2). According to special investigation report #2022A0581004, in September and October 2021 multiple residents were not provided with their medications due to the medications not being available at the facility. The facility's corrective action plan, dated 01/04/2022, indicated all the facility's staff were retained on what to do if medication could not be located for administration. According to the CAP, direct care staff were to contact the facility's nurse or medical on-call so nursing staff could address the issue as soon as possible.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 05/18/2022, direct care staff, Tashia Doubley, administered Resident B's evening medications of Pravastatin 40 mg, Quetiapine 400 mg, Quetiapine 100 mg, and Oxybutynin 5 mg to Resident A. Subsequently, on 05/18/2022, Ms. Doubley did not administer Resident B's medication pursuant to label instructions, as required.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR 2022A0581004, CAP DATED 01/04/2022]**

ADDITIONAL FINDINGS

INVESTIGATION:

When I conducted my on-site inspection at the facility with RRO, Ms. Suchyta, we both observed the closet near the front door to be opened. Ms. Suchyta stated this closet was where Resident C keeps his coat and shoes and indicated it was supposed to be locked otherwise, Resident C can access the items and elope from the facility, which he had done in the past. Upon looking in the closet, I did observe Resident C's coat and shoes were present.

Ms. Suchyta and I informed Ms. Burns about the door, which she subsequently locked.

Both Ms. Burns and Ms. Baldwin indicated the door is regularly locked, but staff may have "forgot" to relock it with "everything going on." They both reported Resident C often relocks the door or will ask staff to lock the door after he comes in from smoking; however, both staff reported a lot going on with the on-site inspection and residents needing breakfast, medications, or smoking.

I attempted to interview Resident C during the on-site inspection; however, he was unable to respond to me. Ms. Suchyta also indicated Resident C has significant vision impairment and does not communicate well.

I interviewed Resident D who indicated Resident C's closet door is usually closed and locked. Resident D indicated Resident C will elope from the facility if the door is left unlocked and he is able to access his coat and shoes.

Ms. White stated Resident C has his closet locked because he elopes if he has access to his coat and shoes. She stated staff are expected to lock the door when Resident C is done smoking or is on an outing. Ms. White also indicated there are times when the door is not locked due to staff "forgetting", "being busy" or are "distracted." She stated staff should check the door is locked even if it is shut.

Ms. Wilson's and Ms. Doubley's statements to me were consistent with Ms. White's statement to me.

On 05/27/2022, Ms. Suchyta emailed me a copy of Resident C's Integrated Services of Kalamazoo "Behavior Assessment and Plan", dated 08/24/2021. According to this plan, Resident C has a restriction on his personal property (i.e., shoes and jacket/coat) to prevent elopement and maintain safety. His plan states Resident C "has a high likelihood of attempting to wander or elope if he's wearing shoes and has a coat (in cold weather)". His plan clearly states, "His shoes and coat will be kept secured in a locked closet". Furthermore, the plan states the following:

> "When [Resident C] asks for a cigarette, ensure he only has his slippers on (and a coat as needed depending on the weather) staff will give him a cigarette and light it when he can be supervised. If staff are unable to supervise [Resident C] while he is smoking, ask him to wait until staff are able to supervise before lighting his cigarette. Staff will only light his cigarette outside when staff are able to see him outside. [Resident C] does have slippers that he wears throughout the day and he has demonstrated that he will not leave the home in just his slippers, therefore [Resident C] should wear his slippers when outside smoking. The only time [Resident C] will need his shoes is when he is going on an outing."

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and *plans of service shall be implemented* for individuals residing in the facility.

ANALYSIS:	During my 05/24/2022 on-site inspection, I observed the hallway closet near the facility's front door, which is dedicated to Resident C's belongings, to be unlocked allowing Resident C access to his coat and shoes; despite there being a clear restriction in his Integrated Services of Kalamazoo Behavior Assessment and Plan, dated 08/24/2021. The plan indicates Resident C's coat and shoes should be locked up as unrestricted access to these items increases the likelihood of Resident C eloping from the facility. Subsequently, facility staff were not sufficiently implementing Resident C' behavior plan, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site inspection, Resident A stated he had gone to the hospital approximately one week prior and had not been accompanied by direct care staff. Recipient Rights Officer, Ms. Suchyta, indicated Resident A is supposed to be supervised while in the community, which includes the ER.

On 05/24/2022, I requested any IRs from the facility's Administrator, Aubry Napier, where Resident A had gone to the ER in the last two weeks. Ms. Napier sent me via email an IR where Resident A had gone to the ER on 05/16/2022 when direct care staff, Artilla White, was working. According to the IR, at approximately 9 pm, Resident A reported to Ms. White he was contacting 911 and requesting an ambulance due to falling earlier. Ms. White indicated in the IR she tried to "redirect" Resident A, but he insisted on going to the hospital because his head hurt. Ms. White indicated in the IR the "fire marshall[*sic*]" stated if Resident A requested to go to the ER, then it was "his choice" since he was his own guardian. The IR indicated Resident A was discharged and staff transported back home once tests were completed. The IR stated "management will be reviewing the process for contacting management as text messages are not an appropriate form of communication"

On 05/27/2022, I interviewed direct care staff, Artilla White, via telephone. Ms. White confirmed she had been working on or around 05/16/2022 when Resident A went to the ER without staff supervision during her shift. She stated she was the only direct care staff in the facility when Resident A contacted 911 and requested to be taken to the hospital because he was experiencing a concussion from a fall, he reported he had earlier in the day. Ms. White stated she did not observe Resident A contact 911 but was informed by police as to why he contacted them after she spoke to them on the phone. Ms. White stated when emergency services came out to the facility the "fire marshal" informed her he would be taking Resident A to the ER, which was approximately 11 pm.

Ms. White stated she contacted her home manager twice the night Resident A went to the ER. She stated she contacted Ms. Wilson after the police told her an ambulance was being sent to the facility and then sent her a text message after Resident A was headed to the ER. Ms. White indicated she was aware Resident A required staff supervision while out in the community, which included the ER, but indicated she was confused about what his rights were in terms of supervision. Ms. White stated she was unsure what time Resident A came back to the facility as she had left at 8 am and he still had not returned.

Ms. Wilson's statement to me was consistent with Ms. White's statement to me. Additionally, she stated she had been on-call the night Resident A went to the ER. She stated she spoke to Ms. White on the phone about Resident A wanting to go to the ER; however, she stated Ms. White later texted her about Resident A going to the ER rather than calling her. Subsequently, Ms. Wilson stated she did not hear her text alert and did not see the notification until the morning. Ms. Wilson stated staff are expected to contact on-call if a resident wants or needs to go to the ER. She stated the on-call service will contact the on-call home manager who will then either come in or meet the resident at the ER. Ms. Wilson confirmed Resident A requires staff supervision while in the community, which includes the ER.

My interview with Ms. Doubley indicated third shift or overnight staff typically work alone. She stated Resident A has community access and has gone to the hospital "multiple times" by himself. She stated if a resident went to the hospital and needed staff supervision then she would have to call on call who then contacts the on-call home manager who would try and find someone to go to the hospital or facility in order to provide additional coverage.

On 05/27/2022, I reviewed Resident A's *Assessment Plan for AFC Residents*, dated 01/26/2022. According to this assessment plan, Resident A is not able to move independently in the community and "requires supervision while the community and at work." Additionally, I reviewed Resident A's ISK Behavior Assessment and Plan, dated 08/24/2021, which also stated Resident A is to be supervised by staff while in the community "unless he is on an LOA with an approved family member or other authorized person." The plan defined "community supervision" as "staff or another authorized person will be able to see [Resident A] while he is in the community".

On 05/27/2022, I reviewed the licensee's Emergency Medical Care/First-Aid Policy, dated 12/06/2018, which directed direct care staff to "always remain with the resident including the waiting room and exam rooms" after a resident is transported to an appointment or ER room from the facility. The policy further stated "on-call staff may be called to relieve staff during long waits."

This is a repeat violation of Adult Foster Care Rule 400.14403(2). According to special investigation report #2022A1024020, a resident required supervision while out in the community, including the hospital. The investigation determined the resident was not supervised by direct care staff, due to staffing shortages, on at

least seven occasions in December 2021 and January 2022. The facility's corrective action plan (CAP), dated 03/17/2022, indicated a staff received a written disciplinary action.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On or about 05/16/2022 at approximately 11 pm, Resident A was transported to the Emergency Room via ambulance while only one direct care staff, Artilla White, was working at the facility. Though Ms. White contacted the facility's home manger, Amanda Wilson, to inform her an ambulance was coming to the facility, she did not follow the facility's Emergency Medical Care/First-Aid Policy by contacting on-call staff to ensure Resident A continued to be supervised at the ER or to provide relief coverage at the facility. Both Resident A's *Assessment Plan for AFC Residents*, dated 01/26/2022, as well as, his ISK Behavior Assessment and Plan, dated 08/24/2021, clearly state Resident A requires supervision while in the community; however, Ms. White allowed Resident A to be transported to the ER by himself where he stayed by himself without staff supervision until the next morning. Subsequently, the facility did not have sufficient direct care staff on duty for Resident A's protection and supervision when he was transported to the ER and remained there during the overnight hours on 05/16/2022.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR 2022A1024020, CAP DATED 03/17/2022]**

INVESTIGATION:

During my on-site inspection, I observed the facility's laundry room unlocked and within the unlocked laundry room, I observed heavy duty degreaser and toilet bowl cleaner in an unlocked corner cabinet to the left of the washer, which were accessible to residents.

Direct care staff, Ms. Burns, Ms. Baldwin, Ms. White, and Ms. Doubley all indicated cleaning products are usually locked up. None of the staff interviewed had any knowledge as to how the cleaning products got into the laundry room or why they were in the room unlocked. Additionally, all the staff interviewed indicated residents can access the laundry room without staff presence or supervision.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	During my inspection, I observed the facility's laundry room unlocked and within this laundry room, I observed cleaning products, such as heavy duty degreaser and toilet bowl cleaner, accessible to residents. Subsequently, these cleaning products, which could be poisonous and dangerous to residents, were not stored or safeguarded, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my on-site inspection, I observed the facility's laundry room, which is accessible to residents, cluttered and in disarray. The floor was covered in multiple piles of clothes and bedding with the pile, to the left of the washer, at least a couple feet tall. The laundry on the floor made it difficult to walk in the laundry room to access the washer and dryer and extra linens. Additionally, I observed clothing and a bathmat covering half of the laundry room's counter space.

Neither Ms. Burns, Ms. Baldwin, Ms. White nor Ms. Doubley had any explanation for how the laundry room came to be in its current state.

Ms. Wilson stated staff are not cleaning the facility, which includes the laundry room, in a timely manner. She stated she is in the process of creating a laundry schedule so staff will know which day(s) will be dedicated as a laundry day for each resident. Ms. Wilson indicated overnight staff should be washing resident bedding and linens.

This is a repeat violation of Adult Foster Care Rule 400.14403(2). According to special investigation report #2022A0581004, a resident's bedroom was not presenting in a comfortable, clean, or orderly manner based on observation of the resident's bedroom being in disarray and having excessive clutter. The investigation determined the resident's bedroom floor was littered with a variety of the resident's personal items, which were creating obstructions to move about the bedroom and causing a tripping hazard in the event of an emergency. The facility's corrective action plan, dated 01/04/2022, stated the resident's bedroom was cleaned and the power strips and electrical cords were unplugged. The CAP also indicated the resident was spoken to about the hazards in his bedroom and it was indicated staff would prompt the resident to clean his room more regularly and assist when needed moving forward.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	On 05/24/2022, I observed multiple piles of clothes and bedding on the laundry room floor making it difficult to walk in and access the washer and dryer and the extra linens. Additionally, approximately half of the laundry room's countertops were covered in clothing and a bathmat. Subsequently, the laundry room did not present a comfortable, clean, and orderly appearance, as required.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR 2022A0581004, CAP DATED 01/04/2022]**

On 06/09/2022, I conducted an exit conference with licensee designee, Ramon Beltran, via telephone. Mr. Beltran acknowledged my findings but expressed frustration with staffing shortages and updating plans with local community mental health agencies.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

06/09/2022

Cathy Cushman — Date
Licensing Consultant

Approved By:

07/08/2022

Dawn N. Timm — Date
Area Manager