GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 30, 2022

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

RE: License #: AS390406162
Investigation #: 2022A1024047
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 (616) 356-0183.

Sincerely,

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 #:	AS390406162
Investigation #:	2022A1024047
Complaint Receipt Date:	08/03/2022
Investigation Initiation Date:	08/03/2022
Report Due Date:	10/02/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Melissa Williams
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?
Staff failed to take Resident A to doctor appointment to receive medication.	Yes

III. METHODOLOGY

08/03/2022	Special Investigation Intake 2022A1024047
08/03/2022	Special Investigation Initiated – Telephone with recipient rights officer Suzie Suchyta
08/10/2022	Contact - Telephone call made with Alicia Burns and Resident A
09/07/2022	Contact - Telephone call made with district direct Aubry Napier
09/07/2022	Contact - Document Received Resident A's *Assessment Plan for AFC Residents, Provider Contacts, AFC Care Agreement* and facility's appointment calendar.
09/14/2022	Inspection Completed On-site with direct care staff member Arethia Dixon
09/15/2022	Contact-Telephone call made with case manager Jackelin Corbitt.
09/23/2022	Exit Conference with licensee designee Ramon Beltran
09/23/2022	Inspection Completed-BCAL Sub. Compliance
09/23/2022	Corrective Action Plan Requested and Due on 09/23/2022
09/30/2022	APS Referral made

ALLEGATION:

Staff failed to take Resident A to doctor's appointment to receive his medication.

INVESTIGATION:

On 8/3/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged staff failed to take

Resident A to his doctor's appointment to receive his medication.

On 8/3/2022, I conducted an interview with recipient rights officer Suzie Suchyta who stated she was advised by Resident A's psychiatrist that Resident A went 24 days without his Invega injection medication because Resident A missed his doctor's appointment on July 5th to receive the medication. Ms. Suchyta stated direct care staff members are required to coordinate Resident A's medical appointments and provide transportation to all Resident A's medical appointments. Ms. Suchyta stated it was not discovered that Resident A missed his July 5th medical appointment until July 28th when Resident A met with his mental health treatment team for his medication review at which time a direct care staff member stated they were not aware that Resident A had an appointment on July 5th. Ms. Suchyta stated direct care staff members are aware Resident A is required to take his Invega injection every 28 days and an appointment card is given to the staff member that transports Resident A at each doctor's visit. Ms. Suchyta further stated Resident A experienced increased behavioral issues from not getting his scheduled injection on July 5th.

On 8/10/2022, I conducted interviews with direct care staff member Alicia Burns and Resident A. Ms. Burns stated staff are required to take Resident A to all of his doctor appointments including his appointment to receive his injection medication every month. Ms. Burns stated direct care staff members are made aware of Resident A's medical appointments by the facility's appointment calendar completed regularly by the home manager. Ms. Burns stated there was no appointment written down for Resident A on the appointment calendar for July 5th therefore Resident A missed his appointment scheduled for July 5th to receive his Invega injection. Ms. Burns stated she believes the home manager forgot to enter this appointment on the calendar therefore direct care staff had no knowledge of it.

Resident A stated staff members take him to his appointments daily and he has not had issues with going to get his injection medication.

On 9/7/2022, I conducted an interview with district director Aubry Napier. Ms. Napier stated she was made aware on 7/28/2022 by Resident A's case manager that Resident A missed his appointment to receive his Invega injection on 7/5/2022. Ms. Napier stated the home manager has been on medical leave and Ms. Napier was unsure why the appointment was not placed on the calendar. Ms. Napier stated she has been acting as home manager currently and is now making sure all appointments are reflected on the facility appointment calendar so staff members can ensure residents get to their appointments when scheduled. Ms. Napier stated Resident A is ordered to get an injection every month and direct care staff members are required to take him to his medical appointments.

On 9/7/2022, I received Resident A's *Assessment Plan (plan) for AFC Residents* dated 12/15/2021. This plan states that staff is required to administer and manage Resident A's medications.

I also reviewed Resident A's *AFC Care Resident Agreement* (agreement) dated 12/3/2021. According to this agreement, medication management and coordination of appointments are included in Resident A's basic payment fee and there is no extra fee for local transportation services.

I also reviewed the facility's *Provider Contact* signed by Resident A's medical provider. This note stated, "On 7/28/2022 [Resident A] did not show up for his injection appointment on 7/5/2022 and did not call to reschedule." The contact stated he will receive his injection today and there has been an increase in adverse behaviors that may be a result of this noncompliance. This contact further stated it is the responsibility of staff members to get Resident A to his appointments.

I also reviewed the facility's appointment calendar that showed that Resident A had a medication review appointment on 7/28/2022 and occupational therapy appointment on 7/19 and 7/26. I did not observe any appointments for Resident A on 7/5/2022.

On 9/14/2022, I conducted an onsite investigation at the facility with direct care staff member Arethia Dixon who stated that she was aware Resident A has routine monthly medical appointments which includes Resident A receiving an anti-psychotic injection. Ms. Dixon further stated direct care staff members utilize an appointment calendar that is updated regularly by the home manager to manage all resident appointments as transportation is provided by direct care staff members. Ms. Dixon stated she has no knowledge of Resident A missing any scheduled medical appointments to receive his medications.

On 9/15/2022, I conducted an interview with Resident A's mental health case manager Jackelin Corbitt who stated that direct care staff members failed to transport Resident A to receive his Invega medication on 7/5/2022 which was reported to her by Resident A's psychiatrist at a medication review meeting on 7/28/2022. Ms. Corbitt stated the staff members routinely transports Resident A to all his medical appointments and they are made aware of any future appointments at each doctor visit. Ms. Corbitt stated it is the staff's responsibility to ensure Resident A gets to all his appointments, and she has no knowledge of Resident A missing any other medical appointments.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Alicia Burns, Arethia Dixon, district director Aubry Napier, recipient rights officer Suzie Suchyta, case manager Jackelin Corbitt, review of Resident A's assessment plan, care agreement, provider contacts, and facility's appointment calendar, Resident A did not receive his Invega Injection on 07/05/2022 as scheduled. Ms. Burns, Ms. Napier, Ms. Suchyta and Ms. Corbitt all stated that staff did not transport Resident A to his medical appointment on 7/5/2022 to receive his routine monthly injection medication. According to Resident A's Resident Care Agreement direct care staff members coordinate Resident A's appointments and provide transportation. Based on this evidence, the staff members did not follow the health care provider's instructions in regard to Resident A's monthly injection.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/23/2022, I conducted an exit conference with licensee designee Ramon Beltran. I informed Mr. Beltran of my findings and allowed him an opportunity to ask questions or make comments.

On 9/26/2022, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

I received an acceptable corrective action plan, therefore, I recommend the current license status remain unchanged.

Ondrea Johnson 9/26/2022

Ondrea Johnson Date
Licensing Consultant

Approved By:

Dawn Timm 09/30/2022

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Dawn N. Timm Date
Area Manager