GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 31, 2023

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

RE: License #: AS630408237
Investigation #: 2023A0611009
Beacon Home at Wolverine Lake

Dear Ms. Rawlings:

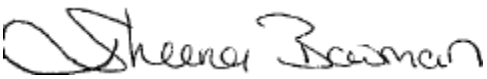
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



Sheena Bowman, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630408237
Investigation #:	2023A0611009
Complaint Receipt Date:	01/13/2023
Investigation Initiation Date:	01/18/2023
Report Due Date:	03/14/2023
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 Wolverine Lake
Facility Address:	1615 Glengary Rd Wolverine Lake, MI 48390
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	12/17/2021
License Status:	REGULAR
Effective Date:	06/17/2022
Expiration Date:	06/16/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff member Shareka Branson was tasked with transitioning medication records between E-MAR's and was supposed to also have paper medication sheets printed. She did not complete the transfer correctly and did not print out paper forms. This caused medication documentation errors and Resident O to miss some medications.	Yes

III. METHODOLOGY

01/13/2023	Special Investigation Intake 2023A0611009
01/18/2023	Special Investigation Initiated – Letter I sent an email to recipient rights specialist, Dawn Krull regarding information pertaining to the allegations.
01/18/2023	Contact - Document Received I received two incident report from recipient rights specialist, Dawn Krull.
01/20/2023	Inspection Completed On-site I completed an unannounced onsite. I interviewed staff member Mariah Harris and Resident O. I received copies of Resident O's MAR for the month of January.
01/26/2023	Contact - Telephone call made I left a voice message for the home manager, Mathew Abbilla requesting a call back.
01/26/2023	Contact - Telephone call made A voice message was left for the district director, Emily Ferguson requesting a call back.
01/26/2023	Contact - Telephone call made I left a voice message for the licensee designee, Kimberly Rawlings requesting a call back.
01/26/2023	Contact – Telephone call made I completed a zoom meeting with staff member, Mariah Harris. I reviewed Resident O's Atorvastatin and Chlorpromazine bubble packets.

01/26/2023	Contact – Telephone call received I received a return phone call from Emily Ferguson. The allegations were discussed.
01/26/2023	Contact – Telephone call made I made a telephone call to Wendy Blanton who is the nurse for the AFC group home. The allegations were discussed.
01/26/2023	Exit Conference I received a returned phone call from the licensee designee, Kimberly Rawlings. The allegations were discussed, and an exit conference was completed.

ALLEGATION:

Staff member Shareka Branson was tasked with transitioning medication records between E-MAR's and was supposed to also have paper medication sheets printed. She did not complete the transfer correctly and did not print out paper forms. This caused medication documentation errors and Resident O to miss some medications.

INVESTIGATION:

On 01/17/23, I received an intake regarding the abovementioned allegations. In addition to the allegations, it was reported that Ms. Branson was terminated from the home and Resident O is the only resident that missed medications due to the documentation error. On 01/18/23, I received two incident reports from the recipient rights specialist Dawn Krull. The date of incident on the first incident report is 01/03/23. The incident report was completed by Wendy Blanton on 01/13/23. The incident report is not signed or dated by the licensee designee, Kimberly Rawlings. The first incident report indicates that paper MAR's were not printed for staff to utilize per policy and procedure. The incident report also indicates that paper MAR's will be printed per policy and procedure at the beginning of each month to ensure if E-MAR fails staff will have documents to capture the administration of medications.

The date of incident on the second incident report is 01/05/23. The incident report was completed by Wendy Blanton on 01/13/23. The incident report is not signed or dated by the licensee designee, Kim Rawlings. According to the second incident report, there were missing staff initials on the E-MAR and the paper MAR for Resident O's Atorvastatin 20mg and Thorazine (Chlorpromazine) on 01/01/23.

On 01/20/23, I completed an unannounced onsite. I interviewed staff member Mariah Harris and Resident O. I received copies of Resident O's MAR for the month of January.

On 01/20/23, I interviewed staff member Mariah Harris. Regarding the allegations, Ms. Harris stated Shareka Branson was one of the manager's in the AFC group home however; she was terminated. Ms. Harris stated Resident O was administered his medications however; it was not documented because Ms. Branson did not print off the E-MAR that included the new dosage for one of Resident O's medications. The staff received an email from Ms. Branson regarding the new dosage. Ms. Harris stated Resident O received a new dosage for the medication that "starts with a C". Ms. Harris stated this incident occurred in the beginning of January 2023.

On 01/20/23, I interviewed Resident O. Resident O has lived at the AFC group home for three years. Resident O stated he likes living at the AFC group home. Regarding the allegations, Resident O stated he has been prescribed medications since 2008. Resident O currently takes medications at 12:00pm and 8:00pm. The staff administer Resident O his medications every day. Resident O stated the staff do not forget to give him his medications. Resident O stated there has been times when Ms. Branson has administered his medications.

On 01/20/23, I received a copy of Resident O's MAR for the month of January 2023. Ms. Harris provided two sets of MAR as one MAR has electronic staff initials, and the other MAR has staff written initials. Ms. Harris explained that sometimes the electronic MAR does not work properly therefore; the staff would have to manually write their initials when they administer medications.

According to the electronic and written MAR, there were missing staff initials for the following medications:

- Atorvastatin 20 mg - 01/01/23, 01/08/23
- Benztropine 1 mg 8:00am – 01/01/23, 01/02/23
- Benztropine 1 mg 8:00pm – 01/01/23, 01/06/23, 01/08/23
- Blood pressure checks 12:00pm – 01/03/23, 01/09/23, 01/10/23, 01/16/23
- Blood pressure checks 5:00pm – 01/02/23, 01/03/23, 01/08/23
- Chlorpromazine (Thorazine) 200mg 8:00pm - 01/01/23
- Chlorpromazine 100mg 8:00pm - 01/01/23
- Chlorpromazine 100mg 4:00pm - 01/02/23, 01/03/23
- Depakote 500mg 8:00 am – 01/01/23, 01/02/23
- Depakote 500mg 8:00pm – 01/01/23, 01/08/23
- Metformin 500mg 12:00pm – 01/01/23,01/02/23, 01/03/23, 01/10/23, 01/11/23, 01/16/23
- Metformin 500mg 5:00pm – 01/01/23, 01/02/23, 01/03/23, 01/08/23
- Olanzapine 15mg 8:00am – 01/01/23, 01/05/23
- Olanzapine 15mg 8:00pm – 01/01/23, 01/06/23, 01/08/23, 01/11/23

On 01/26/23, I completed a zoom meeting with staff member, Mariah Harris. I reviewed Resident O's Atorvastatin and Chlorpromazine bubble packets. I was unable to confirm

if Resident O was not administered these medications on 01/01/23 as the staff are not following the days of the month on the bubble packets. It appears as if the staff started punching out the pills from the end of the month. The staff did not write the start date as to when they started punching out the medications. Ms. Harris explained that the medications are not received at the beginning of each month and the bubble packets run into the following month. The prescribed dates for Atorvastatin and Chlorpromazine was 01/17/23.

On 01/26/23, I received a return phone call from the district director Emily Ferguson. Regarding the allegations, Ms. Ferguson explained that the AFC group home was switching to a new E-MAR system (doctor first system) which allows doctors to have access to the E-MAR and send orders. In order to transition to the new E-MAR system, the former home manager, Ms. Branson was instructed to transition all the medications at once for each resident at a time and discontinue the medications from the previous E-MAR system. However, Ms. Branson transition a couple medications at a time for each resident. Ms. Ferguson stated this still would not have caused an issue if Ms. Branson would have printed out the paper MAR's for the staff before she started transitioning to the new E-MAR system. As a result, Ms. Branson was terminated. This is the reason why there were discrepancies on the MAR's that I reviewed.

Ms. Ferguson stated the staff are supposed to write the start date on the bubble packets when they start administering medications. Ms. Ferguson stated a medication count was completed on 01/03/23 however; she does not know the results. Ms. Ferguson stated she does believe Resident O missed some of his medications. However, the in-home nurse Wendy Blanton would be able to confirm if Resident O was not administered his medications.

On 01/26/23, I made a telephone call to the in-home nurse Wendy Blanton. Regarding the allegations, Ms. Blanton stated the paper MAR's were not printed out in the beginning of January 2023. Ms. Blanton was present in the AFC group home during the afternoon on 01/03/23. On 01/03/23, Ms. Blanton noticed there were missing staff initials for 01/01/23, 01/02/23, and during the morning of 01/03/23 on the E-MAR. Ms. Blanton completed a medication count on 01/07/23 and the count was accurate. Ms. Blanton stated Resident O received all of his medications however; the staff did not initial the MAR's.

Ms. Blanton stated Ms. Branson completed a medication count on 01/02/23 which was a week prior to the medication count she completed on 01/07/23. Ms. Blanton stated Ms. Branson medication count was accurate with the exception of Resident O's Atorvastatin as some of the medications she counted were expired. Ms. Blanton stated the expired medications were disposed of. Ms. Blanton provided a copy of the medication counts completed by her and Ms. Branson. Regarding Resident O's Atorvastatin, Ms. Branson counted 64 and Ms. Blanton counted 30 a week later. Regarding Resident O's Chlorpromazine 200mg, Ms. Branson counted 48 and Ms. Blanton counted 93. Ms. Blanton explained there was a significant increase of pills for Chlorpromazine when she did her count as a result of several dosage changes.

On 01/26/23, I received a returned phone call from the licensee designee, Kimberly Rawlings. The allegations were discussed, and an exit conference was completed. Regarding the allegations, Ms. Rawlings stated she returned from medical leave on 01/09/23; which was the same day the interim home manager, Shareka Branson was terminated. Ms. Rawlings does not know the details surrounding Ms. Branson termination. Ms. Rawlings explained that the staff are required to utilize the E-MAR to document when medications are administered. The paper MAR's are printed out as needed as they are used as a backup whenever there is a power outage in the AFC group home and/or when the residents are on an outing during the timeframe when medications need to be passed. The staff are expected to review the E-MAR and paper MAR at the end of each shift to ensure both MAR's match. Ms. Rawlings stated essentially the home manager is responsible to ensure the paper MAR's are printed out for the staff. However, whoever is responsible for administering the medications should also make sure the paper MAR's are printed out.

I completed an exit conference with Ms. Rawlings. Ms. Rawlings was advised that there were a lot of discrepancies between the E-MAR and paper MAR. Ms. Rawlings was informed that the allegations will be substantiated, and a corrective action plan will be required.

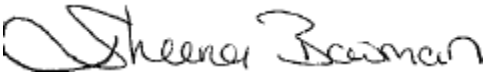
APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered, there is not sufficient information to confirm that Resident O was not administered any of his medications. The in-home nurse, Wendy Blanton completed a medication count on 01/07/23 and determine the medication count was accurate.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	Based on the information gathered, there is sufficient information to confirm the allegations. An incident report was completed on 01/05/23 indicating there were missing staff initials on the E-MAR and the paper MAR for Resident O's Atorvastatin 20mg and Thorazine (Chlorpromazine) on 01/01/23. On 01/20/23, I reviewed Resident O's E-MAR and paper MAR and observed several staff initials for several medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

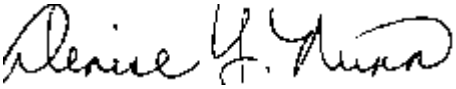
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



Sheena Bowman
Licensing Consultant

01/27/23
Date

Approved By:



01/31/2023
Date

Denise Y. Nunn
Area Manager