GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 2, 2023

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

RE: License #: AS630387850
Investigation #: 2023A0991009
Beacon Home at County Line

Dear Ms. Rawlings:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Kristen Donnay

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630387850
Investigation #:	2023A0991009
Complaint Receipt Date:	12/29/2022
Investigation Initiation Date:	12/29/2022
Report Due Date:	02/27/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St. Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at County Line
Facility Address:	10750 County Line Road Ortonville, MI 48462
Facility Telephone #:	(248) 793-7232
Original Issuance Date:	10/10/2017
License Status:	1ST PROVISIONAL
Effective Date:	09/27/2022
Expiration Date:	03/26/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct care worker, Jermaine Blue, was being verbally aggressive towards Resident J. Ms. Blue fell asleep during her shift.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/29/2022	Special Investigation Intake 2023A0991009
12/29/2022	Special Investigation Initiated - Letter Email to home manager, Andrea Lapp
01/04/2023	Contact - Telephone call made Interviewed direct care worker, James Hartman, via telephone
01/04/2023	Contact - Telephone call made Interviewed direct care worker, Jermaine Blue, via telephone
01/09/2023	Inspection Completed On-site Unannounced onsite inspection, interviewed home manager, staff, and residents
01/09/2023	Contact - Document Received Received medication logs and incident report
01/10/2023	Contact - Telephone call made Left message for Office of Recipient Rights worker, Sarah Rupkus
01/10/2023	Referral - Recipient Rights Contacted Office of Recipient Rights workers, Sarah Rupkus (Oakland) and Juwan Chapman (Saginaw)
01/10/2023	Contact - Telephone call made To direct care worker, Jacqueline Warren
01/10/2023	Contact - Telephone call made To Resident D's guardian
01/10/2023	APS Referral Referred to Adult Protective Services (APS) Centralized Intake

01/10/2023	Contact - Document Received Email from Melissa Williams- Beacon Chief Administrative Officer
01/11/2023	Contact - Document Sent Email to Melissa Williams- Beacon Chief Administrative Officer
01/13/2023	Contact - Document Received Email from Melissa Williams- Beacon Chief Administrative Officer re: medication reconciliation procedures
01/12/2023	Contact - Document Sent Email to ORR worker, Sarah Rupkus
01/27/2023	Contact - Telephone call received From APS worker, Nina Higgins- substantiating allegations
02/24/2023	Exit Conference Via Microsoft Teams with the licensee designee, Kim Rawlings, Beacon's Chief Administrative Officer, Melissa Williams, and Beacon's Executive Vice President, Kevin Kalinowski.

ALLEGATION:

Direct care worker, Jermaine Blue, was being verbally aggressive towards Resident J. Ms. Blue fell asleep during her shift.

INVESTIGATION:

On 12/29/22, I received an incident report from Beacon Home at County Line which indicated that on 12/27/22, direct care worker, Jermaine Blue, was observed by staff, James Hartman, verbally berating Resident J and using profane language. Resident J was talking to staff about how he was excited to go home for the New Year's holiday because he did not get to go home for Christmas due to being sick with a sinus infection. Ms. Blue told Resident J, "Maybe you would have gotten to go home for Christmas if you knew how to fucking act." She told Resident J, "It's your own fault you didn't get to go, because you don't know how to take care of yourself." Ms. Blue also began shouting complaints about what Resident J wears when he goes out to smoke. Ms. Blue stated that she has rules on her shift and that she does not let anyone out of the house to smoke after 10:00pm. She instructs the residents to go back to their rooms and stay there once she arrives so that she can complete her deep cleaning and shift responsibilities. The incident report also noted that Resident J has caught Ms. Blue asleep on the couch, and he had to wake her up to remind her to pass his medications. I created a special investigation intake based on the information contained in the

incident report, which was assigned to me for investigation. I initiated my investigation on 12/29/22, by contacting the home manager, Andrea Lapp.

On 01/04/23, I interviewed direct care worker, James Hartman, via telephone. Mr. Hartman stated that there are currently two residents living at Beacon Home at County Line. On 12/27/22. Mr. Hartman came in to work first shift from 7:00am-7:00pm. He was relieving direct care worker, Jermaine Blue, who was the only staff working third shift from 7:00pm-7:00am. Mr. Hartman stated that Ms. Blue told him that she fell asleep and almost forgot to pass 8:00pm medications the night before. She told Mr. Hartman that Resident J had to wake her up to remind her to pass his medications. A few moments later, Resident J was talking to staff and expressed that he was happy to be going home, because it had been a while. Ms. Blue responded by saying to Resident J, “It’s your own fucking fault you can’t go home. You can’t dress like a fucking adult.” Ms. Blue then went on to tell Mr. Hartman that staff don’t make Resident J dress appropriately for the weather and that is why he got sick and could not go home previously. Mr. Hartman stated that Resident J is his own guardian, and he can dress himself. Mr. Hartman stated that Resident J seemed upset after this interaction. He shut down and stopped talking. Ms. Blue was cussing and using profanity during the interaction. Mr. Hartman stated that both Resident J and Ms. Blue also told him that she has rules on her shift. She puts restrictions in place as to when the residents can go out to smoke and tells them that they must be in their rooms by 10:00pm. Ms. Blue has made comments stating, “That is how I run my shift.” Mr. Hartman stated that Ms. Blue is rude to the residents and Resident J does not feel comfortable around her.

On 01/04/23, I interviewed direct care worker, Jermaine Blue, via telephone. Ms. Blue stated that she never had a conversation with Resident J where she told him that he didn’t get to go home because he didn’t dress or act right. She denied ever yelling or swearing at or in front of Resident J. She stated that it is not in her nature, and she is not that type of person. Ms. Blue stated that she typically works alone. She never heard anyone else being rude or disrespectful towards any of the residents. She stated that she gets along with the residents. They laugh and play Uno until 2:00am. Ms. Blue stated that she never fell asleep while on shift. There was never a time when one of the residents had to wake her up to pass medications. Ms. Blue denied having rules on her shift. She stated that she does not require the residents to be in their room at a certain time. She does ask them to be careful when she is mopping the floors. Both residents typically go to their rooms for the night between 8:00-10:00pm. Resident J is the only one who smokes. He can go outside and smoke at any time.

On 01/09/23, I conducted an unannounced onsite inspection at Beacon Home at County Line. I interviewed Resident J. Resident J stated that he moved into the home in December. Resident J stated that there was a time when he had to wake up direct care worker, Jermaine Blue, because Ms. Blue was sleeping on the couch. He woke her up and told her to give him his medications. He could not recall when this happened, but Ms. Blue was the only staff on shift. Resident J and Resident D were both in the home at the time. Resident J stated that he also recalled a time when Ms. Blue yelled at him. She told Resident J, “If you had fucking worn pants, you wouldn’t have been sick and

could have gone home." Ms. Blue was blaming Resident J for getting sick because of the way he dressed. She swore at him "and that was it." Resident J also stated that Ms. Blue and the other third shift staff, D'Angelo, make him go to his room at a certain time. They tell him that he cannot go out to smoke and that he must be in his room at 10:00pm. Resident J stated that the home manager, Andrea, told him that this is not true and that they cannot have rules like that. Resident J stated that Ms. Blue is a bully who tries to push her weight around. She yells a lot. Resident J stated that he does not have issues with any other staff.

On 01/09/23, I interviewed Resident D. Resident D stated that he never saw staff, Jermaine Blue, sleeping on the couch, but he recalled a time when direct care worker, D'Angelo Williams, was sleeping on the couch. Resident D stated that he woke up in the morning and Mr. Williams was sleeping the whole time. His alarm went off, but he didn't get off the couch. Resident D got ready and got on the bus to go to school. He did not get his morning medications. He told his teacher that Mr. Williams was on the couch sleeping and he did not get his medications. Resident D's teacher contacted his guardian. His guardian was "pissed" and called the home. Direct care worker, Jacqueline Warren, brought his medications up to the school. Resident D stated that direct care worker, Jermaine Blue, yells at him sometimes. She tells him to stop doing things or to put a shirt on. She does not swear, except for when she is on the phone or on Facetime talking to her friends. Resident D stated that he can go to his room at any time of night. He is not required to be in his room by a certain time. He did not know of any staff telling Resident J that he could not go outside to smoke. Resident D stated that the other staff in the home are fine.

On 01/09/23, I interviewed direct care worker, James Hartman. The information Mr. Hartman provided was consistent with the information that he provided during my phone interview with him on 01/04/23. Mr. Hartman clarified that Ms. Blue told him directly that she fell asleep and Resident J had to wake her up for his medications. He did not observe her sleeping. He stated that he also directly witnessed Ms. Blue swearing and being disrespectful towards Resident J. Mr. Hartman stated that Resident D told him about the incident when D'Angelo Williams was sleeping on the couch. Resident D went to school and reported it to his teacher. His teacher called Resident D's guardian and staff brought Resident D's medications to his school. Resident D typically gets his medications at 7:15am, but staff can administer them one hour before or after the scheduled time. He stated that he also heard from staff that some time in December, direct care worker, Jacqueline Warren, came in for her shift and caught Mr. Williams sleeping.

During my interview, Mr. Hartman brought up an additional concern regarding Resident D's medications. He stated that Resident D returned to the home after a Thanksgiving visit with family with several doses of his medications in plastic Ziploc bags. Mr. Hartman stated that he contacted Beacon's on-call medical personnel, who asked if the pills looked like Resident D's medications. Mr. Hartman stated that they looked like Resident D's medications, but he could not verify it, as they were no longer in the bubble packs. The on-call staff instructed Mr. Hartman to pass the medications. Mr.

Hartman followed the instructions and passed the medications. Additional information regarding this incident is located in the additional findings section of this report.

On 01/09/23, I interviewed the home manager, Andrea Lapp. Ms. Lapp stated that she did not have any direct knowledge of the incident that occurred between Ms. Blue and Resident J. James Hartman reported the information to her and completed an incident report. She reported the information to Beacon Vice President, Ramone Beltran. Mr. Beltran instructed her to remove Ms. Blue from the schedule. Ms. Lapp stated that the report does not sound like it is out of character for Ms. Blue. Ms. Blue typically works alone on the midnight shift. Ms. Lapp worked with Ms. Blue on one occasion, but she did not see much interaction between Ms. Blue and the residents. She stated that Ms. Blue completed her daily responsibilities. Resident J has reported some issues to Ms. Lapp regarding Ms. Blue establishing rules that he was not allowed to go out and smoke or go into the living room area. Resident D never expressed that he was not allowed to move freely around the home. Ms. Lapp never observed Ms. Blue sleeping while on shift, but it was reported in the incident report.

Ms. Lapp stated that she was aware of the allegation that D'Angelo Williams was sleeping on shift. She received a call from Resident D's guardian, who had been contacted by Resident D's teacher. She confirmed that Resident D did not receive his morning medications that day. Direct care worker, Jacqueline Warren came in at 7:00am and brought Resident D's medications to the school. She did not write an incident report regarding this issue, but Ms. Warren did write a statement. Ms. Lapp stated that they were not able to verify if D'Angelo Williams was sleeping. He stated that he was in the basement checking the temperatures on the freezers when Resident D got up and went to school. Mr. Williams is no longer on the schedule at Beacon Home at County Line, as he was a no call/no show for three shifts in a row.

On 01/10/23, I interviewed Resident D's guardian via telephone. She stated that there was a day sometime in December, before the holidays, when she received a call from Resident D's teacher around 8:00am. Resident D woke up, got ready, went to school, and told his teacher that staff at the home was sleeping, and he did not receive his morning medications. Resident D's guardian called and reported this to the home manager. They sent staff to the school to bring Resident D his medications. Resident D's guardian stated that the staff who fell asleep is no longer working at the home. Resident D's guardian stated that there was one other occasion when Resident D reported that the same staff person was sleeping in the morning. Resident D's guardian stated that Resident D moved into the home in April 2022. The home closed temporarily, and Resident D moved back into the home before Thanksgiving. She stated that while the home was temporarily closed, they redid the house and got rid of staff who were lazy. She stated that the staff who are currently working in the home are fabulous. The home manager, Andrea, is very accessible and accommodating. Resident D also loves staff, James and Jacqueline. Resident D's guardian stated that there have not been any issues with Resident D not getting his medications since the other staff are no longer working in the home. She stated that direct care worker, Jermaine Blue, was "one of the biggest problems," but she is no longer working in the

home. Resident D's guardian stated that she was told that Ms. Blue yells. There was one time when Resident D reported that she yelled at him. She did not know what was said. She stated, "sometimes Resident D can make you yell." Resident D's guardian reiterated that the current staff are fabulous, and she does not have to watch after things at the home as much anymore.

On 01/10/23, I interviewed direct care worker, Jacqueline Warren, via telephone. Ms. Warren stated that she could not recall the exact date, but she remembered that it was sometime before the holidays when she arrived at the home for her shift around 7:00am and observed direct care worker, D'Angelo Williams, sleeping on the couch. She called his name, but he did not respond. Ms. Warren stated that she went into the medication room and started doing her medication counts. A short while later, Mr. Williams finally got up. He noticed that Ms. Warren was in the medication room and asked her how long she had been there. She told him that she had been there for a while and she was calling his name, but he did not answer. Mr. Williams went back and checked in Resident D's room. He came back and said, "Oh, Resident D already is already gone to school." Ms. Warren stated that the manager came in and asked her to go up to the school to give Resident D his morning medications. Resident D is scheduled to take his medications at 7:15am, but he can receive them one hour before or after that time. He typically gets his medications around 6:30-7:00am and is usually gone when Ms. Warren gets to the home for her shift. Ms. Warren stated that this was the first time she observed Mr. Williams or any other staff person sleeping on shift. She stated that D'Angelo Williams "was definitely sleeping" on the couch. She wrote a statement and gave it the home manager. She did not write an incident report. Ms. Warren stated that she did not have any concerns about any other staff in the home. The residents have not expressed any concerns regarding staff other than when staff was sleeping. Resident D told her that he tried to wake Mr. Williams up, but he would not get up.

On 01/10/23, I made a referral to the Office of Recipient Rights (ORR) in Oakland County regarding the allegations related to Resident D. It was assigned to ORR worker, Sarah Rupkus, for investigation. A referral was also made to Adult Protective Services (APS), which was assigned to Nina Higgins for investigation. On 01/10/23, I spoke with the assigned ORR worker from Saginaw County, Juwan Chapman. Mr. Chapman stated that he was investigating two incidents at the home regarding dignity and respect, including the interaction between Resident J and staff, Jermaine Blue. He stated that both incidents were witnessed by staff, and he would be substantiating the allegations.

I reviewed a copy of Resident D's individual plan of service (IPOS) dated 11/01/2022. The IPOS notes that Resident D has vulnerabilities when in the community alone. There have been multiple times when the police have become involved due to indecent exposure. Resident D should be accompanied by a caregiver whenever he leaves the home, including when spending time in the front/back yard, going for a walk/bike ride, or going into the community. The plan notes that Resident D relies on caregivers to ensure his health and safety needs are met. Beacon Specialized Living/County Line Home will assist Resident D with meeting his physical and emotional health care needs, safety, and well-being 24 hours per day. I reviewed a copy of Resident D's Assessment Plan

for AFC Residents, dated 11/07/22. The assessment plan notes that Resident D does not move independently in the community and staff will assist him.

I reviewed a copy of Resident J's IPOS dated 03/16/22. The IPOS notes that Resident J requires staff assistance with administering medications and ensuring his health and safety in order to reside or be supported in the most integrated, independent community setting. The IPOS notes that AFC staff will use validation instead of confrontation when addressing Resident J's behaviors. Validation can include active listening, helping Resident J identify his feelings, and using reflective statements. AFC staff will also use de-escalation skills such as validating Resident J's view, being non-argumentative, and focusing on his needs. Resident J's IPOS notes that he smokes tobacco and vapes frequently when he can. There are no restrictions noted as to when he can or cannot go outside to smoke. I reviewed a copy of Resident J's Assessment Plan for AFC Residents, dated 06/15/21. It notes that Resident J moves independently in the community. There are no restrictions noted regarding his access to the community or when he can go outside to smoke.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not provide supervision and protection as specified in Resident D and Resident J's written assessment plans. Resident J reported that staff, Jermaine Blue, fell asleep during her shift. He had to wake her up to administer his medications. Ms. Blue denied falling asleep during her shift; however, direct care worker James Hartman stated that Ms. Blue told him directly that she had fallen asleep the night before when he came in for his shift on 12/27/22. Mr. Hartman also witnessed Ms. Blue yelling and swearing at Resident J. Resident J's individual plan of service notes that he requires supervision to ensure his safety and that staff should not be confrontational with him. Resident D and direct care worker, Jacqueline Warren, also stated that direct care worker, D'Angelo Williams, fell asleep during his shift. Resident D woke up, got on the school bus, and went to school where he told his teacher staff was sleeping and he did not get his morning medications. Ms. Warren observed Mr. Williams sleeping on the couch when she came in for her shift at 7:00am. She called out to him several times and he did not respond. She brought Resident D his medications at school.

	Resident D's individual plan of service indicates that he requires 24-hour supervision and needs supervision while in the community. He relies on caregivers to ensure his health and safety needs are met.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not attend to Resident D and Resident J's protection and safety at all times. On separate occasions, direct care workers, Jermaine Blue and D'Angelo Williams, fell asleep while working the third shift from 7:00pm-7:00am. They were the only staff on shift at the time, leaving the residents without appropriate supervision. Resident D left the home and went to school without having any interaction with staff or receiving his medications in the morning. In addition, staff did not ensure Resident D's protection and safety when they passed medications that were returned to the home from Resident D's relative in a plastic bag on 11/24/22 and 11/25/22. Direct care worker, James Hartman, stated that the medications looked like Resident D's medications, but he could not be sure they were the correct medications as they were no longer in the bubble packs. Staff could not follow proper medication passing procedures and did not complete the five rights of medication passing due to the medications being removed from the bubble packs.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #2020A0611044 dated 10/22/20; CAP dated 10/27/20; Special Investigation Report #2022A0993005 dated 01/27/22, CAP dated 01/31/22; Special Investigation Report #2022A0993009 dated 03/14/22, CAP dated 03/31/22; Special Investigation Report #2022A0611020 dated 04/12/22; CAP dated: 04/15/22.**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (f) Subject a resident to any of the following: (ii) Verbal abuse. (iii) Derogatory remarks about the resident or members of his or her family.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff, Jermaine Blue, was verbally abusive and made derogatory remarks towards Resident J on 12/27/22. Ms. Blue denied the allegations; however, Resident J and direct care worker, James Hartman, observed Ms. Blue yelling and swearing at Resident J. Ms. Blue blamed Resident J for getting sick because he did not dress appropriately. Ms. Blue stated, “It’s your own fucking fault you can’t go home. You can’t dress like a fucking adult.” Resident D and Resident D’s guardian also reported that Ms. Blue has yelled at Resident D in the past.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #2022A0991035 dated 09/21/22; CAP dated 10/10/22**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection on 01/09/23, I interviewed Resident D and Resident J. Both residents reported that direct care worker, Jermaine Blue, dropped their medications on the floor and then instructed them to take the medications. Resident D did not provide any additional information. Resident J stated that this happened sometime in December. Ms. Blue spilled his pills on the floor, picked them up, and forced him to take them. She made him show her his tongue to prove that he swallowed the pills.

On 01/09/23, I interviewed direct care worker, James Hartman. Mr. Hartman stated that he had no direct knowledge of staff dropping medication on the floor and passing it to the residents, but the residents did mention this to him. He stated that if he dropped medication, he would dispose of the pills and would not pass them. During my interview, Mr. Hartman brought up an additional concern regarding Resident D’s medications. He stated that Resident D went home for the Thanksgiving holiday. While he was home, his

family popped out his medications from the bubble packs. They returned Resident D to the home with several doses of his medications in plastic Ziploc bags. Mr. Hartman stated that he contacted Beacon's on-call medical personnel, but he could not recall the name of the person with whom he spoke. The on-call staff asked Mr. Hartman if the pills looked like Resident D's medications. Mr. Hartman stated that they did look like Resident D's medications, but he could not verify it, as they were no longer in the bubble packs. The on-call staff instructed Mr. Hartman to pass the medications because they looked like Resident D's medications. Mr. Hartman followed the instructions and passed the medications. He completed an incident report to document that this occurred.

I reviewed a copy of the incident report dated 11/25/22. It notes that Resident D returned early from LOA (leave of absence) on Thursday, 11/24/22, at 11:59am. Resident D's grandpa handed staff medications and stated that he popped the resident's nighttime medications for 11/24/22 and the next morning's medications and put them in Ziploc bags. He also told staff that he popped Resident D's 3:00pm medications for 11/24/22 and left them at his own personal residence. Later that night, Resident D brough a Ziploc bag of medications to staff and stated that they were his nighttime medications from Wednesday, 11/23/22. Resident D stated that he found them in his bag upon returning to the home. Direct care worker, James Hartman, contacted the home manager who instructed him to call the on-call medical number. On-call medical staff told Mr. Hartman to pass the 3:00pm medications. They stated to keep the medications for 11/24/22 and the morning medications for 11/25/22. They told staff to destroy the medications from 11/23/22. Staff told on-call medical that a controlled substance was popped and in a Ziploc bag. On-call medical stated to keep it, complete the medication count like normal, and pass the medications like normal.

On 01/10/2023, I interviewed direct care worker, Jacqueline Warren, via telephone. Ms. Warren stated that she was not aware of medications being dropped on the floor and passed to the residents. She stated that if this happened while she was passing medications, she would let on-call medical know and would dispose of the medications. Ms. Warren stated that she recalled the time when Resident D returned to the facility from spending time with his family over the Thanksgiving holiday. She stated that his family put his medications in a small plastic baggie and returned them to the home. Direct care worker, James Hartman, contact the on-call medical staff. She did not hear his conversation with the on-call staff, but they did pass the medications to Resident D that were in the plastic bag. Ms. Warren stated that they disposed of other pills that were found on the floor, because they did not know where they came from.

I reviewed copies of Resident D and Resident J's medication administration records for December 2022 and January 2023. Beacon Home at County Line utilizes an electronic medication administration record (eMAR) system. Staff click and initial within the computer system to indicate that medications were administered. They also print a "paper MAR" as a backup, which staff initial by hand if the computer system is not functioning properly.

I noted the following with regards to Resident D's MARs:

- The December 2022 eMAR and paper MAR were not initialed for 7:15am medications on 12/01/22.
- The December 2022 eMAR and paper MAR were not initialed for the 7:15am dose of Trileptal (Oxcarbazepine) 300mg on 12/08/22.
- The December 2022 eMAR and paper MAR were not initialed for the 3:00pm dose of Trileptal (Oxcarbazepine) 300mg on 12/07/22.
- The December 2022 eMAR and paper MAR were not initialed for the 8:00pm dose of Trileptal (Oxcarbazepine) 300mg on 12/07/22 or 12/08/22.
- The January 2023 eMAR and paper MAR were not initialed for the 7:15am dose of Abilify 30mg on 01/03/23.
- The January 2023 eMAR and paper MAR were not initialed for the 7:15am dose of Prozac 40mg on 01/03/23.
- The January 2023 eMAR and paper MAR were not initialed for the 8:00pm dose of Trileptal 300mg on 01/01/23.
- The January 2023 eMAR and paper MAR were not initialed for the 7:15am dose of Vyvanse 60mg on 01/03/23.

I noted the following with regards to Resident J's MARs:

- The January 2023 eMAR and paper MAR were not initialed for the 8:00pm dose of Abilify 15mg on 01/01/23.

During the onsite inspection, I reviewed the medication bubble packs for Resident D and Resident J. It could not be determined if medications were being given as prescribed. The home utilizes medication bubble packs, which are delivered on various dates throughout the month. Staff begin passing medications from each bubble pack from the bubble dated the 30th, rather than passing from the bubble that corresponds to the date the medication is passed. Per Beacon policy, staff do not initial or write the actual date the medication was passed on the bubble pack. Staff were not consistently writing a start date on the back of the bubble packs, so it could not be determined how many pills should be remaining in each pack for the month. Some bubble packs had a start date written on the back; however, the number of pills remaining in the bubble packs did not align with the start date. I noted the following:

- Resident D's 7:15am bubble pack for Aripiprazole 30mg tab had a start date of 12/28/22 written on the back of it. During my onsite inspection on 01/09/23, there were 14 pills popped from the bubble pack (13 should have been administered).
- Resident D's 7:15am bubble pack for Daily-Vite Tab had a start date of 12/31/22 written on the back of it. During my onsite inspection on 01/09/23, there were 8 pills popped from the bubble pack (10 should have been administered).

- Resident J's 8:00am bubble pack for Rexulti tab 2 mg had a start date of 12/13/22 written on the front of it. During my onsite inspection on 01/09/23, there were 29 pills popped from the bubble pack (28 pills should have been administered)
- Resident J's 8:00am bubble pack for Allergy Relf. Tab had a start date of 12/14/22 written on it. During my onsite inspection on 01/09/23, there were 26 pills popped from the bubble pack (27 pills should have been administered.) This medication was not listed on Resident J's December 2022 or January 2023 MAR.

During the onsite inspection on 01/09/23, I interviewed the home manager, Andrea Lapp. Ms. Lapp stated that there might be some discrepancies with the bubble packs due to the residents going on leave with family members and transferring from other homes; however, she could not provide a clear explanation for the discrepancies noted above. Ms. Lapp was not aware that there were previous licensing violations at Beacon Home at County Line related to medication administration and documentation, which contributed to the issuance of a provisional license.

On 01/13/23, I received an email from Melissa Williams, Beacon's Chief Administrative Officer. Ms. Williams stated that they were sending a team to Beacon Home at County Line to assess the home and medication issues. She stated that as of 01/13/23, all start dates were added to the bubble packs in the home. Both residents would have a medication reconciliation completed to have an active count of what medications are on hand. Ms. Williams stated that several bubble packs came from other homes when the residents moved to Beacon Home at County Line. Ms. Williams also stated that a medication reconciliation would be completed on all medications in NextStep (electronic medication program) which would allow for an ongoing correct count of medications on hand. This will also be implemented for any new admissions and leave of absences to account for medications leaving and returning to the home.

Ms. Williams also noted that per Beacon policy, medications falling on the floor must be destroyed. All medication outside of the bubble pack is viewed as contaminated and staff should follow the Medication Disposal Policy. The home maintains a Drug Destruction Log to document incidences as such and anyone found not following this policy is grounds for disciplinary action, up to termination. Beacon has a policy that pills can be kept when refused until the next dose time up to the end of shift to ensure there are enough pills for the month if a resident chooses to take the medication after the scheduled time. Nurses must be involved when this occurs. The pill cup is placed in a baggie and labelled with the date, time, and resident's name so staff know what administration time the medications came from.

On 02/24/23, I conducted an exit conference via Microsoft Teams with the licensee designee, Kim Rawlings, Beacon's Chief Administrative Officer, Melissa Williams, and Beacon's Executive Vice President, Kevin Kalinowski. Mr. Kalinowski stated that most of the individuals who were involved in this investigation are no longer employed by Beacon. He stated that the current home manager and staff at Beacon Home at County Line are doing a wonderful job and continue to make improvements at the home. The

residents and their guardians are happy with the care they are receiving, and the residents do not want to leave the home. Mr. Kalinowski stated that it has been a struggle to hire and maintain quality staff throughout COVID and the difficult economic climate.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff passed medication that was not in the original pharmacy-supplied container. Resident D's medications were popped from the bubble packs by his relative when he was home for a visit during the Thanksgiving holiday. The medications were returned to the home in plastics bags. Direct care worker, James Hartman, contacted Beacon's on-call medical number. He stated he followed the instructions that were given and staff passed the medications to Resident D that were removed from the original pharmacy container on 11/24/22 and 11/25/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 through my investigation, it could not be determined if medications were being given pursuant to label instructions. During the onsite inspection on 01/09/23, I reviewed the medications for Resident D and

	Resident J. The home utilizes medication bubble packs, which are delivered on various dates throughout the month. Staff begin passing medications from each bubble pack from the bubble dated the 30th, rather than passing from the bubble that corresponds to the date the medication is passed. Per Beacon policy, staff do not initial or write the actual date the medication was passed on the bubble pack. Staff were not consistently writing a start date on the back of the bubble packs, so it could not be determined how many pills should be remaining in each pack for the month. Some bubble packs had a start date written on the back; however, the number of pills remaining in the bubble packs did not align with the start date.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #2022A0993005 dated 01/27/22; CAP dated 01/31/22; Renewal Licensing Study Report dated: 05/06/22; CAP dated: 10/10/22;**

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: (i) The medication. (ii) The dosage. (iii) Label instructions for use. (iv) Time to be administered. (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 through my investigation, there is sufficient information to conclude that staff did not initial Resident D and Resident J's medication administration records (MARs) at the time medication was administered. There were multiple dates on Resident D's December 2022 and January 2023 MAR that were not initialed, as well as one date on Resident J's January 2023 MAR that was not initialed.

	Resident J's December 2022 and January 2023 MAR did not list Allergy Relf. Tab but the medication was being administered.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report dated 07/28/20; CAP dated 08/07/20; Special Investigation Report #2022A0993005 dated 01/27/22; CAP dated 01/31/22; Renewal Licensing Study Report dated: 05/06/22; CAP dated: 10/10/22; Special Investigation Report #2022A0991035 dated 09/21/22; CAP dated 10/10/22**

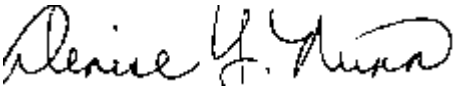
IV. RECOMMENDATION

I recommend revocation of the license.

02/24/2023

Kristen Donnay — Date
Licensing Consultant

Approved By:



02/24/2022

Denise Y. Nunn — Date
Area Manager