GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 18, 2023

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

RE: License #: AS380398559
Investigation #: 2023A0007013
Beacon Home at Martemucci

Dear Ms. Rawlings:

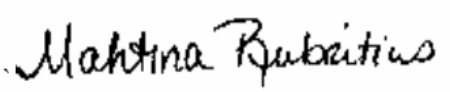
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
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Detroit, MI 48202
(517) 262-8604
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Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380398559
Investigation #:	2023A0007013
Complaint Receipt Date:	03/28/2023
Investigation Initiation Date:	03/28/2023
Report Due Date:	05/27/2023
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 Martemucci
Facility Address:	11219 Wamplers Lake Road Brooklyn, MI 49230
Facility Telephone #:	(517) 938-8722
Original Issuance Date:	03/17/2020
License **Status:**	REGULAR
Effective Date:	09/17/2022
Expiration Date:	09/16/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Allegations that seven adults reside in the home. The staff go out back and smoke, and presumably no one is monitoring inside the home. This has caused the adults to exit the front of the home and wander into traffic on multiple occasions. Today, a white male approximately 25-35 y/o was seen wandering in traffic. He was making a banging motion with his head. Cars had to stop and honk to avoid hitting him. Staff approached the front of the home and brought the individual inside. Police are also investigating.	No
Allegations that Resident C did not receive his medication, Lorazepam, as prescribed.	Yes

III. METHODOLOGY

03/28/2023	Special Investigation Intake - 2023A0007013
03/28/2023	Special Investigation Initiated - On Site - Face to face contact with Ms. Shephard, Home Manager, APS Worker #1, Employee #1, Employee #2, staff member, Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F.
03/28/2023	Contact - Document Received from APS Worker #1. Status update.
03/30/2023	Contact - Telephone call received from Ms. Shepard. A medication error occurred at the home. I requested that she send me a copy of the medication logs and information.
03/30/2023	APS Referral made.
03/30/2023	Contact - Document Received - Copy of the Daily Controlled Medication Charts and Information.
04/26/2023	Contact - Document Received - Email from APS Worker #1.
05/16/2023	Contact - Document Sent - Email sent to ORR. Status update requested.
05/16/2023	Contact - Telephone call made - Interview with Employee #2.

05/17/2023	Contact - Document Received - Email from ORR Officer #1.
05/17/2023	Contact - Document Received - Copy of ORR Unsubstantiated Investigative Report.
05/17/2023	Contact - Telephone call made to the facility. I left a message for Ms. Shephard and obtained the contact information for Employee #3.
05/17/2023	Contact - Telephone call made to Employee #3, no answer.
05/17/2023	Contact - Telephone call received from Employee #3. Interview.
05/17/2023	Contact - Telephone call made to Ms. Shephard. Follow-up questions and discussion.
05/17/2023	Exit Conference conducted with Ms. Rawlings, Licensee Designee.

ALLEGATIONS:

Allegations that seven adults reside in the home. The staff go out back and smoke, and presumably no one is monitoring inside the home. This has caused the adults to exit the front of the home and wander into traffic on multiple occasions. Today, a white male approximately 25-35 y/o was seen wandering in traffic. He was making a banging motion with his head. Cars had to stop and honk to avoid hitting him. Staff approached the front of the home and brought the individual inside. Police are also investigating.

INVESTIGATION:

On March 28, 2023, I conducted an unannounced on-site investigation and made face to face contact with Ms. Shephard, Home Manager, APS Worker #1, Employee #1, Employee #2, staff member, Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F.

APS Worker #1 was already in the home when I arrived. Ms. Shephard was aware of the allegations as ORR had also contacted them regarding the same allegations. Ms. Shephard stated that this incident never happened. Ms. Shephard reported that she also contacted Columbia Police Department to inquire if they investigated, responding to the home for a complaint regarding these allegations, and the police said they had nothing. Ms. Shephard informed there were also visitors at the home

throughout the day. Ms. Shephard informed me that Employee #1 and Employee #2 worked 7:00 a.m. to 7:00 p.m. that day, and she provided the contact information for Employee #2. Employee #1 was at the home at the time of the on-site inspection.

During the interview with Employee #1, she informed me that she does smoke and that she had taken smoke breaks while on shift that day. She informed that they have a protocol including informing the other staff when they step outside. The other staff remains in the home to supervise the residents. Employee #1 stated that she never witnessed any residents being in the road and staff having to intervene. She also stated that none of the residents eloped from the home yesterday.

During the interview with Ms. Shephard, she informed me that Resident C will go out to the van; however, they never had multiple incidents of him leaving the home. According to Ms. Shephard, Resident C's mother was at the home visiting yesterday. She also informed that the residents utilize the backyard, but this usually occurs more in the summertime. Ms. Shephard informed me that there were six residents admitted into the home. I inquired about interviewing the residents and Ms. Shephard informed me that Resident A was the verbal resident in the home.

I attempted to interview Resident A; however, he did not appear to want to talk.

Later that day, APS Worker #1 emailed and informed me that she emailed Columbia Police Department, Michigan State Police, and the Sherriff's Department. She had not heard back from the Sherriff's department, but MSP and Columbia did not get a call about the Beacon Home.

In addition, that she spoke to Resident C's mother (Guardian C) and Ms. Tingly (Nurse), and they both reported that they did not see anyone wander away from the home. Ms. Tingly was at the home from about 10:30 a.m. to 2:30 p.m. and Resident C's mother was there around 6:00 p.m. She was still waiting to hear from Employee #2.

APS Worker #1 completed additional contacts and interviews. During the course of this investigation, APS Worker #1 informed me that her case was closed as the allegations appeared to be false.

On May 16, 2023, I interviewed Employee #2, who was cooperative with the interview. Employee #2 informed me that she had already spoken to someone about these allegations. She stated that the incident never happened. She stated that Resident C does go on the back porch but there has not been an issue with him taking off. She stated that this would not occur on her watch.

On May 17, 2023, ORR Officer #1 informed me that they investigated the allegations and did not substantiate the complaint.

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:	An unannounced on-site investigation was coordinated with APS Worker #1. Ms. Shephard, Home Manager, and Employee #1 reported that there were no incidents of a resident wandering into traffic and law enforcement investigating. Ms. Shephard reported to contact the local law enforcement agency to determine if they had been dispatched to the home and they had not. APS Worker #1 also contacted law enforcement and was informed that they were not dispatched to the facility on the day in question. In addition, that she spoke to Resident C's mother (Guardian C) and Ms. Tingly (Nurse), and they both reported that they did not see anyone wander away from the home. APS Worker #1 interviewed the three staff on duty, and they all denied that a resident left the home and was unsupervised. APS Worker #1 did not substantiate the case. ORR Officer #1 did not substantiate the complaint. During the interview with Employee #2, she stated that the incident never happened. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that the residents were not treated with dignity and their personal needs, including protection and safety were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

Allegations that Resident C did not receive his medication, Lorazepam, as prescribed.

INVESTIGATION:

During the course of this investigation, Ms. Shephard, Home Manager, informed me that a medication error occurred. In addition, that Resident C did not get his medication, Lorazepam, as prescribed.

Ms. Shephard provided me with a copy of the incident report and medication documentation.

A review of the incident report reflected that on March 29, 2023, at 7:20 p.m., during shift change, while counting medications off with Employee #3, Employee #4 noticed that Resident C did not receive his 8:00 a.m. dosage of Lorazepam 2 mg. Employee #3 and Employee #4 separately counted the medications twice and confirmed that Resident A did not receive his medication that morning.

Employee #4, who was arriving for night shift, contacted the home manager and on-call medical, notifying them of the medication error.

Management documented the medication error and spoke with Employee #3, issuing a Progressive Action. In addition, Employee #3 was removed from administering medications until she received additional training and was observed passing medications. The additional training and observations would occur before she could be designated to pass medications.

On May 17, 2023, I interviewed Employee #3. Employee #3 stated that she was a new employee, as she was hired in November of 2022, and she made a mistake that morning. She stated that it was a serious mistake as this was a controlled medication. Employee #3 stated that she was retrained to pass medications the following day and that supervision observed her complete three medication passes.

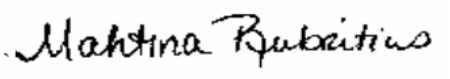
On May 17, 2023, I spoke with Ms. Shephard, as I had some follow-up questions. Ms. Shephard informed me that Employee #3 was retrained to pass medications, and that she continued to be supervised while passing meds. In addition, that there was another matter in which allegations were substantiated against Employee #3 and her employment status was being evaluated. I informed Ms. Shephard that I would be requesting a written corrective action plan to address the established rule violation for the medication error.

On May 17, 2023, I conducted the exit conference with Ms. Rawlings, Licensee Designee. I informed her of the conclusion of the investigation and my findings, and that I would be requesting a written corrective action plan. She agreed to submit a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	A review of the incident report reflected that on March 29, 2023, at 7:20 p.m., during shift change, while counting medications off with Employee #3, Employee #4 noticed that Resident C did not receive his 8:00 a.m. dosage of Lorazepam 2 mg. Employee #4, who was arriving for night shift, contacted the home manager and on-call medical, notifying them of the medication error. Employee #3 stated that she was a new employee, as she was hired in November of 2022, and she made a mistake that morning. Ms. Shephard informed me that Employee #3 was retrained to pass medications, and that she continued to be supervised while passing meds. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident C did not receive his medication, Lorazepam, as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



5/17/2023

Mahtina Rubritius Licensing Consultant — Date

Approved By:

5/18/2023

Ardra Hunter Area Manager — Date