GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 18, 2024

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

RE: License #: AS370413382
Investigation #: 2024A1029042
Beacon Home At Nottawa

Dear Roxanne Goldammer:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care violations identified in the report, a six-month provisional license is recommended and 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

I. IDENTIFYING INFORMATION

License #:	AS370413382
Investigation #:	2024A1029042
Complaint Receipt Date:	04/17/2024
Investigation Initiation Date:	04/17/2024
Report Due Date:	06/16/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St., Suite 110, Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home At Nottawa
Facility Address:	7302 S Nottawa Rd, Mount Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/14/2022
License Status:	REGULAR
Effective Date:	05/14/2023
Expiration Date:	05/13/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

ALLEGATION(S)

	Violation Established?
Resident A did not receive medical care promptly. Direct care staff members waited for four hours before calling 911 although Resident A was lethargic, disorientated, could not sit up, and did not know his name.	Yes
Resident A did not have his insulin available at Beacon Home at Nottawa.	Yes

II. METHODOLOGY

04/17/2024	Special Investigation Intake 2024A1029042
04/17/2024	Special Investigation Initiated – Telephone to Katie Hohner ORR
04/17/2024	Referral - Recipient Rights Made complaint to ORR.
04/18/2024	APS Referral to Centralized Intake
04/18/2024	Contact - Telephone call received to complainant.
04/18/2024	Contact - Telephone call made to Ambulance Supervisor, Bryan
04/18/2024	Contact - Document Sent to Marlo Derry and Roxanne Goldammer
04/19/2024	Inspection Completed On-site - Face to Face - Katie Hohner and I interviewed Naomi Vorhees, Cynthia Watson, Roxanne Goldammer, Ramon Beltran at Beacon Home at Nottawa.
05/01/2024	Contact - Telephone call made to direct care staff members Jaden Davis, Safa Ibrahim, Joyce Human, RN Marcy Villeneuve, LPN Remillard
05/08/2024	Contact - Telephone call received message from Ramon Beltran
05/10/2024	Contact - Document Received – Email exchange with APS James Helwig
05/14/2024	Contact - Telephone call received from Melissa Williams
05/14/2024	Contact - Telephone call made to Beacon Specialized Living Director of Operations Ramon Beltran

05/30/2024	Contact - Telephone call made to Katie Hohner
05/31/2024	Contact – Document sent – Email to Roxanne Goldammer and Marlo Derry
06/04/2024	Contact – Telephone call to Katie Hohner
06/04/2024	Exit conference with licensee designee Roxanne Goldammer and telephone call from Melissa Williams.

ALLEGATION:

Resident A did not receive medical care promptly. Direct care staff members waited for four hours before calling 911 although Resident A was lethargic, disorientated, could not sit up, and did not know his name.

INVESTIGATION:

On April 17, 2024, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns that Resident A did not receive medical care promptly. According to the complaint direct care staff members waited for four hours before calling 911 although Resident A was lethargic, disorientated, could not sit up, and did not know his name.

On April 18, 2024, I interviewed Complainant who stated there was a four hour delay before direct care staff members called 911 for Resident A. According to Complainant, when Emergency Medical Services (EMS) arrived Resident A was unconscious and could not move and the unknown direct care staff member stated Resident A was prescribed insulin but did not know why it was not available to be administered. Complainant stated “this is one of the most severe cases of negligence” she has observed. Complainant stated Resident A needed to have his clothes cut off him and he had ventricular tachycardia (V-TACH) with a pulse which is rare when she arrived. Complainant stated she was surprised Resident A was still alive due to his condition upon EMS arrival and being in this condition since 5 AM on April 16, 2024. Complainant stated she received a page to respond at 9:25 AM and she arrived around 9:42 AM. Complainant reiterated direct care staff members knew of his condition since 5 AM but did not do anything for Resident A in this time frame. Complainant stated she has “never observed a situation where the resident was actively dying and the staff did not do anything.”

On April 19, 2024, Office of Recipient Rights (ORR) Officer Katie Hohner and I completed an unannounced onsite investigation at Beacon Home at Nottawa and interviewed direct care staff member whose current role is home manager, Naomi Vorhees. Ms. Vorhees stated Cynthia Watson was the day shift direct care staff

member responsible for administering medications starting at 8 AM. Ms. Vorhees stated on the day of the incident she received a phone call at 4 AM from direct care staff member Jaden Davis however Ms. Vorhees stated, “I do not remember what was said because it was early but they said they (Mr. Davis) called medical and they said to keep an eye on him.” Ms. Vorhees stated around 9 AM direct care staff member Cynthia Watson reported Resident A’s blood sugar reading was around 580 mg/dL. Ms. Vorhees stated she told her to call 911. Ms. Vorhees stated Resident A’s blood sugar was required to be checked before meals, after meals, at bedtime and if he asks, direct care staff members will check it throughout the night for his piece of mind. Ms. Vorhees was able to check the blood sugar readings for the following times which were recorded as follows on Resident A’s glucose monitor. Those readings are listed below:

April 14, 2024: (all times were not recorded)
7:45 AM: 139 mg/dL
AM: 265 mg/dL
Afternoon: 243 mg/dL
PM check: 292 mg/dL

April 15, 2024:
AM before breakfast: 363 mg/dL
AM after breakfast: 330 mg/dL
Before lunch: 318 mg/dL
Lunch time: 377 mg/dL

April 16, 2024:
4 AM: 514 mg/dL
6:30 AM 537 mg/dL
8:30 AM 540 mg/dL
9 AM 587 - This is when 911 was contacted.

Ms. Vorhees stated medical on-call RN Villeneuve was contacted the evening of April 15, 2024, because Resident A’s blood sugar reading was up to 357 mg/dL. Ms. Vorhees stated the instructions provided to direct care staff members included: having Resident A walk around and drink fluids. Ms. Vorhees stated this was a high blood sugar reading as Resident A’s normal blood sugar readings were between 90-150/160 mg/dL and even 265 mg/dL is a higher blood sugar reading that what was normal for Resident A. Ms. Vorhees stated the facility policy is that any resident who receives insulin and the blood sugar reads over 350 mg/dL, direct care staff members they are supposed to call the facility medical on-call team for instruction or guidance. Ms. Vorhees stated the facility policy has a specific blood sugar reading level which determines 911 should be called, but Ms. Vorhees did not recall that specific blood reading number.

Ms. Vorhees stated that on April 15, 2024,direct care staff member Kelly Halstead asked Resident A if he wanted to go to the walk-in clinic or the emergency room but Resident A refused. Ms. Vorhees stated because Resident A is his own guardian, he can refuse treatment. Ms. Vorhees stated she also worked on April 15, 2024 and

offered to take Resident A to the walk-in clinic when his blood sugar reading was over 377 but again he refused to go.

On April 19, 2024, ORR Ms. Hohner and I interviewed Cynthia Watson. Ms. Watson stated she worked on April 16, 2024, when Resident A went to the hospital. Ms. Watson stated when she arrived at work, Mr. Davis told her Resident A's blood sugar was high so he called the facility on-call medical team for guidance and they told him to "keep an eye on him" and that "they were doing everything they could." Ms. Watson stated "keeping an eye on" means to "keep checking the sugar levels to make sure they are not getting higher." Ms. Watson stated she checked Resident A's blood sugar every 30 minutes after that time but Ms. Watson did not recall what time she started taking Resident A's blood sugar reading. Ms. Watson stated she called facility on-call medical at 8 AM because his blood sugar reading was 340 mg/dL and again, the on-call medical personnel, whose name Ms. Watson did not recall, stated they were doing everything possible. Ms. Watson stated at 9 AM, Resident A's blood sugar reading was 587 mg/dL, so she stated she called 911 and then direct care staff member/home manager Naomi Vorhees. Ms. Watson stated Resident A was "in and out of it", however Ms. Watson stated Resident A was able to talk, but his words were slurred, which was abnormal for him. Ms. Watson stated she decided to call when she saw his blood sugar was 587 mg/dL. Ms. Watson stated she was never told to call 911 by any administrative or medical on-call staff rather she made this decision based on her experience with diabetes and knowing any blood sugar reading near 600 mg/dL was high. Ms. Watson stated when EMS came, the paramedics started screaming at them and informed her they were reporting the concerns because it was neglect. Ms. Watson stated she told EMS personnel they were following facility protocols to which Ms. Watson stated one EMS personnel said, "F protocols" and told her EMS should have been called sooner. Ms. Watson stated she told EMS personnel they were following facility protocols. Ms. Watson stated that she did not tell anyone that medical said not to call 911. Ms. Watson stated Mr. Davis also told her Resident A was "in and out and slurring words" before she arrived at work.

After reviewing Resident A's blood sugar readings saved in Resident A's continuous glucose monitor, Ms. Hohner and I spoke to Ms. Watson again and showed her the glucometer reading of 540 mg/dL at 8:30 AM. Ms. Watson stated she must have misread the number and thought it was a number '3' at the beginning of the blood sugar reading. Ms. Hohner and I also reviewed written documentation on the *Blood Sugar Monitoring Log* but there was no blood sugar reading listed for 8:00AM or 8:30 AM. Ms. Watson stated she wrote Resident A's blood sugar readings on a sticky note with the number but did not write it on the sheet. Ms. Watson continued to state she did not know that Resident A's blood sugar was 540 mg/dL when she arrived.

On April 19, 2024, ORR Ms. Hohner and I interviewed licensee designee Roxanne Goldammer who stated there are policies in place which guide direct care staff members on when to call 911. Ms. Roxanne Goldammer stated anytime a resident's blood sugar readings read over 500 mg/dL, then 911 or EMS should be called to assess the resident. Ms. Goldhammer stated EMS should be called before management in this

circumstances. Ms. Hohner and I reviewed the policy regarding high blood sugar readings which included the following guidance:

"The Hyperglycemia (High Blood Sugar) policy"

"Purpose: To clarify the correct protocol when a resident's blood sugar is greater than or equal to 350 the purpose is to provide safe consistent care treatment and services for all residents.

Policy: All staff will be compliant with the protocol when a resident's blood glucose levels are greater than or equal to 350.

Procedure: When a resident's blood glucose level is greater than or equal to 350 the following protocol will be followed:

1. *When a resident is conscious administer insulin as prescribed*
   a. *Monitor for any symptoms of high blood sugar that may exist extreme thirst, dry skin, irritability, frequent urination.*
   b. *Recheck glucose level one hour after initial reading greater than or equal to 350.*
   c. *Once the resident has received the above treatment contact the medical department.*
2. *When a resident is unconscious no insulin is to be administered even when it is a regularly scheduled medication.*
   a. *Dial 911 for hospital transport*
   b. *Provide supportive care and CPR if necessary.*
   c. *Perform a set of vital signs and document.*
   d. *Once the resident has received the above treatment contact the medical department."*

I reviewed the nursing note from the call on April 15, 2024, written by LPN Remillard. The note documented the following:

> *"On call nurse received call from floor staff. Nurse was informed [Resident A] had a blood glucose level of 353 nurse reviewed medication list with the floor staff nurse requested meds administered per PCP orders. Floor staff informed nurse the home did not have insulin glargine that was ordered nurse asked why this was the case nurse was informed staff have attempted to obtain the insulin glargine at a medical equipment store and that the home did not obtain this medication from the pharmacy nursing informed to monitor and encourage fluid nurse requested floor staff to encourage a resident to ambulate as tolerated nurse contacted SED (Marcy Villeneuve, RN) of medical."*

I reviewed Resident A's resident record. According to his *Resident ID sheet, Health Care Appraisal,* and *Assessment Plan for AFC Residents*, Resident A is diagnosed with

Type 1 diabetes mellitus without complications. According to Resident A's *Assessment Plan for AFC Residents* "staff will continue to administer [Resident A]'s medication per doctor's orders" and "[Resident A] is a Type 1 Diabetic."

I reviewed Resident A's Community Mental Health Plan of Service which included the personalized goal:

> *"Staff will hold and administer all medications as they have been prescribed and will pass those medications for [Resident A]. Requires assistance to maintain safe placement. Goal of medication compliance.*
>
> *Under Barriers and obstacles:*
>
> *[Resident A] has diabetes and needs to be monitored for that."*

I also reviewed a training Attestation for Resident Licensing Binder form indicating direct care staff members that were trained on Resident A's Plan of Service and Person-Centered Plan. There were five direct care staff members listed and none of them were involved in this incident (M. Recker, K. DeRosia, H. Smith, A. Jensen, and C. Yankson).

On May 1, 2024, ORR Katie Hohner and I interviewed direct care staff member Jaden Davis. Mr. Davis stated he worked third shift the night before Resident A went to the hospital and he was the direct care staff member responsible for medication administration. Mr. Davis stated the only symptoms that Resident A had was that he was not able to make it to the toilet in time and looked drowsy and tired. Mr. Davis stated these symptoms started around 3:30 AM /4 AM. Mr. Davis stated Resident A reported he was not feeling well around 4 AM, so he kept monitoring Resident A and noted Resident A was not able to make it to the bathroom twice before having a toileting accident. Mr. Davis stated the incontinence has happened before a few times, but was not a regular occurrence with Resident A. Mr. Davis stated he took Resident A's blood sugar reading twice starting at 4 AM. Mr. Davis stated Resident A's 4 AM blood sugar reading was 514 mg/dL so he called home manager Ms. Vorhees. Mr. Davis stated she asked if he had contacted on-call medical to which he reported that he initially could not get in touch with the on-call medical number while using the house phone so he used his cell phone instead and talked to the nurse from on-call medical (he could not recall their name) for about 5 minutes. Mr. Davis stated he informed on-call medical about Resident A's current condition including there was no insulin in the facility to administer to Resident A. Mr. Davis stated he was informed by on-call medical that he "did his job" and "all he could do is monitor him". Mr. Davis stated he "really didn't know" how he was supposed to monitor Resident A but did not ask any clarifying questions. Mr. Davis stated he was second guessing this guidance and wanted to call 911 but he also did not know how much trouble he would be in if he went against on-call medical guidance. Mr. Davis denied that on-call medical person told him he could not call 911. Mr. Davis stated he did not write progress notes after he called on-call medical however, he did complete progress notes a few days later. Mr. Davis stated he contacted on-call medical at 6 AM. Mr. Davis stated he did not tell the on-call medical person that the blood sugar was 315 mg/dL so he was not sure why this blood sugar reading is in

Resident A's medical notes. Mr. Davis stated he follows a resident's MAR instructions regarding blood sugar readings and insulin administration but there were no instructions on Resident A's MAR for a blood sugar reading over 500 mg/dL. Mr. Davis stated direct care staff are only supposed to call 911 if it's an actual emergency or a life-or-death situation. Mr. Davis stated he felt like this was a medical emergency and he did check with Resident A but Resident A stated he was 100% set on not going to the hospital. Ms. Hohner informed Mr. Davis EMS could have come to the home and given him insulin even if he did not go to the emergency room and Mr. Davis stated he did not know this was a possibility. Mr. Davis stated he was suspended from his position currently because of this incident.

On May 1, 2024, ORR Katie Hohner and I interviewed direct care staff member Safa Ibrahim. Ms. Ibrahim stated she worked with Mr. Davis and she was the 1:1 with Resident B during third shift on April 15, 2024. Ms. Ibrahim stated Resident A reported to her that he was not feeling well and asked to have his blood sugar checked. Ms. Ibrahim stated she was focused on what was occurring with Resident B since that was her current work assignment. Ms. Ibrahim stated when Resident A reported he was not feeling well she observed he was not walking well and told her he "was not doing well" and "needed help." Ms. Ibrahim stated she called Mr. Davis around 2 AM because he was the in the basement area of the facility and requested he address Resident A's needs as she was supervising Resident B. Ms. Ibrahim stated it was "not my business because I needed to focus on my 1:1". Ms. Ibrahim stated she took Resident B outside to smoke so she did not know what occurred after that. Ms. Ibrahim stated she did not know if Mr. Davis checked Resident A's blood sugar. Ms. Ibrahim stated Resident A was shaking, running into the walls, and barely able to speak. Ms. Ibrahim stated she told Mr. Davis Resident A needed assistance, however other than telling Resident A to sit down so he would not fall, she did not provide further assistance to him. Ms. Ibrahim continuously repeated that she was responsible for Resident B even though she was aware of Resident A's current condition. Ms. Ibrahim stated she cannot be responsible for all six residents and "cannot leave my 1:1" to assist other residents.

On May 1, 2024, ORR Katie Hohner and I interviewed direct care staff member Joyce Human. Ms. Human stated the morning Resident A was sick she was 1:1 supervision for Resident C and started working at 9 AM. Ms. Human stated she was working with Ms. Watson and Ms. Ibrahim. Ms. Human stated when she arrived at 9 AM the other direct care staff members were discussing Resident A's high blood sugar readings of 514 mg/dL at 6 AM and 530 mg/dL or 547 mg/dL when taken by Ms. Watson. Ms. Human stated she observed Resident A fall back on his back on bed and Ms. Watson checked his blood sugar and it was 587 mg/dL. Ms. Human stated she took Resident A's vitals at 9:30 AM and his vitals were: pulse 50 bpm, oxygen was 74, and his blood pressure was 97/47. Ms. Human stated after taking Resident A's vitals, Ms. Watson called on-call medical and Ms. Human stated she called 911. Ms. Human stated she does not know if Ms. Watson called on-call medical before Ms. Human arrived to work but she knows Mr. Davis stated he did contact them. Ms. Human stated when EMS arrived, the EMTs were upset telling her and other direct care staff members that they could have killed Resident A. Ms. Human stated she agreed 911 should have been

called sooner. Ms. Human denied being told not to call EMS. Ms. Human stated she was the only direct care staff member who checked Resident A's vitals despite him not feeling well all night.

On May 1, 2024, ORR Katie Hohner and I interviewed medical on-call RN Marcy Villeneuve. RN Villeneuve stated Resident A's blood sugar was in the 300s during evening hours on April 15, 2024, before but he displayed no other symptoms. RN Villeneuve stated direct care staff were direct to have Resident A drink water, encourage Resident A to move around and monitor Resident A. RN Villeneuve stated Resident A's blood sugar readings were not at a critical level of 300 mg/dL. RN Villeneuve stated medical on-call LPN Remillard was contacted one time that she was aware of around 7 PM the evening of April 15, 2024. RN Villeneuve stated no direct care staff member called during early morning hours of April 16, 2024 or throughout the nighttime hours of April 15, 2024, until the mid-morning of April 16, 2024 to seek guidance for Resident A's condition. RN Villeneuve stated she knows this because she checked with the assigned on-call medical nurse about receiving any calls regarding Resident A and checked all the call logs but no calls were documented. RN Villeneuve stated any call made goes to the on-call system whether Mr. Davis called from his personal cell phone or the AFC house telephone. RN Villeneuve stated there is an "Emergency Needs" training which trains direct care staff members that if resident is in distress, direct care staff members call 911 at any time. RN Villeneuve stated direct care staff members are trained on the policy for high blood sugars and are instructed to call on-call medical for any blood sugar reading over 350 mg/dL. RN Villeneuve confirmed Resident A has a history of high blood sugar readings and after reviewing Resident A's blood sugar readings for April 15, 2024 and April 16, 2024 along with the symptoms Resident A was displaying such as being unsteady and delirious at 5 AM, direct care staff members working should have called 911 at that time. RN Villeneuve stated direct care staff should not have waited until after 9AM to call 911. RN Villeneuve stated it is harder to control blood sugar for Type 1 diabetics than Type 2 diabetes, regardless Resident A's blood sugar readings were so high 911 should have been contacted earlier during this incident.

On May 1, 2024, ORR Ms. Hohner and I interviewed licensed practical nurse (LPN) Remillard. LPN Remillard stated he entered a note on April 15, 2024 at 6:05 PM that on-call medical was contacted regarding Resident A. LPN Remillard stated there is a facility system in place for direct care staff members to call with questions or concerns and it is open seven days during all off hours between 5:01 PM and 8 AM. LPN Remillard stated he was on-call that evening and checked his call log to see if he received any other calls on April 15, 2024. LPN Remillard confirmed this was the only call received and lasted approximately five minutes. LPN Remillard stated he informed direct care staff member Mr. Davis to monitor for high blood pressures, encourage fluids, and monitor for symptoms of hyperglycemia. LPN Remillard stated he feels there are "excuses of incompetent staff" and he stated based off the blood sugar reading of 353 it was not too far out of the norm for Resident A. LPN Remillard stated he never received another on-call telephone call regarding Resident A but had he been informed

about the symptoms Resident A was exhibiting he would have directed direct care staff to call 911.

On May 14, 2024, I interviewed Beacon Specialized Living Services Director of Operations Ramon Beltran. Mr. Beltran stated direct care staff member Naomi Vorhees will not be returning to her position as home manager because this situation was unacceptable. Mr. Beltran stated there are other home managers from other licensed AFC facilities owned by the licensee assisting with training to fix several items at Beacon Home at Nottawa. Mr. Beltran stated because of this investigation several direct care staff members were terminated from employment. Mr. Beltran stated none of the direct care staff members working called any administrative staff for guidance nor did they call any on-call medical personnel to assist with Resident A during the early morning hours of April 16, 2024. Mr. Beltran stated Mr. Davis' lack of action during Resident A's medical event along with his fabricated statements about calling on-call medical for instruction led to his termination from employment. Mr. Beltran stated the RN call report was ran and there were no calls from direct care staff member Mr. Davis despite his statements otherwise. Mr. Beltran stated there is a policy in place informing direct care staff members when to call 911 and he has told direct care staff members in training "when in doubt, call" for any medical emergency.

On May 31, 2024, I received an email from Ms. Goldammer stating that due to unrelated health issues from his insulin, Resident A would not be returning to Beacon Home at Nottawa.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Resident A's blood sugar readings were over 500 mg/dL and he reported not feeling well throughout the night of April 15, 2024, to both direct care staff members Mr. Davis and Ms. Ibrahim but no action was taken to assess Resident A's condition. Mr. Davis stated he called medical on call however according to on-call medical RN Villeneuve and LPN Remillard, there was no record of these calls on April 16, 2024. Ms. Ibrahim stated that she did not aid Resident A because she was assigned to provide 1:1 staffing coverage to Resident B and it "was not her business" despite realizing around 2 AM that Resident A was walking unsteady and running into walls. Ms. Ibrahim did not follow up to make sure Mr. Davis provided care to Resident A. EMS was not contacted until 9 AM when first shift direct care staff members Ms. Human and Ms. Watson arrived on shift and assessed Resident A's condition. According to Beacon Specialized Living's Hyperglycemia (high blood sugar) policy, direct care staff members should have contacted medical on-call or 911 after Resident A's blood sugar readings reached 350 mg/dL or higher.
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:	Direct care staff members Mr. Davis and Ms. Ibrahiim did not treat Resident A with dignity or consider his personal needs of protection and safety during the evening of April 15, 2024 when they waited to obtain medical treatment after Resident A's blood sugar levels were dangerously high.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A did not have his insulin available at Beacon Home at Nottawa.

INVESTIGATION:

On April 17, 2024, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns Resident A did not have his prescribed

insulin available at Beacon Home at Nottawa. According to the allegations, Resident A's insulin was not reordered by direct care staff member Naomi Vorhees whose role is home manager.

On April 18, 2024, I interviewed Complainant who stated direct care staff members at Beacon Home at Nottawa first informed her Resident A did not have insulin prescribed to him but then stated he did not have insulin available at Beacon Home at Nottawa. Complainant stated since Resident A has Type 1 Diabetes direct care staff members should have known that he had insulin prescribed to him.

On April 19, 2024, ORR Katie Hohner and I completed an unannounced onsite investigation at Beacon Home at Nottawa and interviewed direct care staff member Naomi Vorhees. On April 14, 2024 Ms. Vorhees documented her initials and the number 6 for Resident A's insulin however Ms. Vorhees did not know what this represented. Ms. Vorhees was able to show Ms. Hohner and I the medication administration record (MAR) which documented insulin glargine was administered to Resident A in the AM on April 15, 2024 and April 16, 2024 however Ms. Vorhees stated these were not correct because there was no insulin in the facility for Resident A on either date.

Ms. Vorhees stated Resident A received his last dose of insulin on April 13, 2024. Ms. Vorhees stated she called Resident A's primary care provider on April 12, 2024 in the afternoon to reorder the medication but received voicemail. Ms. Vorhees stated she contacted a medical supply company on April 8, 2024 and April 12, 2024 as well to try to fill Resident A's insulin prescription and left a voicemail but did not follow up further. Ms. Vorhees stated Resident A did not receive his prescribed insulin from April 14, 2024 through the morning of April 16, 2024 because it was not available in the facility. Ms. Vorhees stated on April 16, 2024 she found out his insulin was changed because of insurance coverage. Ms. Vorhees stated pharmacist, Mr. Rousch from Gull Pointe Pharmacy said the insulin had to come from the medical supply company because of his Medicare insurance. Ms. Vorhees stated there was no issue with the prescription however she stated she did not send it to another pharmacy to be filled.

On April 19, 2024, ORR Ms. Hohner and I interviewed direct care staff member Ms. Watson who stated Resident A did not have any insulin in the facility at the time of his medical event. Ms. Watson stated various direct care staff have been "fighting for 1.5 months to get it in the home" with various pharmacies. Ms. Watson stated she did not contact any pharmacy herself nor did she try to get any insulin at any time.

On April 19, 2024, ORR Ms. Hohner and I interviewed licensee designee Ms. Goldammer who stated she is frustrated with the situation and believes the "ball was dropped." Ms. Goldammer stated RN Chasity Campbell, who was working with Ms. Vorhees to fix Resident A's medication challenges, resigned from her position right when this occurred and did not leave any notes regarding Resident A's insulin medication. Ms. Goldammer stated when she received an email from Ms. Halstead stating Resident A was out of insulin on April 13, 2024, this was the first she knew about

Resident A not having insulin in the home. Ms. Goldammer stated the challenge to fill Resident A's insulin prescription was never communicated to her nor was she aware that Ms. Vorhees did not follow up to ensure the prescription was filled.

Ms. Hohner and I were able to verify there was FIASP FlexTouch (insulin aspart injection) available at Beacon Home at Nottawa at the time of our on-site inspection. This insulin prescription was filled on April 16, 2024, per the label, from Health Park Pharmacy in Mt. Pleasant, Michigan.

I reviewed an email that was sent from Ms. Vorhees on April 2, 2024, to pharmacist Chris Rousch asking for three resident prescriptions that were not delivered to the facility including Resident A's Lantus (insulin) medication. There was another email from Ms. Vorhees to Mr. Rousch on March 25, 2024, asking for Resident A's insulin supplies to which Mr. Rousch replied stating since Resident A had Medicare insurance, those supplies would need to come from the medical supply company.

On April 19, 2024, Ms. Hohner and I interviewed Beacon Specialized Living Director of Operations Mr. Beltran. Mr. Beltran stated insulin was not ordered which resulted in Resident A going to the hospital with no insulin and high blood sugar. Mr. Beltran stated he would be suspending Ms. Vorhees pending the outcome of the investigation.

On May 1, 2024, ORR Katie Hohner and I interviewed RN Marcy Villeneuve. RN Villeneuve stated she was contacted by RN Remillard who stated to her there was no insulin in the home for Resident A and asked her what should be done in that situation. RN Villeneuve stated Resident A did not have any fast-acting insulin or any long acting insulin available in the facility. RN Villeneuve stated it was her understanding it was supposed to be on the order for April 8, 2024, and she said Ms. Vorhees said they should have had more than enough because there was 140 units left. RN Villeneuve stated Ms. Vorhees requested "diabetic supplies" and the pharmacy stated they needed to get them from a medical supply company not the pharmacy. RN Villeneuve stated Resident A was out of the facility April 11, 2024 and April 12, 2024 with a family member and when they returned, Ms. Vorhees then realized he did not have any insulin.

On May 1, 2024, ORR Ms. Hohner and I interviewed LPN Gerard Remillard. LPN Remillard stated direct care staff should have called him as soon as they realized they did not have the insulin and they never did. LPN Remillard stated insulin is not a narcotic and it could be obtained easily from a local pharmacy and there was no reason this was not available in the home.

On May 14, 2024, I interviewed Mr. Beltran. Mr. Beltran stated Resident A was out of insulin for about four days at Beacon Home at Nottawa. Mr. Beltran stated Resident A remains in the hospital but is out of the intensive care unit. Mr. Beltran stated Resident A's insulin is available at the facility now and RN Villeneuve is helping with the prescription orders. Mr. Beltran stated Ms. Vorhees sent an email ordering the insulin but there was no follow up on the e-mail or follow up to ensure the insulin was in the

facility. Mr. Beltran stated he has no doubt pharmacist Mr. Rousch from Gull Pointe Pharmacy would have had the medication there immediately if contacted because they work closely with the pharmacy when situations like this arise.

On June 4, 2024, I completed the exit conference with Ms. Goldammer. Ms. Goldammer stated the employees involved in this situation Naomi Vorhees, Mr. Davis, Ms. Watson, Ms. Halstead, and Ms. Ibrahiim have all been terminated from their position. Ms. Goldammer stated they are in the process of finding a new home manager for Beacon Home at Nottawa. Ms. Goldammer stated there is another home manager filling in three days per week and there is a program director there 1-2 days per week, and Ms. Goldammer stated she has been there for 1-2 days per week. Ms. Goldammer stated they have done extensive training regarding medication administration and various policies to make sure all the direct care staff members are retrained. Ms. Goldammer stated Ms. Hohner will also provide a recipient rights refresher for the direct care staff members. Ms. Goldammer stated Resident A initially was admitted to the hospital but has since been discharged to a nursing home. Ms. Goldammer stated she stated his overall health is poor and he is not physically able to live in an AFC at this point. Ms. Goldammer stated Resident A has been back in the hospital two times since he has been in the nursing home. Ms. Goldammer stated regarding the insulin, Ms. Vorhees was trying to get insulin supplies rather than insulin but did not reach out to administration when she hit roadblocks. Ms. Goldammer stated she found out there was no insulin in the home on April 13, 2024, via a note from Ms. Halstead stating Resident A would be without insulin starting April 14, 2024.

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 S333.1101 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:	Resident A did not have insulin in the facility when he was experiencing blood sugar increases in the 500 mg/dL range. Resident A did not receive his insulin on April 14, 2024 or April 15, 2024, despite having a current insulin prescription. This resulted in Resident A's being hospitalized on April 16, 2024, and later discharged to a nursing home. Although direct care staff member Naomi Vorhees sent emails to the pharmacist attempting to fill Resident A's insulin prescription, she did not follow through or notify facility administration or medical on-call about this issue. Consequently, Resident A went multiple days without insulin resulting in hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Due to the quality of care violations cited, a six month provisional license is recommended upon receipt of an approved corrective action plan.

Jennifer Browning _____06/06/2024_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 06/18/2024

_____

Dawn N. Timm Date
Area Manager