GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 19, 2024

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

RE: License #: AM590387878
Investigation #: 2024A0622050
Beacon Home At The Lodge

Dear Ms. Hunter:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM590387878
Investigation #:	2024A0622050
Complaint Receipt Date:	08/29/2024
Investigation Initiation Date:	08/29/2024
Report Due Date:	10/28/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Katrina Pierce
Licensee Designee:	Suzanne Hunter
Name of Facility:	Beacon Home At The Lodge
Facility Address:	1550 E. Colby Road Stanton, MI 48888
Facility Telephone #:	(989) 831-0626
Original Issuance Date:	04/17/2018
License **Status:**	REGULAR
Effective Date:	10/17/2022
Expiration Date:	10/16/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A's hydrocodone went missing under the care of two direct care workers.	Yes

III. METHODOLOGY

08/29/2024	Special Investigation Intake 2024A0622050
08/29/2024	Special Investigation Initiated – Telephone phone call with Sarah Watson, recipient rights officer.
09/10/2024	Inspection Completed-BCAL Sub. Compliance
09/19/2024	Exit Conference with Katrina Pierce

ALLEGATION: Resident A's hydrocodone went missing under the care of two direct care workers.

INVESTIGATION:

On 08/29/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, an incident report was received, which stated that three of Resident A's prescribed medication hydrocodone went missing under the care of two direct care workers.

On 08/29/2024, I interviewed, recipient rights officer, Sarah Watson. She reported that she has received an incident report but has not interviewed staff or residents yet.

On 09/10/2024, I completed an unannounced onsite investigation to Beacon Home at the Lodge. During the investigation, I interviewed direct care worker, April McCreery in person, who is also the home manager. She stated that she was informed of the incident afterwards. DCW McCreery explained that Resident A attends a doctor's appointment weekly due to a foot surgery he had and due to the length of time it takes to get to the appointment, prescribed medications are taken along for the appointment. DCW McCreery reported that she was informed after this incident that the lock box that is taken along had a broken side. DCW McCreery, reported that Resident A's hydrocodone is a PRN, therefore Resident A did not miss any doses after his medication went missing.

On 09/10/2024, I interviewed direct care worker, Denise Svoboda in person, who assists with medications at Beacon Home at the Lodge. She confirmed that she contacted Resident A's doctor on 08/09/2024 regarding the missing hydrocodone. Resident A's doctor prescribed additional hydrocodone for the month of August.

On 09/10/2024, I interviewed direct care worker (DCW), Mindy Allen in person. DCW Allen reported that on 08/08/2024, she took Resident A to his doctor's appointment in Grand Rapids, MI. DCW Allen stated that she has taken Resident A to his appointment over ten times and has never had any problems with medication going missing. DCW Allen reported that his prescribed medications were placed in the locked medication box, which has a key lock on one side. DCW Allen explained that she placed the locked medication box on the front seat next to her on the way to the appointment and Resident A sat in a back seat. DCW Allen explained that she administered Resident A one of his prescribed medications before going into his appointment. While in the waiting room, DCW Allen reported that she kept the locked medication box on her lap the whole time. DCW Allen explained that they were in the waiting room for some time, and she had to administer another prescribed medication while waiting to be seen at the doctor's office. DCW Allen stated that Resident A was called back to be seen, while administrating the medication. DCW Allen reported that Resident A was not given any additional prescribed medication during the appointment or drive home. DCW Allen did report that on the way back to Beacon Home at the Lodge, she placed the locked medication box on the middle arm rest. While driving in traffic, DCW Allen stated that the locked medication box fell in the back of the van, near the resident. Due to being in traffic and driving, DCW Allen explained that she was unable to pick up the locked medication box for about 15-20 minutes. DCW Allen reported that she does not believe that Resident A opened the locked box when it fell in the back of the car, but she can't confirm he didn't. DCW Allen also reported that she is unsure what side of the medication box she put the lock on, and she could have put it on the broken side, which would have allowed Resident A to open the medication box when it fell in the backseat while driving. DCW Allen reported that when they returned to Beacon Home at the Lodge, she brought the medication box to the direct care worker, who was on medication duty and then ran to the bathroom quick. DCW Allen stated that she then heard DCW Cassandra Finney call her back to the medication room. DCW Finney explained to DCW Allen that three of Resident A's prescribed hydrocodone was missing from the locked medication box. The rest of his prescribed medications that were checked out, were within the locked medication box. DCW Allen reported that she then searched the company van to see if they fell out of the medication box. She reported that the prescribed hydrocodone could not be found in the company van. DCW Allen reports that she does not know where the medication could have gone and as of 09/10/2024, the prescribed three hydrocodone pills have not been found. DCW Allen stated that after searching for the missing medication, she left her shift. DCW Allen explained that Resident A went straight to his bedroom when they returned.

On 09/10/2024, I interviewed DCW Cassandra Finney in person. DCW Finney stated that before DCW Allen left, she was assigned to medications and they both prepared the medications needed for Resident A's doctor appointment. Four hydrocodone medications were prepared for Resident A before his outing by DCW Finney. DCW Finney stated that when Resident A and DCW Allen returned to Beacon Home at the Lodge, DCW Allen brought the locked medication box to her in the medication room and then left. DCW Finney stated that she is unaware where DCW Allen went. She

then called DCW Allen back within the next few minutes to the medication room, as she found that three hydrocodone medications were missing. DCW Finney reported that DCW Allen should not have left without counting the medications together first. DCW Finney reported that she was aware that the medication box for travel was broken on one side, and it has been broken for at least several months. Staff were instructed to make sure the lock was on the proper side. DCW Finney reported that she asked Resident A if he knew where the medications were and he said no. DCW Finney explained that Resident A went to his room, skipped dinner and came down around 9:30pm. DCW Finney reported that she is unaware where the medications went and that she did not take them because she is allergic to hydrocodone.

On 09/10/2024, I interviewed direct care worker, Candis Wale in person. She explained that she was working at Beacon Home at the Lodge, when Resident A and DCW Allen returned from the doctor appointment. She reported that she overheard DCW Finney yell for DCW Allen right after they returned. DCW Wale stated that she observed DCW Allen panic, and she tried to help her brainstorm regarding the missing medications. DCW Wale also reported that she helped DCW Allen search the van for the missing medications. DCW Wale reported that all staff were aware that one side the medication travel box was broken.

On 09/10/2024, I attempted to interview Resident A, but he refused to be interviewed. During the investigation, I also confirmed that Resident A did receive one hydrocodone pill during his outing according to his medication administration record.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on interviews with three direct care workers, it was determined that a travel medication box was broken and not working properly if locked on the wrong side. All three direct care workers confirmed that they were aware that the travel medication box was broken and had been broken for several months. While last using this medication travel box, three hydrocodone went missing. Beacon Home at the Lodge did not take reasonable precautions to ensure that prescription medication is not used by another person after using a broken medication box that did not lock as designed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

09/18/2024

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Amanda Blasius Date
Licensing Consultant

Approved By:

09/19/2024

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Dawn N. Timm Date
Area Manager