GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 13, 2025

Jessica Kross
Pine Rest Christian Mental Health Services
300 68th Street SE
Grand Rapids, MI 49548

RE: License #: AM410344414
Investigation #: 2025A0340035
Beechwood Crisis Residential Program

Dear Mrs. Kross:

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 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 (616) 356-0100.

Sincerely,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410344414
Investigation #:	2025A0340035
Complaint Receipt Date:	04/28/2025
Investigation Initiation Date:	04/28/2025
Report Due Date:	06/27/2025
Licensee Name:	Pine Rest Christian Mental Health Services
Licensee Address:	300 68th Street SE Grand Rapids, MI 49548
Licensee Telephone #:	(616) 455-5000
Administrator:	Candy McKenney
Licensee Designee:	Jessica Kross
Name of Facility:	Beechwood Crisis Residential Program
Facility Address:	7053 Madison Grand Rapids, MI 49548
Facility Telephone #:	(616) 258-7560
Original Issuance Date:	07/03/2014
License Status:	REGULAR
Effective Date:	12/18/2024
Expiration Date:	12/17/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Olivia Maslin mixed up Resident A's dosage of insulin and gave him 50 units of Lispro and 4 units of Lantus instead of 4 units of Lispro and 50 units of Lantus. Resident A was taken to the hospital twice that day for his blood sugar.	Yes

III. METHODOLOGY

04/28/2025	Special Investigation Intake 2025A0340035
04/28/2025	APS Referral Referral Made
04/28/2025	Special Investigation Initiated - Telephone Candy McKenney
04/28/2025	Inspection Completed On-site
05/09/2025	Contact - Telephone call made Staff Olivia Maslin-left message
05/12/2025	Contact – Telephone call made Staff Olivia Maslin-left message
05/13/2025	Exit Conference Designee Jessica Kross

ALLEGATION: Olivia Maslin mixed up Resident A's dosage of insulin and gave him 50 units of Lispro and 4 units of Lantus instead of 4 units of Lispro and 50 units of Lantus. Resident A was taken to the hospital twice that day for his blood sugar.

INVESTIGATION: On April 28, 2025, a complaint was filed with the BCHS Online Complaints. It stated that staff Olivia Maslin mixed up Resident A's dosage of insulin and gave him 50 units of Lispro and 4 units of Lantus instead of 4 units of Lispro and 50 units of Lantus. Resident A was taken to the hospital twice that day for his blood sugar.

On April 28, 2025, I contacted Administrator Candy McKenney. I informed her of the complaint. She stated she was aware of the incident and confirmed it happened.

Ms. Maslin received a corrective action, was taken off med passing, received education, was retrained and recertified in med passing.

On April 28, 2025, I conducted an unannounced home inspection. I first met with Home Manager Senaite Tewelde. She informed me that Resident A no longer lives at Beechwood Crisis home. It is a short-term crisis home so he was discharged and went to a Drug Rehab facility. Ms. Tewelde confirmed the medication error did happen and confirmed what Ms. McKenney had stated about the corrective action. Ms. Tewelde did not have access to his Medication Administration Record (MAR) since he was discharged. She provided me with Ms. Maslin's contact information.

On April 28, 2025, I called Ms. McKenney again and requested Resident A's MAR, Health Care Appraisal and Assessment Plan. I received and requested the documents.

Resident A's Health Care Appraisal was dated 3/4/25 and signed by RN Tom VanDerSchuurt. Under "Diagnosis" it states, "Alcohol use disorder, depression". There was nothing relevant to this investigation in the Assessment Plan. Resident A's MAR listed Lisinipro injection 10 units and Lantus injection pen 50 units. All medications were discontinued on 3/25/25 when Resident A moved out of the home. It is documented on 3/17/25 that the two medication doses were "flip flopped".

Ms. McKenney also found the Incident Report (IR) regarding the allegations. It was dated 3/17/25 and completed by Olivia Maslin. It stated: *'When administering morning medication staff believes they switched the doses of insulin prescribed. Staff believes they gave 50 units of Lispro when the MAR called for 4 units. Staff also believes they administered 4 units of Lantus when the MAR called for 50 units. When administered staff called and advised nursing of the med error. Nursing advised for an ED send out. Client left with EMS around 8:36. Client received treatment at the hospital and arrived back at Beechwood around 1500.'*

On May 13, 2025, I interviewed staff Olivia Maslin. I asked her to clarify the events in the incident. She stated she prepped both pens at the same time and realized that the amounts were wrong, but it was only after they were administered. Ms. Maslin stated that she should have prepared one pen at a time.

The other reason for a trip to the hospital was later in the day, after dinner, because they were not administering fast acting insulin due to the error earlier in the day. So per nursing they sent him to the hospital for monitoring.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	A complaint was filed stating staff Olivia Maslin mixed up Resident A's dosage of insulin and gave him 50 units of Lispro and 4 units of Lantus instead of 4 units of Lispro and 50 units of Lantus. Resident A was taken to the hospital twice that day for his blood sugar. Ms. McKenney and Ms. Tewelde confirmed the medication error occurred. The IR completed by Ms. Maslin confirmed she made the medication error which resulted in Resident A going to the hospital. There is a preponderance of evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On May 13, 2025, I conducted an exit conference with Designee Jessica Kross. She had been made aware of the medication error and understood the finding of a rule violation. I requested a Corrective Action Plan which she agreed to send. Ms. Kross had no further questions.

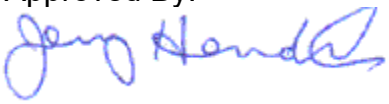
IV. RECOMMENDATION

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

May 13, 2025

Rebecca Piccard — Date
Licensing Consultant

Approved By:



May 13, 2025

Jerry Hendrick — Date
Area Manager