



RICK SNYDER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

SHELLY EDGERTON  
DIRECTOR

October 13, 2017

Eric McBean  
McBean Transitional Care, LLC  
P. O. Box 113  
Swartz Creek, MI 48473

RE: License #: AS250315962  
Investigation #: 2017A0501061  
McBean Transitional Care - Lynton

Dear Mr. McBean:

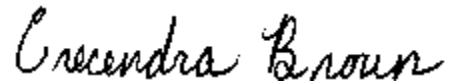
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (810) 787-7031.

Sincerely,

A handwritten signature in black ink that reads "Crecendra Brown". The script is cursive and fluid.

Crecendra Brown, Licensing Consultant  
Bureau of Community and Health Systems  
4809 Clio Road  
Flint, MI 48504  
(810) 931-0965

Enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS250315962
<b>Investigation #:</b>	2017A0501061
<b>Complaint Receipt Date:</b>	09/19/2017
<b>Investigation Initiation Date:</b>	09/19/2017
<b>Report Due Date:</b>	11/18/2017
<b>Licensee Name:</b>	McBean Transitional Care, LLC
<b>Licensee Address:</b>	P. O. Box 113 Swartz Creek, MI 48473
<b>Licensee Telephone #:</b>	(810) 877-1814
<b>Administrator:</b>	Eric McBean
<b>Licensee Designee:</b>	Eric McBean
<b>Name of Facility:</b>	McBean Transitional Care - Lynton
<b>Facility Address:</b>	1410 Lynton Ave Flint, MI 48507
<b>Facility Telephone #:</b>	(810) 820-0840
<b>Original Issuance Date:</b>	05/09/2012
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	11/14/2016
<b>Expiration Date:</b>	11/13/2018
<b>Capacity:</b>	6
<b>Program Type:</b>	MENTALLY ILL DEVELOPMENTALLY DISABLED AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
On September 16, 2017, Staff Turquoise Hodge was found sleeping in Resident A's bed. Resident A has to have visual contact made every two minutes he is awake.	Yes

## III. METHODOLOGY

09/19/2017	Special Investigation Intake 2017A0501061
09/19/2017	Special Investigation Initiated - Letter
09/19/2017	APS Referral Genesee County Adult Protective Services is investigating.
09/20/2017	APS Referral APS Referral was denied.
10/10/2017	Inspection Completed On-site Licensee Designee Eric McBean and Resident A.
10/10/2017	Exit Conference Licensee Designee Eric McBean.
10/10/2017	Contact - Telephone call made Staff Turquoise Hodge.
10/11/2017	Contact - Telephone call made Guardian 1.

### **ALLEGATION:**

On September 16, 2017, Staff Turquoise Hodge was found sleeping in Resident A's bed. Resident A has to have visual contact made every two minutes he is awake.

### **INVESTIGATION:**

On October 10, 2017, I conducted an unannounced onsite investigation at McBean Lynton AFC. Licensee Designee Eric McBean and Resident A were interviewed.

Licensee Designee Eric McBean stated that on September 16, 2017 he found Staff Turquoise Hodge sleeping in Resident A's bed with the door closed while Resident A was in the family room alone. Mr. McBean stated that he reported the incident to Genesee County Recipient Rights and he fired Staff Turquoise Hodge. Mr. McBean stated that Staff Hodge told him that she went to sleep in Resident A's bed because he [Resident A] was not in it. Mr. McBean stated that Resident A is on line-of-sight supervision and cannot be left alone because he has pica.

Resident A is nonverbal. Resident A was clean, dressed appropriately and watching television in the family room.

I reviewed Resident A's health care appraisal and assessment plan. Resident A's diagnoses listed on his health care appraisal are COPD, malnutrition, peg tube fed, schizophrenia and constipation. Resident A's assessment plan states that he does not move independently in the community, he is on line-of-sight supervision while in the home and in the community.

On October 10, 2017, I conducted an exit conference with Licensee Designee Eric McBean at McBean Lynton AFC. I informed Mr. McBean that a corrective action plan would be requested for the violation. Mr. McBean stated that he would be completing the corrective action plan.

On October 10, 2017, I conducted a phone interview with Staff Turquoise Hodge. Staff Hodge stated that the allegation was true and she was sleeping in Resident A's bed. Staff Hodge stated that she could not fully talk at the current time because she was walking into class, but asked me to call her back later that day. I called Staff Hodge and left a voice message. To date, I have not received a return phone call.

On October 11, 2017, I conducted a phone interview with Guardian 1. Guardian 1 stated that she did not know anything about the allegation. Guardian 1 stated that she did not have any concerns about the AFC home.

<b>APPLICABLE RULE</b>	
<b>R 400.14303</b>	<b>Resident care; licensee responsibilities.</b>
	(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.

<b>ANALYSIS:</b>	Licensee Designee Eric McBean and Staff Turquoise Hodge stated that Staff Turquoise Hodge fell asleep in Resident A's bed while Resident A was awake in the family room.  Resident A's assessment plan states that he does not move independently in the community, he is on line-of-sight supervision while in the home and in the community.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Upon the receipt of an acceptable and approved corrective action plan, no change to the license status is recommended.

*Crecendra Brown*      October 13, 2017

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Crecendra Brown      Date  
Licensing Consultant

Approved By:  
*Mary Holton*      October 13, 2017

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Mary E Holton      Date  
Area Manager