RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 5, 2018

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

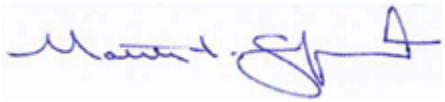
RE: License #: AM490380698
Investigation #: 2018A0360013
St. Ignace Shores - Hombach

Dear Ms. Williams:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (989) 732-8062.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
931 S Otsego Ave Ste. 3
Gaylord, MI 49735
(989) 370-8320

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM490380698
Investigation #:	2018A0360013
Complaint Receipt Date:	11/08/2017
Investigation Initiation Date:	11/09/2017
Report Due Date:	01/07/2018
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110, 890 N. 10th St., Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Melissa Williams
Licensee Designee:	Melissa Williams
Name of Facility:	St. Ignace Shores - Hombach
Facility Address:	799 Hombach Street, St. Ignace, MI 49781
Facility Telephone #:	(906) 984-2300
Original Issuance Date:	11/07/2016
License Status:	REGULAR
Effective Date:	11/07/2017
Expiration Date:	11/06/2019
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED,

	TRAUMATICALLY BRAIN INJURED

ALLEGATION(S)

	Violation Established?
Resident A was in the hallway of the facility naked and refused to go back to her room. The home manager, Tia Sager, dragged Resident A back to her room.	No

II. METHODOLOGY

11/08/2017	Special Investigation Intake 2018A0360013
11/09/2017	Special Investigation Initiated - Telephone North Country Community Mental Health Recipient Rights Officer Kim Rappleyea
11/15/2017	Inspection Completed On-site Home manager Tia Sager, Direct Care Worker Sandie Osga, Nurse Dawn Stagman-Tyrer, Resident A and B.
01/03/2018	Contact - Telephone call made Kurt Klein- Northern Lakes Community Mental Health
01/03/2018	Contact - Telephone call made NLCMH Psychologist Bill Skillman
01/04/2018	Contact - Telephone call made Home manager Tia Sager
01/04/2018	Contact - Telephone call made NLCMH Psychologist Bill Skillman
01/04/2018	Contact - Telephone call received Beacon Regional Vice President of Operations, Kevin Kalinowski
01/05/2018	Exit Conference with licensee designee Melissa Williams

ALLEGATION: Resident A was in the hallway of the facility naked and refused to go back to her room. The home manager, Tia Sager, dragged Resident A back to her room.

INVESTIGATION: On 11/8/2017 I was assigned a complaint from the LARA online complaint system.

On 11/9/2017 I talked with the North Country Community Mental Health Recipient Rights officer Kim Rappleyea. Ms. Rappleyea stated Resident A was not receiving services through NCCMH but rather Northern Lakes Community Mental Health.

On 11/15/2017 I conducted an unannounced on-site inspection at the facility. I interviewed home manager Tia Sager. Ms. Sager stated Resident A was admitted to the home on October 2nd. She is diagnosed with severe mental impairment, cerebral palsy and multiple health issues including renal failure, urinary tract infections and incontinence. Ms. Sager explained that Resident A is non-verbal using a couple of signs to communicate. The most recent medical appointment was on 11/3/2017 in which she had a catheter put in for a urinalysis because of a possible urinary tract infection. Ms. Sager stated that the multiple medical issues are likely contributing to her behavior of coming out of her room naked. She stated that when Resident A was admitted she was provided funding through Community Mental Health for one-on-one staffing. After a month the funding for one-on-one staffing was removed by CMH and since then they have noticed an increase in behaviors with Resident A. CMH thought that one month would give her time to adjust to the home however her needs appear to be more than what the home can meet long term. Ms. Sager stated on 11/10/2017 they issued a 30 day discharge notice. I was provided a copy of the discharge notice. Ms. Sager stated that Resident A comes out of her room naked on an almost a daily basis. They are often able to redirect her back into her room and assist with getting her clothed. On a handful of occasions Resident A has refused to go back into her room after coming out of the room naked. On 11/6/2017 she threw herself on the floor and refused to go back to her room. Ms. Sager stated that they are trained in Crisis Prevention Interventions (CPI) and always try to use non-physical interventions first. She covered Resident A with a blanket and she placed a blanket under Resident A and pulled her back into her room when she refused to put on clothes. Ms. Sager stated she does not remember ever dragging Resident A, only pulling her back into her room with a blanket. She stated this has happened a couple of times. Ms. Sager provided me with Resident A's written assessment plan. She denied that there were any specific behavior guidelines developed for this specific behavior.

While at the facility on 11/15/2017 I observed Resident A leaving her bedroom. She attempted to go into the kitchen and had to be redirected multiple times by the staff. She refused redirection several times yelling and pushing the staff. She was unable to be interviewed. I then interviewed direct care staff Sandie Osga. Ms. Osga stated 95% of the time Resident A comes out of her bedroom naked. She stated she usually is able to redirect her and get her to return to the room and put on clothes. Ms. Osga stated if Resident A refuses to return to her room she will cover her with a blanket or a towel and continue to try and redirect her to go back to her room and get dressed. She stated she has not ever seen Ms. Sager drag Resident A back to her

room however they have placed a blanket under Resident A and pulled her back into her room when she is absolutely refusing to go back to her room when she is naked.

I then interviewed the facility nurse Dawn Stagman-Tyrer. Ms. Stagman-Tyrer stated that hygiene is a concern for Resident A and she receives two showers a day because of her incontinence. She stated Resident A's behaviors include disrobing and coming out of her bedroom. She stated she will sometimes lay on the floor after coming out of the room naked. Ms. Stagman-Tyrer has witnessed this behavior 2 times. Both times she has witnessed this they have laid out a blanket and have had to pull Resident A back to her room after multiple prompts to get her to return failed.

I then interviewed Resident B who has a bedroom in the same hallway as Resident A. Resident B stated Resident A comes into the hallway naked about 75% of the time. He said that she clearly struggles to communicate but the staff ask her to go back to her room to get dressed and when she refuses they assist her by using a blanket and pulling her back into the room. He stated the staff are very good at the facility.

On 1/3/2018 I contacted Resident A's caseworker Kurt Klein from Northern Lakes Community Mental Health. He stated that he was aware of Resident A's behaviors. He stated they received the 30 day discharge notice on 11/10/17 but that Resident A was still residing at the facility while CMH attempted to find another placement. Mr. Klein stated he has been reviewing the incident reports from the facility regarding Resident A. He stated he was aware of her coming out of her bedroom naked but has not heard anything about her being dragged back to her room by the staff. Mr. Klein referred me to the NLCMH psychologist Bill Skillman assigned to Resident A.

On 1/4/2018 I contacted NLCMH psychologist Bill Skillman. Mr. Skillman stated there are not any specific behavior guidelines developed for Resident A coming out of her room naked and refusing to return to her room and get dressed. He stated she does have a behavior plan that addresses 7 specific behaviors but not this one in particular. He stated that he understood the facility used CPI for behavioral interventions. He stated a physical intervention should only be used for emergencies to prevent harm to self or others. Mr. Skillman stated that Resident A is not a person with a simple cognitive impairment. He stated she has a number of complex medical and co-existing behaviors. He stated they are exploring the possibility that she may be going through early menopausal stages which could be contributing to her coming out of the room without clothes on because she is hot and unable to communicate her needs. He stated this may also be contributing to her recurrent aggressions refusing to go back to her room and going from 0-60 so fast. Mr. Skillman stated he has now sent over a checklist of behaviors for the facility to complete so they can begin to drill down on specific behaviors and develop appropriate treatment and interventions.

On 1/4/2018 I contacted the home manager Tia Sager. Ms. Sager stated Resident A remains at the facility despite the 30 day discharge notice as Beacon and NLCMH

attempt to find another appropriate placement for Resident A. Ms. Sager stated that Resident A's behavior of coming out of her room naked has continued but she has noticed a decrease in frequency. She stated in the past month she has only come out of her room about 5 times without clothes on and all of the times they have been able to redirect her to return to her room and put on clothes.

On 1/4/2018 I was contacted by Kevin Kalinowski the regional vice president of Beacon services. He stated they provide CPI training to all of their staff at the facility. He stated that they are working with NLCMH to find appropriate placement for Resident A at a Beacon home in Midland which is why they have not yet discharged Resident A though it is past the 30 discharge period.

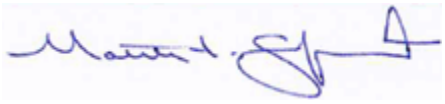
On 1/05/2018 I conducted an exit conference with the licensee designee Melissa Williams. Ms. Williams stated she concurred with the findings of the investigation. She stated about a month ago another female resident was discharged from the facility and they noticed a significant drop in the frequency of Resident A's behavior of coming out of her room naked. She stated that in the past 30 days out of the 5 times she has come out of her room naked there have been no times when staff were unable to redirect Resident A and on each occasion she returned to her room without a physical intervention. She stated an updated behavioral assessment was scheduled for January 2018 but she has not received a specific date from NLCMH. She stated despite the significant reduction in Resident A's behavior of coming out of the room naked and refusing to get clothed they are still working on placement at another facility. Ms. Williams stated she would have Resident A moved from the facility within 2 weeks. Regardless if Resident A is moved within 2 weeks Ms. Williams stated she would be in contact with NLCMH immediately to develop at least an interim behavioral plan within the next 24 hours to address Resident A's needs prior to her full behavioral plan meeting which is set to be scheduled later this month.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(1) A licensee shall ensure that methods of behavior intervention are positive and relevant to the needs of the resident.
ANALYSIS:	The complaint alleged that Resident A was in the hallway of the facility naked and refused to go back to her room. The home manager, Tia Sager, dragged Resident A back to her room. Resident A is cognitively impaired with a number of complex medical and co-existing behaviors. She was coming out of her room naked daily. On several occasions she threw herself on the floor and refused to go back to her room. The staff attempted multiple times to redirect her and prompt her to return to her room. On several occasions when Resident A absolutely

	refused to return to her room after being in the hallway floor naked a blanket was placed under her and she was pulled back into her room. NLCMH and Beacon are both working on finding a more suitable placement for Resident A that will better meet her individual needs. In the meantime, NLCMH is attempting to drill down the specific behaviors she is exhibiting to provide interventions that are appropriate for her medical and behavioral needs. There is not a preponderance of evidence that the licensee failed to ensure that methods of behavior intervention are positive and relevant to the needs of the resident.
CONCLUSION:	VIOLATION NOT ESTABLISHED

III. RECOMMENDATION

I recommend no change in the status of the license.



1/5/2018

Matthew Soderquist — Date
Licensing Consultant

Approved By:

1/5/2018

Jerry Hendrick — Date
Area Manager