GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 26, 2021

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

RE: License #: AS390406162
Investigation #: 2021A1024034
Beacon Home at Sprinkle

Dear Ms. VanNiman:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On June 25, 2021, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved 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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AS390406162 |
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| **Investigation #:** | 2021A1024034 |
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| **Complaint Receipt Date:** | 06/01/2021 |
| | |
| **Investigation Initiation Date:** | 06/02/2021 |
| | |
| **Report Due Date:** | 07/31/2021 |
| | |
| **Licensee Name:** | Beacon Specialized Living Services, Inc. |
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| **Licensee Address:** | Suite 110<br>890 N. 10th St.<br>Kalamazoo, MI 49009 |
| | |
| **Licensee Telephone #:** | (269) 427-8400 |
| | |
| **Administrator:** | Nichole VanNiman |
| | |
| **Licensee Designee:** | Nichole VanNiman |
| | |
| **Name of Facility:** | Beacon Home at Sprinkle |
| | |
| **Facility Address:** | 6457 N. Sprinkle Rd.<br>Kalamazoo, MI 49004 |
| | |
| **Facility Telephone #:** | (269) 488-8118 |
| | |
| **Original Issuance Date:** | 02/18/2021 |
| | |
| **License Status:** | TEMPORARY |
| | |
| **Effective Date:** | 02/18/2021 |
| | |
| **Expiration Date:** | 08/17/2021 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff shaved Resident A's head without consent from guardian. | Yes |
| Staff failed to seek medical attention for Resident A. | Yes |
| Staff did not take Resident B to his medical appointment to receive his injection. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 06/01/2021 | Special Investigation Intake 2021A1024034 |
| 06/01/2021 | Contact - Document Received-Resident A's *AFC Licensing Division- Incident/Accident Report* |
| 06/02/2021 | Special Investigation Initiated – Telephone with Adult Protective Services Specialist Jessica Mellen |
| 06/02/2021 | Contact - Telephone call made with Relative A1 |
| 06/07/2021 | Contact - Document Received new allegations received from Intake # 179994 regarding Resident B |
| 06/09/2021 | Inspection Completed On-site with home manager Margo Lewis, direct care staff member Marcell and Resident B |
| 06/24/2021 | Exit Conference with licensee designee Nichole VanNiman |
| 06/24/2021 | Inspection Completed-BCAL Sub. Compliance |
| 06/24/2021 | Corrective Action Plan Requested and Due on 06/24/2021 |
| 06/25/2021 | Corrective Action Plan Received |
| 06/25/2021 | Corrective Action Plan Approved |

**ALLEGATION:**

**Staff shaved Resident A's head without consent from guardian**

**INVESTIGATION:**

On 6/1/2021, I received this complaint through the Bureau of Community and Health Systems online complaint system. This complaint alleged a direct care staff member shaved Resident A's head without consent from Resident A's guardian, Relative A1.

On 6/2/2021, I spoke with Adult Protective Specialist Jessica Mellen who stated she is also investigating this allegation.

On 6/2/2021, I conducted an interview with Relative A1 regarding this allegation. Relative A1 stated Resident A has legal restrictions and is not able to give consent due to her cognitive impairment. Relative A1stated she has been Resident A's guardian for many years and relocated Resident A to Beacon at Sprinkle 5 years ago. Relative A1 stated during a recent visit with Resident A, Relative A1 noticed Resident A's hair had been shaved bald. Relative A1 stated she was very upset to see this change in Resident A's appearance because Resident A's hair was long at shoulder length and healthy. Relative A1 stated she talk to the facility staff members regularly and no one at the facility asked her permission to shave Resident A's hair or notified her that Resident A's hair was altered. Relative A1 further stated when she asked the staff member about not being notified, the staff member informed her that he didn't realize that Resident A had a guardian.

On 6/9/2021, I conducted an onsite investigation at the facility and interviewed home manager Margo Lewis and direct care staff member Marcell Johnson. Ms. Lewis stated she was working at the facility when direct care staff member Marcell Johnson shaved Resident A's head bald. Ms. Lewis stated she was not made aware by Mr. Johnson that he was going to make changes to Resident A's hair and was informed by Mr. Johnson after the incident that Resident A had requested to have her hair shaved. Ms. Lewis stated she discussed with Mr. Johnson about notifying Resident A's guardian however she does not believe the guardian was ever notified.

Mr. Johnson stated Resident A repeatedly asked him to shave her hair bald for about five days. Mr. Johnson stated Resident A complained about not wanting long hair anymore and wanting to "look different." Mr. Johnson stated he eventually succumbed to Resident A's request and shaved her hair bald. Mr. Johnson further stated he was aware Resident A had a guardian however he did not realize he needed to get consent from the guardian to shave Resident A's head.

| **APPLICABLE RULE** | |
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| **R 400.14304** | **Resident rights; licensee responsibilities.** |
| | **(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or** |

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| | **the resident's designated representative, a copy of all of the following resident rights:**<br>**(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**<br>**(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.** |
| **ANALYSIS:** | Based on this investigation which included interviews with home manager Margo Lewis, direct care staff member Marcell Lewis, and Relative A1 there is evidence to support the allegation direct care staff shaved Resident A's head without consent from Resident A's guardian, Relative A1. Relative A1 stated she was upset when she discovered that Resident A's long, healthy hair was shaved bald without her permission. Ms. Lewis stated Mr. Johnson did not inform her that he was going to shave Resident A's head nor did he notify Relative A1 to ask permission prior to performing this grooming task. Mr. Johnson stated he realized Resident A had a guardian however was not aware that he needed to get consent to shave Resident A's hair bald. Mr. Johnson did not consult with Resident A's guardian before performing a major grooming change to Resident A therefore he did not treat Resident A with consideration and respect with due recognition of person dignity and individuality. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Staff failed to seek medical attention for Resident A.**

**INVESTIGATION:**

This complaint also alleged staff failed to seek medical attention for Resident A. This complaint further stated medical attention was needed because Resident A had an UTI and/or bladder infection and was found in her room lying in her own feces and incoherent. In addition, 911 was eventually contacted by Resident A's family member.

On 6/1/2021, I reviewed Resident A's AFC Licensing Division-Incident/Accident Report (report) dated 6/1/2021 written by Marshall Mead. According to this report, on 5/29/2021 between 8:45am and 9:00am, direct care staff member Mr. Mead offered Resident A her morning medication however Resident A refused to get up to take her medications and staff noticed that Resident A's pants were soiled. Direct care staff Mr. Mead offered Resident A assistance in taking a shower and doing laundry however Resident A refused and asked staff to let her sleep. According to the report, direct care staff periodically checked on Resident A throughout the day and offered

assistance. The report stated, Resident A's guardian called to check on Resident A and offered to take her the hospital. Resident A eventually got off the couch and laid down on the floor and once Resident A's guardian arrived at the house at 1:30pm, emergency medical team (EMT) was called and Resident A was admitted to the hospital and diagnosed with having a Urinary Tract Infection (UTI).

On 6/2/2021, I conducted an interview with Relative A1 regarding this allegation. Relative A1 stated she suspected Resident A to have an infection because staff called her to inform her that Resident A was acting out with having verbal outburst and delusions for about 5 days which are behaviors Resident A demonstrates when she has an UTI infection. Relative A1 stated on 5/29/2021, Relative A1 offered to take Resident A to the doctor due to past unusual behaviors however staff did not report to Relative A1 that Resident A refused to get out of bed and to receive assistance from direct care staff with hygiene. Relative A1 stated when she arrived to take Resident A to see her doctor, she discovered Resident A to be incoherent and lying in her own feces. Relative A1 stated she immediately instructed direct care staff to call 911 and to assist with cleaning Resident A. Relative A1 stated Resident A was not able to physically get up which is why she stayed lying in her own feces and was not responsive to Relative A1's directions. Relative A1 stated direct care staff member Mr. Mead informed her that he did not take Resident A in to be seen by a doctor because there were not have enough direct care staff working to take her. Relative A1 stated Resident A was assisted by EMT, transported to the hospital, and later diagnosed with having a UTI. Relative A1 stated she believe medical care should have been obtained by direct care staff due to Resident A's significant change in her behaviors. Relative A1 further stated it is very unusual for Resident A to lie in her own feces, refuse medications, and refuse to get up.

On 6/9/2021, I conducted an onsite investigation at the facility and interviewed home manager Margo Lewis and direct care staff member Marcell Johnson. Ms. Lewis stated Resident A began to behave strangely for about five days by having verbal outburst and sleeping on the living room couch. Ms. Lewis stated she was not working on 5/29/2021 however was made aware by Mr. Mead at 11:44am that Resident A refused to get up and laid in her own feces which is highly unusual behavior for Resident A. Ms. Lewis stated she did not instruct Mr. Mead to called 911 for further evaluation when she was notified by Mr. Mead of Resident A's adverse conditions and unusual behaviors.

Mr. Johnson stated he was not working during the morning shift of 5/29/2021 however was notified by Mr. Mead via text that Resident A wasn't doing well, and Mr. Mead expressed that "he didn't know what to do" therefore he contacted Resident A's guardian, Relative A1. Mr. Johnson stated Mr. Mead reported to him that Resident A was "acting like a completely different person and didn't recognize anyone." Mr. Johnson stated he advised Mr. Mead to notify the home manager.

| APPLICABLE RULE | |
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| **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:** | Based on this investigation which included interviews with home manager Margo Lewis, direct care staff member Marcell Lewis, Relative A1, and review of *AFC Licensing Division-Incident/Accident Report* there is evidence to support the allegation direct care staff failed to seek medical attention for Resident A. Relative A1 stated she discovered Resident A to be incoherent and lying in her own feces and had to instruct staff member to call 911 to get additional assistance for Resident A. According to the incident report, Mr. Mead noticed Resident A at around 9am lying in her own feces and refused to get up to take her medications. The report further stated Resident A eventually got up off the couch and laid down on the floor and once Resident A's guardian arrived at the AFC at 1:30pm, emergency medical team (EMT) was called and Resident A was later admitted to the hospital and diagnosed with having a Urinary Tract Infection (UTI). Ms. Lewis and Mr. Johnson both stated that Mr. Mead contacted them to express his concern for Resident A as Resident A was observed to act unusual to Mr. Mead however at no point during this time did Mr. Mead contact emergency medical services and only called 911 after being advised to do so by Resident A's guardian once the guardian arrived at the home. Resident A had a change in her physical condition and staff failed to obtain needed care immediately. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Staff did not take Resident B to his medical appointment to receive his injection.**

**INVESTIGATION:**

On 6/7/2021, I received an additional allegation through the Bureau of Community and Heath Systems online complaint system that alleged direct care staff did not take Resident B to his medical appointment to receive his scheduled prescribed injection.

On 6/9/2021, I conducted an onsite investigation at the facility and interviewed home manager Margo Lewis and direct care staff member Marcell Johnson. Ms. Lewis

stated Resident A has to be seen by a physician every two weeks to receive an injection for his psychiatric needs. Ms. Lewis stated direct care staff at the facility is responsible for providing transportation to his medical appointments. Ms. Lewis stated Resident A is responsible for providing the staff with the medical appointment dates along with the provider. Ms. Lewis stated there were two occasions Resident B's appointments were rescheduled due to the home not having enough staff to transport Resident B and Resident B not wanting to go. Ms. Lewis stated she was not aware of Resident B missing any of his appointments because the appointments were rescheduled within a timely manner.

Mr. Johnson stated he takes Resident B to receive his psychiatric injections every two weeks. Mr. Johnson stated they have moved the appointments to alternate dates due to staffing issues and also because Resident B not wanting to go however no appointments have been missed. Mr. Johnson stated Resident B has his next appointment scheduled for today and direct care staff is prepared to take him for this visit.

I also interviewed Resident B. Resident B stated he is his own guardian. Resident B stated he does not have any issues with taking his medications and takes all his medications regularly on time. Resident B stated direct care staff members take him to all of his scheduled medical appointments and he has never missed receiving his injection shot. Resident B stated he takes his injection shot twice a month as prescribed by his psychiatrist.

| **APPLICABLE RULE** | |
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| **R 400.14301** | **Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.** |
| | **(7) A department resident care agreement form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department. A resident shall be provided the care and services as stated in the written resident care agreement.** |

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| **ANALYSIS:** | Based on this investigation which included interviews with home manager Margo Lewis, direct care staff member Marcell Lewis, and Resident B, there is no evidence to support the allegation direct care staff did not take Resident B to receive his injection. Ms. Lewis and Mr. Johnson stated direct care staff is responsible to provide transportation for Resident B to receive injection shots. Ms. Lewis and Mr. Johnson further stated staff has had to reschedule Resident B's appointments on two occasions due to staffing issues and also because Resident B not wanting to go however Resident B has not missed any appointments and gets his injection shots every two weeks. Resident B stated the staff takes him to all his medical appointments and he has not missed receiving his injection shots which he receives twice a month. Resident B is provided the care and services as required. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

While at the facility, direct care staff members were not able to provide resident records *AFC Care Agreement, Assessment Plan for AFC Residents, and Health Care Appraisal* for Resident A and Resident B.

On 6/24/2021, I conducted an interview with Ms. VanNiman who stated that she is the new licensee designee for the facility who was also not able to provide resident records for Resident A and Resident B at this time as the previous administer has them stored in an unspecified location.

| **APPLICABLE RULE** | |
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| **R 400.14209** | **Home records; generally.** |
| | **(1) A licensee shall keep, maintain, and make available for department review, all the following home records:**<br>**(d) Resident records.** |

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| **ANALYSIS:** | While at the facility, neither the licensee designee nor direct care staff members were able to provide the following resident records for Resident A and Resident B: *AFC Care Agreement, Assessment Plan for AFC Residents, and Health Care Appraisal.* Ms. VanNiman stated that she is the new licensee designee for the facility and the previous administer stored resident records in an unspecified location. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 6/24/2021, I conducted an exit conference with licensee designee Nichole VanNiman. I informed Ms. VanNiman of my findings and allowed her an opportunity to ask questions or make comments.

On 6/25/2021, I received and approved an acceptable corrective action plan.

## IV. RECOMMENDATION

An acceptable corrective action plan was received therefore I recommend the current license status remain unchanged.

_____ 7/23/2021

Ondrea Johnson Date
Licensing Consultant

Approved By:

07/26/2021

_____

Dawn N. Timm Date
Area Manager