GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 13, 2021

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

RE: License #: AM280299145
Investigation #: 2021A0230035
Beacon Home at Silverview

Dear Ms. Goldammer:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (231) 922-5309.

Sincerely,

Rhonda Richards

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

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

I. IDENTIFYING INFORMATION

License #:	AM280299145
Investigation #:	2021A0230035
Complaint Receipt Date:	09/01/2021
Investigation Initiation Date:	09/01/2021
Report Due Date:	10/31/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110, 890 N. 10th St., Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer,
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home at Silverview
Facility Address:	4024 Wyatt Road, Traverse City, MI 49684
Facility Telephone #:	(231) 922-9791
Original Issuance Date:	04/15/2010
License Status:	REGULAR
Effective Date:	10/16/2020
Expiration Date:	10/15/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff on duty was found asleep in his car.	Yes

III. METHODOLOGY

09/01/2021	Special Investigation Intake 2021A0230035
09/01/2021	Special Investigation Initiated - On Site interview with Home Manager Micah Haven
09/08/2021	Contact - Telephone call made Staff member Brandon McDaniel
09/08/2021	Contact - Telephone call made Staff member Jessica Knapp
09/08/2021	Exit Conference Roxanne Goldammer

ALLEGATION: Staff on duty was found asleep in his car.

INVESTIGATION: On 09/01/2021, I conducted an unannounced on-site investigation at the facility and interviewed facility manager Micah Haven. Mr. Haven confirmed the above allegations were true. He stated he arrived for work at 8:00 a.m. on 08/28/2021 and discovered staff member Brandon McDaniel to be asleep in his car. He and another staff who arrived at the same time had to shout and bang on his door very loudly as Mr. McDaniel was in a “deep sleep”.

After Mr. McDaniel woke up Mr. Haven spoke with him regarding the situation and sent him home. Mr. McDaniel reportedly told Mr. Haven he had been dealing with some personal issues and had not slept for several days. He went to take a break during his shift and fell asleep. Mr. Haven provided a written disciplinary action and took him off the schedule for a few days to ensure Mr. McDaniel could get some sleep. Mr. Haven stated Mr. McDaniel is a new staff and expressed that he felt very remorseful about what had happened.

Mr. Haven stated that the Beacon at Silverview AFC home is a contract home for Community Mental Health serving 12 residents. It is required per Community Mental Health contract rules as well as the Beacon policy that the staffing ratio is 1 staff per 6 residents to meet the needs of the residents in this setting. This home requires 24-hour awake staffing as well. This is due to the high level of care the residents in this

particular facility require. I concurred with this as I receive numerous weekly incident reports from the facility regarding residents with aggressive behaviors and residents with medical issues. Law Enforcement and emergency medical personal are frequently at the facility due to 911 calls for assistance.

On 09/08/2021, I spoke with direct care worker Jessica Knapp who was working on the shift with Mr. McDaniel on 08/28/2021. She stated around 5:00 or 6:00 a.m. Mr. McDaniel stated he was going to his car to take a break and he did not return. She stated she went out to his car around 7:00 a.m. and found him asleep in his car. Ms. Knapp stated she tried several times to wake him up by speaking loudly and opening his door, but he would not respond. Ms. Knapp stated she had not observed this behavior before with Mr. McDaniel and thought he had just had a lack of sleep.

On 09/08/2021, I interviewed staff member Brandon McDaniel regarding the allegation. He stated that in the early morning hours of 08/28/2021 he had been working his shift which was 8:00 p.m. to 8:30 a.m. when he went to take a break asking his co-worker Ms. Knapp if it was ok that he went to his car to have a red bull energy drink and a cigarette, and she stated that was fine. He stated he remembered thinking it was so warm in his car and he lit a cigarette and the next thing he knew Mr. Haven was banging on his door and woke him up. He noticed he did not even finish his cigarette and that it had burned a hole in his sideboard. He stated he thought he had been in the car for maybe a half hour or an hour. He could not remember. He stated, “I was scared I thought something bad had happened.” He stated he felt very bad about the whole situation and felt confident that it would never happen again. He stated he had always worked third shift jobs and never had these problems but due to some personal issues he had not been sleeping. He indicated that these personal issues have now been resolved.

On 09/08/2021, I conducted an exit conference with Licensee Designee Roxanne Goldammer and reviewed the findings of the investigation. She concurred with findings and had no additional questions. She will provide a plan of correction.

APPLICABLE RULE	
R 400.14305	**Resident Protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	There was not sufficient staff on duty at all times for the supervision and protection of the residents while Mr. McDaniel was asleep in his car. The residents in this Community Mental Health contract home require 24-hour awake staff with a ratio of 1 to 6. There are currently 12 residents in this facility. With the population in this home having medical needs, and displaying

	aggressive behaviors, one awake staff does not provide safety to the residents and places them at risk for harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

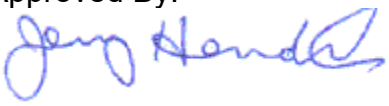
IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction I recommend the status of this license remain unchanged.

09/13/2021

Rhonda Richards Date
Licensing Consultant

Approved By:



09/13/2021

Jerry Hendrick Date
Area Manager