GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 10, 2021

Ramone Beltran, II
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AM800299049
Investigation #: 2021A1024048
Beacon Home at Woodland

Dear Mr. Ramone Beltran, II:

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 November 08, 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. 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.

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

License #:	AM800299049
Investigation #:	2021A1024048
Complaint Receipt Date:	09/16/2021
Investigation Initiation Date:	09/16/2021
Report Due Date:	11/15/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Ramone Beltran, II
Name of Facility:	Beacon Home at Woodland
Facility Address:	56832 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	09/12/2016
License Status:	REGULAR
Effective Date:	03/12/2021
Expiration Date:	03/11/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A direct care staff member caused a car accident that resulted in injury to four residents.	Yes

III. METHODOLOGY

09/16/2021	Special Investigation Intake 2021A1024048
09/16/2021	Special Investigation Initiated – Telephone with direct care staff member Danielle Hoch
09/17/2021	Contact - Telephone call made with Genesee County Recipient Rights Officer Pat Shepherd
09/24/2021	Inspection Completed On-site with direct care staff member Sabrina Baird, Residents A, B, C, and D
09/27/2021	Contact - Telephone call made with administrator Nichole VanNiman
09/27/2021	Contact - Document Received-Residents A, B, C, D *After Visit Summary, Uniform Law Citation, Vehicle Staff Transportation Requirements Policy, Cellular Phones Policy,* Drug/Alcohol Test, *Progressive Action Form, Training Acknowledgment.*
11/05/2021	Exit Conference with licensee designee Ramone Beltran
11/05/2021	Inspection Completed-BCAL Sub. Compliance
11/05/2021	Corrective Action Plan Requested and Due on 11/15/2021
11/08/2021	Corrective Action Plan Received
11/08/2021	Corrective Action Plan Approved

ALLEGATION:

A direct care staff member caused a car accident that resulted in injury to four residents.

INVESTIGATION:

On 9/16/2021, I received this complaint through the Bureau of Community and Health Systems. This complaint alleged direct care staff member Danielle Hoch caused a car accident that resulted in injury to four residents. This complaint further stated the incident took place on 9/8/2021 and there is concern direct care staff member Danielle Hoch was on her cell phone while driving.

On 9/16/2021, I conducted an interview with direct care staff member Danielle Hoch regarding this allegation. Ms. Hoch stated she took four residents on a scheduled outing to a store in Benton Harbor, MI around 3pm. Ms. Hoch stated while driving on the highway back to the facility from the outing she noticed a car in front of her had completely stopped but their breaks lights were not on. Ms. Hoch stated when she noticed the car, she tried to slow down however hit the car and subsequently another car that was behind them struck their car. Ms. Hoch stated she did not realize the car in front of her had completely stopped because she did not see any break lights on. Ms. Hoch stated none of the residents were wearing seatbelts therefore upon impact of the accident all four residents flew forward to the front of the vehicle and received minor injuries. Ms. Hoch stated she observed that all the residents were wearing seatbelts on the way to the store however none of the residents complied with her request when she prompted them to buckle their seatbelts before and during the car ride back from the store. Ms. Hoch denied that she was speeding or distracted while driving. Ms. Hoch further stated her cell phone was out and visibly seen by the residents however she was not using her cell phone while driving. Ms. Hoch stated at the scene of the accident emergency medical services (EMS) took them all to the hospital where she took a drug and alcohol test which both showed negative results. Ms. Hoch denied being under the influence of any substances at the time of the accident and stated she has a valid Michigan driver's license. Ms. Hoch further stated she was cited at the scene of the accident for failure to stop and has future court proceedings.

On 9/17/2021, I conducted an interview with Recipient Rights Officer Pat Shepherd who stated she was notified by Residents A, B, C and D who all stated Ms. Hoch was distracted and was not paying attention which caused them to get in a car accident. Ms. Shepherd stated these four residents also stated that they were not wearing seatbelts to or from the store nor were they asked to wear seatbelts by Ms. Hoch. Ms. Shepherd stated Residents A, B, and C further reported that Ms. Hoch was texting and listening to music on her phone while driving. Ms. Shepherd stated she conducted an investigation regarding this allegation and found substantial evidence to support neglect by Ms. Hoch to the four residents.

On 9/24/2021, I conducted an onsite investigation at the facility with direct care staff member Sabina Baird. Ms. Baird stated on 9/8/2021, she was working with other

residents at the facility when Ms. Hoch transported Residents A, B, C, and D to a scheduled outing and got into a car accident on the way back from the outing. Ms. Baird stated she was notified by Ms. Hoch that she hit a white van that had completely stopped in front of her, and all the residents suffered minor injuries. Ms. Baird stated the four residents informed her upon their return from the hospital that none of them were wearing seatbelts when the accident occurred.

While at the facility I also conducted interviews with Residents A, B, C, and D. Resident A stated Ms. Hoch was not paying attention while she was driving because she was driving extremely fast and was texting on her cell phone which caused them to hit a vehicle from behind. Resident A stated she and the other residents were not wearing seatbelts therefore she flew forward when Ms. Hoch slammed on the car breaks then hitting the car in front of them. Resident A further stated she sustained a cut on her head and a fractured hip. Resident A stated Ms. Hoch was not wearing a seatbelt at the time of the accident and Ms. Hoch never asked the residents to wear their seatbelts.

Resident B stated on the way back from the store Ms. Hoch started speeding and texting on her cell phone while driving on the highway which led to Ms. Hoch hitting a vehicle in front of them. Resident B stated she was not wearing her seatbelt therefore she hit her head on the window and bruised her leg. Resident B stated the other residents were not wearing seatbelts and none of them were asked to wear their seatbelts while in the vehicle.

Resident C stated Ms. Hoch hit a vehicle from behind because she was speeding and texting on her cell phone when they were returning from an outing. Resident C stated subsequently another vehicle hit the back of their vehicle causing Resident C to hit and sustain a bruise to her leg. Resident C stated no one in the vehicle was wearing their seatbelt and Ms. Hoch never requested the residents to wear a seatbelt.

Resident D stated while driving back from an outing she noticed that a vehicle stopped in front of the vehicle she was in however Ms. Hoch, who was driving, did not slow down and ultimately hit the vehicle. Resident D stated she observed Ms. Hoch texting on her cell phone prior to hitting the vehicle in front of them. Resident D stated she and three other residents “got hurt and was very upset” when the accident occurred. Resident D stated she ended up with a sprained wrist, bruises and had to wear a neck brace for the day. Resident D further stated no one in the vehicle was wearing seatbelts and the residents were never asked to wear seatbelts by Ms. Hoch.

On 9/27/2021, I conducted an interview with administrator Nichole VanNiman who stated that Ms. Hoch was ultimately disciplined for violating company policy for having her personal cell phone out while transporting residents and not ensuring the residents were safely secure in the vehicle with seatbelts. Ms. VanNiman stated Ms. Hoch will also be retrained on Beacon Specialized Living Services transportation and cellular usage policy. Ms. VanNiman also stated Ms. Hoch was tested for drugs and alcohol immediately at the hospital after the accident occurred and tested negative for both alcohol and drugs.

ON 9/27/2021, I reviewed Residents A, B, C, D *Bronson Hospital After Visit Summaries* (summary) dated 9/8/2021. According to Resident A's summary, reason for hospital visit was hip pain, motor vehicle crash, and head injury. Resident A's discharge diagnosis was motor vehicle collision and scalp laceration.

According to Resident B's summary, reason for visit was shoulder injury, leg injury and motor vehicle crash. Resident B's discharge diagnosis was motor vehicle crash, injury, contusion of left shoulder, initial encounter, and contusion of left leg.

According to Resident C's summary, reason for visit was motor vehicle crash and Resident C's discharge diagnosis was motor vehicle collision initial encounter.

According to Resident D's summary, reason for visit was rib pain, wrist pain and leg pain. Resident D's discharge diagnosis was motor vehicle collision.

I also reviewed *State of Michigan Uniform Law Citation* issued to Ms. Hoch on 9/18/2021 for the description; failure to stop within an assured distance written by Coloma Charter Township Police Department.

I also reviewed the facility's *Vehicle Staff Transportation Requirements Policy* (transportation policy) and *Cellular Phones Policy* (phone policy). According to the transportation policy the purpose of this policy is to ensure safety of employees and residents. This transportation policy further stated all employees and drivers of the organization's vehicles, or when using their own vehicle to conduct business for the organization, shall have a valid Michigan operator's license or chauffeur's license as required by law, be insurable under the organization's automobile insurance policy; or when using their own vehicle, have proper and adequate automobile insurance. All occupants in any vehicle shall be properly restrained as required by law.

According to the facility's phone policy, the possession of a personal or assigned work cell phone and/or any other social networking device is not permitted during a staff member's working time.

I also reviewed drug/alcohol test form for Ms. Hoch. According to this *Custody Control Form* dated 9/8/2021 a urine sample was collected for Ms. Hoch and a breath alcohol test was also conducted. No positive findings indicated.

I also reviewed the facility's *Progressive Action Form* dated 9/14/2021 which stated that Ms. Hoch was in violation of disregarding the company's policy during the accident that took place on 9/8/2021.

I also reviewed two *Training Acknowledgment* forms for staff transport requirements and cellular use policy dated 9/14/2021 signed by Ms. Hoch. According to these acknowledgments Ms. Hoch was trained on 9/14/2021.

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:	Based on my investigation which included interviews with direct care staff members Sabrina Baird, Danielle Hoch, administrator Nichole VanNiman, Recipient Rights Officer Pat Shepherd, Residents A, B, C, D, as well as a review of the following records Residents A, B, C, D *After Visit Summary, Uniform Law Citation, Vehicle Staff Transportation Requirements Policy, Cellular Phones Policy,* Drug/Alcohol Test, *Progressive Action Form, Training Acknowledgment* there is evidence to support direct care staff member Danielle Hoch caused a car accident that resulted in injury to Residents A, B, C, and D. Ms. Hoch stated while transporting the residents, she hit a car that was completely stopped in front of her resulting in another vehicle rear-ending her vehicle. All four residents were treated and released for minor injuries according to hospital summaries. Although Ms. Hoch stated she prompted all four residents to wear seatbelts, based on my interviews with those residents Ms. Hoch never asked or required any resident to wear a seatbelt during any point. Ms. Hoch did not follow Beacon Specialized Living Services transportation policy requiring all those in a vehicle to wear a seatbelt. Residents A, B, C, D, all stated that Ms. Hoch was texting and listening to music on her cell phone which caused her to hit a vehicle. Ms. Hoch was cited by the police at the time of the accident for failure to stop within an assured distance. Ms. VanNiman stated Ms. Hoch was disciplined for violating the company's transportation and cellular usage policy by having her cell phone while driving with the residents and not ensuring the residents were wearing their seatbelts therefore Ms. Hoch failed to provide safety and protection to the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/5/2021, I conducted an exit conference with licensee designee Ramone Beltran, II and administer Nichole VanNiman. I informed both Mr. Beltran and Ms. VanNiman of my findings and allowed them an opportunity to ask questions or make comments.

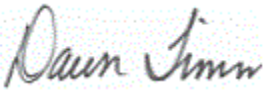
On 11/8/2021, I received and approved an acceptable corrective active plan.

IV. RECOMMENDATION

On 11/8/2021, I approved an acceptable written corrective action plan therefore I recommend the status of the license remains unchanged.

Ondrea Johnson — 11/5/2021
Licensing Consultant — Date

Approved By:



11/10/2021

Dawn N. Timm — Date
Area Manager