GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 7, 2021

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

RE: License #: AS140393268
Investigation #: 2022A1024006
Beacon Home At Red Mill

Dear Ms. VanNiman:

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 (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 #:	AS140393268
Investigation #:	2022A1024006
Complaint Receipt Date:	10/13/2021
Investigation Initiation Date:	10/16/2021
Report Due Date:	12/12/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Melissa Williams
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At Red Mill
Facility Address:	51721 Red Mill Road Dowagiac, MI 49047
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/15/2018
License Status:	REGULAR
Effective Date:	04/13/2021
Expiration Date:	04/12/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Medical treatment for Resident A was delayed because staff did not call their medical on-call staff in a timely manner.	No

III. METHODOLOGY

10/13/2021	Special Investigation Intake 2022A1024006
10/16/2021	Special Investigation Initiated – Letter email correspondence with Recipient Rights Officer Michele Schiebel.
10/16/2021	Contact - Telephone call made attempt to talk with Resident A.
11/29/2021	Contact-Telephone call made with home manager Tony Giancaspro
11/29/2021	Inspection Completed On-site with direct care staff member Victoria Matamoros
11/29/2021	Contact - Telephone call made with medical on-call nurse Wendy Blanton
11/29/2021	Contact - Document Received- *Discharge* paperwork, *Medication Administration Record* (MAR), *AFC Division-Incident/Accident Report*
11/29/2021	Contact-Document Received-email correspondence with Recipient Rights Officer Michele Schiebel
11/30/2021	Contact - Telephone call made with Relative A1
11/30/2021	Contact - Document Received-*Physician Script*
12/03/2021	Exit Conference with licensee designee Nichole VanNiman

ALLEGATION:

Medical treatment for Resident A was delayed because staff did not call their medical on-call staff in a timely manner.

INVESTIGATION:

On 10/13/2021, I received this complaint through the Bureau of Community and Health Systems online complaint system. This complaint alleged medical treatment was delayed for Resident A because staff did not call their medical on-call in a timely manner. This complaint also stated on 10/9/2021 Resident A notified staff that his private area was sore but Resident A refused medical attention after staff called Resident A's guardian. This complaint further stated on 10/10/21, Resident A had surgery to fix an issue of having an erection for over 24 hours that was believed to have been caused by an increased psychiatric medication.

On 10/16/2021 and 11/29/2021, I conducted an interview with Michele Schiebel from Office of Recipient Rights who stated she conducted an investigation regarding this allegation and found that staff took appropriate steps to call Resident A's guardian and offered medication for Resident A's initial complaint of having pain therefore Ms. Schiebel found no findings of medical neglect.

On 10/16/2021, I attempted to speak with Resident A however due to Resident A's cognitive impairment an interview was not conducted.

On 11/29/2021, I conducted an interview with home manager Tony Giancaspro regarding this allegation. Mr. Giancaspro stated on 10/09/2021, Resident A reported to direct care staff member Victoria Matamoros that he was in pain at which time Ms. Matamoros offered to give Resident A his prescribed medication that he takes for pain as needed. Mr. Giancaspro stated Ms. Matamoros also called Resident A's guardian who informed Ms. Giancaspro that Resident A tends to self-pleasure himself and informed staff "not to worry about it". Mr. Giancaspro stated staff monitored Resident A for the rest of the night and eventually called the medical on-call the following morning due to Resident A presenting with the same complaint of being in pain. Mr. Giancaspro stated the on-call nurse advised staff to transport Resident A to the emergency room since Resident A was having the same pain as the day before. Mr. Giancaspro stated when Resident A arrived at the hospital it was determined that Resident A suffered from a prolonged, persistent erection that required surgery upon admission to hospital.

On 11/29/2021, I conducted an onsite investigation at this facility with direct care staff member Victoria Matamoros. Ms. Matamoros stated on 10/09/2021 Resident A complained of pain during the morning hours however was unable to articulate the location of the painful area. Ms. Matamoros stated Resident A is nonverbal however can say some simple words like "pain", "food' and "yes". Ms. Matamoros stated when Resident A stated to her that he had pain she offered Resident A his pain medication that is prescribed as needed however Resident A refused this medication. Ms. Matamoros stated an hour later she asked Resident A if he was experiencing pain and he shook his head "no". Ms. Matamoros stated later in the evening Resident A complained again of having pain therefore, Ms. Matamoros called his guardian who stated that Resident A informed her that he has been self-

pleasuring himself a lot and has pain in his genital area. Ms. Matamoros stated the guardian informed her that Resident A tends to self-pleasure himself regularly and she believed the frequency of this act caused him to have pain therefore the guardian did not think it was serious and informed Ms. Matamoros not to worry about anything. Ms. Matamoros stated she offered Resident A his pain medication again and asked if he wanted medical attention however Resident A informed her and his guardian that he did not want medical attention. Ms. Matamoros stated the staff monitored Resident A for the rest of the night and there were no other complaints made for the remainder of the night. Ms. Matamoros stated the following morning when she arrived to work, she was informed by the overnight staff that Resident A complained of pain again therefore Ms. Matamoros called the facility's medical on-call nurse Wendy Blanton who advised her to transport Resident A to the emergency room since Resident A continued to complain of pain. Ms. Matamoros stated Resident A was diagnosed with having a prolonged erection due to the pain medication he was taking when evaluated at the hospital which required immediate surgery.

On 11/29/2021, I conducted an interview with the facility's medical on-call nurse Wendy Blanton. Ms. Blanton stated on 10/10/2021 she was contacted by direct care staff member Ms. Matamoros and was notified that Resident A had complained of being in pain since the day before however his guardian did not believe he needed medical attention. Ms. Blanton stated due to the time frame that Resident A complained of being in pain she advised the staff to transport Resident A to the hospital for further evaluation. Ms. Blanton stated she believe the direct care staff members responded to Resident A's initial complaint of being in pain appropriately by offering his prescribed medication that he is allowed to take as needed for pain and contacting his guardian. Ms. Blanton stated she does not believe she needed to be contacted on 10/09/2021 for Resident A's condition at that particular time and appropriate steps were taken.

On 11/29/2021, I reviewed Resident A's *Discharge Report* from Ascension Borgess Medical Center dated 10/10/2021 with a discharge date of 10/11/2021. According to this report Resident A was diagnosed with Priapism and seen by a urologist.

I also reviewed Resident A's Medication Administration Record (MAR) for the month of October which showed 1 tablet of Ibuprofen 600 mg to be taken by mouth every 8 hours as needed for mild or moderate pain.

I also reviewed the facility's *AFC-Division Accident/Incident Report* dated 10/10/2021 at 8am. According to this report, Resident A was transported to Borgess in Dowagiac because he has a painful erection. This report stated while at the hospital the staff were unable to provide treatment therefore a request for surgery in Kalamazoo was granted. The report stated the doctors informed staff that Resident A was having an issue due to the medications he was on and transported to Kalamazoo for surgery.

On 11/30/2021, I conducted an interview with Relative A1. Relative A1 stated she is Resident A's guardian. Relative A1 stated on 10/09/2021, Resident A informed her that he has pain in his genital area however Resident A informed her and staff that he did not want to go to the hospital. Relative A1 stated she did not see any abnormalities at the time of speaking with Resident A because he tends to self-pleasure himself frequently and Relative A1 assumed the frequency caused Resident A to have some pain. Relative A1 stated she believed it was appropriate to take him to the hospital the next day since Resident A expressed prolonged pain. Relative A1 believed appropriate steps were taken by direct care staff members.

I also reviewed Resident A's *Physician Script* written by WMED Health Pediatric and Adolescent Medicine with a start date of July 26, 2021. According to this script, Resident A is prescribed to take 1 tablet of 600mg Ibuprofen (Motrin) by mouth every 8 hours as need for mild or moderate pain.

APPLICABLE RULE	
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 my investigation which included interviews with home manager Tony Giancaspro, direct care staff member Victoria Matamoros, Relative A1, medical on-call nurse Wendy Blanton as well as a review of *AFC Division Incident/Accident Report, Discharge* paperwork, *Medication Administration Record* (MAR), and *Physician Script* there is no evidence to support the allegation that medical treatment for Resident A was delayed because staff did not call their medical on-call staff in a timely manner. According to Mr. Giancaspro and Ms. Matamoros, Resident A made an initial complaint of being in pain however was not able to articulate the location of the painful area due to his cognitive impairment. Mr. Giancaspro and Ms. Matamoros both stated Resident A was offered pain medication prescribed to him to take as needed for pain however Resident A refused. Ms. Matamoros stated Resident A denied of being in pain when asked later in the day however eventually made a 2nd complaint of being in pain during the evening at which time Ms. Matamoros contacted Resident A's guardian who advised that Resident A made her aware that he self-pleasured himself therefore Relative A1 did not believe Resident A was having a medical issue and not in need of any medical attention at that time. Relative A1 also stated she did not believe Resident A needed medical attention at the time she was informed of Resident A being in pain on 10/09/2021. Ms. Matamoros stated on 10/10/2021, she called the facility's medical on-call nurse because Resident A continued to complain of being pain at which time she was advise by the on-call nurse to transport Resident A to the hospital for further evaluation. Ms. Blanton stated due to the time frame that Resident A complained of being in pain she advised the staff to transport Resident A to the hospital for further evaluation. Ms. Blanton stated she believed direct care staff members responded to Resident A's initial complaint of being in pain appropriately by offering his prescribed medication that he is allowed to take as needed for pain and contacting his guardian. Ms. Blanton stated she does not believe she needed to be contacted on 10/09/2021 for Resident A's condition at that particular time and appropriate steps were taken by direct care staff members. I reviewed Resident A's physician script that shows Resident A is prescribed to take 1 tablet of 600mg Ibuprofen (Motrin) by mouth every 8 hours as needed for mild or moderate pain. The staff took appropriate steps by contacting their medical on-call nurse when Resident A expressed complaints of having prolonged pain and sought out medical attention for further evaluation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 12/03/2021, 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 and make comments.

IV. RECOMMENDATION

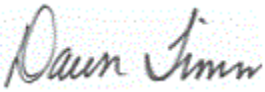
I recommend the current license status remain unchanged.

12/3/2021

Ondrea Johnson
Licensing Consultant

Date

Approved By:



12/07/2021

Dawn N. Timm
Area Manager

Date