GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 20, 2022

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

RE: License #: AM030402101
Investigation #: 2022A0350019
Beacon Home at Hammond

Dear Mr. Beltran:

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030402101
Investigation #:	2022A0350019
Complaint Receipt Date:	04/11/2022
Investigation Initiation Date:	04/12/2022
Report Due Date:	05/11/2022
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:	Ramon Beltran, II
Name of Facility:	Beacon Home at Hammond
Facility Address:	318 East Hammond Street Otsego, MI 49078
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	07/09/2020
License Status:	REGULAR
Effective Date:	01/26/2022
Expiration Date:	01/25/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A, who has a history of eloping, left this home late at night unnoticed by staff.	Yes

III. METHODOLOGY

04/11/2022	Special Investigation Intake 2022A0350019
04/11/2022	APS referral – Denied by APS for investigation
04/12/2022	Special Investigation Initiated - On Site I spoke with Jamara White, Home Manager, and with Resident A
04/12/2022	Contact - Telephone call made I spoke with Shamoni Northern-Swanigan, DCW
04/13/2022	Contact - Telephone call made I spoke with Alicia Berens, DCW
04/13/2022	Contact - Telephone call made I spoke with Shannon Golden, DCW
04/13/2022	Contact - Telephone call made I spoke further with Ms. White
04/13/2022	Contact - Document Sent I sent an email to Melissa Williams, Chief Administrative Officer
04/13/2022	Contact - Document Received I received an email response from Ms. Williams
04/13/2022	Contact - Document Received I received an email from Ramon Beltran, II, Licensee Designee
04/14/2022	Contact - Document Sent I sent Ms. Williams and Mr. Beltran an email requesting information
04/17/2022	Contact - Document Received I received an email from Mr. Beltran with his responses to my questions

04/18/2022	Contact – Telephone call made I spoke with Mr. Beltran
04/19/2022	Contact – Telephone call received I spoke again with Mr. Beltran
04/19/2022	Exit conference – Held with Ramon Beltran, II, Licensee Designee

ALLEGATION: Resident A, who has a history of eloping, left this home late at night unnoticed by staff.

INVESTIGATION: This complaint, which was forwarded to Licensing and Regulatory Affairs on 04/11/2022, was denied for investigation by Adult Protective Services.

On 04/12/2022, I made an onsite inspection. I met with Jamara White, Home Manager, who told me that Resident A was found at a nearby park by the police sometime after 1:00 a.m. that Saturday night (04/09). Ms. White said that Resident A tested .156 for intoxication. Ms. White informed me that Resident A was taken to the hospital where he spent the night. Ms. White did not have any more details, but she did provide me with the names and phone numbers of the staff members who worked 2nd shift on 04/09 to 04/10. I was aware that this home has a door alarm that rings like a doorbell when the front door is opened, and asked Ms. White if it sounds even at night, during sleeping hours, and she said it did. Ms. White told me that they ordered alarms for Resident A's bedroom door and windows and that the alarms had arrived in today's (04/12) mail and would be installed as soon as possible. Ms. White informed me that Community Mental Health does not have an issue with these alarms because Resident A is an elopement risk. Ms. White reported that Resident A had come from a locked-in facility due to his elopement risk. I asked for a copy of Resident A's Behavior Treatment Plan and she provided it to me. Ms. White also provided me with the report from Borgess-PIPP Hospital, which shows that Resident A was seen in the Emergency Department for intoxication.

On 04/12/2022, I spoke with Resident A in private. It was obvious that his mental illness prohibited him from following my questions, as he began rambling speech, saying that "they are putting sanitizer in my food;" "I have a hundred staples in my face" (which he clearly didn't); "I think I have AIDS;" that he got killed a long time ago, and other such statements. I asked him if he left the home on Saturday night, and he said that he did because staff would not take him to the store and he needed alcohol for his pain. Resident A told me that the police found him in the park and that he was "buzzed."

On 04/12/2022, I called and spoke with Shamoni Northern-Swanigan, Direct Care Worker (DCW), one of the staff members who worked 2nd shift on 04/09 to 04/10. Ms. Northern-Swanigan informed me that she worked from 7:00 p.m. to 7:00 a.m. and that she last had contact with Resident A between 11:40 p.m. and 12:00 a.m.

when she was cleaning the resident bedrooms' doorknobs. Ms. Northern-Swanigan stated that while she was cleaning Resident A's doorknob he yelled; "Get away from my door." She did not see or hear him after this during the remainder of her shift.

On 04/13/2022, I called and spoke with Alicia Berens, DCW, who told me she was "support staff" on 04/10 from 1:00 a.m. to 5:00 a.m. She explained that support staff come in when there are new DCWs to help them learn the job better. Ms. Berens told me that Resident A had already left the home by the time she got to work, and that she found out he was not in the home when the police came to the home between 3:00 and 3:30 a.m. and told the staff that they had taken him to the hospital because he was highly intoxicated. Ms. Berens told me that Resident A has eloped before, and that he will stay outside on the property for a long time, and when he thinks the staff members have forgotten about him, he leaves.

On 04/13/2022, I called and spoke with Shannon Golden, DCW, who told me that she worked from 7:00 p.m. on 04/09 to 7:00 a.m. on 04/10. Ms. Golden stated that she was busy most of the night assisting two other residents and did not hear Resident A leave. Ms. Golden reported that the police showed up at the home (time unknown) and told the staff members that Resident A was at the police station. She said that Resident A was taken to the hospital where he would spend the night because of his high alcohol level. Ms. Golden stated that the police called Jamara White and informed her of the situation.

On 04/13/2022, I called and spoke again with Ms. White. I asked how staff members are made aware of potential risks for each resident, and she stated that staff members have to read each resident's Behavior Treatment Plan and sign a document stating when they have done so. I requested a copy of this document for Ms. Northern-Swanigan and Ms. Golden (not for Ms. Berens as Resident A had eloped before she started working that day). Ms. White said that she would send me the documents. Later this same day (04/13), Ms. White sent me the requested document, which is the Behavior Plan Signature form. This form is signed by staff members after they review a resident's Behavior Treatment Plan. I observed that Ms. Berens signed this form verifying her review of Resident A's Plan on 01/02/2022 and Ms. Northern-Swanigan signed it on 02/26/2022.

On 04/13/2022, I reviewed Resident A's Behavior Treatment Plan. I read in this report that Resident A has a traumatic brain injury "due to his multiple car accidents." The Plan further states that; "Due to (Resident A's) history of elopement from nursing homes and AFCs, he resides at a secure home to maintain health and safety." This Plan also states that; "Staff will implement agency policy (CTS-003) regarding protocol details."

On 04/13/2022, I sent Melissa Williams, Chief Administrative Officer, an email. In it I wrote, "I read in his (Resident A's) Behavior Treatment Plan that he is to reside in a "secure home." I know that Hammond has doorbell sounds when someone opens an

exterior door; are there other means that make this a secure home? Also, can you send me the language for CTS-003?"

On 04/13/2022, Ms. Williams sent me an email, stating; "Obviously, the plan is outdated. Because Hammond is not in a secure home. The only secure homes we have is in Bangor and Lawrence. The CMH is fully aware that this home is not secure as well." In a separate email on this same day, Ms. Williams wrote; "That policy (CTS-003) only applies to homes with a fence. Which is Breakwater West, Highland, Hartford and our former Beacon Springs home."

On 04/13/2022, I received an email from Ramon Beltran II, Licensee Designee, stating; "The 'secure home' wording was for when he (Resident A) was at Beacon Springs and was supposed to be removed prior to him moving to Hammond. I will follow up with the home to ensure that you were given the correct BTP for (Resident A)." Mr. Beltran was copied on the emails between Ms. Williams and me.

On 04/14/2022, I sent Ms. Williams and Mr. Beltran an email with the following questions:

1. How long had he gone without elopement behaviors before he was moved into a non-locked home?
2. Was/is there any other documentation besides the outdated assessment plan that supports the move to a home without a lock and fence?
3. What is the reason for putting this resident in a setting that does not comply with the last assessment plan that was written for this resident?

On 04/17/2022, Mr. Beltran sent me an email with responses to the questions I had sent him on 04/14. His responses are as follows:

1. How long had he gone without elopement behaviors before he was moved into a non-locked home?

   '(Resident A) was in a locked setting before moving to the Hammond home and did not have any elopements attempts at that home. (Resident A) did not have any elopement behaviors at the previous setting either. (Resident A) did not show interest in community outings during his time at the previous setting.

   This is the first elopement that has occurred since (Resident A) came to the Hammond home on 1/10/22.'

2. Was/is there any other documentation besides the outdated assessment plan that supports the move to a home without a lock and fence?

   'AFC Assessment dated 1/11/22 (attached)

   Email with CEI dated 11/10/21 (attached)

Behavior Support Plans dated 12/20/21 (attached), the first version was created while (Resident A) was at Beacon Springs West but preparing for the transfer to Hammond and notes the upcoming changes to the restrictive interventions. The second version was created for his residence at the Hammond home.'

3. What is the reason for putting this resident in a setting that does not comply with the last assessment plan that was written for this resident?

   'The last AFC Assessment dated 1/11/22 does not appear to require that (Resident A) be placed in a locked setting. (Resident A) did not show elopement risk for a considerable period and so was placed in a less restrictive setting.'

   On 04/18/2022, I reviewed Mr. Beltran's responses to my questions and the documents he sent me. Resident A's most current Assessment Plan, dated 01/11/2022, does not specify that he requires special monitoring, unless he is in the community. Additionally, there is nothing stated in this plan that states Resident A needs to be in a fenced-in facility. I also reviewed an email sent to Nicole VanNiman of Beacon by Brooke Hall, Housing and Residential Supervisor for the Community Mental Health Authority of Clinton, Eaton, Ingham Counties and dated 11/10/2022.

   In this email, Ms. Hall wrote: *'Following the meeting and further discussion internally, we continue to prefer that (Resident A) be relocated to a secured site, if possible, or a remote setting given his history of elopement and substance use in coordination with his behavioral treatment plan. That said, we understand that bed availability is limited and so we may not be able to obtain our first choice and would be required to move forward with the Hammond Home as identified by Beacon. Would it be possible to provide a list of alternative options and, if beds are not available, consideration for wait lists?*

   If Beacon is unable to locate a secured or remote site, CEI would support moving forward with a move to Hammond Home with the following provisions outlined/updated in the behavioral treatment plan to address the unsecured setting:

   Plans to outline how the house staff can support (Resident A)'s continued sobriety/urges to obtain ETOH (Ethanol Alcohol)

   Plans to outline what community access will look like

   How will staff ensure his safety in the community and history of/potential for elopement?

   How will staff ensure his safety with regard to traffic due to his history of being hit by a vehicle?'

   In Resident A's Behavior Treatment Plan dated 12/20/2021, it states that:

“Restrictive Interventions:

1. Fenced home: Due to (Resident A)’s history of elopement from nursing homes and AFCs, he resides at a secure home to maintain his health and safety. Staff will implement agency policy (CTS-003) regarding protocol details.

However, because he has not eloped since coming to Beacon Springs, he will soon move to a non-secure home. In this instance, restrictive intervention #1 will be replaced by intervention #2 and utilized as needed to address increased supervision support in his transition to a new home.’

In another section of this report, it states:

‘Restrictive Interventions:

1. Door and window alarms: Because of (Resident A)’s history of elopement from non-secure AFCs, door and window alarms will be used as needed. These will not prevent (Resident A) from leaving but will provide staff an auditory cue for assistance.’

On 04/18/2022, I called and spoke with Mr. Beltran. I asked him what the reason was for the alarms not being placed on Resident A’s bedroom door and windows until after 04/10/2022 even though his Treatment Plan stated they needed to have these alarms put on back on 12/20/2021. Mr. Beltran told me he needed to look into this and would get back with me on it.

On 04/19/2022, Mr. Beltran called me and informed me that the reason the alarms were not put on Resident A’s door and windows until several months after it was documented in his Treatment Plan that they needed the alarms was because the Home Manager, Jamara White, failed to follow-up on this and have them installed. Mr. Beltran stated that the alarms were installed sometime after 04/10/2022.

On 04/19/2022, I called and held an exit conference with Ramon Beltran, II, Licensee Designee. I informed Mr. Beltran that I was citing a violation of this rule. Mr. Beltran stated that he did not disagree with this finding and had no further comments.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A was admitted to this home on 01/10/2022. He has a history of eloping and in a previous Behavior Treatment Plan it

	stated that he should be in a facility with a lockable fence, and he was residing at one. However, he went a long period without eloping and was then relocated to a home that does not have a lockable fence. It was stated in Resident A's most recent Behavior Treatment Plan, dated 12/20/2021, that door and window alarms needed to be used to alert staff members of his possible elopement attempts. These alarms would be in addition to the doorbell sounding off when an exterior door is opened that this home already has. Resident A was admitted to this home on 01/10/2022 and as of 04/12/2022, the door and window alarms had not been installed, and Resident A had eloped and got intoxicated on 04/10/2022. Mr. Beltran informed me that the door and window alarms were installed sometime after 04/10/2022, and that the reason they were not installed sooner was because the Home Manager failed to follow through with this in a timely manner. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

April 19, 2022

Ian Tschirhart — Date
Licensing Consultant

Approved By:

April 20, 2022

Jerry Hendrick — Date
Area Manager