



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 27, 2022

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

RE: License #: AM280299145
Investigation #: 2022A0230024
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.
- 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 (231) 922-5309.

Sincerely,



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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM280299145
Investigation #:	2022A0230024
Complaint Receipt Date:	03/15/2022
Investigation Initiation Date:	03/16/2022
Report Due Date:	05/14/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110, 890 N. 10th St., Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	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?
Resident A has lost weight. Facility staff are not following his prescribed diet.	No
Additional Findings	Yes

III. METHODOLOGY

03/15/2022	Special Investigation Intake 2022A0230024
03/16/2022	Special Investigation Initiated - On Site Observed Resident A, interviewed staff member Cindy McCarthy, home manager Melissa Gomez and Administrator Roxanne Goldammer
04/14/2022	Contact - Face to Face Interview with facility staff Micah Haven and Melissa Gomez
04/20/2022	Contact - Document Received received requested documents
04/25/2022	Contact - Telephone call made Staff member Kaylee Knudsen
04/26/2022	Contact - Telephone call made Staff member Kimberly Thompson
04/26/2022	Contact - Telephone call made Staff member Brian Blount
04/26/2022	Contact - Telephone call made staff member Chris Calangelo
04/26/2022	Contact - Telephone call made facility nurse Tracie Vineyard
04/26/2022	Contact -Telephone call made staff member Hollisue Wicksall
04/26/2022	Exit Conference With Administrator Roxanne Goldammer

ALLEGATION: Resident A has lost weight. Facility staff are not following his prescribed diet.

INVESTIGATION: On 03/16/2022, I conducted an unannounced on-site investigation at the facility. I interviewed staff members Micah Haven, Cindy McCarthy, home manager Melissa Gomez and Administrator Roxanne Goldammer. I observed Resident A while he was in bed but was unable to interview him due to cognitive limitations associated with his traumatic brain injury, and his inability to speak English. He appeared clean and well groomed.

While at the facility I reviewed Resident A's file, noting his health care appraisal was dated 11/11/2021. The appraisal indicated his diagnosis was traumatic brain injury, hypothyroidism, hypoglycemia, and anxiety. He uses a walker and wheelchair to ambulate. The special diet instructions were to continue protein drinks and consume only liquids and soft foods. I noted an order from Resident A's nurse practitioner dated 02/28/2022, indicating that Resident A is to be provided with protein mix or liquid drink three times per day and to encourage exercise three times per day.

All staff members indicated that Resident A has been receiving his protein shakes as prescribed. Ms. Gomez stated she is new to the facility but is developing a log and consumption spread sheet so that staff can document when they give Resident A his protein shakes. Staff indicated it is difficult to encourage Resident A to exercise as he often refuses but attempts are always made.

On 04/14/2022, I conducted another on-site inspection and spoke with Mr. Haven and Ms. Gomez. They reported the new logging of shakes for Resident A had been going fairly well. Ms. Gomez stated that on a few occasions she knew Resident A had received his shakes as she had observed this herself, however staff did not remember to document it. She is working with staff on having the chart more visible and reminders on the documentation.

I reviewed the protein shake logs which indicated from 03/16/2022 through 04/14/2022 shakes were given and documented. There were four dates missing documentation which were the dates that Ms. Gomez stated she observed staff give Resident A the shakes but they failed to document it.

On 04/20/2022, I reviewed Resident A's weight records from 05/01/2021 through 04/02/2022 they were as follows:

05/01/2021 -146 pounds
06/01/2021 -143 pounds
07/01/2021 -142 pounds
08/01/2021 -144 pounds
September 2021-**MISSING**
October 2021-**MISSING**

11/01/2021 -138 pounds **NOTE ALSO WEIGHED 11/11/2021 145 pounds at physician's office**

12/06/2021 -138 pounds

01/04/2022 -134 pounds

February 2022 – **MISSING**

03/04/2022 -130 pounds

03/14/2022 -135 pounds

03/24/2022 -139 pounds

04/02/2022 -138 pounds

On 04/25/2022, I interviewed staff member Kaylee Knudsen regarding the above allegation. Ms. Knudsen stated that she had worked in the facility for five months and had always given Resident A his protein shakes at every meal when she worked and observed that other staff members do the same.

On 04/26/2022, I spoke with staff members Kim Thompson, Chris Calangelo, Hollisue Wicksall and Brian Blount. Both Ms. Thompson and Ms. Wicksall indicated that they have always provided protein shakes to Resident A at every meal and have observed other staff members do the same. Mr. Blount reported he has worked at the facility since November of 2021 and it is well known that Resident A receives a protein shake at every meal and he and all staff adhere to this recommendation. Mr. Calangelo stated he is in charge of ordering the premade shakes which are now used for Resident A. The last time he ordered shakes he noted there were a few more shakes than there should be if staff was giving them consistently. He brought this to the attention of his home manager, and she explained that some staff were still using the powder form which is left upstairs in the kitchen therefore the premade shakes are not always used. Mr. Calangelo stated that made sense to him as there is a container of protein powder still upstairs.

On 04/26/2022, I spoke with facility nurse Tracie Vineyard. She stated she has monitored Resident A closely for the past six months. She stated she is not aware of any staff not providing Resident A his protein shake as is prescribed by his nurse practitioner. She noted he has lost some weight but then has recently gained again. Additionally, she stated that Resident A does not want to exercise and most of the time refuses. This is contributing to his loss of muscle mass, and he is deconditioning due the aging process. She will continue to monitor his health and seek additional medical attention if necessary.

APPLICABLE RULE	
R 400.14310	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (b) Special diets.

ANALYSIS:	According to all staff interviewed and the most recent documentation in Resident A's file staff members were following recommendations of Resident A's nurse practitioner to provide his special diet of a protein shake three times per day.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14313	Resident nutrition.
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	According to all staff members interviewed and my observation of documentation logs Resident A was provided his prescribed special diet.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: As noted above while reviewing Resident A's weight records, I observed three separate months of weights for Resident A were not documented those being September and October of 2021 and February of 2022.

APPLICABLE RULE	
R 400.14310	Resident health care.
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	No weights were recorded for three separate months.
CONCLUSION:	VIOLATION ESTABLISHED

On 04/26/2022, I conducted an exit conference with Licensee Designee Roxanne Goldammer and reviewed the findings of the investigation. Ms. Goldammer stated she would provide a plan of correction.

IV. RECOMMENDATION

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



04/27/2022

Rhonda Richards
Licensing Consultant

Date

Approved By:



04/27/2022

Jerry Hendrick
Area Manager

Date