GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 4, 2022

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

RE: License #: AM030402101
Investigation #: 2022A0350037
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 #:** | 2022A0350037 |
| | |
| **Complaint Receipt Date:** | 08/01/2022 |
| | |
| **Investigation Initiation Date:** | 08/03/2022 |
| | |
| **Report Due Date:** | 08/31/2022 |
| | |
| **Licensee Name:** | Beacon Specialized Living Services, Inc. |
| | |
| **Licensee Address:** | Suite 110<br>890 N. 10th St.<br>Kalamazoo, MI 49009 |
| | |
| **Licensee Telephone #:** | (269) 427-8400 |
| | |
| **Administrator:** | Ramon Beltran, II |
| | |
| **Licensee Designee:** | Melissa Williams |
| | |
| **Name of Facility:** | Beacon Home at Hammond |
| | |
| **Facility Address:** | 318 East Hammond Street<br>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<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| Resident A and Resident B have left the home unbeknownst to staff on multiple occasions between 07/28 and 07/30/2022. There is concern these two residents are not receiving adequate supervision. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 08/01/2022 | Special Investigation Intake<br>2022A0350037 |
| 08/02/2022 | Special Investigation Initiated - Letter<br>I sent an email to Tamika McGovernor, Home Manager, stating I would be making an onsite inspection later that day |
| 08/02/2022 | Contact - Document Received<br>I received an email from Ms. McGovernor acknowledging my email |
| 08/02/2022 | Contact - Face to Face<br>I met with Ms. McGovernor and attempted to speak with Resident A and Resident B |
| 08/03/2022 | Contact - Document Sent<br>I sent an email to Ms. McGovernor requesting further information |
| 08/03/2022 | Contact - Document Received<br>I received an email response from Ms. McGovernor |
| 08/03/2022 | Contact - Telephone call made<br>I spoke with Katha Smith, DCW |
| 08/03/2022 | Contact - Telephone call made<br>I spoke with Alexis Trevino, DCW |
| 08/03/2022 | Contact - Telephone call made<br>I spoke with Anette Reeber, DCW |
| 08/03/2022 | Contact - Telephone call made<br>I spoke with Justice Keyzer, DCW |
| 08/03/2022 | Contact - Telephone call made<br>I spoke with Merissa Thorpe, DCW |

| | |
|---|---|
| 08/04/2022 | Exit conference – Held with Ramon Beltran, II, Licensee Designee |

**ALLEGATION: Resident A and Resident B have left the home unbeknownst to staff on multiple occasions between 07/28 and 07/30/2022. There is concern these two residents are not receiving adequate supervision.**

**INVESTIGATION:** On 08/02/2022, I sent an email to Tamika McGovernor, Home Manager, informing her of the complaint, and that I would be making an onsite inspection later this day, and requesting that she have copies of certain documents ready for me.

On 08/02/2002, I received an email response from Ms. McGovernor stating that she would be expecting my visit and would have the requested documents for me.

On 08/02/2022, I made an onsite inspection and met with Ms. McGovernor, and she explained to me that the sound alarm on the front door has not worked for the past few days, and that maintenance was made aware of it and would be fixing it soon. (This house has alarms that sound-off when any of the exterior doors are opened). Ms. McGovernor also reported that this home has had several new staff members who are not familiar with the residents, including how they watch for opportunities to elope. Ms. McGovernor informed me that Resident B's Case Manager, and others, would be meeting to discuss having Resident B evaluated for dementia and to assess whether she requires one-on-one supervision. Ms. McGovernor told me that Resident B does not know who or where she is most of the time. Ms. McGovernor stated that she believes Resident B may be eloping more now because the Prednisone she has been taking lately has made her feel better, causing her to feel more energetic. Ms. McGovern informed me that since Resident B has been eloping more recently, staff members have been instructed to do visual checks on her every 15 minutes. Ms. McGovernor stated that the home has group outings as much as they can, which include going to the zoo, picnics, etc. and that the company, Beacon Specialized Living, is also working on providing larger capacity vehicles for this home, so that most or all of the 12 residents can go on outings together. She reported that the home currently has a Toyota RAV and a transport van that can transport about four or five passengers with space to take walkers and a wheelchair. Ms. McGovernor further told me that they have been trying to relocate Resident A to a more secure setting but have been unable to find one for him so far. I asked Ms. McGovernor for a list of Resident B's mental health diagnoses, and she was not immediately able to find it, so I requested she send it to me by email when she does, and she said she would.

While onsite on 08/02/2022, I attempted to engage Resident A and Resident B in conversation, separately, but their degree of mental illness did not allow for either of them to follow my line of questioning.

On 08/02/2022, I received an email from Ms. McGovernor with Resident B's mental health diagnoses in it. They were: Major neurocognitive disorder…with behavioral disturbance; Unspecified bipolar and related disturbance; Unspecified, schizophrenic spectrum and other disorder; Obsessive-Compulsive Disorder; Delirium due to multiple etiologies; essential (primary) hypertension, among many physical maladies.

On 08/02/2022, I reviewed the documents I requested from Ms. McGovernor. Among them were the Incident Reports, two involving Resident B and one for Resident A.

On 08/03/2022, I sent Ms. McGovernor an email requesting further information. I asked, "What are staff members supposed to do when they hear one of the door alarms sound? Several residents there are smokers and may just be going outside for a cigarette. Does someone check on the resident going outside every time the alarm sounds?"

On 08/03/2022, I received an email response from Ms. McGovernor. She wrote, "Yes, when we hear the door alarms go off, we check to see who's going out the door to make sure it's not one of the residents who are at high risk for elopements. If it is one of the high risk residents, we will monitor them closely by going out to sit with them or check on them in 5-minute intervals."

On 08/03/2022, I called and spoke with Katha Smith, Direct Care Worker (DCW) who worked on 07/28 from 7:00 a.m. to 7:30 p.m. Ms. Smith stated that one of the two back doors leading to the outside does not have an alarm on it, and Resident B looks for opportunities to elope, such as when staff are not looking. Ms. Smith reported that Resident B does not have 1:1 supervision, but said she should have that level of supervision. Ms. Smith told me that when she hears one of the door alarms sound, she checks to see which resident went outside to make sure he or she is not eloping. Ms. Smith said that she checks on Resident B every 15 minutes, but more frequently when she goes outside. However, Resident B is still able to get out of the house unnoticed if she wants to. Ms. Smith informed me that when a resident elopes, a staff member is supposed to follow that person, verbally prompt him or her to return to the home, and call the Home Manager.

On 08/03/2022, I called and spoke with Alexis Trevino, DCW, who worked on 07/28 from 7:00 a.m. to 7:30 p.m. Ms. Trevino stated that she asked Resident B if she would like her to brush her hair and Resident B said yes. When Ms. Trevino went to get Resident B's hairbrush, which only took a few seconds, Resident B left the house. Ms. Trevino told me that two other staff members, Katha Smith and Anette Reeber, went looking for Resident B while she stayed in the home to monitor the other residents. Resident B was found at a house a couple of houses down and was brought back to Hammond. Ms. Trevino said that this was her first day working at this home. She stated that when the door alarm sounded, she checked to see who was going outside and to make sure that person wasn't trying to elope. However, as

stated above, one of the four exit doors does not have an alarm on it and the alarm on the front door was not working.

On 08/03/2022, I called and spoke with Anette Reeber, DCW, who worked on 07/31 from 7:00 a.m. to 7:30 p.m. Ms. Reeber reported that while doing resident checks in the mid-afternoon, she discovered that Resident B was not in her room, so she and the other two staff members looked around the house for her, but she could not be found. Ms. Reeber said that she and Ms. Smith went looking for Resident B outside and found her two houses down at someone's house. She said that neighbor must have called the police because an Officer was at the scene. Resident B returned to the home without any problems. Ms. Reeber told me that she has only been working at this home for about a month, and that the protocol upon hearing one of the exit door alarms is to go check on the resident who left to make sure he or she is not trying to elope.

On 08/03/2022, I called and spoke with Justice Keyzer, DCW, who said she worked from 3:00 p.m. on 07/30 to 8:30 a.m. on 07/31. She told me she was filling in for another staff member, and that this was only her second time working at this home. Ms. Keyzer reported that Resident A was sitting on the porch at around 11:00 p.m. during this shift and Resident C was also on the porch and began yelling at Resident A. Staff separated Resident A and Resident C and no further incidents occurred between them. However, a few minutes later, when Ms. Keyzer went to check on Resident A, he was no longer on the porch or in the house. She looked around outside for him and saw him down the street and went to catch up with him but couldn't. Ms. Keyzer finally found Resident A at Schoop's, a nearby party store and spoke with him there. Police Officer Weber arrived and spoke with Resident A. Officer Weber escorted Resident A back to the home and he did not try to elope after that.

On 08/03/2022, I called and spoke with Merissa Thorpe, DCW. Ms. Thorpe said that she worked from 7:00 a.m. on 07/28 to 7:30 a.m. on 07/29, and that during that time Resident B eloped twice. Ms. Thorpe informed me that she was still new to this home and Resident B was not following her verbal prompts, so another staff member, either Katha Smith or Nicole Aukerman, approached Resident B and used verbal prompts to get her to return home. Ms. Thorpe stated that Resident B only got as far as one house away on her two elopements. Ms. Thorpe told me that when any of the exit door alarms go off, all staff members check to see where each resident is to account for all of their whereabouts.

On 08/04/2022, I conducted 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 they (Beacon) were having the door alarms repaired and were in the process of finding more suitable placements for Resident A and Resident B.

| APPLICABLE RULE | |
|---|---|
| **R 400.14301** | **Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.** |
| | **(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:**<br>**(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** |
| **ANALYSIS:** | Resident A and Resident B have a history of elopement, both at this home and their previous placements. Neither of them has been assessed to require 1:1 supervision.<br><br>Although this home has alarms that sound when an exit door is opened, one of the four exit doors does not have an alarm on it, and the front door alarm was out of service during the days these residents eloped.<br><br>Staff members are aware of the protocol to check to see which resident left whenever a door alarm goes off to make sure that person is not trying to elope. They are also aware that if a resident does elope, at least one staff member is to follow that resident, verbally prompt him or her to return to the house, and contact the Home Manager or District Manager.<br><br>The combination of this home having several new staff members, there being two exit doors without working alarms on them, and Resident A and Resident B being intent on eloping, led to several elopement incidents involving these two residents between 07/28 and 07/31.<br><br>Tamika McGovernor, Home Manager, and Katha Smith, Direct Care Worker, expressed their opinion that Resident B should receive 1:1 supervision.<br><br>My findings support that this rule was violated because the services needed by Resident A and Resident B were not being provided, as indicated by their multiple elopements. |
| **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.

August 4, 2022

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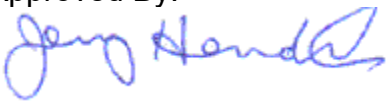
Ian Tschirhart — Date
Licensing Consultant

Approved By:



August 4, 2022

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Jerry Hendrick — Date
Area Manager