GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 27, 2022

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

RE: License #: AS390396198
Investigation #: 2022A0581035
Beacon Home At Augusta

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action 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 (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**
**BUREAU OF COMMUNITY AND HEALTH SYSTEMS**
**SPECIAL INVESTIGATION REPORT**
**THIS REPORT CONTAINS QUOTED PROFANITY**

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AS390396198 |
| | |
| **Investigation #:** | 2022A0581035 |
| | |
| **Complaint Receipt Date:** | 06/02/2022 |
| | |
| **Investigation Initiation Date:** | 06/02/2022 |
| | |
| **Report Due Date:** | 08/01/2022 |
| | |
| **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:** | Aubrey Napier |
| | |
| **Licensee Designee:** | Ramon Beltran |
| | |
| **Name of Facility:** | Beacon Home At Augusta |
| | |
| **Facility Address:** | 817 Webster St.<br>Augusta, MI 49012 |
| | |
| **Facility Telephone #:** | (269) 427-8400 |
| | |
| **Original Issuance Date:** | 11/29/2018 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 05/29/2021 |
| | |
| **Expiration Date:** | 05/28/2023 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION

| | **Violation Established**? |
|---|---|
| Direct care staff, Chad Jones, threatened Resident B and physically managed him inappropriately. | Yes |
| Direct care staff, Katrina Burr, told Resident B to “shut up.<br><br>Direct care staff, Eric Evans, was rough with Resident C while he was being toileted. | No |
| Staff did not assist Resident C with toileting, as required. | No |
| Additional Findings | Yes |

**To maintain the coding consistency of residents across several investigations, the residents in this special investigation are not identified in sequential order.*

## III. METHODOLOGY

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|---|---|
| 06/02/2022 | Special Investigation Intake<br>2022A0581035 |
| 06/02/2022 | Referral - Recipient Rights- Confirmed Shiawassee Recipient Rights office received allegations and is investigating. |
| 06/02/2022 | Special Investigation Initiated - Telephone<br>Interview with Shiawassee RRO, Ardis Bates. |
| 06/07/2022 | Contact - Document Received<br>Received additional allegations. |
| 06/09/2022 | Contact - Document Received<br>Received additional allegations from intake #187772 |
| 06/10/2022 | Inspection Completed On-site<br>Interviewed direct care staff and residents. |
| 06/11/2022 | Contact - Document Received<br>Received email from facility home manager. |
| 06/13/2022 | Contact - Telephone call made<br>Interview with direct care staff, Chad Jones |
| 06/13/2022 | Contact - Telephone call made<br>Interview with direct care staff, Eric Evans. |
| 06/13/2022 | Contact – Telephone call made<br>Left voicemail with direct care staff, Cynthia Longstreet. |

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|---|---|
| 06/13/2022 | Contact – Telephone call made<br>Interview with direct care staff, Katrina Burr. |
| 06/16/2022 | Contact - Document Received<br>Received 1:1 schedules for May 2022 for residents |
| 06/28/2022 | Referral - Recipient Rights<br>ISK and Shiawassee counties. |
| 07/11/2022 | Contact - Telephone call made<br>In conjunction with Shiawassee and ISK recipient rights, we interviewed via MiTeams direct care staff, Eric Evans, and home manager, Marie Ulrich. |
| 07/11/2022 | Contact - Document Received<br>Email from Ms. Ulrich. |
| 07/11/2022 | Contact - Document Received<br>Emails from Ms. Suchyta. |
| 07/14/2022 | Contact - Document Received<br>Email from Ms. Suchyta |
| 07/20/2022 | Inspection Completed-BCAL Sub. Non-Compliance |
| 07/21/2022 | Contact – Telephone call made<br>Interview via MiTeams with direct care staff. |
| 07/26/2022 | Exit conference with licensee designee, Ramon Beltran. |

**ALLEGATION:**

- **Direct care staff, Chad Jones, threatened Resident B and physically managed him inappropriately.**
- **Direct care staff, Katrina Burr, told Resident C to "shut up.**
- **Direct care staff, Eric Evans, was rough with Resident C while he was being toileted.**

**INVESTIGATION:**

On 06/02/2022, I received this complaint through the Bureau of Community Health Systems (BCHS') online complaint system. The complaint alleged that on 05/28/2022, Resident B was experiencing behavioral issues and direct care staff, Chad Jones, followed Resident B into his bedroom with a closed fist and said to him, "you going to make me hit you?" and, "I don't have time for your shit today." The

complaint alleged when Resident B came out of his bedroom to sit on the facility's loveseat but Mr. Jones removed the loveseat so Resident B could not sit down.

On 06/02/2022, I interviewed Shiawassee Recipient Rights Officer, Ardis Bates, via telephone. Ms. Bates confirmed she received the allegations and was investigating the complaint. She stated the facility's Administrator and Executive Director, Aubry Napier, contacted Shiawassee Recipient Rights about the alleged incident. She stated it was indicated to her Mr. Jones threatened Resident B twice about removing the loveseat before removing it and putting it on the facility's porch. Ms. Bates stated Ms. Napier reported there were additional staff at the facility when the alleged incident occurred. Ms. Napier reported to Ms. Bates the additional direct care staff members had attempted to redirect Mr. Jones away Resident B; however, he ignored their redirection.

On 06/07/2022, I received additional allegations concerning Mr. Jones and Resident B. The additional allegations alleged that on 06/04/2022, direct care staff members Katrina Burr, Jaime Kniss and Resident B returned to the facility after watching a local parade and after entering the facility, Resident B was mistreated by direct care staff member Mr. Jones. The additional complaint alleged Mr. Jones put his arms under Resident B's arms, yanked him backwards, and pulled Resident B into Resident B's bedroom. The complaint alleged Resident B said "no, please" and "no, stop." The complaint alleged when Ms. Katrina observed Mr. Jones, she told him to let go of Resident B and he complied. The complaint indicated Mr. Jones was physically managing Resident B because Resident B hit another resident upon coming into the facility.

On 06/09/2022, I received additional allegations alleging Ms. Burr told Resident C to "shut up", direct care staff member Eric Evans was "rough" when assisting Resident C after he was toileted.

On 06/10/2022, I conducted an unannounced on-site investigation at the facility, as part of my investigation. I interviewed direct care staff member and home manager, Marie Ulrich. Ms. Ulrich stated she was not working on 05/28/2022 or 06/04/2022 and therefore, had no firsthand knowledge of the alleged incidences from those dates. Ms. Ulrich stated she had worked with Mr. Jones before, but had not observed or heard him be inappropriate with any of the residents, including Resident B.

Regarding the concerns with Resident C, Ms. Ulrich denied hearing or being aware of direct care staff members, including Ms. Burr, being rude to Resident C. She stated Resident C requires little to no assistance from direct care staff with toileting. She stated Mr. Evans works third shift when Resident C is sleeping further indicating there would have been limited time for Resident C to require assistance from Mr. Evans. She stated she was not aware of any incidences where Mr. Evans or any other direct care staff members would have been "rough" with Resident C while assisting him with toileting.

I interviewed direct care staff member Jamie Kniss who stated she was not working on 05/28/2022; therefore, she had no direct knowledge of the alleged incident with Mr. Jones and Resident B. She stated she had been working on 06/04/2022. Ms. Kniss stated on 06/04/2022, at approximately lunch time, she was in the facility's kitchen getting medications ready for residents when she heard Resident B say "stop", then she heard a "thud", so she turned around and saw Resident B visually agitated and on the floor. She stated Mr. Jones reported to her "he fucking spit on me." She stated Resident B also reported to her "I spit on Chad." She stated Resident B was on the floor and Mr. Jones had Resident B's arms behind his back. She stated she told Mr. Jones to let Resident B go, which he complied and then he went outside to calm down.

Ms. Kniss stated she does not work with Mr. Evans; therefore, had no knowledge of his interactions with Resident C. She stated she had not heard any staff, aside from Mr. Jones, talk inappropriately to any of the residents.

During the inspection, I attempted to interview Resident B and Resident C. I asked Resident B about direct care staff member Mr. Jones. He stated "he choked me". Resident B was unable to provide any additional information, but indicated Ms. Kniss and Ms. Burr were both present when Mr. Jones choked him. Resident B did not respond to any additional questions that I asked and was unable to provide any additional information relating to either the 05/28/2022 or 06/04/2022 alleged incidences. I did not observe any injuries or marks on Resident B's face or body.

Resident C was sleeping during my inspection. Ms. Kniss went into his bedroom with me in an attempt to wake him up in order to be interviewed; however, he would not respond to my questions or engage in conversation. Ms. Kniss indicated Resident C was incontinent while sleeping and while I was present, she attempted to get him up and in the shower.

On 06/13/2022, I interviewed direct care staff member Chad Jones via telephone. Mr. Jones stated he typically works 1st shift at the facility, which is from 7 am until 7:30 pm. He stated he has worked at the facility since February 2022. Regarding the 05/28/2022 allegations, Mr. Jones stated he had been outside taking out trash and when he came back inside the other staff working informed him Resident B was hitting staff. Mr. Jones stated the other two female staff working, one of which was pregnant, were not comfortable utilizing nonviolent crisis intervention (CPI) techniques so he attempted to utilize CPI by himself. Mr. Jones stated he tried verbally redirecting Resident B out of the living space, but Resident B was non-compliant. He stated Resident B pulled his hair and was trying to hit him. Mr. Jones stated he put his hands up to block the hits and to prevent Resident B from striking him. Mr. Jones stated two direct care staff are typically needed when physically managing Resident B with one staff on each side of the resident. Mr. Jones stated that since none of the other staff wanted to assist, he attempted to put Resident B's arms behind his back to prevent Resident B from hitting him. He stated during the

process of walking Resident B to his bedroom, in order to separate Resident B from the other residents, they both fell down. Mr. Jones stated while he was physically managing Resident B, the other staff were attempting to remove the other residents from the space to protect them. Mr. Jones indicated when the physical management was not effective at calming Resident B, he decided to remove the facility's loveseat from the living room because he did not want Resident B to remove and throw the cushions or flip/throw the loveseat and hurt any staff or residents. Mr. Jones denied harming Resident B during the incident or intending to harm him. He denied saying he was going to hit Resident B or act like he was going to hit him. Mr. Jones indicated he was protecting himself from being harmed by Resident B and to protect the other staff and residents.

Regarding the 06/04/2022 incident, Mr. Jones stated he was in the living room with two other residents when Resident B came inside and hit one of the residents in the arm. Mr. Jones stated Resident B told him he was going to hit the resident again and then spit on Mr. Jones. Mr. Jones stated he tried guiding Resident B to this bedroom by getting behind him and holding his arms, but they tripped and Mr. Jones stated he fell on top of Resident B. Mr. Jones stated Ms. Kniss told him he could not grab Resident B from behind and physical manage him into his bedroom. Mr. Jones denied calling Resident B any names or threatening him. He also denied intentionally trying to hurt Resident B.

On 06/13/2022, I interviewed direct care staff member Katrina Burr via telephone. Regarding the 05/28/2022 incident, Ms. Burr stated Resident B was "having a behavior" and Mr. Jones threatened Resident B by telling him he was going to make him punch him. Ms. Burr did not have any additional information regarding the 05/28/2022 incident. Regarding the 06/04/2022 incident, Ms. Burr stated when she came into the facility after being outside, she observed Resident B on the couch with Mr. Jones behind him with his arms under Resident B's arms trying to pull him up. She stated Mr. Jones reported to her Resident B had hit one of the other residents. She stated she had to scream at Mr. Jones to get off Resident B. Ms. Burr confirmed she was unable to engage in any kind of physical management of a resident, like CPI techniques, due to pregnancy restrictions.

On 06/13/2022, I interviewed direct care staff member Eric Evans via telephone. Mr. Evans stated he typically works the overnight shift. Mr. Evans stated he had not been working with Mr. Jones during any of the alleged incidences with Resident B. Mr. Evans stated Resident C does not require assistance with toileting; therefore, he has not had to help him go to the bathroom. Mr. Evans denied ever being rude to Resident C or seeing staff being rude or disrespectful to him. Additionally, Mr. Evans denied seeing or hearing Mr. Jones being disrespectful to Resident B. Mr. Evans stated Resident B had reported to him that he does not like Mr. Jones but stated Resident B did not report to him why he did not like him.

On 06/14/2022, I interviewed RRO, Ms. Bates, via telephone. Ms. Bates stated she interviewed Resident B who denied hitting a peer or spitting on anyone after he

came into the facility on 06/04/2022. Resident B reported to Ms. Bates that Mr. Jones tried choking him, put his arms under his arms and tried pulling him to the ground. Ms. Bates stated Resident B could not recall who his 1:1 staff was when the incident occurred.

I reviewed Resident B's *Behavior Assessment and Support Plan* (BSP), dated 01/03/2022, which was created by the licensee's behavior management team. According to this BSP, Resident B has a history of aggressive outbursts and self-injurious behaviors. The BSP indicated Resident B requires a 1:1 staff to assist him in keeping "engaged in activity and to redirect and maintain safety when [Resident B] becomes agitated and/or engages in aggressive behavior toward vulnerable peers." Resident B's BSP also indicated if Resident B escalated and was becoming physically aggressive then, "staff should verbally redirect him to stop or engage in alternative behavior such as saying "[Resident B], hands down"." The BSP also indicated staff should try and get in between Resident B and the other resident; however, the BSP indicated if Resident B continued displaying physical aggression that is harming others, "staff should utilize the least intrusive crisis management strategy to maintain safety."

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | **(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.** |

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|---|---|
| **ANALYSIS:** | Despite conflicting interviews with direct care staff and my inability to interview Resident B, direct care staff, Chad Jones' acknowledged he did not use an approved CPI technique when he grabbed and/or attempted to grab Resident B's arms and put them behind his back, which caused them both to fall on top of one another on or around 06/04/2022. By using this unapproved physical management technique, Mr. Jones exposed Resident B to potential physical injury.<br><br>Alternatively, there is no evidence indicating direct care staff, Katrina Burr told Resident C to "shut up" or direct care staff, Eric Evans, was rough with Resident C when he was allegedly toileting him. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Staff did not assist Resident C with toileting, as required.**

**INVESTIGATION:**

On 06/09/2022, I received additional allegations alleging Resident C was found soiled in bed when direct care staff were working indicating Resident C's care and needs were not being addressed.

On 06/09/2022, I confirmed Integrated Services of Kalamazoo Recipient Rights Officer, Suzie Suchyta, had also received the allegations. Ms. Suchyta stated she observed Resident C on 06/09/2022 and he was not soiled. She stated she was not able to interview him as he only responded in one word answers and did not appear to comprehend her questions. Ms. Suchyta indicated she was not substantiating the allegations.

I interviewed Ms. Ulrich, the facility's home manager and direct care staff member, during my on-site investigation. She stated Resident C is typically incontinent while sleeping or napping and upon waking up, direct care staff assist him with getting cleaned up and showered. She stated there had been an incident when Resident C's family members came to visit Resident C on or around 05/30/2022. She described the incident as a situation where Resident C's family visited right when Resident C woke up from a nap and was soiled due to being incontinent while sleeping. She stated that due to staff handling another resident's behaviors they did not have the immediate opportunity to shower Resident C. Ms. Ulrich denied staff not caring for Resident C's needs. She stated direct care staff informed Resident C's family they would shower him; however, his family refused and left with Resident C on an outing.

I interviewed direct care staff member Kristina Burr whose statement to me was consistent with Ms. Ulrich's statement to me about Resident C waking up from a nap on or around 05/30/2022 when his family arrived to take him on an outing. Ms. Burr stated Resident C's needs are addressed and he is changed when found incontinent.

I was unable to interview Resident C while at the facility due to his limited vocabulary and difficulty with communicating. Resident C had been napping while I was at the facility and when staff attempted to wake him up, he was observed to be soiled but direct care staff member Jamie Kniss encouraged Resident C to shower. Resident C appeared to be well taken care of and did not appear under distress.

Ms. Kniss' statement to me concerning Resident C's incontinence and assistance with toileting was consistent with Ms. Ulrich's and Ms. Burr's statements to me.

I reviewed the *AFC Licensing Division – Incident / Accident Report* (IR) for the 05/30/2022 incident. The IR indicated around 10:55 am on 05/30/2022, two direct care staff were attempting to redirect another resident back to the facility when Resident C's family arrived. When direct care staff member Katrina Burr got back to the facility she observed Resident C, with urine soaked underwear, outside with his family. The IR indicated direct care staff attempted to explain to Resident C's family that Resident C had been incontinent during his nap as he was wearing the same underwear that he had been changed into after his shower that morning; however, Resident C's family put Resident C in a vehicle and left. The IR also indicated the staff had offered to take Resident C back into the facility for a shower and change of clothes.

I reviewed Resident C's *Behavior Support Plan*, dated 02/18/2022, which was created by Psychological Assessment and Treatment Services. The BSP indicated Resident C is "independent with using the bathroom". His *Assessment Plan for AFC Residents,* dated 01/13/2021, indicated he wears pull ups at night and dislikes wiping himself. Resident C's Treatment Plan, dated 10/08/2021, through Western Michigan University's Center for Disability Services also indicated Resident C requires "limited assistance with toileting."

| **APPLICABLE RULE** | |
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| **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.** |

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|---|---|
| **ANALYSIS:** | Based on my review of the facility's *AFC Licensing Division – Incident / Accident Report* (IR), dated 05/30/2022, Resident C's Behavior Support Plan, dated 02/18/2022, his *Assessment Plan for AFC Residents,* dated 01/13/2021, and his Treatment Plan, dated 10/08/2021, in addition to, interviews with the facility's home manager, Marie Ulrich, direct care staff members Kristina Burr and Jamie Kniss, and Integrated Services of Kalamazoo Recipient Rights Officer, Suzie Suchyta, there is no evidence direct care staff are not assisting Resident C with toileting when needed or addressing his incontinence when it's been observed. My investigation indicates Resident C had been napping on or around the morning of 05/30/2022 when his family unexpectedly came to the facility to take him on an outing; however, due to staff attempting to get another resident back to the facility they were unable to immediately address Resident C's incontinence when he was woken up by his family. There is no evidence indicating the facility direct care staff failed to address his toileting needs, as required. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS**

**INVESTIGATION:**

On 06/14/2022, I interviewed Shiawassee RRO Ardis Bates via telephone regarding concern for lack of 1:1 staffing services to Resident B. Ms. Bates stated Ms. Kniss, who was Resident B's assigned 1:1 on 06/04/2022, reported to her she was putting away groceries in the kitchen while Resident B was in the living room. Ms. Bates stated Ms. Kniss told her she heard Ms. Burr yelling at Mr. Jones to "stop." Ms. Bates stated that given Ms. Kniss was not providing the 1:1 service to Resident B she was supposed to be providing that she would be subsequently citing her.

On 06/16/2022, I reviewed the facility's *Resident Register* and established there were five residents residing at the facility. I requested and reviewed Resident A's, B's, C's, E's, and F's respective Community Mental Health plans.

Resident B's *Behavior Assessment and Support Plan* (BSP), dated 01/03/2022, through Shiawassee Health and Wellness in conjunction with the licensee stated Resident B requires "1:1 staff during targeted hours to assist keeping [Resident B] engaged in activity and to redirect and maintain safety when [Resident B] becomes agitated and/or engages in aggressive behavior towards vulnerable peers."

Resident B's supervision in the BSP stated direct care staff will know the general whereabouts of Resident B while in the home and would complete bed checks every 30 minutes during the day and every hour during the overnight, but "for a designated

time frame “awake” hours each day, [Resident B] will have a 1:1 staff to help keep him engaged in activity, to facilitate appropriate interactions with others, and to help maintain safety if [Resident B] escalates”. The BSP stated “1:1 staff should be able to see him and be close enough to intervene when needed”. The BSP also indicated “there may be times during the day when [Resident B] may not have 1:1 staff due to staffing circumstances”. The BSP indicated examples of these situations would be if staff have to run appointments for another resident; however, the BSP indicated these situations may only occur if Resident B was not presenting with agitation.

Resident C’s *Behavior Support Plan* (BSP), dated 02/18/2022, was created in conjunction with Psychological Assessment and Treatment Services through Western Michigan University and Integrated Services of Kalamazoo (ISK). The BSP stated the following regarding Resident C’s 1:1 staffing requirements:

> Resident C “should have a 1:1 staff member assigned to him for 16 hours each day. His 1:1 staff member should stay within 10 feet of [Resident C]. When [Resident C] is in a common areas (e.g., kitchen, shared areas, etc.) staff should also keep [Resident C] within eyesight. The 1:1 staff member should not continuously monitor [Resident C] while he is using the bathroom, masturbating, and/or while he is in his room sleeping (although 30-min check-ins are still required). The 1:1 should provide [Resident C] with access to attention and activities throughout the day, and complete his Activates Data Sheet (**Appendix A**). **Rationale**: [Resident C] requires a high level of attention to reduce the likelihood of his target behaviors from occurring. However, [Resident C] is independent with using the bathroom, masturbating, and sleeping, and does not require supervision during these times to maintain his safety.

Resident A’s *Positive Behavior Support Plan* (BSP), dated 05/19/2022, through ISK stated Resident A “has been approved for enhanced 1:1 staffing for 12 hours daily (6 pm until 6 am). The 1:1 staffing will engage [Resident A] in activities of his choice during the awake hours to deter him from eloping. Activities that [Resident A] enjoys are listed earlier within this plan”.

Resident E’s Behavioral Assessment and Behavior Guidelines (assessment), dated 04/26/2022, through ISK did not indicate Resident E had enhanced staffing or 1:1 supervision from staff; however, it stated Resident E should “receive social interaction and praise (i.e., pointed praise) every five to thirty minutes (depending on the situation) in the absence of target behaviors.

Resident F's Interim *Behavior Support Plan* (BSP), dated 04/05/2022, was also through ISK. His BSP did not indicate enhanced or 1:1 staffing at the facility but stated staff should be "… close by and available" while in the community.

On 06/16/2022, I reviewed the facility's 1:1 sign in sheets for May and June 2022 for Residents B, C, and A. According to these sign in sheets, Resident B's assigned 1:1 staff is from 8 am until 6 pm, Resident C's 1:1 staff is from 8 am until 12 am, and Resident A's 1:1 staff is from 6 pm until 6 am. After reviewing all three sign in sheets, I determined there were four days where the same direct care staff was assigned as the 1:1 staff for two separate residents during the same time frame. These dates were the following:

- 05/09/2022
  - 8 am – 6 pm, Direct care staff, Kristina Burr, assigned as Resident B's 1:1
  - 8 am – 7 pm, Direct care staff, Kristina Burr, assigned as Resident C's 1:1
- 05/16/2022
  - 8 am – 6 pm, direct care staff, Kristina Burr, assigned as Resident B's 1:1
  - 8 am – 7 pm, direct care staff, Kristina Burr, assigned as Resident C's 1:1
- 05/21/2022
  - 8 am – 6 pm, direct care staff, Chad Jones, assigned as Resident B's 1:1
  - 8 am – 7 pm, direct care staff, Chad Jones, assigned as Resident C's 1:1
- 05/24/2022
  - 7 pm- 12 am, direct care staff, Eric Evans, assigned as Resident C's 1:1
  - 6 pm - 12 am, direct care staff, Eric Evans, assigned as Resident A's 1:1

I also reviewed the facility's staff schedule for May and June 2022. According to these schedules, the facility has two twelve hour shifts, which are identified as "first" and "third". The schedules indicated first shift is from 7 am until 7:30 pm and third shift is from 7 pm until 7:30 am. In my review of the schedules for May 2022 and June (06/01/202 – 06/18/2022), there were at least three direct care staff scheduled for first shift except 05/09, 05/21, 05/30, and 06/11 when the staff schedule indicated there were only two direct care staff scheduled for first shift.

Alternatively, in my review of the schedules for May 2022 and June (06/01/202 – 06/18/2022), there were only two direct care staff scheduled for third shift except 05/30, 05/31, and 06/08 when the staff schedule indicated there were three direct care staff scheduled for third shift.

I also reviewed the facility's fire drills records from 01/2022 through 06/2022 and determined the following:

- 04/04/2022 – two direct care staff working for a third shift fire drill at 1:15 am
- 06/04/2022 – two direct care staff working for a third shift fire drill at 8:35 pm

On 07/11/2022, in conjunction with ISK RRO, Ms. Suchyta, and Shiawassee RRO, Ms. Bates, we interviewed direct care staff, Eric Evans, and home manager, Marie Ulrich, via MiTeams.

Mr. Evans stated only two direct care staff work the overnight shift from 7 pm until 7:30 am. He initially stated Resident A requires 1:1 staffing at night, starting at 12 am until the morning, but later in the interview he acknowledged Resident C's 1:1 staffing starts at 6 pm. He stated Resident B and Resident C also have 1:1 staffing, but it was during the day. Mr. Evans was unable to recall the specific time frames in which Resident B and Resident C receive 1:1 staffing.

The facility's home manager, Marie Ulrich, confirmed Residents A, B and C require 1:1 staffing at various times throughout the day. She stated 1:1 staffing meant staff were to be in the same room as the resident and to have "eyes on" them. She indicated none of the residents required staff to be with them in the bathroom and if the resident was in their bedroom, then staff could complete 15 minute checks on the resident. Ms. Ulrich's statement regarding the specific times frames for the resident 1:1 staffing schedules were consistent with what was indicated on the 1:1 sign in sheets.

Ms. Ulrich stated she only schedules two direct care staff during third shift. She stated when the two overnight staff are assigned to two residents, who both require 1:1 staffing, then those two staff are still responsible for "monitoring" the other residents in the facility. She also stated there are typically two to three staff scheduled for first shift, in addition to herself. Ms. Ulrich acknowledged staffing was an issue but denied bringing the specific 1:1 staffing issues up to upper management like the Administrator or the Licensee Designee. She stated she had been informed by the facility's former Administrator, who she acknowledged had not been working for the licensee for at least six months, that she was not allowed to have more than two staff working third shift.

Ms. Ulrich denied one staff being assigned to two residents who both required 1:1 staffing at the same time. Ms. Ulrich stated if this scenario was indicated on any paperwork, then it was a paperwork error on her behalf. She stated she found direct care staff were not signing their names to the 1:1 staffing tracking sheets; therefore, she had to go back and write in their names and she may have incorrectly written names in. Ms. Ulrich also stated staff were not completing chart notes, which required her to go into the facility's online charting system, NextStep, and complete notes on staff's behalf to ensure documentation was being completed, as required.

On 07/21/2022, I interviewed direct care staff member Chad Jones via MiTeams, in conjunction with ISK RRO, Ms. Suchyta. Mr. Jones stated he typically worked first shift at the facility and confirmed he had been assigned as Resident A's, B's, and C's 1:1 staff on numerous occasions. Mr. Jones acknowledged the requirements of a 1:1 staff, indicating he was expected to stay within arm's length of the resident who required 1:1 staffing and have "eyes on" the resident at all times. He stated exceptions were if the resident was in the bathroom or the resident's bedroom. Mr. Jones stated there had been several instances where he was the 1:1 staff to two residents at the same time; indicating these instances often occurred on Sundays when the other direct care staff at the facility would leave on outings with the other residents. He stated during these instances, he was alone at the facility with two residents who both required 1:1 staffing. Mr. Jones stated he did not contact his home manager, Ms. Ulrich, or upper management while these instances were occurring, but he stated he had let Ms. Ulrich know he was being left by himself to care for two residents who required 1:1 staffing services.

In my review of the facility file, I determined the facility has multiple repeat violations for special certification rule 330.1806(1) and adult foster care licensing rule 400.14206(2).

According to SIR #2022A0581031, dated 07/05/2022, the facility was in violation of certification of specialized programs rule 330.1806(1) when it was established Resident D's Community Mental Health Central Michigan Person Centered Plan (PCP), dated 01/22/2022, stated one of Resident D's goals was to "…get along with these guys most of the time" and the objective to this goal was to "…have appropriate social interactions with peer/staff on a daily basis as evidenced by no hitting; yelling; swearing; throwing objects etc. for 1 plan year". Despite this goal and objective being stated in Resident D's PCP, my interviews with direct care staff, Joshua Terpstra, Katrina Burr, Jamie Kniss, and Jessica Garten, and home manager, Marie Ulrich, indicated former direct care staff, Sarah Thorne, engaged in "food throwing" and horseplay with Resident D while he resided at the facility. All the staff I interviewed stated both Ms. Thorne and Resident D would both throw and smear peanut butter at and on one another indicating Ms. Thorne was not only not implementing Resident D's PCP but was an active participant in him not following his PCP. The facility's approved Corrective Action Plan (CAP), dated 07/20/2022, stated direct care staff, Ms. Thorne, was no longer employed by the licensee effective 04/04/2022 and facility staff within the home would receive retraining on the resident's PCP's  and the in-service would be provided to the Department by 09/16/2022.

According to SIR #2022A0462005, dated 12/17/2021, the facility was again in violation of certification of specialized programs rule 330.1806(1) when it was established a resident's Behavior Treatment Plan included a "freedom of movement restriction", but direct care staff did not implement the supervision and protection protocols as specified in the residents' Behavior Treatment when on 10/17/2021 the resident eloped from the facility unsupervised, went to the neighbors' home, and was

transported back to the facility by a police officer.

Additionally, the investigation established two direct care staff, Robert Lovely and Joshua Terpstra, and four residents left the facility to go trick-or-treating before one of the resident's required 1:1 enhanced supervision ended at 6:00 PM. Based the investigation, there should have been at least three facility staff members with the four residents when leaving the facility; two direct care staff to provide two residents with 1:1 enhanced supervision and enhanced 1:1 supervision with "continuous attention" and at least one additional direct care staff to provide supervision and protection to the remaining two residents. Therefore, it was established when Mr. Lovely, Mr. Terpstra, and the four residents left the facility to go trick-or-treating on 10/31/2021, there was not a sufficient number of direct care staff to implement the supervision protocols indicated in two of the residents' Behavior Treatment Plans, and to provide supervision and protection to the remaining two residents.

The facility's approved CAP, dated 01/04/2022, stated direct care staff, Mr. Lovely, resigned from employment on 11/05/2021 and Mr. Terpstra was terminated effective 12/23/2021. The CAP stated all direct care staff were retrained on the residents Behavior Treatment Plans and the requirements for supervision as outlined in their plan by 01/18/2022. The CAP indicated all staff would sign training acknowledgments which would be maintained in their personnel files. Additionally, the CAP stated the home manager, Marie Ulrich, would be retrained on scheduling by 01/18/2022 to ensure adequate staffing and ratios were maintained, at all times, with the enhanced staffing needs of several residents and to cover outings and appointments. The CAP stated Ms. Ulrich would sign a training acknowledgment, which would also remain in her personnel file. The licensee submitted Mr. Lovely's and Mr. Terpstra's "Change of Status" forms confirming they were no longer employed with the licensee. Additionally, the licensee submitted training verification for direct care staff at the facility relating to specific resident Behavior Treatment Plans, mandatory reporting, and "line of sight" for specific residents.

According to SIR #2021A0462046, dated 10/08/2021, the facility was again in violation of certification of specialized programs rule 330.1806(1) when it was established two residents were not provided with their required 1:1 enhanced supervision, per their Behavior Treatment Plans, during the facility's first shift. It was established the facility did not consistently schedule a sufficient number of direct care staff to provide this enhanced supervision, and also provide for the supervision, personal care, and protection of the facility's other residents. The facility's approved CAP, dated 10/22/2021, indicated the facility's home manager received written "progressive disciplinary action" for not maintaining appropriate staffing ratios in the facility. A copy of this disciplinary action was received by the Department to verify compliance with the CAP.

According to SIR #2020A0462058, dated 10/01/2020, the facility was again in violation of certification of specialized programs rule 330.1806(1) when it was established after a review of pertinent documentation and photographs relevant to

the investigation, as well as interviews with the licensee designee at that time, Patricia Miller, and home manager, Marie Ulrich, that according to a resident's Behavior Support Plan, the resident was to be supervised by direct care staff while away from the facility; however, Resident D eloped from the facility unsupervised on 09/15/2020 and then again on 09/24/2020.

The facility's approved CAP, dated 10/15/2020, stated the topic and importance of resident supervision and completing appropriate checks was reviewed by the facility's home manager, Marie Ulrich and the facility's District Director, Navi Kaur, at a meeting on 10/06/2020. Additionally, the licensee indicated the resident was in the transition of transferring to another facility with a fenced yard and more rural setting, but until the transfer took place the resident would be provided with enhanced 1:1 staffing. The CAP stated that going forward, the licensee would ensure staff have appropriate training on IPOS' and BTP's and that the licensee's leadership team would explore additional staffing or other placement options for the resident should it be medically or clinically necessary after the resident was transferred.

Additionally, according to SIR #2021A0462046, dated 10/08/2021, the facility was in violation of adult foster care licensing rule 400.14206(2), when it was established the facility was not consistently scheduling a sufficient number of direct care staff to provide for the supervision, personal care and protection of the residents. The facility's approved CAP, dated 10/22/2021, indicated the facility's home manager received written "progressive disciplinary action" for not maintaining appropriate staffing ratios in the facility. A copy of this disciplinary action was received by the Department to verify compliance with the CAP. The CAP also indicated the facility's home manager was retrained on 09/27/2021 on the expectation that the District Director and/or VP of Operations need to be informed when there are staffing issues with the home, to be able to provide or find additional coverage to maintain the necessary staffing ratio.

| **APPLICABLE RULE** | |
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| **R 330.1806** | **Staffing levels and qualifications.** |
| | **(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.** |

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| **ANALYSIS:** | Based on my investigation, which included a review of Resident B's *Behavior Assessment and Support Plan* (BSP), dated 01/03/2022, Resident C's *Behavior Support Plan* (BSP), dated 02/18/2022, and Resident A's *Positive Behavior Support Plan* (BSP), dated 05/19/2022, my review of the facility's fire drills records, the facility's 1:1 sign in sheets, and the facility's May and June 2022 staff schedules, as well as, interviews with the facility's home manager, Marie Ulrich, and direct care staff member Eric Evans and Chad Jones, there is substantial evidence the facility is not sufficiently staffed to implement Resident A's, B's, and C's, plans of service, as required.<br><br>The facility has routinely only scheduled two direct care staff for third shift (7 pm until 7 am) when Resident C requires a 1:1 staff from 8 am until 12 am and Resident A requires a 1:1 staff from 6 pm until 6 am. By the facility only staffing two direct care staff during this time means the facility is not providing adequate supervision of Resident C and Resident A, in addition to, the remaining residents in the facility. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br><br>**[SEE SIR #2022A0581031, DATED 07/05/2022, AND CAP, DATED 07/20/2022]**<br><br>**[SEE SIR #2022A0462005, DATED 12/17/2021 AND CAP, DATED 01/04/2022]**<br><br>**[SEE SIR #2021A0462046, DATED 10/08/2021 AND CAP, DATED 10/22/2021]**<br><br>**[SEE SIR #2020A0462058, DATED 10/01/2020 AND CAP, DATED 10/15/2020]** |

| **APPLICABLE RULE** | |
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| **R 400.14206** | **Staffing requirements.** |
| | **(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.** |

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| **ANALYSIS:** | Resident C requires a 1:1 staff from 8 am until 12 am and Resident A requires a 1:1 staff from 6 pm until 6 am, based on my review of their plans of service. My review of the facility's staff schedule and by the facility's home manager, Marie Ulrich's own admission, the facility is insufficiently staffed during third shift (7 pm until 7:30 am), when there are only two direct care staff working to implement Resident C's and Resident A's plans of service and still provide supervision to Resident B, E, and F.<br><br>The only two staff working in the facility from 6 pm until 12 am are expected to both provide 1:1 staffing to Resident C and Resident A and provide adequate supervision to Resident B, E, and F, which is not possible based on their plans of service.<br><br>Ms. Ulrich acknowledged she had only been staffing two third shift direct care staff since the facility's former Administrator instructed her to do so; however, this Administrator has not worked for the facility for at least six months implicating the facility has been insufficiently staffed the entire time. |
| **CONCLUSION:** | **REPEAT VIOLATION ESTABLISHED**<br><br>**[SEE SIR #2021A0462046, DATED 10/08/2021 AND CAP, DATED 10/22/2021]** |

| **APPLICABLE RULE** | |
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| **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:** | Based upon my investigation, which included a review of pertinent documentation, the facility has not been providing Resident B, Resident E, and Resident F with appropriate supervision and protection daily during third shift from at least 6 pm until 12 am for at least the last six months due to the only scheduled two staff have been providing 1:1 services to Resident C and Resident A during those times. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

The facility's home manager, Ms. Ulrich, stated the facility's staff schedules are not updated to reflect who is working at the facility because she does not have time to print and update them with the names of staff who have called off or who was called in.

| **APPLICABLE RULE** | |
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| **R 400.14208** | **Direct care staff and employee records.** |
| | **(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information:**<br>**(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.**<br>**(b) Job titles.**<br>**(c) Hours or shifts worked.**<br>**(d) Date of schedule.**<br>**(e) Any scheduling changes.** |
| **ANALYSIS:** | Based on the facility's home manager, Marie Ulrich's, own admission, the facility's staff schedules are not updated to accurately reflect scheduling changes, as required, due to her not having time to print and update them. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 07/26/2022, I conducted my exit conference with licensee designee, Ramon Beltran, and the licensee's Chief Administrative Officer, Melissa Williams, via telephone. Ms. Williams identified readdressing the facility's management as a potential corrective action for the issues indicated in the report. Ms. Williams also she needed to review the report before she and Mr. Beltran made a decision about how to proceed with the recommendation.

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of correction, I recommend a provisional license due to the repeat quality of care violations cited in the report.

07/22/2022

Cathy Cushman Date
Licensing Consultant

Approved By:

07/26/2022

Dawn N. Timm Date
Area Manager