GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 27, 2022

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

RE: License #: AS390396198
Investigation #: 2022A0581044
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.
- 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 feel free to 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 (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

I. IDENTIFYING INFORMATION

License #:	AS390396198
Investigation #:	2022A0581044
Complaint Receipt Date:	08/05/2022
Investigation Initiation Date:	08/05/2022
Report Due Date:	10/04/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubrey Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At Augusta
Facility Address:	817 Webster St. 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 MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Despite direct care staff, Cynthia Longstreet, not being trained on Resident C's behavior plan she was allowed to be his 1:1 enhanced staff.	Yes
Resident C was punched by direct care staff, Cheyenne Lemon.	No

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

III. METHODOLOGY

08/05/2022	Special Investigation Intake 2022A0581044
08/05/2022	Referral - Recipient Rights Confirmed ISK received the allegations and was investigating.
08/05/2022	APS Referral Integrated Services of Kalamazoo (ISK), Suzie Suchyta, confirmed she called the allegations into APS.
08/05/2022	Referral - Law Enforcement Ms. Suchyta confirmed she was calling the allegations into Augusta police.
08/05/2022	Special Investigation Initiated - Telephone Interview with Ms. Suchyta.
08/05/2022	Contact - Document Received Reviewed Incident Reports.
08/08/2022	Inspection Completed On-site
08/08/2022	Contact - Document Sent Requested documents from home manager, Marie Ulrich.
08/11/2022	Contact - Face to Face Interview with Melissa Williams, via MiTeams.
08/12/2022	Contact - Telephone call made Interview with direct care staff, Eric Evans.
08/12/2022	Contact - Telephone call made

	Left messages for direct care staff, Cynthia Longstreet and Cheyenne Lemon.
08/16/2022	APS Referral APS received complaint.
08/23/2022	Contact - Telephone call received Interview with Ms. Suchyta.
08/24/2022	Contact - Telephone call made Left another message for direct care staff, Ms. Lemon.
08/24/2022	Contact - Telephone call made Left another message for direct care staff, Cynthia Longstreet.
08/24/2022	Contact - Telephone call made Attempted interview with resident. Interview with Jamie Kniss, direct care staff.
08/24/2022	Contact - Document Sent Email correspondence with APS, Melissa Pachota.
08/24/2022	Contact - Document Sent Email to APS specialist, Melissa Pachota.
08/24/2022	Contact - Document Received Email from Ms. Pachota.
08/24/2022	Contact - Telephone call made Interview with Ms. Suchyta.
09/02/2022	Contact – Telephone call made Interview with direct care staff, Cynthia Longstreet.
09/14/2022	Inspection Completed-BCAL Sub. Compliance
09/28/2022	Exit conference with licensee designee, Ramon Beltran and Melissa Williams, via telephone.

ALLEGATION:

Despite direct care staff, Cynthia Longstreet, not being trained on Resident C's behavior plan she was assigned as his 1:1 enhanced staff.

INVESTIGATION:

On 08/05/2022, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged direct care staff, Cynthia Longstreet, had been assigned as Resident C's 1:1 enhanced staff when she had not been trained on his behavior plan.

On 08/08/2022, I conducted an unannounced on-site inspection at the facility; however, Resident C was not present at the facility due to being in school. Subsequently, I was unable to interview him.

On 08/08/2022, I requested the facility's home manager, Marie Ulrich, provide me with verification of staff who had received training on Resident C's behavior and/or treatment plan and/or *Individual Plan of Service*. I indicated to Ms. Ulrich it was typically an in-service sign in sheet, but allowed her to provide any additional information as well to indicate direct care staff members were trained on the information.

On 08/10/2022, Ms. Ulrich sent via email Resident C's *Person Centered Plan* Signature Form behavior support plan sign in sheet, confirming which facility staff had received training on Resident C's behavior support plan. According to this training sign in sheet, Ms. Longstreet had not been trained on Resident C's behavior support plan.

The document indicated that by signing the document direct care staff confirm the following:

> "…have READ, understand, and have had the opportunity to ask questions about this document. This acknowledges that training occurred covering each treatment/service goal and objective including target date, criteria, frequency, data collection, and specific precautions in the plan. And that you understand the role you play in this plan as Direct Care Staff and/or other Staff involved in providing care, treatment, and services to this resident."

I also received the facility's assigned 1:1 enhanced staffing sign in sheet. According to this 1:1 enhanced sign in sheet, Ms. Longstreet was the assigned staff to Resident C on 08/02/2022.

I reviewed Resident C's *Behavior Support Plan* (BSP), dated 02/18/2022, which 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."

On 08/12/2022, I interviewed direct care staff, Eric Evans, via telephone. Mr. Evans stated he had been working on 08/02/2022, along with Ms. Lemon and Ms. Longstreet. He confirmed Ms. Longstreet and Ms. Lemon were assigned as Resident C's and Resident B's enhanced staff, respectively. He stated he was responsible for monitoring and providing care to the remaining residents in the facility. Mr. Evans stated Ms. Longstreet has worked approximately one month at the facility and has primarily been assigned as Resident C's 1:1 enhanced staff. Mr. Evans stated if Resident C was displaying maladaptive behaviors, then he would attempt to de-escalate him rather than Ms. Longstreet because Resident C listened to him. Mr. Evans stated direct care staff are expected to review resident records, which are located in binders, every shift to determine if anything relating to the resident had changed or there were updates. He stated the facility's manager would inform them of any changes and then it was expected direct care staff review the changes in the resident binders. Mr. Evans did not have any information relating to Ms. Longstreet receiving training on Resident C's behavior support plan.

On 08/24/2022, I interviewed Ms. Suchyta, via telephone. Ms. Suchyta stated she had interviewed both Ms. Longstreet and Ms. Lemon. She stated Ms. Longstreet confirmed she was Resident C's 1:1 on 08/02/2022. Ms. Suchyta also stated Ms. Longstreet reported to her she did not know Resident C's behavior support plan and had not been trained on it despite being a full-time staff for two years. Ms. Longstreet reported to Ms. Suchyta she did not know how to de-escalate Resident

C's behaviors. She stated to Ms. Suchyta that Ms. Lemon normally calms Resident C down, but on that night, Mr. Evans had to assist her.

On 08/24/2022, I interviewed direct care staff, Jamie Kniss, via telephone and Resident C. Ms. Kniss stated direct care staff must sign a resident's "in-service" sheet indicating they were trained on a resident's behavior or treatment plan. Ms. Kniss stated Ms. Longstreet typically works at another facility for the licensee but indicated she had worked at Beacon Home at Augusta numerous times.

I attempted to interview Resident C; however, Resident C's answers were limited because of his cognitive abilities. Resident C reported knowing Ms. Longstreet as a staff at the facility.

On 09/02/2022, I interviewed direct care staff, Cynthia Longstreet, via telephone. Longstreet confirmed being assigned as Resident C's 1:1 direct care staff when she worked at the facility, which included 08/02/2022. She stated she had been assigned as his 1:1 staff "since March or April" of 2022. She stated she had just received training on Resident C's BSP "a couple of nights ago" and confirmed she signed a document indicating she had been trained. Ms. Longstreet stated she had known "very little" about Resident C's BTP, but knew he was "autistic", "prone to violence" and knew how to utilize general CPI training. She stated she didn't know anything specific to Resident C's BSP though and had been "thrown into" the position as his 1:1 staff.

In my review of the facility file, I determined the facility has multiple repeat violations for special certification rule 330.1806(1).

According to SIR #2022A0581035, dated 07/26/2022, the facility was in violation of certification of specialized programs rule 330.1806(1) when it was established the facility was not sufficiently staffed to implement three resident plans of services, as required. The facility routinely only scheduled two direct care staff for third shift (7 pm until 7 am) a resident required a 1:1 staff from 8 am until 12 am and another resident required a 1:1 staff from 6 pm until 6 am. By the facility only staffing two direct care staff during that time meant the facility was not providing adequate supervision of either resident, in addition to, the remaining residents in the facility. At the time of this report, an acceptable plan of correction had not been received by the licensee.

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, the resident 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 were 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.

APPLICABLE RULE	
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.

ANALYSIS:	Based on my investigation, which included a review of the facility's assigned 1:1 staff for Resident C, Resident C's 1:1 in-service training sheet, my review of Resident C's BSP, and my interview with direct care staff, Cynthia Longstreet, the licensee assigned Ms. Longstreet to implement Resident C's Behavior Support Plan as a 1:1 enhanced staff when she had not been trained on it.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR #2022A0581035, DATED 07/26/2022, CAP NOT RECEIVED]** **[SEE SIR #2022A0581031, DATED 07/05/2022, AND CAP, DATED 07/20/2022]** **[SEE SIR #2022A0462005, DATED 12/17/2021 AND CAP, DATED 01/04/2022]** **[SEE SIR #2021A0462046, DATED 10/08/2021 AND CAP, DATED 10/22/2021]** **[SEE SIR #2020A0462058, DATED 10/01/2020 AND CAP, DATED 10/15/2020]**

ALLEGATION:

Resident C was punched by direct care staff, Cheyenne Lemon.

INVESTIGATION:

The complaint alleged on 08/02/2022, direct care staff, Cheyenne Lemon, punched Resident C with a closed fist. The complaint alleged the punch landed on Resident C's upper shoulder and may have hit his face. The complaint alleged Ms. Lemon was mad because Resident C threw a cap from a hand sanitizer at her. The complaint alleged Ms. Lemon instigated Resident C, which caused further behaviors.

On 08/05/2022, I confirmed with Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Suzie Suchyta, she had received the allegations and was investigating. She confirmed she made a mandatory referral to Adult Protective Services (APS) and Law Enforcement (LE).

On 08/05/2022, I reviewed an *AFC Licensing Division – Incident / Accident Report* (IR), from the facility pertaining to the incident, which was completed by Ms.

Longstreet. The IR described Resident C's behaviors throughout the evening on 08/02/2022 (e.g., breaking his fishing pole, breaking the facility phone, throwing and hitting objects, threatening staff, and physically assaulting staff); however, the IR did not indicate Ms. Lemon hitting Resident C.

I also reviewed an ISK IR, dated 08/03/2022, which stated Resident C reported to the Psychological Assessment and Treatment Services (PATS) team and direct care staff, Jamie Kniss, that Ms. Lemon had "slapped" Resident C on the face because he cussed at her. The IR stated Resident C was not observed to have any marks or swelling on his face.

Mr. Evans stated around 8:30 pm on 08/02/2022 he had been inside with another resident watching TV when Ms. Longstreet came inside requesting his assistance as Resident C was displaying aggressive behavior. Mr. Evans stated he went outside, and Resident C was kicking things like the facility's speaker rock and broke his fishing pole in half. Mr. Evans stated he was able to get Resident C in the facility as Resident C stated he wanted a shower. He stated when Resident C was in the bathroom, he threw a hand sanitizer cap at Ms. Lemon. He stated after he threw the cap at Ms. Lemon, she "lost it." He stated she closed fist hit Resident C in the shoulder. Mr. Evans did not observe any injuries on Resident C like bruises, marks, redness, or bleeding. Resident C also did not report his arm or shoulder hurting him.

Ms. Suchyta stated she interviewed both Ms. Lemon and Ms. Longstreet regarding the allegations. She stated Ms. Lemon denied the allegations. She stated Ms. Longstreet's statement to her indicated Ms. Lemon didn't intentionally hit Resident C in the shoulder. Ms. Longstreet indicted to Ms. Suchyta that Ms. Lemon had one arm out in front of her to prevent Resident C from charging her as he was acting like he was going to come towards her. Ms. Longstreet reported to Ms. Suchyta that Resident C ran into Ms. Lemon's arm and she stumbled back but did not fall. She did not indicate to Ms. Suchyta that Resident C had any injuries from hitting Ms. Lemon's arms. Ms. Longstreet stated to Ms. Suchyta that she heard Ms. Lemon tell Resident C, "go ahead and hit me" because Resident C was threatening to hit all the staff.

On 08/24/2022, I received an email from APS specialist, Melissa Pachota. She stated in her email she had completed her investigation. She stated she had to interview Resident C with the assistance of the facility's home manager, Ms. Ulrich due to Resident C being limited verbally. She stated after interviewing Resident C and Ms. Ulrich she concluded Ms. Lemon hit Resident C. She indicated in her email Ms. Lemon had been "let go from the company." Ms. Pachota indicated she would be closing her investigation.

Resident C was unable to answer my questions but stated "yes" when I asked if Ms. Lemon had ever hit him or put her hands on him; however, he also indicated he liked Ms. Lemon.

On 08/24/2022, I interviewed Ms. Kniss and Resident C, via telephone. Ms. Kniss stated she had no firsthand knowledge of the alleged incident between Resident C and Ms. Lemon but indicated Resident C had reported the incident to her and the PATS team the following morning. Ms. Kniss stated Resident C reported to her Ms. Lemon “slapped” him. She stated she did not observe any scratches, redness or bruising on Resident C that morning.

Ms. Longstreet stated she was unable to see well the night of the incident with Resident C and Ms. Lemon because her glasses had been off to prevent Resident C from breaking them. Her statement to me was consistent with Mr. Evans’ statement to me in regard to Resident C displaying behaviors prior to the alleged incident with Ms. Lemon. Ms. Longstreet stated, “it didn't look to [her] like [Ms. Lemon] hit [Resident C]”. She stated it looked like Ms. Lemon was “blocking” Resident C’s swings at her and did observe Resident C’s hand come down to block a hit and touched Resident C’s arm.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on my investigation, there is not enough evidence to establish direct care staff, Cheyenne Lemon, intentionally struck Resident C in the arm on 05/02/2022 as indicated in the complaint. My interviews with direct care staff were inconsistent with one another, Resident C was unable to report what occurred, and Resident C had no observable injuries.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 09/28/2022, I conducted the exit conference with the Licensee Designee, Ramon Beltran, and the facility’s Chief Administrative Officer, Melissa Williams, via telephone. They both acknowledged my findings and indicated they would provide an acceptable plan of correction.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend the facility continue on a provisional license status due to the quality of care violations cited in Special Investigation Report #2022A0581035.

09/20/2022

Cathy Cushman Date
Licensing Consultant

Approved By:

09/27/2022

Dawn N. Timm Date
Area Manager