GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 7, 2022

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

RE: License #: AM030402101
Investigation #: 2022A1024054
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 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 (616) 356-0183.

Sincerely,

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030402101
Investigation #:	2022A1024054
Complaint Receipt Date:	09/14/2022
Investigation Initiation Date:	09/15/2022
Report Due Date:	11/13/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Hammond
Facility Address:	318 East Hammond Street Otsego, MI 49078
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	07/09/2020
License **Status:**	REGULAR
Effective Date:	01/26/2022
Expiration Date:	01/25/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff failed to provide protection as Resident A eloped from the facility and broke into a neighboring home.	Yes

III. METHODOLOGY

09/14/2022	Special Investigation Intake 2022A1024054
09/15/2022	Special Investigation Initiated – email correspondence with City of Otsego representative Ms. Monica Nagel.
09/15/2022	Contact - Telephone call made with Adult Protective Service (APS) Supervisor Lorena Frederick
09/19/2022	Contact-Document Received-Otsego Police Report
09/26/2022	Contact-Document Received-Otsego Police Report
09/26/2022	Contact - Telephone call made with Witness 1
09/30/2022	Inspection Completed On-site with district director Jamarra White, direct care staff members Hazel Owen, Olivia Stratton, Anette Reeber, Katherine Lee, and Resident A
09/30/2022	Contact - Telephone call made left voicemail for direct care staff member Nathan Fenner
10/28/2022	Contact - Telephone call made with home manager Tamika Mcgovernor
10/30/2022	Contact - Telephone call made left voicemail for direct care staff member Nathan Fenner
10/31/2022	APS Referral-contact with APS supervisor during this investigation. No referral necessary
10/31/2022	Exit Conference with licensee designee Ramon Beltran
10/31/2022	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Staff failed to provide protection as Resident A eloped from the facility and broke into a neighboring home.

INVESTIGATION:

On 9/14/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged staff failed to provided protection as Resident A eloped from the facility and broke into a neighboring home.

On 9/15/2022, I received email correspondence from Otsego Police Department representative Ms. Monica Nagel who stated there have been multiple calls made regarding Resident A and provided a police report dated 9/8/2022.

According to *Police Report* #22-02029 law enforcement was dispatched because a USPS mail carrier called to report a homeless person and upon the police officer's arrival Resident A was found standing in front of a residence. Resident A stated she did not feel safe in her adult foster care home, and she wanted to be transported to see her family members. The report stated the reporting officer called Beacon Home at Hammond and it was reported by staff that Resident A had walked away from the facility and had been missing. According to the report, direct care staff member Ms. Annette Reeber further stated there were three staff working with 12 residents and the staff members lost track of Resident A which was why she was able to walk away from the facility without staff realizing.

On 9/15/2022, I conducted an investigation with APS supervisor Lorena Frederick who stated APS is familiar with Resident A as they have recently been involved for similar allegations.

On 9/19/022, I received email correspondence from Otsego Police Department representative Ms. Nagel who stated Resident A once again eloped from Beacon Home at Hammond and illegally entered a nearby private residence. Ms. Nagle provided a police report dated 9/17/2022.

According to *Police Report* #22-02113 the reporting officer was dispatched to a residence and the victim reported Resident A entered the home through her doggie door located at the rear of the property without anyone's permission. The police report documented the victim described being familiar with Resident A from previous incidents where Resident A has entered her home without authorization. The police report described this as "an ongoing issue." The police report stated Resident A was then located in soiled clothing and stated to officers she wanted to leave the home and go to the hospital due to her arthritis pain. The report stated two staff members who were also looking for Resident A at the time in a nearby area reported they had three staff working however one staff member had an ankle sprain which limited

her mobility therefore Resident A was able to elope from the AFC home again.

On 9/26/2022, I received email correspondence from Ms. Nagel who stated Resident A once again eloped from her adult foster home facility and provided a police report dated 9/23/2022.

According to *Police Report* # 22-02164 the reporting police officer was dispatched to an area nearby Beacon Home at Hammond due to Resident A eloping from the facility. The report stated repeated requests have been made to staff to watch Resident A more closely but at this point there have been no positive results. The report stated contact was made with Resident A who advised that she was not going back to the facility however agreed to go back to the facility once staff from the home arrived to the scene and convinced Resident A to return.

On 9/26/2022, I conducted an interview with Witness 1 who stated Resident A has illegally entered his home on two occasions in the last two months. Witness 1 stated Resident A once came in through his doggy door and during the most recent incident, Resident A was found sitting in his vehicle. Witness 1 stated he believes Resident A lives a few blocks down from his residence at an adult foster care home And that she is eloping without staff's knowledge.

On 9/30/2022, I conducted an onsite investigation at the facility with district director Jamarra White, direct care staff members Hazel Owen, Olivia Stratton, Anette Reeber, Katherine Lee, and Resident A. Ms. White stated Resident A does not require 1:1 staff supervision however the home has been staffed with three staff members lately to keep a closer eye on Resident A since she continues to elope from the facility. Ms. White stated the home has talked to Resident A's case manager about this issue in hopes to officially assign her to 1:1 staffing. Ms. White stated Resident A will usually leave the AFC home during the day and is "very sneaky" when she decides to leave the AFC home.

Ms. Owen stated she works regularly with Resident A and there are always three direct care staff members to work with the 12 residents in the home however Resident A has still managed to elope from the facility without staff's knowledge on numerous occasions. Ms. Owen stated recently four staff members working as well however there are times when staff, who are assigned to monitor Resident A, do not carry out this responsibility and Resident A elopes from the facility. Ms. Owen stated she believes if staff pays attention and monitor Resident A as instructed, then Resident A would have less opportunities to elope from the facility.

Ms. Stratton stated Resident A typically stays in her room and only comes out during mealtimes to eat. Ms. Stratton stated Resident A has never eloped out of the facility while she has been working and there is always adequate staffing working to provide the supervision and safety to Resident A.

Ms. Reeber stated Resident A complains that she does not want to live in an adult

foster care setting and wants to go back to her family. Ms. Reeber stated Resident A is very strategic when she elopes from the home without staff's knowledge as Resident A will wait until staff gets busy working with other residents and then will sneak out the backdoor of the home. Ms. Reeber stated they have been trying to keep at least three staff working in the home so there is a staff designated to keep a closer watch on Resident A. Ms. Reeber stated despite having a staff member assigned to supervising Resident A, she believed there was a recent incident when a staff member wasn't doing what he was supposed to be doing and allowed Resident A to leave the facility without staff knowledge and was later found in a neighbor's home.

Ms. Lee stated Resident A usually prefers to stay in her bedroom yet craves attention from staff members to sit with her at her bedside. Ms. Lee stated she has been noticing if staff cannot interact with her in her room, she will sneak out the back door of the home when staff is occupied with other residents and not paying close attention to her. Ms. Lee stated Resident A has a history of breaking into homes therefore the home manager has start requiring at least one staff member to monitor Resident A more closely. Ms. Lee stated there was a recent incident where a staff member was disciplined because he was assigned to provide close supervision to Resident A and failed to do so due to watching television. Ms. Lee stated this resulted in Resident A eloping from the facility and breaking into a neighbor's home. Ms. Lee believes if staff would have been monitoring Resident A as instructed, she would not have been able to leave the home.

Resident A stated staff doesn't watch her the way they are supposed to, therefore she leaves the AFC home without staff's permission when they are busy and cannot see her. Resident A stated she does not want to live this home and would like to live with her family.

While at the facility, I reviewed Resident A's *Assessment Plan for AFC Residents* dated 2/16/22 which states that Resident A does not move independently in the community and needs supervision and monitoring.

I reviewed the facility's staff schedules for months July 2022 though September 2022. According to the schedule, the facility was usually staff with at least two to three staff members during day and evening shifts. I also observed days four staff worked on shift in more recent months.

I reviewed nine facility incident reports dated 9/23/2022, 9/17/2022, 9/13/2022, 9/11/2022, 9/8/2022, 8/11/2022, 8/10/2022, 7/29/2022, and 7/28/2022 that documented Resident A eloping from the facility.

On 10/28/2022, I conducted an interview with direct care staff member Tamika Mcgovernor who stated that they have been keeping three staff members on shift as Resident A continues to walk away from the facility. Ms. Mcgovernor add the supervision from additional direct care staff members had been working until a

recent incident involving direct care staff member Nathan Fenner. Ms. Mcgovernor stated staff member Nathan Fenner was specifically scheduled to work to monitor Resident A which included always keeping eyes on Resident A however, Mr. Fenner did not follow this instruction which resulted in Resident A eloping from the facility and illegally entering a neighbor's home. Ms. Mcgovernor stated Mr. Fenner was instructed to sit next to Resident A's bedroom door to monitor her whereabouts when she left her room but instead Mr. Fenner chose to watch TV and got distracted by attempting to program his phone to the facility's television. Mr. Mcgovernor stated Mr. Fenner was immediately sent home for the remainder of the shift due to not following instructions and carrying out his responsibilities.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on my investigation which included interviews with district director Jamarra White, home manager Tamika Mcgovernor, direct care staff members Hazel Owen, Olivia Stratton, Anette Reeber, Katherine Lee, Resident A, review of the facility's incident reports, staff schedules and Resident A's *Assessment Plan for AFC Residents,* facility direct care staff members did not provide protection and adequate supervision to Resident A thus allowing her to elope from the facility and illegally enter a private residence. Ms. White, Ms. Mcgovernor, and direct care staff members interviewed all stated they were aware of Resident A's history of eloping from the home and her need to closely be monitored. I reviewed nine incident reports from July 2022 to September 2022 that documented Resident A elopements from the home and Resident A's *Assessment Plan for AFC Residents* dated 02/16/2022 that clearly documented Resident A is not independent in the community and requires monitoring. I also reviewed three police reports dated 09/08/22, 09/17/22 and 09/23/22 which documented Resident A's elopements from the AFC home along with her illegal entry into private residences during each of those elopements. Even after adding another direct care staff member to specifically monitor Resident A to stop her from eloping, Resident A was able to elope from the facility and illegally enter a private residence on 09/17/2022. Despite having more than adequate numbers of direct care staff members working, Resident A's protection and safety needs have not been attended to at all times nor in accordance with her assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/31/2022, I conducted an exit conference with licensee designee Ramon Beltran. I informed Mr. Beltran of my findings and allowed him an opportunity to ask questions or make comments.

IV. RECOMMENDATION

Upon an acceptable corrective action plan, I recommend the current license status remain unchanged.

10/31/2022

Ondrea Johnson — Date
Licensing Consultant

Approved By:

11/07/2022

Dawn N. Timm — Date
Area Manager