GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 5, 2022

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

RE: License #: AS390396198
Investigation #: 2023A0581002
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 #:	2023A0581002
Complaint Receipt Date:	10/18/2022
Investigation Initiation Date:	10/18/2022
Report Due Date:	12/17/2022
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 Augusta
Facility Address:	817 Webster St. Augusta, MI 49012
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/29/2018
License Status:	1ST PROVISIONAL
Effective Date:	10/03/2022
Expiration Date:	04/02/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident C did not have one to one enhanced staffing on 10/08/2022, for approximately 2 hours, as required in his treatment plan.	Yes
Direct care staff, Alexis Trevino, pushed, slapped, and swung at Resident F on or around 08/30/2022.	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

10/18/2022	Special Investigation Intake 2023A0581002
10/18/2022	Special Investigation Initiated - Telephone Interview with home manager, Kelly Fox.
10/18/2022	Contact - Telephone call made Interview with ISK, Suzie Suchyta
10/18/2022	Referral - Recipient Rights ISK
10/18/2022	APS Referral Due to allegations, an APS referral isn't necessary.
10/18/2022	Contact - Document Received Received 1:1 sign in sheet for residents
10/20/2022	Contact - Telephone call made Interviews with direct care staff and home manager, via MiTeams.
10/20/2022	Contact - Document Received Email from Ms. Suchyta.
10/21/2022	Contact - Document Received Additional allegations received via intake #191177
10/21/2022	Contact - Document Sent Email to licensee's human resource director requesting staff timesheets. Received email back with timesheets for Ms. Garten, Ms. Cardenas-Jones, and Ms. Fox.

10/21/2022	Contact - Telephone call made Interview with direct care staff, Ashaunti Cardenas-Jones, via MiTeams.
10/26/2022	Inspection Completed On-site Attempted to interview residents
10/27/2022	Contact - Telephone call made Interview via MiTeams with direct care staff, Jamie Anderson
11/03/2022	Contact – Telephone call made Interview with direct care staff, Alexis Trevino.
11/09/2022	Contact – Telephone call made Left voicemail with direct care staff, Jessica Garten.
11/10/2022	Contact – Telephone call received Interview with Ms. Garten.
11/28/2022	Contact – Document sent Email to Ms. Fox.
12/05/2022	Exit conference with licensee designee, Ramon Beltran.

ALLEGATION:

Resident C did not have one to one enhanced staffing on 10/08/2022, for approximately 2 hours, as required in his treatment plan.

INVESTIGATION:

On 10/18/2022, I received an *AFC Licensing Division – Incident / Accident Report* (IR), dated 10/08/2022, completed by the facility's home manager, Kelly Fox. According to the IR, on 10/08/2022, direct care staff, Nashaunti Cardenas-Jones, arrived for her shift five hours late and upon entering the facility she did not greet or talk to anyone. The IR indicated Resident C became agitated and asked for a van ride so the other two direct care staff on shift got the all the residents, including Resident C, into the van and left the facility. The IR indicated the van ride was a way to prevent Resident C from displaying significant behaviors at the facility. The IR alleged when staff were getting the residents in the van, Ms. Cardenas-Jones was in her vehicle talking on her phone. The IR alleged the facility's home manager contacted the staff in the van to tell them to return to the facility because "they were

out of ratio." The IR indicated when the van returned to the facility Ms. Cardenas-Jones was still in her car.

The IR alleged the facility was out of ratio from approximately 1:15 pm – 3 pm as Resident C did not have his required 1:1 enhanced staff supervision. The IR indicated Ms. Cardenas-Jones was no longer working in the facility.

On 10/18/2022, I interviewed Ms. Fox via telephone. Ms. Fox stated Ms. Cardenas-Jones arrived to the facility at approximately 12 pm on 10/08/2022 when she was supposed to start her shift at 7 am. Ms. Fox stated direct care staff, Jessica Garten, who was an overnight staff, stayed at the facility until Ms. Cardenas-Jones arrived. Ms. Fox stated additional staff at the facility were Brandon Hewitt and Jamie Kniss. Ms. Fox stated Mr. Hewitt and Ms. Kniss were trying to avoid Resident C from having more significant behaviors so they got him in the facility van for an outing. Ms. Fox stated there were five residents at the facility and all five residents were in the van with only two direct staff while Ms. Cardenas-Jones stayed at the facility in her car. She stated Ms. Cardenas-Jones began texting her at approximately 12:11 pm indicating she didn't want to work due to staff not being nice to her. Ms. Fox stated when she arrived to the facility at approximately 3 pm, Ms. Cardenas-Jones had already left.

Ms. Fox stated Resident B and Resident C both required 1:1 enhanced staffing on 10/08/2022, which is why three staff were scheduled to work during the day. She stated Resident B's enhanced 1:1 staffing was from 8 am until 6 pm while Resident C's enhanced 1:1 staffing was from 7 am until 11 pm. She stated Ms. Cardenas-Jones was expected to be Resident C's 1:1 enhanced staff for her shift.

Ms. Fox stated if a staff calls in or does not show up, then the facility home manager (Ms. Fox) is required to come in and cover until another staff can come in and cover. Ms. Fox stated she was busy with a family event and was unable to immediately come into the facility; therefore, she did not arrive until approximately 3 pm.

On 10/18/2022, Ms. Fox sent via email Resident C's 1:1 enhanced staffing sign in sheet for 10/08/2022. According to this hourly 1:1 enhanced CLS staffing documentation sheet, Ms. Garten provided 1:1 services to Resident C from 7 am until 12 pm, Ms. Fox provided 1:1 services to Resident C from 2 pm until 7 pm and then Mr. Hewitt provided 1:1 services from 7 pm until 11 pm. The 1:1 enhanced documentation sheet indicated Resident C did not have an assigned 1:1 staff from 12 pm until 2 pm.

I also reviewed Resident B's 1:1 enhanced staffing sign in sheet for 10/08/2022, which indicated Mr. Hewitt was Resident B's assigned staff from 8 am until 6 pm.

On 10/20/2022, in conjunction with Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Suzie Suchyta, we interviewed via MiTeams direct care staff, Brandon Hewitt, Jamie Kniss, and Ms. Fox.

Mr. Hewitt's statement to me was consistent with Ms. Fox's statement to me. Mr. Hewitt stated he and Ms. Kniss only had the residents in the facility van for approximately 10 minutes before they returned to the facility. He stated Ms. Fox instructed them to return due to not having sufficient staff in the van for all the residents due to two of the residents requiring 1:1 enhanced staffing. Mr. Hewitt was unable to recall which staff members were assigned as the 1:1 enhanced staff for the two residents.

Ms. Kniss' statement to me was consistent with Ms. Fox's and Mr. Hewitt's statements to me. Ms. Kniss stated Ms. Cardenas-Jones did not talk to her upon her, Mr. Hewitt, or the residents when she came in late for her shift on 10/08/2022. Ms. Kniss acknowledged she and Mr. Hewitt should not have taken both residents who required 1:1 staffing on the van ride without Ms. Cardenas-Jones, but she and Mr. Hewitt were trying to avoid escalating behaviors from Resident C.

I reinterviewed Ms. Fox whose statement to me was consistent with her statement to me on 10/18/2022. Ms. Fox stated Ms. Cardenas-Jones was not a regular staff for the facility and typically worked at another facility in Kalamazoo. Ms. Fox stated that though Ms. Cardenas-Jones had been asked by the facility's assistant home manger to sign Resident C's support plan, she failed to do so.

During the MiTeams interviews, I attempted to interview Resident C; however, Resident C was unable to recall direct care staff, Ms. Cardenas-Jones.

On 10/20/2022, Ms. Fox provided via email a copy of Resident C's Behavior Plan Signature form, which had all the facility staff signatures who acknowledged they had read, understood, and had the opportunity to ask questions about Resident C's BSP. Upon my review of this document, there was no indication Ms. Cardenas-Jones' signature was on the document.

On 10/21/2022, Ms. Suchyta and I interviewed direct care staff, Nashaunti Cardenas-Jones, via MiTeam. Ms. Cardenas-Jones stated she arrived to the facility at approximately 11:15 am. She stated she did not know she was any resident's 1:1 enhanced staff because she did not have access to the licensee's online schedule, Makeshift, due to her phone being broken. She stated when she arrived to the facility, she went directly into the facility kitchen. She stated the residents were getting ready for their day and all the staff working had an "attitude." She stated no one told her what to do and she felt "totally disrespected." She stated at approximately 12 pm she started texting and calling Ms. Fox, the facility's home manager. Ms. Cardenas-Jones stated Mr. Hewitt and Ms. Kniss left the facility with all the residents at approximately 12:30 pm or 12:45 pm. She stated it was her understanding Mr. Hewitt was Resident B's 1:1 staff and Ms. Kniss was Resident C's 1:1 staff. Ms. Cardenas-Jones stated when the staff left with the residents in the van, she walked around the facility to ensure no one was left home. She stated she contacted Ms. Fox at approximately 12:45 pm letting her know staff left with the

residents. Ms. Cardenas-Jones acknowledged she did not work or provide services to any residents while she was at the facility because she didn't know what she was supposed to be doing. She stated she left the facility at approximately 4 pm.

Ms. Cardenas-Jones stated she read Resident C's behavior support plan, but indicated she was not trained on it. She stated she did not sign anything acknowledging she had been trained on his plan either. She stated she had heard from other direct care staff about Resident C's behaviors, but she stated she did not know what she would need to do to de-escalate his behaviors if he was exhibiting them.

On 10/21/2022, the licensee's Human Resource executive director, Danielle Lambrechts, provided Ms. Fox's, Ms. Cardenas-Jones', and Ms. Garten's timesheets. According to these timesheets, on 10/08/2022, Ms. Garten left the facility at 12 pm, Ms. Cardenas-Jones arrived at 12 pm and left at 3 pm and Ms. Fox arrived at 3:30 pm and left at 7:36 pm.

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 BSP, dated 02/18/2022, was created in conjunction with Psychological Assessment and Treatment Services through Western Michigan University and 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.

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 #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 routinely only scheduled two direct care staff for third shift (7 pm until 7 am) when Resident A requires a 1:1 staff from 6 pm until 6 am and Resident C requires a 1:1 staff from 8 am until 12 am. By the facility only staffing two direct care staff during this time means the facility is not providing adequate supervision of Resident A and Resident C, in addition to, the remaining residents in the facility and had not sufficiently staffed the facility to implement Resident A's, B's, and C's plans of service, as required. Due to the repeat quality of care violations cited in the report, a provisional license was recommended.

The facility's approved Corrective Action Plan (CAP), dated 10/10/2022, accepted the provisional license recommendation. The CAP indicated the facility's leadership team reviewed the three resident's Behavior Treatment Plans, the current 1:1 enhanced staffing needs, and the required hours to ensure the necessary staff coverage and rotation. The CAP indicated the facility had been implementing the appropriate staffing ratio by providing the home with additional staff, utilizing specific staff from other homes to assist as needed, and monitoring the home maintains the correct ratio. The CAP stated specific staff from other homes would be required to be in-serviced on the resident's *Behavior Treatment Plan* prior to working with the resident's enhanced staffing or they would be assigned to other residents to ensure all requirements are being met. The CAP stated the District Director who oversees the facility would continue to monitor the homes staffing by reviewing the resident's Enhanced Staffing Forms regularly to ensure staff completing them are trained on the residents Behavior Treatment Plans. The CAP also indicated the facility's District Director who oversees the facility would continue to monitor the home's staffing by reviewing the facility's staff schedule as well as the timesheets reflecting the actual schedule worked, in conjunction with the license designee, by utilizing the Punch Report that is sent out weekly to ensure the appropriate staffing ratio is being maintained. The CAP stated if adequate staffing was not provided, the errors would

be consulted with the Home Manager and additional training, or progressive action would take place, if needed.

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 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	
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:	On 10/08/2022, from approximately 12 pm until 3:30 pm, the facility only had two direct care staff providing care to five residents when two out of the five required one to one enhanced staffing per their behavior support plans. Though a third direct care staff, Nashaunti Cardenas-Jones, was at the facility, she acknowledged that upon showing up to work she did not do anything because she did not know what was expected of her. During this time, both Resident B and Resident C required one to one enhanced staffing; however, the facility only had two direct care staff to implement the one-to-one enhanced staffing, which did not leave adequate staffing for the remaining three residents of the facility from 12 pm until approximately 3:30 pm. Subsequently, facility direct care staff did not provide adequate supervision to Resident B and Resident C, in addition to, the remaining three residents of the facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR # 2022A0581035, DATED 07/26/2022, AND CAP, DATED 10/10/2022]** **[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:

Direct care staff, Alexis Trevino, pushed, slapped, and swung at Resident F on or around 08/30/2022.

INVESTIGATION:

The intake received on 10/21/2022 alleged Resident F was assaulted by direct care staff, Alexis Trevino. The complaint alleged Resident F was exhibiting behaviors in

the facility kitchen and Ms. Trevino yelled at Resident F and then placed her hand on his forehead and pushed him away. The complaint alleged Resident F punched and slapped Ms. Trevino several times and Ms. Trevino swung back at Resident F. The complaint further alleged Ms. Trevino pushed and slapped Resident F's arm out of her way and had her hand on his chest pushing him away while he was swinging at her.

ISK RRO, Ms. Suchyta, stated she had interviewed Ms. Anderson, who reported to her she had witnessed Ms. Trevino hitting Resident F. Ms. Anderson reported to Ms. Suchyta that Ms. Trevino did not try and block Resident F hitting her.

Ms. Suchyta forwarded me the facility's IRs regarding the incident. The first IR, which was completed by direct care staff, Jessica Garten, indicated on 08/30/2022 at approximately 8 am, Resident F was in front of the facility refrigerator and then charged at Ms. Anderson; hitting her in the arm. The IR indicated Ms. Anderson yelled for her and Ms. Garten told Ms. Anderson and Ms. Trevino to get themselves and another resident out of the kitchen, but the staff wouldn't listen to her. The IR indicated Resident F then went after Ms. Trevino, hit her, tried grabbing and biting her arm. Ms. Garten indicated in the IR that Ms. Trevino was able to get her arm away to prevent Resident F from biting her. Ms. Garten indicated in the IR she told Ms. Trevino and Ms. Anderson to take another resident and all go into the facility garage to get away, which she indicated they were eventually able to do. Ms. Garten indicated in the IR Resident F then threw a variety of items, including cooking appliances, before he calmed down and sat in a chair.

Ms. Suchyta indicated she followed up on the IR and interviewed Ms. Garten and Ms. Anderson. She forwarded me her interviews. Ms. Suchyta indicated in her interview with Ms. Garten that Ms. Garten stated to her she could only hear what was occurring in the kitchen because she was passing resident medication in another area and was not in the kitchen.

Ms. Suchyta's interview with Ms. Anderson indicated Resident F swung at her. Ms. Anderson stated to Ms. Suchyta that she raised her arm to block his swing. She stated she went to the garage as instructed by Ms. Garten. While in the garage, Ms. Anderson stated to Ms. Suchyta that she heard Ms. Trevino yelling. When Ms. Anderson looked into the kitchen, she stated to Ms. Suchyta that she saw Ms. Trevino standing at the refrigerator with Resident F with her hand on Resident F's forehead pushing him. Ms. Anderson stated to Ms. Suchyta that Ms. Trevino's hands were pushing and slapping Resident F in the arm and that she had a hand on his chest pushing him back because he was swinging at her. Ms. Anderson indicated to Ms. Suchyta that Ms. Trevino was not trying to block Resident F's hits or trying to restrain him. Ms. Anderson indicated the whole incident occurred very fast but did not indicate an actual amount of time.

Ms. Suchyta also indicated she interviewed Ms. Fox who informed her Ms. Trevino "walked off the job" after the incident occurred. Ms. Fox stated to Ms. Suchyta that it

was not reported to her that Ms. Trevino had pushed or swung at Resident F when the incident occurred.

On 10/26/2022, I conducted an unannounced onsite inspection at the facility to attempt to interview Resident F; however, he was not present at the facility. In review of Resident F's ISK's Individualized Service Plan (ISP), dated 10/01/2021, Resident F is able to only speak in "…2-3 word phrases when motivated to communicate. He has Echolalia associated with his diagnosis of Autism", which would make it difficult to interview him regarding the allegations.

On 10/27/2022, I interviewed direct care staff, Jamie Anderson, via MiTeams, with ISK RRO, Ms. Suchyta. Ms. Anderson stated it was her first day shadowing staff when the incident occurred, and she had only been working for approximately 40 minutes. Ms. Anderson stated direct care staff, Alexis Trevino, was in the facility kitchen making breakfast using a griddle while she was talking to her mother-in-law on speakerphone. Ms. Anderson stated Resident F came into the kitchen and started swinging his arms at Ms. Trevino. Ms. Anderson stated Ms. Trevino put her arm up because Resident F was swinging at her. Ms. Anderson stated she yelled for the other staff, Jessica Garten, to come help, but Ms. Garten was in a resident bedroom trying to administer morning medications. She stated Ms. Garten yelled to take the other resident that was in the kitchen into the garage to avoid him getting assaulted by Resident F. While in the garage, Ms. Anderson stated she heard Ms. Trevino yell for help and when she looked into the kitchen, she saw Ms. Trevino's arm and wrist being held by Resident F and he was bringing it close to his mouth. Ms. Anderson stated she observed Ms. Trevino put her other hand on Resident F's forehead and push away. She stated that when Ms. Trevino did this, Resident F let go of her wrist. Ms. Anderson stated Ms. Trevino was also yelling that Resident F was hitting her. She stated Ms. Trevino appeared to "slap" Resident F's wrist to get him to let her go. Ms. Anderson stated Ms. Trevino was yelling, "no, don't" to Resident F and was also saying "he's going to bite me."

Ms. Anderson stated Resident F did not have any marks or bruises on his body but stated he had burn marks on his fingertips from picking up the hot griddle and throwing it.

On 11/03/2022, I interviewed direct care staff, Alexis Trevino, via telephone. Ms. Trevino stated it had been her first day working at the facility but indicated she had worked for the licensee since May 2022 at other facilities. She stated on the day of the incident, she was making breakfast when she heard Resident F become loud in the living room. She stated when Resident F came in the kitchen, he tried biting Ms. Anderson. She stated Ms. Anderson told Resident F to stop hitting her; however, he would not listen to her. Ms. Trevino stated she attempted to redirect Resident F by telling him he was ok and encouraging him to go into the living room rather than the kitchen; however, he was unresponsive to her redirection.

Ms. Trevino stated then Resident F started hitting her, throwing items from the refrigerator onto the floor and around the kitchen, which included the hot griddle. She stated Ms. Garten told her and Ms. Anderson to get the other resident in the kitchen out of the area, which they were able to do. Ms. Trevino stated she had some bruising on her forearm from Resident F hitting her. She denied having any bite marks. Ms. Trevino denied hitting, assaulting, or putting her hands on Resident F. She stated the incident occurred so quickly she didn't have any opportunity to utilize any physical management techniques.

Ms. Trevino also denied talking to her mother-in-law on speakerphone but acknowledged she had been communicating with her via text messaging.

On 11/10/2022, I interviewed Ms. Garten, via telephone. Ms. Garten's statement to me was consistent with her statement to Ms. Suchyta and what she wrote in the IR. She stated while administering medication to a resident she did hear one of the staff yell her name and she confirmed she instructed staff to take the other resident in the kitchen into the garage to avoid the resident from being assaulted by Resident F. Ms. Garten stated after she administered medications she went into the kitchen and observed the kitchen in disarray from Resident F "destroying" it. She stated food was "all over the place" and she observed Resident F at the kitchen table. When she went over to him, he pointed at his finger and said "ow". She stated his fingertips were burnt from him picking up the hot griddle and throwing it. Ms. Garten stated she didn't observe any marks or bruises on Resident F indicating he had been assaulted or hit by Ms. Trevino. She also didn't observe any marks or bruises on either Ms. Trevino or Ms. Anderson when she observed them in the living room after everything calmed down. Ms. Garten stated Ms. Trevino left the facility shortly after the incident occurred and then Ms. Fox arrived.

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.

ANALYSIS:	There are inconsistent accounts from direct care staff Alexis Trevino and Jamie Anderson of the incident involving Resident F that took place on or around 08/30/2022. Subsequently, I am unable to determine if Ms. Trevino mistreated Resident F or inappropriately physically managed him when he became assaultive to staff on 08/30/2022. Ms. Trevino denied assaulting Resident F in any manner.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 12/05/2022, I conducted the exit conference with licensee designee, Ramon Beltran, via telephone. He agreed with my findings and indicated a corrective action plan would be submitted.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend continuation of the facility's provisional license.

11/28/2022

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Cathy Cushman Date
Licensing Consultant

Approved By:

12/05/2022

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Dawn N. Timm Date
Area Manager