GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 4, 2023

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

RE: License #: AS130405804
Investigation #: 2023A0581006
Beacon Home At Battle Creek

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 #:	AS130405804
Investigation #:	2023A0581006
Complaint Receipt Date:	11/09/2022
Investigation Initiation Date:	11/10/2022
Report Due Date:	01/08/2023
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 Battle Creek
Facility Address:	5555 Bauman Rd. Battle Creek, MI 49017
Facility Telephone #:	(269) 223-7662
Original Issuance Date:	01/08/2021
License Status:	REGULAR
Effective Date:	07/08/2021
Expiration Date:	07/07/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Takisha Alexander, passed out at work from being intoxicated and was not able to care for residents.	Yes
On the night Ms. Alexander passed out at work, Resident D and Resident B did not receive their evening medications.	Yes

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

III. METHODOLOGY

11/09/2022	Special Investigation Intake 2023A0581006
11/09/2022	Referral - Recipient Rights ISK received the allegations and are investigating. No referral necessary.
11/10/2022	Contact - Telephone call made Interview with Ms. Suchyta.
11/10/2022	Special Investigation Initiated - Telephone Interview with staff, via MiTeams.
11/10/2022	Referral - Law Enforcement Requested police report from Battle Creek police dept.
11/10/2022	Contact - Telephone call made Interview via MiTeams with direct care staff, Michelle Robinson, and home manager, Amanda Wilson.
11/10/2022	Contact - Telephone call made Interview via MiTeams with Takisha Alexander.
11/10/2022	Contact - Document Sent Email to Battle Creek city clerk requesting police report, if applicable.
12/05/2022	Exit conference with licensee designee, Ramon Beltran, via telephone.
12/09/2022	Inspection Completed-BCAL Sub. Compliance

12/09/2022	APS Referral Via email.
12/14/2022	Inspection Completed On-site Interviewed residents.
12/16/2022	Contact – Telephone call received Interview with APS specialist, Jennifer Stockford.

ALLEGATION:

Direct care staff, Takisha Alexander, passed out at work from being intoxicated and was not able to care for residents.

INVESTIGATION:

On 11/09/2022, I received this complaint through the Bureau of Community Health Systems (BCHS') online complaint system. The complaint alleged on 11/06/2022, direct care staff, Takisha Alexander, was the only direct care staff working at the facility when she was found intoxicated, "disrobed", and passed out on the living room floor with the facility's house keys and medication keys near her person.

On 11/10/2022, I interviewed Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Suzie Suchyta. Ms. Suchyta stated she got an *AFC Licensing Division - Incident / Accident Report* (IR), completed by the facility's home manager, Amanda Wilson, which were consistent with the allegations in my complaint. Ms. Suchyta stated the IR indicated on 11/06/2022, a resident contacted the facility's on-call nurse to report he had not received his evening medications because the staff was passed out. The IR indicated the on-call nurse contacted the facility's District Director, Aubry Napier, who then contacted Ms. Wilson. Ms. Suchyta stated when Ms. Wilson checked the residents' electronic Medication Administration Records, she found there were medications that had not been passed. Ms. Suchyta stated the IR further indicated when Ms. Wilson walked into the facility at approximately 10 pm she discovered Ms. Alexander face down on the floor topless. Ms. Alexander was able to be awakened by Ms. Wilson who was picked up by a friend as the police, who also arrived at the facility, encouraged Ms. Wilson not to drive.

Ms. Suchyta forwarded me the IR, which was consistent with her review of it. The IR also stated medical personnel were contacted to obtain approval to pass resident's missed medication.

On 11/10/2022, Ms. Suchyta and I interviewed direct care staff, Takisha Alexander, via MiTeams. Ms. Alexander stated she had been hungover from binge drinking the day and night before she came into work. She stated she drank from 9 am on

Saturday (11/5/2022) until 3 am on Sunday morning (11/06/2022). She stated she slept from 5 am Sunday morning until she had to go into work around 7 pm on Sunday. Ms. Alexander stated she hadn't eaten on Sunday, but thought she was fine when she got into work, but then her head began hurting. Ms. Alexander stated she passed all resident medications but indicated the facility's electronic medication administration record (eMAR) kept going in and out, so she wasn't able to document on the system that she had passed all the medications.

She stated when she came out of the medication room at approximately 9:20 pm she took her "hoody" sweatshirt off because she felt hot. She stated she was sitting in the facility living room talking on the phone when she just "went out." She stated she then remembered coming to while sitting on the couch talking to direct care staff, Michelle Robinson, at approximately 10 pm. She stated Ms. Robinson came to finish the overnight shift for her. Ms. Alexander stated police were also at the facility and talked to her. She stated someone came to pick her up because police did not want her to drive. Ms. Alexander indicated blackouts are unusual for her, but indicated she had one after experiencing a car accident over a year ago.

Ms. Alexander stated the facility's medication and house keys were around her neck when she came to while talking to Ms. Robinson. She stated she handed the keys to Ms. Robinson when she left the facility.

Ms. Alexander stated Resident D was outside smoking, while the remaining residents were in their rooms. She stated she recalled Resident B being present in the living room when she was "coming to." She stated Resident B told her she did not give him his medications; however, she stated she had. She stated Ms. Robinson told her she had been on the floor, but Ms. Alexander stated she did not recall ever being on the floor. She stated when she came to, she had a shirt on.

On 11/10/2022, Ms. Suchyta and I also interviewed direct care staff, Michelle Robinson and home manager, Amanda Wilson, via MiTeams. Ms. Robinson confirmed she was called into work the overnight shift by Ms. Wilson. She stated when she arrived at the facility and went inside, she observed Ms. Alexander topless and laying on her side. She stated she covered Ms. Alexander up with a sheet and then put her bra and shirt on her. She stated it took 15-20 minutes to wake Ms. Alexander up. She stated she had the residents stay away from the living room while she assisted Ms. Alexander. Ms. Robinson stated when the officers came in to talk to Ms. Alexander, she was unable to report her birthday, what year it was, or her last name and tried making a call using the facility's TV remote. Ms. Robinson stated the facility keys were on the couch and the medication keys were on the floor near Ms. Alexander.

Ms. Robinson stated she did not see any alcohol at the facility or on Ms. Alexander's person but could smell it. She stated when she left around 7:30 pm the night of the incident, Ms. Alexander seemed mostly like herself, "but a little off." Ms. Robinson stated she thought she smelled alcohol on Ms. Alexander at that time, but when she

questioned Ms. Alexander about it, she told her she had drank earlier in the day and she was not acting like herself because she went to a funeral the day before.

Ms. Wilson stated she had gotten the call that one of the residents had contacted the on-call medical about Ms. Alexander being passed out. She stated when she called Ms. Alexander, she answered her phone and “sounded fine.” Ms. Wilson stated Ms. Alexander did not talk as if she were disoriented and was not slurring her words. Ms. Wilson stated 10 minutes later one of the resident’s guardians contacted her alleging the resident said Ms. Alexander was passed out on the floor. Ms. Wilson stated she called the facility again, but Ms. Alexander did not answer so she contacted Ms. Robinson and headed to the facility. She stated she arrived at the facility at approximately 10 pm. Ms. Wilson stated all of the residents were in their rooms when she arrived except two were in the fenced in backyard. Ms. Wilson’s statement to me regarding how Ms. Alexander appeared when she arrived at the facility was consistent with Ms. Robinson’s statement to me.

Ms. Wilson stated Resident B told her he saw Ms. Alexander laying on the living room floor, but he stated to her he did not get close to her because he did not want to be accused of anything. Ms. Wilson did not indicate if any other residents observed Ms. Alexander on the facility floor. Ms. Wilson stated Ms. Alexander was not currently on the facility staff schedule due to investigations. She stated prior to this incident she had not had any concerns with Ms. Alexander being inappropriate at work.

On 12/14/2022, I completed an unannounced onsite inspection at the facility as part of my investigation. I interviewed Resident B, Resident D, and Resident F.

Resident B’s statement to me was consistent with the allegations. Resident B stated Ms. Alexander came into work and administered medications but did not pass his. He also stated she was slurring her words and smelled like alcohol. Resident B stated after Ms. Alexander administered resident medications he went into his bedroom, but after 15 minutes or so he went back to the living room and discovered her on the floor with no shirt on. He stated he stayed away from her because he did not want anyone saying he did anything to her. Resident B stated he did take pictures of her passed out, but later deleted the pictures after showing the staff that came in to relieve Ms. Alexander. Resident B stated he did not observe Ms. Alexander take her clothes off or get onto the floor; indicating he only found her that way. He stated he observed the facility’s keys, which he stated has keys to all the resident bedrooms, the room with the cleaning products, and the medication room keys on the living room floor as well. He stated he did not touch these keys either. Resident B stated only Resident F observed Ms. Alexander as the other residents were in their rooms. He stated she was passed out on the living room floor for approximately one hour. He stated during that time, none of the residents left the facility, were harmed, or got into the medication room/cleaning products.

Resident D stated he was sleeping the evening Ms. Alexander was found passed out on the living room floor and therefore had no direct knowledge of how she was acting that night or what took place the evening she worked.

Resident F stated Ms. Alexander was “mumbling” and had “glossy eyes” the evening she was discovered passed out on the living room floor. He stated he had primarily spent time in his room, but indicated Resident B came to his room to show him pictures of Ms. Alexander and requested he come out to the living room to see. He stated that while he did go out into the living room, he did not get close to Ms. Alexander. He stated he did not see where the facility or medication keys were but recalled seeing another picture of the keys that Resident B had taken to show him. Resident F also stated none of the residents left the facility or were harmed in any way while she was passed out. He also stated she was passed out for approximately one hour.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	On 11/06/2022 at approximately 10 pm, direct care staff, Takisha Alexander, was found passed out and incapacitated from still being intoxicated after drinking the day and night before arriving to work. All six residents of the facility were in the facility when Ms. Alexander was discovered incapacitated with two of the residents observing her on the floor. Based on my investigation, Ms. Alexander was not suited to meet the physical, emotional, intellectual, and social needs of any of the residents on 11/06/2022 when she arrived to work still under the influence of alcohol that eventually led to her becoming incapacitated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and

	shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Direct care staff, Takisha Alexander, was intoxicated, passed out and became incapacitated while working at the facility on 11/06/2022 from approximately 8:30 pm until found by direct care staff at 10 pm. During that time frame, the facility was not appropriately staffed with at least 1 direct care staff to 12 residents, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On 11/06/2022, direct care staff, Takisha Alexander, arrived to work intoxicated and subsequently became incapacitated. While incapacitated she not only left the facility unattended without direct care staff, but also left the facility's house and medication keys out in the open accessible to all six residents of the facility. Despite no residents eloping from the facility or harmed while Ms. Alexander was incapacitated, she was not providing the residents with protection and safety at all times, as required. Additionally, she put their safety and protection at risk when they had immediate access to the facility's keys and medication keys.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On the night Ms. Alexander passed out at work, Resident B and Resident D did not receive their evening medications.

INVESTIGATION:

The complaint alleged Resident D did not receive his evening medications on 11/06/2022 when direct care staff, Ms. Alexander, was discovered passed out.

Ms. Suchyta stated Resident D missed his evening dose of Risperdal and Campral on 11/06/2022.

Ms. Alexander stated she passed all the resident's their medications, including Resident D. She stated she administered Resident B's medications but didn't pop out the medication from the correct date on his pill pack. Ms. Alexander stated she finished administering medications around 8:30 pm – 8:35 pm. She stated the internet was in and out so she could not log in the eMAR that the medications were administered, but indicated she initialed the paper MARS. Ms. Alexander indicated staff are expected to complete both the eMAR and paper MARs due to internet issues at the facility. She stated it is normal for her to document immediately on the eMAR when a resident's medication is administered; however, she stated she waits until the morning, before day shift arrives before she completes the paper MARs.

Ms. Wilson stated on 11/06/2022, Resident B had not gotten his evening medications from Ms. Alexander. She stated when she checked the facility's eMAR she could determine the medications were not administered to him. She stated after she arrived at the facility, she contacted the on-call medical and got permission to administer Resident B's medications. Ms. Wilson stated that upon counting all the resident's medication she then discovered Resident D had also not gotten his medication, which included 2 tablets of 333 mg of Campral and 1 mg of Risperdal. She stated when she interviewed the residents, four out of the six residents indicated they had gotten their medication, which was consistent with counting the medication.

I reviewed Resident D and Resident B's November eMARs, which confirmed on 11/06/2022 the two residents did not receive the following medications:

- Resident B
    - Divalproex ER, 500 mg, 1 tablet, at 8 pm
    - Quetiapine, 100 mg, 1 tablet, at 8 pm
    - Quetiapine, 200 mg, 1 tablet, at 8 pm

- Resident D
    - Campral 333 mg tab, 2 tablets, at 8 pm
    - Risperdal 1 mg, 1 tablet, at 8 pm

I also reviewed the facility's paper MARs, which confirmed Resident D had not received his two medications; however, Resident B's paper MAR indicated Resident B received the three mediations on 11/06/2022 as Ms. Alexander initialed she had administered them to him.

Resident B stated he did not receive his 11/06/2022 evening medications despite Ms. Alexander telling him she administered them to him. Resident B stated he could not recall the names of all the medications he did not receive that evening, but knew one was "Depakote." He did not know if any other residents did not receive their medications that night.

Resident D stated he was sleeping when the incident with Ms. Alexander occurred. He stated he did not wake up until the morning and did not recall be woken up the evening of the incident to take medications; therefore, he assumed he did not receive them. He stated normally, if he is asleep when evening medication are administered, then staff will awaken him.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 11/06/2022, Resident B and Resident D did not receive their prescribed medication, as required. After the facility's home manager discovered direct care staff, Takisha Alexander, incapacitated at the facility, she reviewed and counted all the resident's medications and determined Ms. Alexander did not administer Resident B's Divalproex ER, 500 mg, 1 tablet, Quetiapine, 100 mg, 1 tablet or Quetiapine, 200 mg, 1 tablet at 8 pm or Resident D's Campral 333 mg tab, 2 tablets, or his Risperdal 1 mg, 1 tablet at 8 pm. Though Ms. Alexander indicated on the facility's paper Medication Administration Record that Resident B's medications were administered, Ms. Wilson stated after she counted the medications, she determined they were not administered as alleged by Ms. Alexander. Subsequently, neither Resident D nor Resident B received their medications at 8 pm on 11/06/2022, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/05/2022, I conducted my exit conference with licensee designee, Ramon Beltran. Mr. Beltran acknowledged my findings.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

12/20/2022

_____

Cathy Cushman — Date
Licensing Consultant

Approved By:

01/04/2023

_____

Dawn N. Timm — Date
Area Manager