STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

April 26, 2023

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

RE: License #: AS130405804
Investigation #: 2023A1034025
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,

Kevin L. Sellers

Kevin Sellers, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-3704

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130405804
Investigation #:	2023A1034025
Complaint Receipt Date:	03/15/2023
Investigation Initiation Date:	03/15/2023
Report Due Date:	05/14/2023
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 worker Brittany Robinson made Resident A steal tennis shoes.	Yes
Direct care worker Brittany Robinson did not follow proper medication administration protocol.	No

III. METHODOLOGY

03/15/2023	Special Investigation Intake 2023A1034025
03/15/2023	APS Referral not made due to APS already investigating.
03/15/2023	Contact - Telephone call made leaving a message for Complainant.
03/15/2023	Special Investigation Initiated – Telephone call received from the Complainant, interviewed the Complainant.
03/15/2023	Contact - Document Received from Complainant.
03/15/2023	Contact - Telephone call made interviewing direct care worker, Brittany Robinson.
03/20/2023	Inspection Completed On-site Interviewing Resident A.
03/20/2023	Contact - Telephone call made interviewing APS specialist, Rebecca Karrar.
03/23/2023	Contact - Telephone call made leaving message for home manager, Diante Taylor.
04/06/2023	Contact - Telephone call made interviewing Rebecca Karrar.
04/06/2023	Contact - Telephone call made interviewing Diante Taylor.
04/07/2023	Exit Conference leaving a message for licensee Ramon Beltran.
04/07/2023	Inspection Completed-BCAL Sub. Compliance.

ALLEGATION: Direct care worker Brittany Robinson made Resident A steal tennis shoes.

INVESTIGATION:

On 03/15/2023, Complainant reported recently direct care worker (DCW) Brittany Robinson transported Resident A out into the community for an outing to a local Walmart store where DCW Robinson told Resident A she would purchase him tennis shoes. Complainant reported Resident A put the new shoes on, but when DCW Robinson and Resident A went to pay for the shoes, DCW Robinson's "Applepay" did not work so DCW Robinson and Resident A walked out of the store without paying. Complainant reported Resident A forgot he had the tennis shoes on his feet when they walked out of the store. Complainant reported DCW Robinson did not attempt to return the shoes once they exited the store, letting Resident A keep the shoes but then DCW Robinson later provided a receipt for the shoes dated on 03/14/2023 showing that she paid for them.

On 03/15/2023, I received a picture from Complainant of the Walmart store receipt for the tennis shoes dated on 03/14/2023.

On 03/15/2023, I interviewed DCW Brittany Robinson via telephone who admitted to transporting Resident A to a local Walmart store to purchase tennis shoes for Resident A. Ms. Robinson reported telling Resident A she would purchase tennis shoes for Resident A due to how worn the shoes were and due to the conditions of the shoes of the possibility Resident A could sustain some sort of foot fungus. Ms. Robinson denied remembering the exact dates her and Resident A went to Walmart but thought maybe it was 03/08/2023 or 03/09/2023. During the interview with DCW Robinson, she first indicated not knowing Resident A was wearing the new shoes when they went to the store register to pay for the shoes, however, DCW Robinson later recalled Resident A was wearing the shoes at the time of checkout. Ms. Robinson reported she attempted to pay for the shoes through her "Applepay" account but it did not work for an unknown reason. Ms. Robinson reported asking for assistance in paying for the shoes from a Walmart representative learning Walmart did not accept Applepay as a form of payment. Ms. Robinson admitted even after the store representative advised her Applepay would not work at the store, her and Resident A walked out of the store. Ms. Robinson reported after her and Resident A exited the store, Resident A asked if she paid for the new shoes and she told Resident A she could not pay for the shoes. Ms. Robinson denied ever telling Resident A it was his fault for walking out of the store with the new shoes on his feet. Ms. Robinson stated repeatedly how she was scared to return the shoes or retrieve Resident A's old tennis shoes. Ms. Robinson reported she made the decision for her and Resident A to leave the store and returned to the facility. Ms. Robinson reported after returning to the facility, she waited a couple hours and told home manager/direct care worker Diante Taylor what happened about not paying for Resident A's new tennis shoes. Ms. Robinson reported Mr. Taylor informed her she needed to return to the store and pay for the shoes. Ms. Robinson stated she returned to the Walmart store on 03/14/2023 and paid for the shoes. Ms. Robinson stated she

understood that approximately seven days had passed between the initial visit to Walmart and the time she paid for the shoes on 03/14/2023. Ms. Robinson reported being aware adult protective services are involved and possibly the police department. Ms. Robinson verified the Walmart store receipt dated on 03/14/2023.

On 03/20/2023, I conducted an unannounced onsite investigation interviewing Resident A who reported being aware of the allegations DCW Robinson transporting him to Walmart store to purchase new shoes, trying on the shoes, wearing the new shoes up to the store register and DCW Robinson paying for the shoes. Resident A denied knowing DCW Robinson did not pay for the new shoes until they both exited the store. Resident A reported DCW Robinson told him while they were in the store parking lot, she was not able to pay for the shoes because her Applepay was not accepted. Resident A reported he repeatedly questioned DCW Robinson about not purchasing the shoes as he was fearful he would get into trouble. Resident A stated DCW Robinson advised him he was not into trouble and that she would come back later to pay for the shoes.

On 04/05/2023, I interviewed APS specialist Rebecca Karrar via telephone who reported investigating this allegation. Ms. Karrar reported through her investigation, DCW Robinson admitted she was not able to pay for the shoes yet still walked out of the store with Resident A wearing the shoes. Ms. Karrar reported DCW Robinson did return to the store to pay for the shoes until seven days afterwards. Ms. Karrar reported making a referral to Battle Creek Police Department to investigate but has not received any confirmation that the police are going to get involved. Ms. Karrar reported she would forward any information involving police involvement. Ms. Karrar reported finding evidence DCW Robinson was neglectful by placing Resident A in the position of walking out of the store and not paying for the shoes.

On 04/06/2023, I interviewed direct care worker/home manager Diante Taylor via telephone who reported he was aware that DCW Brittany Robinson transported Resident A to Walmart, attempted to purchase Resident A new tennis shoes, but did not pay for the shoes before DCW Robinson and Resident A walked out of the store. Mr. Taylor denied know the exact dates of when DCW Robinson and Resident A went to Walmart but when he became aware of what happened days after the incident, he instructed DCW Robinson to return to the store and pay for the shoes. Mr. Taylor reported he told DCW Robinson before she returned to the store how it was not appropriate for her and Resident A to walk out of the store and not pay for the shoes. Mr. Taylor reported telling DCW Robinson, DCWs are role models and certainly must show this to each of the residents.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.

ANALYSIS:	Through my investigation, based on interviews with Resident A, DCW Robinson, direct care worker/home manager Taylor and APS specialist Karrar, there is supporting evidence DCW Robinson put Resident A at risk by letting Resident A walk out of the Walmart store with new shoes on his feet and did not pay for those shoes. At the time he exited, Resident A did not understand the shoes had not been paid for and learned this until he was in the parking lot from DCW Brittany Robinson. DCW Robinson understood it was wrong for her to put Resident A in this position.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care worker Brittany Robinson did not follow proper medication administration protocol.

INVESTIGATION:

On 03/15/2023, Complainant reported on March 14, 2023, Resident A allegedly requested DCW Brittany Robinson administer his extra-strength Tylenol 500 mg but DCW Robinson administered Tylenol 200 mg to Resident A. Complainant reported DCW Robinson allegedly marked the wrong dosage on Resident A's medication log sheet and as a result, Resident A had to wait longer to get more Tylenol.

On 03/15/2023, I interviewed DCW Brittany Robinson via telephone who denied not following proper medication administration protocol when administering Tylenol to Resident A. Ms. Robinson reported Resident A is prescribed Tylenol 200 mg and Tylenol 500 mg by his physician. Ms. Robinson reported on 03/14/2023 Resident A requested for his prescribed Tylenol 500 mg and she administered this medication. Ms. Robinson reported Resident A questioned her about the milligram of the medication but then she showed Resident A the medication milligram was correct. Ms. Robinson reported when administering resident medication, she utilizes a step-by-step procedure that includes cross referencing resident medications with MARs, cross referencing controlled medications and documenting the information on daily controlled medication charts. Ms. Robinson reported each time a medication is administered or a resident refuses medication, she documents reasons for refusal on the medication chart and then initials the paperwork.

On 03/20/2023, I interviewed Resident A who reported he thought DCW Brittany Robinson incorrectly administered his prescribed Tylenol medication. Resident A reported he is prescribed Tylenol 200 mg and Tylenol 500 mg by his physician as needed. Resident A reported on 03/14/2023 he asked DCW Robinson for his Tylenol 500 mg, but when DCW Robinson administered the Tylenol, he questioned DCW Robinson it was the wrong milligram. Resident A stated DCW Robinson showed him it was the correct milligram. Resident A denied having any issues of his prescribed medication wrongly being administered in the past by any DCWs.

On 03/20/2023, during my unannounced onsite investigation, I reviewed Resident A's *Medication Administration Records* (MAR), *Daily Controlled Medication Chart* for the month of February 1- 28 2023 and March 1-31 2023. I did not observe any discrepancies or errors.

On 04/05/2023, I interviewed APS specialist Rebecca Karrar via telephone who reported investigating this allegation and denied finding any evidence.

On 04/06/2023, I interviewed direct care worker/home manager Diante Taylor via telephone who denied DCW Brittany Robinson did not follow proper medication administration protocol and or administered the wrong prescribed Tylenol medication for Resident A. Mr. Taylor reported he reviewed Resident A's MARs, daily controlled medication chart, and found no discrepancies or errors.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Based on interviews with Complainant, Resident A, DCW Robinson, direct care worker/home manager Taylor APS specialist Karrar, my review of Resident A's medication administration record and daily controlled medication charts, there is no evidence DCW Robinson did not follow proper medication administration protocols or incorrectly administered Resident A's prescribed Tylenol 500 mg medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in license is recommended.

Kevin L. Sellers 04/07/2023

Kevin Sellers Date
Licensing Consultant

Approved By:

Dawn Timm 04/26/2023

Dawn N. Timm Date
Area Manager