GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 27, 2023

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

RE: License #: AS130408635
Investigation #: 2023A1034026
Beacon Home at East Ave

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 #:	AS130408635
Investigation #:	2023A1034026
Complaint Receipt Date:	03/15/2023
Investigation Initiation Date:	03/16/2023
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:	Navpreet Kaur
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at East Ave
Facility Address:	20271 East Ave N Battle Creek, MI 49017
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/04/2021
License Status:	REGULAR
Effective Date:	04/04/2022
Expiration Date:	04/03/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A missed doctor's appointments due to direct care staff members.	No
Direct care staff members are not offering meals for Resident A due to the facility having no food.	No
Resident A has lost significant weight in the past several months.	No
Additional Findings.	Yes

III. METHODOLOGY

03/15/2023	Special Investigation Intake 2023A1034026
03/15/2023	APS Referral not needed due to APS already investigating.
03/16/2023	Special Investigation Initiated – Telephone call interviewing APS specialist, Jennifer Stockford.
03/20/2023	Inspection Completed On-site interviewing interim home manager Melissa Carlson, Resident A and gather documents.
03/20/2023	Contact - Document Received additional information through BCAL Online complaint regarding Resident A.
04/05/2023	Contact - Telephone call made interviewing assistant home manager, Anne Wiley.
04/05/2023	Contact - Telephone call made interviewing direct care worker, Meagan DeYoung.
04/13/2023	Inspection Completed-BCAL Sub. Compliance.
04/13/2023	Corrective Action Plan Requested and Due on 04/27/2023
04/14/2023	Exit Conference leaving message for licensee, Ramon Beltran.

ALLEGATION: Resident A missed doctor's appointments due to direct care staff members.

INVESTIGATION:

On 03/15/2023, I received a complaint through the Bureau of Community Health Systems (BCHS) online complaint system alleging Resident A has missed four medical appointments due to direct care staff members and management being unwilling to transport Resident A to these appointments. The complaint alleged Resident A has a history of medical issues/mental health disorders and was complaining of abdominal pain.

On 03/16/2023, I interviewed Calhoun County Department of Health and Human Services Adult Protective Services (APS) Specialist Jennifer Stockford via telephone who reported currently investigating the allegation. Ms. Stockford denied finding any supporting evidence towards the allegations. Ms. Stockford reported Resident A scheduled medical appointments without informing management or DCWs to ensure transportation availability. Ms. Stockford reported when management advised Resident A there were no direct care workers available to transport her due to other residents having already scheduled appointments on these dates. Ms. Stockford stated Resident A became frustrated and then canceled all her appointments. Ms. Stockford reported interim home manager, Melissa Carlson sat with Resident A attempting to reschedule her appointments which did later happen.

On 03/20/2023, I conducted an unannounced onsite investigation and interviewed interim home manager/direct care worker, Melissa Carlson who reported when she first learned Resident A scheduled doctor's appointments before letting her or other direct care staff members know, she advised Resident A that the dates she scheduled these appointments were unavailable due to staff transporting other residents to their scheduled appointments. Ms. Carlson stated she tried working with Resident A on rescheduling new appointments dates in the facility calendar that would be open for staff to transport Resident A to her doctors but Resident A was unwilling to accept her assistance.

On 03/20/2023, I interviewed Resident A who reported direct care staff were unwilling to transport her to her scheduled doctor's appointments. Resident A reported scheduling her appointments on her own and confirmed she did not tell direct care staff about the scheduled appointments or confirm transportation was available. Resident A denied being uncooperative with the home manager or direct care staff about rescheduling her doctor appointments. Resident A reported being able to get the appointments rescheduled.

On 03/20/2023, during the unannounced onsite investigation, I reviewed the resident transportation calendar for *Beacon Home at East Ave N* which documented Resident A has several scheduled medical/doctor's appointments starting on 03/21/2023 for staff to transport Resident A.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(3) A licensee shall assure the availability of transportation services as provided for in the resident care agreement.
ANALYSIS:	Based on my interviews with Resident A, interim home manager Carlson, APS specialist Stockford, and reviewing the transportation calendar at Beacon Home at East Ave N including Resident A's medical records, there is no evidence direct care staff members or management refused to transport Resident A to any of her doctor or medical appointments. Rather there was no transportation for the dates Resident A had unknowingly scheduled her own appointments, so those appointments had to be rescheduled for times when transportation was available. Resident A stated direct care staff worked with her to accomplish this.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff members are not offering meals for Resident A due to the facility having no food.

INVESTIGATION:

On 03/15/2023, I received a complaint through the Bureau of Community Health Systems (BCHS) online complaint system alleging there is no food at the facility, direct care staff are not providing Resident A meals, Resident A was served raw meat on 03/16/2023, Resident A had to order food through a Door Dash App, and there are no standard mealtimes at the facility.

On 03/16/2023, I interviewed APS specialist Jennifer Stockford denied finding any evidence to these allegations as there was ample amount of food at the facility and the facility serves three meals daily including offering snacks for each of the residents.

On 03/20/2023, I interviewed interim home manager/direct care worker, Melissa Carlson who denied Resident A has ever missed a meal at the facility, denied that DCWs refused to serve a meal to Resident A or that the facility does not have food. Ms. Carlson reported direct care staff members prepare three meals daily for residents and snack items are available for residents if they choose to eat a snack. Ms. Carlson reported breakfast is served between 7:30 am to 8:00 am, lunch is 12:00 pm and dinner meals are served around 5:00 pm daily. Ms. Carlson reported each of the residents are aware of when meals are served by looking at the daily meal schedules. Ms. Carlson reported residents are free to prepare small meals if they choose and food is purchased for the facility every three to four weeks in large quantities for every resident. Ms. Carlson denied ever witnessing Resident A go without a meal at the facility and denied having any knowledge about Resident A having to eat raw meat on

03/16/2023. Ms. Carlson reported assistant manager, Anne Wiley was working on that specific date.

On 03/20/2023, I interviewed Resident A who reported sometimes there is not enough food in the facility for every resident, there are limited food choices and not knowing when meals are served. Resident A denied ever going without a meal or ordering food off a Door Dash App on 03/16/2023. Resident A reported how she was served raw meat on her dinner plate on the night of 03/16/2023 and addressed the concern with assistant home manager, Anne Wiley. Resident A denied eating the raw meat even after Ms. Wiley provided suggestions of cooking the meat longer to her liking. Resident A provided a picture from her personal cell phone of the uncooked raw meat.

On 04/05/2023, I interviewed assistant home manager, Anne Wiley and direct care worker, Meagan DeYoung both of whom denied the facility has ever done without food, denied direct care staff or management have ever kept food away from Resident A. Ms. Wiley and Ms. DeYoung denied having any knowledge about Resident A having to eat raw meat on 03/16/2023. Ms. Wiley reported Resident A brought to her attention on that date about having raw meat on her dinner plate but after she observed the meat, she stated it was not raw. Ms. Wiley reported she suggested to Resident A the meat could be cooked longer if Resident A desired. Ms. Wiley reported Resident A did not like her suggest and did not eat the meat. Ms. Wiley denied Resident A ordering food from a Door Dash App on that night. Ms. Wiley and Ms. DeYoung both reported three meals daily are prepared for residents which provide a variety of food options and residents can have snacks.

On 03/20/2023, I reviewed Beacon Home at East Ave N's menu from February 27, 2023 through March 31, 2023. I reviewed the document and determined the facility provides nutritious meals for breakfast, lunch, and dinner meals. There are a variety of food items from which residents can choose. According to the menus, breakfast is served at 7:30 am, lunch at 12:00 pm and dinner at 5:00 pm. I observed the facility refrigerator/freezer, kitchen cup boards and found a variety amount of food.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Based on my investigation, through interviews with Resident A, interim home manager, Carlson, assistant home manager Wiley DCW DeYoung, observation of the facility refrigerator and cupboards, my review of Beacon Home at East Ave N's menu from February 27, 2023 through March 31, 2023 and observation of the picture taken by Resident A of the raw meat on 03/16/2023, there was ample food in the facility for all residents, no evidence of missed meals or food being served undercooked.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A has lost significant weight in the past several months.

INVESTIGATION:

On 03/15/2023, I received a complaint through the Bureau of Community Health Systems (BCHS) online complaint system alleging Resident A has lost a lot of weight. Complainant did not know how much weight Resident A has lost and/or over what period of time the weight loss occurred.

On 03/16/2023, I interviewed APS specialist Jennifer Stockford who reported she did not substantiate this allegation based on her investigative findings.

On 03/20/2023, I interviewed interim home manager/direct care worker, Melissa Carlson who denied allegations Resident A had lost a significant amount of weight due to not being fed or any other reason under their control while at the facility. Ms. Carlson reported resident weights are taken at the beginning of every month and documented for each resident in their resident weight chart. Ms. Carlson denied observing any significant changes in Resident A's weight over the last several months.

On 03/20/2023, I interviewed Resident A who reported she has lost weight over the past several months due to the types of food served or feeling sick to her stomach from her medical issues. Resident A reported at the beginning of every month staff members weigh each resident but she denied knowing if staff weighed her every month.

On 03/20/2023, during my on-site investigation, I observed Resident A's weight record from May 2022 through March 2023. While reviewing Resident A's weight record, I observed Resident A was not weighed in June 2022, October 2022, November 2022, December 2022, January 2023, and February 2023. Through my observations of the months Resident A was weighed there were not significant weight loses.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on my investigation, through interviews with interim home manager Carlson, Resident A and reviewing Resident A's weight record, there were no significant weight losses for Resident A from May 2022 through March 2023.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
During my review of Resident A's weight records, there were multiple months when Resident A was not weighed or her weight was not documented. Based on my review of Resident A's records monthly weights were missing for the following months: June 2022, October 2022, November 2022, December 2022, January 2023, and February 2023.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.
ANALYSIS:	Based on my investigation, after reviewing Resident A's weight records, the facility is not tracking Resident A's monthly weight as weights were missed in June, October, November and December of 2022 along with January and February of 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/27/2023

Kevin Sellers Date
Licensing Consultant

Approved By:

04/27/2023

Dawn N. Timm Date
Area Manager