GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2023

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

RE: License #: AS380398558
Investigation #: 2023A0007016
Beacon Home at Sheffield

Dear Ms. Rawlings:

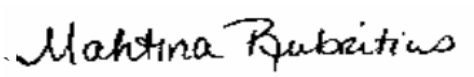
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (313) 456-0380.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380398558
Investigation #:	2023A0007016
Complaint Receipt Date:	04/17/2023
Investigation Initiation Date:	04/18/2023
Report Due Date:	06/16/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Rawlings
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Sheffield
Facility Address:	4162 Sheffield Drive Jackson, MI 49203
Facility Telephone #:	(517) 795-2004
Original Issuance Date:	02/05/2020
License Status:	REGULAR
Effective Date:	08/05/2022
Expiration Date:	08/04/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Allegations that Resident A has bruising and was favoring her right arm. The 1:1 staff said nothing happened. Resident A was taken in for medical treatment and her arm is broken in two spots. Resident A required surgery.	Yes
Allegations that staff were asleep and not caring for the residents.	Yes

III. METHODOLOGY

04/17/2023	Special Investigation Intake - 2023A0007016
04/17/2023	Contact - Telephone call received from Home Manager #1. Discussion.
04/18/2023	Special Investigation Initiated - Face to Face contact with APS Worker #1.
04/18/2023	Contact - Face to Face with APS Worker #1. Appointment arranged.
04/19/2023	Contact - Face to Face with APS Worker #1, APS Worker #2, Resident A, and hospital staff member.
04/19/2023	Contact - Telephone call made - Home Manager #1. Discussion.
04/20/2023	Contact - Telephone call made to Ms. Keinath, Administrative Staff.
05/04/2023	Contact - Telephone call received from Home Manager #1. Resident A is having behaviors. She ran and laid in the dirt. Three staff brought her back into the house. She went running again, falling. She did not fall on her arm. Resident A is more agitated the last couple of days, due to staff always being with her.
06/07/2023	Contact - Document Sent - Email to APS Worker #1.
06/07/2023	Contact - Document Sent - Email to ORR - Copy of Report Requested and received.

06/12/2023	Contact - Telephone call made to Employee #3, no answer; Voicemail is full.
06/12/2023	Contact - Telephone call received Interview with Employee #3.
06/12/2023	Contact - Telephone call made Home Manager #1. Documents requested. Case discussion.
06/12/2023	Contact - Document Received from Home Manager #1.
06/12/2023	Contact - Face to Face with APS Worker #3. Status update provided.
06/12/2023	Contact - Telephone call made to Employee #5. Phone number not in service.
06/13/2023	Contact - Telephone call made to Guardian A. No answer.
06/13/2023	Contact - Document Sent to Guardian A.
06/13/2023	Contact - Telephone call made to Ms. Rawlings, Licensee Designee.
06/13/2023	Contact – Telephone call received from Guardian A. She is the guardian for all the residents in the home. Status update provided.
06/13/2023	Contact - Document Sent - Email to Ms. Rawlings, Licensee Designee. I requested a phone call to conduct the exit conference.
06/13/2023	Exit Conference conducted with Ms. Rawlings, Licensee Designee.

ALLEGATIONS:

- **Allegations that Resident A has bruising and was favoring her right arm. The 1:1 staff said nothing happened. Resident A was taken in for medical treatment and her arm is broken in two spots. Resident A required surgery.**

- **Allegations that staff were asleep and not caring for the residents.**

INVESTIGATION:

On April 17, 2023, I spoke with Home Manager #1 regarding Resident A. She stated that Resident A had bruising to her right arm, she was favoring her arm, as she

would not lift her arm when requested. Resident A was taken for medical treatment, and it was discovered that her arm is broken in two spots. The third shift staff reported that nothing happened; however, one staff made a note on the system at 5:45 a.m. that Resident A was walking around pinching her right arm. Regarding how this occurred, Resident A may have started to fall, and someone caught her by the arm. The nurse said this was a possibility. However, how the injury occurred is unknown at this time. Home Manager #1 also informed me that staff asked Resident A if she fell, and she shook her head yes. Home Manager #1 informed me that Guardian A had been notified, along with ORR. I informed her that APS would need to be contacted as well. Home Manager #1 provided me with the contact information for the staff on third shift and agreed to send me a copy of the incident report.

As a part of this investigation, I reviewed the incident report authored by Employee #1. The following information was noted:

> On April 17, 2023, at 7:45 a.m., Employee #1 documented that when she arrived to work at 7:00 a.m., Resident A was in bed sleeping. Employee #1 took over 15-minute bed checks. At 7:45 a.m. Resident A got up out of bed, and Employee #1 and Employee #2 heard a noise and went running down the hallway and found Resident A going into the restroom. Resident A hit her left side against the door. Staff assisted Resident A into the bathroom on to the toilet. Employee #1 started to change Resident A's clothing when she noticed that Resident A's right arm was not moving and there was a big bruise by the elbow bend. It was dark purple in color. Employee #1 finished dressing Resident A at 8:00 a.m. and helped walk her to her chair at the dining room table. Resident A ate only one bite of food before wanting to return to her recliner. Employee #1 contacted Home Manager #1 to come and evaluate her arm. Resident A then walked back to her to her room and sat on the bed. Home Manager #1 asked Resident A to lift her arm, but she didn't. Resident A went to lay down and laid right on her right arm, and it did not move at all. At 8:48 a.m., Home Manager #1 contacted Nurse #1 to inform her about the situation. Nurse #1 instructed staff to take Resident A to the hospital to have her arm x-rayed. Home Manager #1 contacted Jackson County Guardian Services (Guardian A), licensing, Adult Protective Services, and Office of Recipient Rights. Resident A was transported to the hospital, an x-ray was completed, and it was determined that Resident A's right arm had a spiral fracture and would need surgery.
>
> The corrective measures included staff monitoring Resident A for health and safety, reporting falls, and documenting incidents when needed.

On April 18, 2023, I made face to face contact with APS Worker #1. We discussed the case and set an appointment for the following day. APS Worker #1 also informed me that ORR had been notified regarding this incident.

On April 19, 2023, APS Worker #1, APS Worker #2, and I, made face to face contact with Resident A and a hospital staff member who was supervising Resident A. We

were informed that the surgery had been completed. Resident A was laying in the hospital bed when we arrived. Hospital Staff A informed us that Resident A's arm was broken in three places. In addition, that Resident A has been throwing her arm around. Her arm was not in a cast. Resident A is non-verbal but shook her head yes when asked if she had fallen. We also made face to face contact with Nurse A. She informed us that Resident A had a spiral fracture to the upper right arm (humerus bone). Yesterday, before surgery, Resident A appeared to be in pain. According to Nurse A, the surgery has been completed and Resident A is ready for discharge.

On April 19, 2023, I spoke with Home Manager #1 to inform her that we made face to face contact with Resident A at the hospital. I inquired about the safety plan and supervision levels when she returned to the home. Home Manager #1 informed me that Resident A would receive 1:1 staff supervision when she returned to the home. She also informed me that they would be having an emergency meeting. Home Manager #1 stated that there would be a bandage over the staples, and she was told, by Nurse #1, that because of the type of surgery Resident A had, they would not put a cast on her arm.

Home Manager #1 expressed concerns as she reported that Resident A's falls have been getting worse, she is unsteady on her feet, and she did not want Resident A to get hurt again.

On April 20, 2023, I spoke with Ms. Keinath, Administrative Staff. She informed me that Resident A got good rest and she's almost at her baseline. Her arm is not in a cast. Regarding the (third shift) staffing, Employee #3 was assigned to be Resident A's 1:1. Employee #4 quit. Starting on Monday, there will be five staff on first and second shifts. We also discussed the census in the home, and they may be making some changes.

It should be noted that Home Manager #1 kept licensing informed regarding Resident A's condition once she was released from the hospital. Resident A returned to the hospital for additional treatment, after being discharged, as her arm was bleeding and follow-up care was necessary.

As a part of this investigation, I received and reviewed the investigative report completed by ORR and it was noted that ORR interviewed the administrative staff, doctors, the guardian, case management and staff.

> It was noted that on April 21, 2023, ORR completed an in-person interview with Employee #2 and the following was noted: Employee #2 reported that at the beginning of her shift on April 17, 2023, things were pretty normal. During shift change, third shift staff did not note anything abnormal. Employee #2 reported that third shift staff reported that Resident A was pinching at her arm, but nothing was wrong or happened. Resident A was still in bed during shift change and remained in bed until around 7:45 a.m.

Employee #2 further reported that she and Employee #1 heard a noise and immediately went to Resident A. Resident A had bumped into the door, on her left side, when going into the bathroom. Both staff assisted Resident A on to the toilet and that is when they noticed that Resident A's arm was bruised and hanging, limply. Employee #2 reported that it was way worse than what third shift reported. Resident A was taken to the emergency room after getting dressed.

ORR also interviewed Employee #1, who was assigned as Resident A's 1:1 (1st shift on 4/17/2023). Employee #1 checked on Resident A when she arrived at 7:00 a.m. and every 15 minutes thereafter. Resident A awoke between 7:30 a.m. and 7:45 a.m.

Employee #1 reported to ORR that they heard a sound in the back of the house, so they went back and observed Resident A going into the bathroom. They also heard a knock as Resident A was going into the bathroom, as it appeared she had bumped the door. There was no bruising on Resident A's left side; however, bruising was observed on Resident A's right arm. Employee #1 reported that Resident A was holding her right arm "limp like a noodle."

According to Employee #1, third shift staff did not note any concerns regarding Resident A during the shift change meeting at 7:00 a.m. Employee #1 also informed ORR that on April 20, 2023, Employee #5 (who worked 3rd shift on 4/17/2023) told her (Employee #1) that it was not his fault, as he was smoking and Employee #4 was the one who refused to call the on-call manager after Resident A fell.

ORR also interviewed Employee #6, who reported to be doing laundry in the back room on 4/17/2023 for most of her shift. Employee #6 reported that Employee #3 was assigned as Resident A's 1:1. Employee #6 reported that Employee #3 was asleep, and Employee #5 was smoking throughout the shift. Employee #6 reported that she heard a "ugh" and thought it was Employee #5 or one of the male residents that tends to make noises. Employee #4 and Employee #5 checked on Resident A.

Employee #4 and Employee #5 tried to wake up Employee #3, but she did not wake up. Employee #6 reported that Employee #5 was also half asleep throughout the shift. Employee #6 reported that Employee #5 said everything was fine with Resident A after they checked on her. Employee #5 was finally able to wake up Employee #3, and she (Employee #5) stated that Resident A falls all the time and that everything was fine. Employee #6 said that Employee #4 said that they did not need to call the on-call manager, because Resident A falls frequently.

ORR interviewed Employee #3 and it was noted that Employee #3 had been working for the home since February of 2023. She was assigned as Resident A's 1:1 on April 17, 2023 (3rd shift). Employee #3 reported that Resident A was to

have 15-minute bed checks while sleeping and 1:1 supervision while awake. Employee #3 reported that she was not as familiar with Resident A as she usually worked with other residents. It was further noted that around 2:00 a.m. or 3:00 a.m., Employee #3 went to check on Resident A and after doing so, she returned to the table to complete work. Employee #3 reported to hear a bang and looked back down the hallway and saw Resident A in the hallway on the floor. Employee #3 went to Resident A and called Employee #4 for assistance. Resident A began to get upset with Employee #3. Employee #3 requested for more assistance from Employee #4. Employee #3 reported to not know Resident A but knew if she (Resident A) was getting upset with a specific staff, they should have someone else take over. Employee #3 asked Employee #4 if they should call someone or not, and Employee #4 stated that was normal for Resident A, and they did not need to call on-call. Employee #3 reported to ORR that there were no signs of bruising or anything for Resident A. Employee #3 reported to be in shock as she trusted that Employee #4 was giving her the appropriate advice. Employee #3 reported that Employee #5 was outside during the incident. Employee #3 also reported to be awake during the entire shift. In addition, that she (Employee #3) shared with the first shift staff that Resident A had a behavior and told them what had occurred. Employee #3 reported to ORR that she now recognizes that she should have contacted the on-call staff. Employee #3 no longer works in this home, as she has been transferred to a different home. Employee #3 reported the new home is a better fit.

ORR also interviewed Resident A's primary physician, Dr. #1. Dr. #1 reported to ORR that the type of fracture that Resident A had (a spiral fracture) would not have occurred from a fall; spiral fractures often occur from a forceful twisting motion. Dr. #1 reported that Resident A's arm will never be the same, and it will more than likely have difficulties healing (due to Resident A's behaviors and age). Dr. #1 also reported that Resident A is at an increased risk for a higher mortality rate following this fracture.

ORR substantiated the allegations for Neglect, Class I and Neglect Class I (failure to report). A written corrective action plan was required.

On June 12, 2023, I spoke with APS Worker #3, as APS Worker #1 was on vacation. APS Worker #3 confirmed that APS Worker #1 substantiated the case for neglect and the case is now closed.

A review of the Behavior Treatment Plan for Resident A reflects that she requires 1:1 supervision during all waking hours and 15-minute bed checks during sleeping hours.

On June 12, 2023, I interviewed Employee #3. The information she reported was consistent with what she reported to ORR. Employee #3 confirmed that staff are to be awake during their shift. Employee #3 reported to be awake during the entire shift. She reported that she did not document the fall because she did not know what

to do, and when she asked, she was given the wrong guidance from Employee #4. Employee #3 stated that Employee #4 quit, and Employee #5 was terminated. Employee #3 reported that since being moved to a different home, it's a much better fit. She stated that it was difficult to work in the Sheffield home because no one helped, and no one did their jobs. Since being transferred, she has not had any problems.

On June 12, 2023, I attempted to contact Employee #5; however, his phone number was not in service.

During the course of this investigation, subsequent incident reports were received, and the following was noted regarding Resident B, Resident C, and Resident D:

Regarding Resident B:

> Home Manager #1 documented that on April 24, 2023, "At 4:11am staff member from Sheffield [Employee #7] called home manager [Home Manage #1] to inform her that Employee #3 was sleeping in a folding chair bedside to Resident B. Home Manager #1 immediately contacted Ms. Keinath the AVP and called Manager #2 another home manager to meet at Sheffield. Home Manager #1 went into the home and found Employee #3 sleeping. Home Manager #1 instructed Employee #3 to come into the office and she was dismissed and was removed from the schedule pending investigation. Staff, Employee #7 and Manager #2 went and changed Resident B and found him soaked in urine. Employee #7 and Manager #2 changed Resident B's clothing, brief and his bedding and transferred to his chair. Recipient Rights, Jackson County Guardian Services, and Lifeways were all notified of this incident."

Regarding Resident C:

> Home Manager #1 documented that on April 24, 2023, "At 4:11am staff member from Sheffield [Employee #7] called home manager [Home Manager #1] to inform her that Employee #5 was sleeping in a resident recliner upside down in the living room. Home Manager #1 immediately contacted Ms. Keinath the AVP and called Manager #2 another home manager to meet at Sheffield. Home Manager #1 went into the home and found Employee #5 sleeping. Home Manager #1 instructed Employee #5 to come into the office and Employee #5 was dismissed and was removed from the schedule pending investigation. Staff, Employee #7 and Manager #2 went to change Resident C and found that he hadn't been changed since 11pm the previous night. Employee #7 and Manager #2 changed Resident C's clothing and transferred to his chair. Recipient rights, Jackson County Guardian Services, and Lifeways were all notified of this incident."

Regarding Resident D:

> Home Manager #1 documented that on April 24, 2023, "At 4:11am [Employee #7] called the home manager [Home Manager #1] and reported that Employee #5 was sleeping upside down in a resident's recliner in the living room. Home

> Manager #1 contacted Ms. Keinath the AVP to report and immediately went into the home to finding Employee #5 in the recliner. Home Manager #1 asked Employee #5 to come into the office and Employee #5 was dismissed of his job duties and removed from the schedule pending investigation. Resident D was tended to and found that he was sleeping in a urine-soaked bedding. Resident D was assisted up by Employee #7 and was showered to get him cleaned up. Employee #7 also changed his bedding on his bed to fresh linens. Home Manager #1 reported to recipient rights, Lifeways, and the Jackson County Guardian Services."

During my interview with Employee #3, she admitted to being asleep, and that is why she was transferred to a different home. Employee #3 reported that since being moved to a different home, it's a much better fit. She stated that it was difficult to work in the Sheffield home because no one helped, and no one did their job. She also confirmed that Employee #5 was also asleep (on April 24, 2023). Employee #3 stated that Employee #4 quit, and Employee #5 was terminated. Employee #3 reported that since being transferred, she has not had any problems.

On June 12, 2023, I spoke with Home Manager #1. I inquired about Resident B, Resident C, and Resident D. According to Home Manager #1, Employee #3 was assigned as Resident B's 1:1, and Employee #5 was assigned to care for Resident C and Resident D. She stated that they document the date and time on the back of each resident's brief, so they know when they were last changed. Resident B was soaked in urine. Resident C's brief was from the previous day at 11:00 p.m. Resident D was found lying in urine. When Home Manager #1 and Manager #2 arrived at the home, they assisted and changed the residents. Both Employee #3 and Employee #5 were observed sleeping on shift and were sent home. Employee #3 was transferred to another home and Employee #5 was terminated.

A review of the Behavioral Treatment Plan for Resident B reflected that Resident B "has had a BTP for several years that includes strategies that involve distraction and redirection to keep his hands occupied and away from his feeding tube." It should be noted that Resident B has a history of removing his feeding tube, which has resulted in trips to the emergency room for medical intervention. He requires 1:1 staff supervision during waking hours, and staff are to be at arm's length. Staff are to complete 15-minute bed checks during sleeping hours. This is to prevent and disrupt feeding tube removal.

During the course of this investigation, I also reviewed an investigative report conducted by ORR.

> ORR interviewed the staff involved regarding this matter. It was also noted that ORR reviewed pictures submitted by Home Manager #1. In the photos, Employee #5 was observed laying in a recliner with his feet on the headrest of the recliner and his head laying on the footrest portion of the recliner. In the next

photo, Employee #3 was observed sitting in a folding chair, next to a bed with her arms folded, eyes closed, and mouth open.

ORR substantiated the allegations for Neglect, Class III and a corrective action plan was required.

On June 13, 2023, I conducted the exit conference with Ms. Rawlings, Licensee Designee. I informed her of the findings and my recommendations. We discussed that Employee #3 had been moved to a different home, and the other two employees (Employee #4 and Employee #5) were no longer working for Beacon. Ms. Rawlings agreed to submit a written corrective action plan, and that she would ensure that Employee #3 also received additional training.

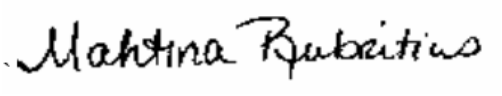
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	On April 17, 2023, I spoke with Home Manager #1 regarding Resident A. She stated that Resident A had bruising to her right arm, she was favoring her arm, as she would not lift her arm when requested. Resident A was taken for medical treatment, and it was discovered that her arm is broken in two spots. The third shift staff reported that nothing happened; however, one staff made a note on the system at 5:45 a.m. that Resident A was walking around pinching her right arm. During the interview, Employee #3 reported that around 2:00 a.m. or 3:00 a.m., she [Employee #3] went to check on Resident A and after doing so, she returned to the table to complete work. Employee #3 reported to hear a bang and looked back down the hallway and saw Resident A in the hallway on the floor. Employee #3 went to Resident A and called Employee #4 for assistance. Resident A began to get upset with Employee #3. Employee #3 requested for more assistance from Employee #4. Employee #3 reported to not know Resident A but knew if she (Resident A) was getting upset with a specific staff, they should have someone else take over. Employee #3 asked Employee #4 if they should call someone or not, and Employee #4 stated that was normal for Resident A, and they did not need to call on-call. Employee #3 reported to ORR that there were no signs of bruising or anything for Resident A. Employee #3 reported to be in shock as she trusted that Employee #4 was giving her the appropriate advice. Employee #3 also reported to be awake during the entire shift. In addition, that she (Employee #3) shared with the first shift staff that Resident A had a behavior and told them what had occurred. Employee #3 reported to ORR that she now recognizes that she should have contacted the on-call staff. Dr. #1 reported to ORR that the type of fracture that Resident A had (a spiral fracture) would not have occurred from a fall; spiral fractures often occur from a forceful twisting motion. Dr. #1 reported that Resident A's arm will never be the same, and it will more than likely have difficulties healing (due to Resident A's behaviors and age). Dr. #1 also reported that Resident A is at an increased risk for a higher mortality rate following this fracture.

	ORR substantiated the allegations for Neglect, Class I and Neglect Class I (failure to report). A written corrective action plan was required. APS Worker #1 substantiated the case for neglect and the case is now closed. **Regarding staff sleeping and not caring for the residents:** According to Resident B's Behavioral Treatment Plan, he requires 1:1 staff supervision. Resident B, Resident C and Resident D require staff assistance with personal care, protection, and supervision. On April 24, 2023, Home Manager #1 went into the home and found Employee #3 and Employee #5 sleeping. Photos were taken and provided to ORR. On April 24, 2023, management found Resident B soaked in urine. Employee #7 and Manager #2 went to change Resident C and found that he had not been changed since 11p.m. the previous night. Resident D was tended to, and it was found that he was sleeping in a urine-soaked bedding. During my interview with Employee #3, she admitted to being asleep on the job. She also confirmed that Employee #5 was also asleep. Employee #3 has been transferred to another home, Employee #4 and Employee #5 no longer work for Beacon homes. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A, Resident B, Resident C, and Resident D were not treated with dignity and their personal needs, including protection and safety were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



06/13/2023

_____

Mahtina Rubritius Date
Licensing Consultant

Approved By:

06/13/2023

_____

Ardra Hunter Date
Area Manager