GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 1, 2023

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

RE: License #: AM030402101
Investigation #: 2023A0578057
Beacon Home at Hammond

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) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030402101
Investigation #:	2023A0578057
Complaint Receipt Date:	09/06/2023
Investigation Initiation Date:	09/07/2023
Report Due Date:	11/05/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Ramon Beltran
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Hammond
Facility Address:	318 East Hammond Street Otsego, MI 49078
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	07/09/2020
License Status:	REGULAR
Effective Date:	01/26/2022
Expiration Date:	01/25/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A had a ruptured catheter, which resulted in a urinary tract infection and damage to Resident A's kidneys.	Yes
Resident A was disheveled, had poor hygiene and was covered in feces.	No
Resident A appeared as if he was not being fed.	No
Additional Findings	Yes

III. METHODOLOGY

09/06/2023	Special Investigation Intake 2023A0578057
09/06/2023	APS Referral
09/07/2023	Special Investigation Initiated - On Site -Interview with direct care staff Annette Reeber. Interview with Resident B.
09/07/2023	Contact-Document Reviewed -*Assessment Plan for AFC Residents* for Resident A, dated 08/31/2022.
09/07/2023	Contact-Document Reviewed -*Health Care Appraisal* for Resident A, dated 02/02/2023.
09/07/223	Contact-Document Reviewed -*Beacon Specialized Living Provider Contact Sheet* from Bronson Hospital for Resident A, dated 01/03/2023.
09/07/2023	Contact-Document Reviewed -*Beacon Specialized Living Provider Contact Sheet* from Bronson Urology for Resident A, dated 01/25/2023. 02/03/2023, 03/16/2023, 04/06/2023, 05/30/2023, and 06/26/2023.
09/07/2023	Contact-Telephone -With Complainant, unsuccessful.
10/24/2023	Contact-Telephone -With Complainant, unsuccessful.
10/24/2023	Contact-Telephone -Interview with Beacon Specialized Living RN Amy Zapf.
10/25/2023	Contact-Telephone

	-Interview with Guardian A1.
10/27/2023	Contact-Telephone -Interview with Marquette Duncan, medical assistant at Bronson Urology.
10/27/2023	Exit Conference -With licensee designee Ramon Beltran II.
10/28/2023	Contact-Documentation -*Beacon Specialized Living Provide Contact Sheet* for Resident A, dated 07/25/2023.

ALLEGATION: Resident A had a ruptured catheter, which resulted in a urinary tract infection and damage to Resident A's kidneys.

INVESTIGATION:

On 09/06/2023, I received this complaint through the BCHS On-line Complaint System. Complainant reported that Resident A is diagnosed with an intellectual disability, chronic kidney disease, neurogenic bladder, dementia, and type II diabetes. Complainant reported that on 08/27/2023, Resident A was admitted to Borgess Hospital. Complainant alleged that while at the hospital, Resident A was diagnosed with a ruptured catheter, which caused damage to Resident A's kidneys and a urinary tract infection. Complainant added that Resident A would be discharged to a rehabilitation facility on 09/06/2023 and would not be returning to this facility. I noted Complainant disclosed the allegations were derived from medical charting and not from direct observations of Resident A.

On 09/07/2023, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Denise Rogers regarding the allegations. Denise Rogers reported this was her first day working at this facility but had been in training to serve as the program director. Denise Rogers reported she was unfamiliar with the details of Resident A's care.

While at the facility, I interviewed direct care staff Annette Reeber. Annette Reeber reported working at this facility for over a year. Annette Reeber was able to recall working with Resident A and clarified that Resident A was currently at the hospital for a urinary tract infection. Annette Reeber acknowledged that Resident A utilized a catheter but clarified that direct care staff would only help empty and flush the catheter bag connected to Resident A's catheter. Annette Reeber reported Resident A's catheter and tubing is changed at this doctor's office monthly.

On 09/07/2023, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 08/31/2022. The *Assessment Plan for AFC Residents* for Resident A documented that direct care staff will empty Resident A's catheter bag as needed. On 09/07/2023, I reviewed a *Beacon Specialized Living Provider Contact Sheet* from Bronson Hospital for Resident A, dated 01/03/2023. The *Beacon Specialized Living Provider Contact Sheet* from Bronson Hospital for Resident A documented the reason for Resident A's emergency room appointment was issues with Resident A's suprapubic catheter and pain in his lower back. The *Beacon Specialized Living Provider Contact Sheet* from Bronson Hospital for Resident A documented that Resident A was diagnosed with acute catheter-associated urinary tract infection and urinary tract obstruction. The *Beacon Specialized Living Provider Contact Sheet* from Bronson Hospital for Resident A documented that Resident A was provided with antibiotics and instructions to return to the hospital if Resident A develops a fever.

On 09/07/2023, I reviewed the *Beacon Specialized Living Provider Contact Sheet* from Bronson Urology for Resident A, dated 01/25/2023, 02/03/2023, 03/16/2023, 04/06/2023, 05/30/2023, and 06/26/2023, documenting Resident A's monthly catheter care. I noted there was no monthly catheter care appointment for Resident A for the months of July and August of 2023.

On 10/25/2023, I interviewed Guardian A1 regarding the allegations. Guardian A1 clarified that Resident A had been discharged and sent to a long-term care facility. Guardian A1 acknowledged receiving a request to treat from Borgess Hospital, which was provided. Guardian A1 acknowledged that Resident A's catheter was emptied by direct care staff and this catheter was changed monthly by his urologist. Guardian A1 reported that Resident A is transported to his urologist by Kalamazoo Integrated Service case manager Abbie Mitchell.

On 10/24/2023, I interviewed Amy Zapf, RN, regarding the allegations. Amy Zapf reported she was overseeing this facility when Resident A was sent to the hospital. Amy Zapf reported she was the one who instructed direct care staff to have Resident A transported to the hospital on 08/27/2023. Amy Zapf reported direct care staff had called and informed her that Resident A was incontinent of bowel and bladder. Amy Zapf reported Resident A was also refusing to eat. Amy Zapf reported that since Resident A had a catheter, there should not have been any urine in his bedding, and therefore she instructed direct care staff to have Resident A examined at the hospital. Amy Zapf acknowledged that Resident A was discharged from this facility and would not be returning.

On 10/27/2023, I contacted Marquette Duncan, medical assistant at Bronson Urology. Marquette Duncan reported the last time Resident A was provided with monthly catheter care at Bronson Urology was 07/11/2023. Marquette Duncan reported Resident A was on a three-week rotation for his catheter care. Marquette Duncan reported that Resident A's appointment on 07/26/2023 and a make-up appointment on 08/01/2023 were cancelled. Marquette Duncan clarified the Bronson

Urology office was called and notified on 07/25/2023 that Resident A's catheter bag was not draining and recommended that Resident A be taken to the ER. Marquette Duncan reported the appointments on 07/26/2023 may have been cancelled if Resident A had received catheter care at the ER. Marquette Duncan reported Resident A was a no-call/no-show for his catheter care appointment on 08/16/2023. When asked if Resident A's missed or cancelled appointments could be responsible for Resident A's catheter rupturing or Resident A's urinary tract infection on 08/26/2023, Marquette Duncan agreed. Marquette Duncan reported that sediment can build up in the catheter and not allow the catheter to drain properly or block the catheter from draining completely, contributing to a ruptured catheter or urinary tract infection. Marquette Duncan noted that on one occasion of Resident A's monthly catheter care, 800ML of fluid was drained from Resident A's catheter due to his catheter not draining properly.

On 10/27/2023, I completed an exit conference with licensee designee Ramon Beltran. Ramon Beltran acknowledged that some medical appointments may have been missed and related this to previous administrator that did not communicate needed appointments. Ramon Beltran reported this administrator was no longer employed by this facility.

On 10/28/2023, direct care staff Denise Rogers provided a *Beacon Specialized Living Provider Contact Sheet* for Resident A, dated 07/25/2023 and occurring at Borgess PIPP Hospital. The reason for the appointment listed on the *Beacon Specialized Living Provider Contact Sheet for Resident A* was "catheter issues", decreased urine output and pain in Resident A's groin. The written orders and instructions on this *Beacon Specialized Living Provider Contact Sheet* for Resident A documented that Resident A was to complete a full course of antibiotics, follow up with urology in 1-3 days and return if Resident A develops a fever or worse symptoms. The *Beacon Specialized Living Provider Contact Sheet* for Resident A did not identify a treating physician.

According to SIR # 2022A1024054, dated 11/07/2022 the facility was in violation of rule 400.14305 when it was established that 09/14/202, Resident A was not provided with adequate protection and safety when a resident eloped from this facility and illegally entered a private residence, despite direct care staff being aware of this resident's history of eloping and the need to be closely monitored. The facilities approved Corrective Action Plan (CAP) dated 11/09/2023 stated this resident would be transitioned to a more secure setting, involved direct care staff would receive progressive discipline, and the supervision requirements for this resident would be increased.

According to SIR # 2023A1024052, dated 08/31/2022, the facility was in violation of rule 400.14305 when a resident was left unattended for hours in the facility vehicle while two direct care staff attended job interviews at another agency. As of 10/27/2023, this facility had not provided a Corrective Action Plan (CAP).

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Based upon my investigation, which consisted of interviews with Bronson Urology medical assistant Marguette Duncan and licensee designee Ramon Beltran, as well as a review of pertinent facility documentation relevant to this investigation, Resident A's catheter care appointments were not maintained on a three-week rotation as instructed by Resident A's health care professionals. Instructions for Resident A to follow up with urology within one to three days after emergency room treatment at Borgess PIPP Hospital were cancelled on 08/01/2023. Resident A's catheter care appointments were cancelled on 07/26/2023 and 08/01/2023 and Resident A was a no call/ no show at this catheter care appointment on 08/16/2023.
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:	Based upon my investigation, which consisted of interviews with Bronson Urology medical assistant Marguette Duncan and licensee designee Ramon Beltran, as well as a review of pertinent facility documentation relevant to this investigation, Resident A's missed catheter care appointments contributed to Resident A's ruptured catheter and urinary tract infection. As such, Resident A's personal need for protection and safety was not attended to at all times.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference SIR #2022A1024054 dated 11/07/2022 and CAP dated 11/09/2022].** **[Reference SIR #2023A1024052 dated 08/31/2023].**

ALLEGATION: Resident A appeared as if he was not being fed.

INVESTIGATION:

On 09/06/2023, Complainant alleged that on 08/26/2023, Resident A was sent to the hospital for generalized weakness and did not appear to be properly eating or drinking.

On 09/07/2023, I completed an unannounced investigation on-site at this facility and reviewed the *Resident Weight Record* for Resident A. The *Resident Weight Record* for Resident A documented that Resident A weighed 167lbs in January 2023 and weighed 169lbs in August 2023. I noted the *Resident Weight Record* for Resident A had no significant weight loss or weight gain.

On 09/07/2023, I reviewed the *Health Care Appraisal* for Resident A, dated 02/02/2023. The *Health Care Appraisal* for Resident A documented that Resident A is diagnosed with diabetes type II, hyperlipidemia, impulse disorder, adjustment disorder, intellectual and developmental disability, and depression. The *Health Care Appraisal* for Resident A documented Resident A's general appearance as, "Frail." The *Health Care Appraisal* for Resident A documented that Resident A is 6'1" in height with an ideal weight range of 174lbs.

On 09/07/2023, I interviewed direct care staff Annette Reeber regarding the allegations Annette Reeber acknowledged that Resident A was provided with three meals a day in addition to snack and denied that Resident A ever missed or refused a meal for any reason. Annette Reeber denied ever not having food to provide residents in this facility and acknowledged being aware of another facility that was investigated for no having food.

While at the facility, I interviewed Resident B regarding the allegations. Resident B could not recall how long she had lived at this facility. Resident B acknowledged receiving three meals a day in addition to snack and denied ever not being provided with a meal for any reason.

While at the facility, I inspected the kitchen and found menus posted in addition to an appropriate supply of shelf stable and frozen food.

On 10/24/2023, I interviewed Amy Zapf, RN, regarding the allegations. Amy Zapf reported that on the day of Resident A's hospitalization, Resident A was also refusing to eat. Amy Zapf reported she instructed direct care staff to have Resident A sent to the ER.

On 10/25/2023, I interviewed Guardian A1 regarding the allegations. Guardian A1 acknowledged that Resident A is of thinner stature and when informed Resident A's most recent weight was 169lbs, Guardian A1 stated this weight was much improved, as Resident A had weighed 142lbs in the past.

On 10/25/2023, I interviewed Integrated Services of Kalamazoo case manager Abbie Mitchell regarding the allegations. Abbie Mitchell denied having any concerns about Resident A being provided with food or meals or water in this facility and reported that Resident A frequently eats while at this facility.

On 10/26/2023, I interviewed Resident A regarding the allegations. Resident A denied ever not being provided with a meal by staff for any reason and denied ever refusing a meal.

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 upon my investigation, which consisted of interviews with direct care staff Annette Reeber, Resident A, Resident B, and Guardian A1, as well as a review of pertinent facility documentation relevant to this investigation, there is not enough evidence that Resident A was not provided with a minimum of three regular nutritious meals daily.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was disheveled, had poor hygiene and was covered in feces.

INVESTIGATION:

On 09/06/2023, Complainant alleged that while at the hospital, Resident A was disheveled, had poor hygiene and was covered in feces.

On 09/07/2023, I interviewed direct care staff Annette Reeber regarding the allegations. Annette Reeber acknowledged that Resident A is a full assist when showering and reported that Resident A is provided with assistance in the shower at most every day and at least every other day. Annette Reeber reported that Resident A is provided with full assistance with his adult undergarments and direct care staff provided this assistance to Resident A when he informs them. Annette Reeber denied ever not having the undergarment supplies to change Resident A, stating that facility nurses usually order these supplies.

On 10/25/2023, I interviewed Guardian A1 regarding the allegations. Guardian A1 acknowledged she was informed that Resident A looked disheveled and hadn't been eating when examined at the hospital and clarified that Resident A always looks disheveled but was unaware that Resident A was incontinent of bowel and does not have a history of this behavior. Guardian A1 reported that Resident A had been "in and out" of the hospital recently but was observed in this facility every few months with no concerns for his cleanliness or hygiene.

On 10/25/2023, I interviewed Integrated Services of Kalamazoo case manager Abbie Mitchell regarding the allegations. Abbie Mitchell reported her only concerns for Resident A's hygiene is that she would observe Resident A with discolored nails and nailbeds due to eating foods with his fingers. Abbie Mitchell denied ever observing Resident A incontinent and not provided with direct care staff assistance.

On 10/26/2023, I interviewed Resident A regarding the allegations. Resident A acknowledged using adult undergarments and denied ever not having the supplies to change these adult undergarments when necessary. Resident A reported that he is allowed the opportunity to shower on his own several times a week or as he feels necessary. Resident A recalled the day of the allegations and reported that he had pain in his stomach area. Resident A reported direct care staff arranged for him to be taken to the hospital. Resident A reported that once he was at the hospital, hospital staff had pulled out his catheter and caused urine to go "everywhere." Resident A denied this event occurred at the facility and clarified that he was incontinent while at the hospital. Resident A denied being incontinent since this event.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care staff Annette Reeber, Guardian A1, and Resident A, as well as a review of pertinent facility documentation relevant to this investigation, there was not enough evidence that Resident A was not provided with the opportunity and instructions necessary for daily bathing and personal hygiene.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 10/25/2023, I contacted licensee designee Ramon Beltran and requested the *Incident Report* related to Resident A's hospitalization on 08/27/2023. Ramon Beltran reported that he would request a copy of this report from the facility directly.

On 10/27/2023, I again requested a copy of the *Incident Report* for Resident A's hospitalization on 08/27/2023. Ramon Beltran reported he had contacted this facility and an *Incident Report* was not available for Resident A's hospitalization on 08/27/2023.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(b) Unexpected and preventable inpatient hospital admission.** **(4) The department may review incident reports during a renewal inspection or special investigation. This does not prohibit the department from requesting an incident report if determined necessary by the department. If the department does request an incident report, the licensee shall provide the report in electronic form within 24 hours**

	after the request. The department shall maintain and protect these documents in accordance with state and federal laws, including privacy laws.
ANALYSIS:	There was no incident report documenting Resident A's unexpected hospitalization on 08/27/2023 available for review as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

10/27/2023

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Eli DeLeon Date
Licensing Consultant

Approved By:

11/01/2023

_____

Dawn N. Timm Date
Area Manager