STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 29, 2023

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

RE: License #: AM030402101
Investigation #: 2023A1024050
Beacon Home at Hammond

Dear Ramon 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 (616) 356-0183.

Sincerely,

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM030402101
Investigation #:	2023A1024050
Complaint Receipt Date:	08/08/2023
Investigation Initiation Date:	08/10/2023
Report Due Date:	10/07/2023
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, Designee
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 eloped from the facility to search for alcohol at a nearby party store. Direct care staff members did not provide Resident A with provide protection and safety.	No
Staff member Jordan Lago mistreats residents in the facility.	Yes

III. METHODOLOGY

08/08/2023	Special Investigation Intake 2023A1024050
08/10/2023	Special Investigation Initiated – Telephone with staff member Jamara White
08/10/2023	Contact - Telephone call made with Adult Protective Service (APS) Specialist Kathleen Woodworth
08/10/2023	APS Referral- APS already involved
08/10/2023	Contact - Document Received-*Police Report* #2023-00001727 regarding Resident A
08/18/2023	Contact - Document Received-Resident A's Assessment Plan for AFC Residents and *Behavior Support Plan*
08/24/2023	Contact - Document Received-additional allegations from Intake #197225 regarding Resident B
08/28/2023	Inspection Completed On-site with direct care staff members Jordan Lago, Keefa Burnett, Annette Reeber, Curtis Cannon Resident A and Resident B
08/28/2023	Contact - Telephone call made with Recipient Rights Officer (RRO) Stephanie Short
08/29/2023	Contact-Telephone call made with direct care staff member Amber Wiersma and Jamara White
08/31/2023	Inspection Completed On-site with direct care staff members Jana Melton, Kalea Love, Rachell Cornell, Resident C, D, and E
09/22/2023	Contact - Telephone call made with Guardian A1

09/25/2023	Contact - Telephone call made with direct care staff member Sierra Cooper
09/26/2023	Contact-Face to Face with staff member Nichole VanNiman
09/26/2023	Exit Conference with licensee designee Ramon Beltran
09/26/2023	Inspection Completed-BCAL Sub. Compliance
09/26/2023	Corrective Action Plan Requested and Due on 10/10/2023

ALLEGATION: Resident A eloped from the facility to search for alcohol at a nearby party store. Direct care staff members did not provide Resident A with protection and safety.

INVESTIGATION:

On 8/8/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint systems. This complaint alleged Resident A eloped from the facility to search for alcohol at a nearby party store and was not provided with protection, safety and supervision from direct care staff members.

On 8/10/2023, I conducted an interview with direct care staff member Jamara White who stated that Resident A eloped on 8/4/2023 while he was sitting on the porch of the facility. Jamara White stated there was one staff working with Resident A with three other residents when he left the facility as the other three direct care staff members were out in the community with other residents. Jamara White stated Resident A has a history of eloping during summer months however has not had many occurrences this summer as Resident A claims to be working on his goals towards moving to an independent setting. Jamara White stated Resident A snuck off the porch because he stated he wanted to buy alcohol. Jamara White stated police were called since direct care staff member Sierra Cooper was not able to search for Resident A without leaving the remaining residents without supervision and the other direct care staff members were supervising residents on outings. The police found Resident A down the street from the facility and brought him back to the facility within about 45 minutes of Resident A leaving the facility. Jamara White stated Resident A requires staff supervision in the community however is not a required to have 1:1 staff supervision while in the community. Jamara White stated Resident A has eloped twice this year however those behaviors have decreased since the beginning of the summer. Jamara White further stated direct care staff member Sierra Cooper was surprised that Resident A eloped while on the porch as the other elopement incidents occurred during the late evening hours when the overnight direct care staff members were working. Jamara White also stated she believed direct care staff member Sierra Cooper had no way of knowing Resident A would leave the porch area when she went inside to tend to another resident as Resident A routinely sits on the porch of the facility without eloping.

On 8/10/2023, I conducted an interview with Adult Protective Service (APS) Specialist Kathleen Woodworth who stated she will not be substantiating abuse or neglect after Resident A eloped from the facility as direct care staff member working had no indication Resident A would elope and responded appropriately by seeking assistance from law enforcement to help locate Resident A.

On 8/10/2023, I reviewed *Police Report* dated 8/4/2023 written by Otsego Police Department, Officer Alyssa McLaughlin. According to this report, at approximately 5:10pm law enforcement was dispatched and advised that Resident A had walked away from the facility and direct care staff member Sierra Cooper was not able to leave immediately to search for Resident A because she was currently the only staff member at the facility with other residents. The report stated Resident A was located in the 100 block of Hammond Street by officer McLaughlin and was advised by Resident A that he went to the store to purchase alcohol and wanted to be taken to Lansing where he is originally from. Officer McLaughlin asked Resident A to walk back to the facility and after an hour later Resident A chose to go back to the facility.

On 8/18/2023, I reviewed Resident A's Assessment Plan for AFC Residents dated 1/10/2023. According to this assessment, Resident A is required direct care staff monitoring while in the community however does not require 1:1 direct care staff supervision. I also reviewed Resident A's *Behavior Support Plan* dated 12/10/2022. According to this plan, Resident A has a history and target behaviors of eloping such as leaving the property without staff supervision, panhandling such as asking strangers in the community to give him preferred items and alcohol use. There is no mention in the report that Resident A requires 1:1 staff supervision.

On 8/28/2023, I conducted an onsite investigation at the facility and interviewed direct care staff members Jordan Lago, Keefa Burnett, Annette Reeber, and Curtis Cannon who all stated being surprised when they heard about Resident A's elopement because he had never eloped during daytime hours. These direct care staff members further stated that Resident A's elopement behaviors have occurred during summer months however have decreased significantly this year with only one occurrence in the late evening hours of the day a couple of months ago.

While at the facility, I also conducted an interview with Resident A who stated that he was sitting on the porch like he normally does and suddenly felt like going to get alcohol from a local nearby store, so he snuck off the porch while the direct care staff member was assisting another resident in the home. Resident A stated he has not been "running away" from the facility lately because he wants to move back home closer to family and is trying to get community access without staff supervision. Resident A stated he does not plan on eloping from the facility anymore because he wants to work on his treatment goals.

On 9/22/2023, I conducted an interview with Guardian A1 who stated Resident A has a history of eloping from adult foster care facilities and she would like to see Resident A reside in a more secure fenced facility where he is not able to easily leave the property. Guardian A1 stated she has talked to Community Mental Health (CMH) about this however they have denied this request as Resident A only elopes during certain times of the year, generally when it is warmer outside, to seek alcohol and CMH believes this is a behavior Resident A can work on as part of his behavior support plan.

On 9/25/2023, I conducted an interview with direct care staff member Sierra Cooper who stated that on 8/4/2023 she was working with three other staff members who went on community outings with other residents leaving her in the home with four residents. Sierra Cooper stated all the residents were “in a good space” and did not demonstrate any agitation or signs of elopement including Resident A. Sierra Cooper stated she had been sitting outside on the porch with Resident A but went inside the facility to speak to another resident and upon return to the porch approximately 5 minutes later, she discovered that Resident A was no longer sitting on the porch. Sierra Cooper stated after searching the exterior areas of the property she realized Resident A had eloped. Sierra Cooper stated she left a voicemail for other staff members who were on a community outing and called the police for search assistance since she was not able to leave the residents unattended to search for Resident A. Sierra Cooper stated police ended up locating Resident A down the street from the facility. Sierra Cooper stated it was very unusual for Resident A to elope during the day and she has never experienced this behavior with him before. Sierra Cooper stated Resident A’s normal routine is to sit on the porch, sleep in his bedroom for most of the day and come out to the common areas to eat meals.

On 09/26/2023, I conducted an interview with staff member Nichole VanNiman who stated that she has discussed Resident A’s most recent elopement with his mental health team, and they have all decided to relocate Resident A to a more secured setting with a fence surrounding the property in another county.

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 on my investigation which included interviews with APS Specialist Kathleen Woodworth, direct care staff members Jamara White, Jordan Lago, Keefa Burnett, Annette Reeber, Curtis Cannon, Sierra Cooper, and Nichole VanNiman and Guardian A1, along with my review of Resident A's assessment plan, behavior support plan, and police report there is no evidence direct care staff members did not provide Resident A with protection and safety when he eloped from the facility. All staff members interviewed stated that although Resident A has a history of having elopement issues, he has never eloped during the daytime hours, he gave no behavioral or verbal indications of his desire to elope and his incidents of eloping have decreased significantly this year with only having one or two elopements a couple of months ago. Direct care staff member Sierra Cooper had no reason to suspect Resident A would elope since he usually sat on the porch during daytime hours. Since this elopement incident, Nichole VanNiman stated she has gotten approval from Resident A's mental health provider to relocate Resident A to a more secure setting therefore will be discharged from the facility soon.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff member Jordan Lago mistreats residents in the facility.

INVESTIGATION:

On 08/24/2023, I received additional allegations that stated direct care staff member Jordan Lago mistreats residents in the facility. The complaint further stated Jordan Lago grabbed Resident B's wrist causing Resident B to fall to the floor and stated, "I'm not fucking helping you because you did this to yourself."

On 8/28/2023, I conducted an onsite investigation at the facility with direct care staff members Jordan Lago, Keefa Burnett, Annette Reeber, Curtis Cannon and Resident B. Jordan Lago stated she had an incident with Resident B when she was coming out of the medication room. Jordan Lago stated Resident B was upset because her personal spending money did not come in the mail for her from her representative payee and Resident B kept yelling at direct care staff members about not getting her money. Jordan Lago stated she noticed Resident B raising her hand towards newer direct care staff member Amber Wiersma, therefore she positioned herself in front of Resident B and asked her to stop yelling at direct care staff members. Jordan Lago stated Resident B then grabbed her hair and Jordan Lago pulled her hair from Resident B's grip and walked away from Resident B. Jordan Lago stated she did not see Resident B fall during this incident and she did not swear at Resident B. Jordan Lago stated she politely asked Resident B to wait to speak with another direct care staff member

concerning her money. Jordan Lago stated she only intervened to try to de-escalate the situation. Jordan Lago stated Resident B eventually was able to talk to her social worker who was able to connect with her representative payee regarding her personal spending money that she was looking for in the mail.

Keefa Burnett stated she did not observe the entire incident between Jordan Lago and Resident B however she saw Resident B grab on to Jordan Lago's hair and Jordan Lago pulled her hair from Resident B's grip and walked away from Resident B. Keefa Burnett stated she did not hear Jordan Lago yell or swear at Resident B and did not see Resident B fall to the floor. Keefa Burnett further stated she heard Jordan Lago tell Resident B to be patient and wait to speak with the district director regarding her spending money. Keefa Burnett stated the situation was resolved after Jordan Lago advised Resident B to be patient.

Annette Reeber and Curtis Cannon both stated they have never seen Jordan Lago mistreat any of the residents including swearing and yelling at the residents.

While at the facility I also interviewed Resident B who stated that she does not remember the incident however remembers that she was feeling really anxious while waiting to receive her personal spending money therefore she pulled Jordan Lago's hair. Resident B stated she immediately calmed down after she pulled her hair and eventually received her $20 of personal spending money. Resident B stated she remembers almost falling after pulling Jordan Lago's hair however she does not remember why she almost fell to the floor. Resident B stated she ended up going to her bedroom after the incident and waited to speak with her social worker regarding her spending money.

On 8/28/2023, I conducted an interview with RRO Stephanie Short who stated that she is substantiating this allegation for neglect after interviewing direct care staff member Amber Wiersma who witnessed Jordan Lago yell, swear and knock Resident B down to the floor.

On 08/29/2023, I conducted an interview with direct care staff member Amber Wiersma and Jamara White regarding this allegation. Amber Wiersma stated she observed staff member Jordan Lago yell, swear at and push Resident B down to the floor when Resident B was confronting staff members about her personal spending money. Amber Wiersma stated Jordan Lago responded very inappropriately to Resident B when she initially asked about her money by screaming at Resident B yelling, "you ain't [sic] getting no fucking money so go to your fucking room!" Amber Wiersma stated Resident B raised her arm towards Jordan Lago and Jordan Lago blocked Resident B from hitting her. Jordan Lago then grabbed Resident B's wrist and during this time Resident B grabbed Jordan Lago's hair while falling to the ground hitting her leg on a nearby mop bucket. Amber Wiersma stated direct care staff members Keefa Burnett and Curtis Cannon were also present during this incident. Direct care staff member Jamara White was in the staff office however did not witness the incident until another resident came into the office to speak to Jamara White and Jordan Lago yelled at the resident and

stated, “get the fuck out of the office.” Amber Wiersma stated Jamara White told Jordan Lago “that is enough and to stop talking to the resident in this way.” Amber Wiersma stated she has heard Jordan Lago repeated yell and swear at all the residents and seems very frustrated working in the home.

Jamara White stated she has never heard Jordan Lago swear at the residents however she has heard her yell at the residents and has prompted Jordan Lago to speak to the residents better. Jamara White stated she did not witness the incident between Jordan Lago and Resident B however when she came out of the office after the incident occurred, she saw Resident B sitting on the floor in the kitchen area and Jordan Lago informed her that Resident B grabbed her hair and voluntarily dropped to the floor. Jamara White stated Resident B began to discuss with her about her personal spending money and did not disclose any events of the incident to her. Jamara White further stated Amber Wiersma did not report what she observed until after she notified RRO after her shift was over.

On 8/31/2023, I conducted an onsite investigation at the facility with direct care staff members Jana Melton, Kalea Love, Rachell Cornell who all stated Jordan Lago regularly swears at the residents as part of her normal language used towards residents and will make statements to residents such as “go to your fucking room” or “shut the fuck up.” Jana Melton and Rachell Cornell both stated that Jordan Lago is “horrible” towards the residents, and they have reported her inappropriate behaviors to manager, Jamara White who has told them that she was not able to do anything about Jordan Lago’s behavior.

Residents C, D, E, all stated that Jordan Lago regularly yells and swears at them, and no one can make her change her behavior. Resident C, D, and E also stated they do not like to be around Jordan Lago and do not feel safe with her.

On 9/25/2023, I conducted an interview with direct care staff member Sierra Cooper who stated that she has worked with Jordan Lago on multiple occasions and has observed Jordan Lago swear at the residents when giving direction and yell at residents. Sierra Cooper further stated she believes Jordan Lago is regularly inappropriate when she speaks to residents and does not treat residents in a respectful manner.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or

	physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on my investigation which included interviews with direct care staff members Jamara White, Jordan Lago, Keefa Burnett, Annette Reeber, Curtis Cannon, Sierra Cooper, Jana Melton, Kalea Love, Rachell Cornell, Amber Wiersma, and Nichole VanNiman, and RRO Stephanie Short and Residents B, C, D, E there is evidence direct care staff member Jordan Lago regularly yells and swears at residents in the facility. Residents B, C, D, and E also stated direct care staff member Jordan Lago mistreats them by constantly yelling and swearing at them making them feel unsafe when she is working. Jamara White stated she had to intervene during an incident when Jordan Lago was observed yelling at a resident and Amber Wiersma also stated that she witnessed Jordan Lago grab Resident B causing her to fall to the floor while yelling and swearing at her. Based on this information, I determined residents are mistreated by staff member Jordan Lago.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/26/2023, I conducted an exit conference with licensee designee Ramon Beltran. I informed Mr. Beltran of my findings and allowed him an opportunity to ask question or make comments.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the current license status remain unchanged.

09/26/2023

Ondrea Johnson
Licensing Consultant

Date

Approved By:

09/29/2023

Dawn N. Timm
Area Manager

Date