GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 17, 2023

Janice Hurst
Progressive Residential Services Inc
Suite # 265
6001 N. Adams Road
Bloomfield Hills, MI 48304

RE: License #: AS130010454
Investigation #: 2023A1024051
Beachfield AIS/MR

Dear Mrs. Hurst:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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

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

I. IDENTIFYING INFORMATION

License #:	AS130010454
Investigation #:	2023A1024051
Complaint Receipt Date:	08/22/2023
Investigation Initiation Date:	08/23/2023
Report Due Date:	10/21/2023
Licensee Name:	Progressive Residential Services Inc
Licensee Address:	Suite # 265 6001 N. Adams Road Bloomfield Hills, MI 48304
Licensee Telephone #:	(248) 641-7200
Administrator:	Ashambi Guy
Licensee Designee:	Janice Hurst
Name of Facility:	Beachfield AIS/MR
Facility Address:	118 Beachfield Drive Battle Creek, MI 49015
Facility Telephone #:	(248) 641-7200
Original Issuance Date:	03/02/1992
License Status:	REGULAR
Effective Date:	12/20/2021
Expiration Date:	12/19/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff members will not allow Resident A to return to the facility when he is discharged from the hospital due to his behaviors.	No

III. METHODOLOGY

08/22/2023	Special Investigation Intake 2023A1024051
08/23/2023	Special Investigation Initiated – Telephone with Bronson social worker Sandrena Hall
08/23/2023	Contact - Telephone call made with mental health case manager Kate Koyak
08/29/2023	Inspection Completed On-site-with direct care staff members with Benika Matthis, Monica Lee and Williams Chesney
09/13/2023	Contact - Document Received-*30-Day Discharge Notice*
10/11/2023	Exit Conference-with licensee designee Janice Hurst

ALLEGATION: Staff members will not allow Resident A to return to the facility when he is discharged from the hospital due to his behaviors.

INVESTIGATION:

On 8/22/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged staff members will not allow Resident A to return to the facility when he is discharged from the hospital due to his behaviors. The complaint further stated Resident A will not have a place to go when he is discharged from the hospital.

On 8/23/2023, I conducted an interview with Bronson ER social worker Sandrena Hall who stated the referral to Licensing and Regulatory Affairs (LARA) was made prematurely as Resident A was discharged from the hospital last night back to the facility. Sandrena Hall stated when Resident A initially came to the hospital the AFC facility manager stated to her the eviction process was going to start due to Resident A's behaviors which had caused a disruption to other residents. Sandrena Hall stated Resident A's case manager, Kate Koyak, got involved and spoke to the facility regarding Resident A's behaviors and arranged for Resident A to return to the facility.

On 8/23/2023, I conducted an interview with Resident A's mental health case manager Kate Koyak who stated direct care staff members called the police and sent Resident A to the hospital due to Resident A masturbating in front of residents, exhibiting aggressive behaviors towards direct care staff members and physical aggression attempts towards other residents. Kate Koyak stated a week prior to this incident, Resident A demonstrated repeated property destruction at the facility therefore direct care staff members were challenged with Resident A's most recent behaviors. Kate Koyak further stated that Resident A is nonverbal and has a hard time being redirected. Kate Koyak stated when Resident A went to the hospital, direct care staff members discussed discharge with her and hospital staff, however, did not say Resident A was not allowed to return to the facility if alternative placement was not obtained. Kate Koyak stated alternative placement is being actively sought out by Resident A's mental health provider Summitt Pointe but the facility is willing to keep Resident A in the home until alternative placement is secured.

On 8/29/2023, I conducted an onsite investigation at the facility with direct care staff members Benika Matthis, Monica Lee and Williams Chesney. Benika Mathis and Monica Lee both stated direct care staff members contacted 911 because Resident A was attacking direct care staff members and other residents in the facility. Moncia Lee and Benika Mathis also stated when the police came out to the home, Resident A continued to demonstrate aggressive behaviors therefore, EMS transported Resident A to the hospital for a psychiatric evaluation. Benika Matthis stated Resident A is new to the facility and was admitted on July 4, 2023. Benika Matthis they are getting to know Resident A better and he is now exhibiting physical aggressive and sexual behaviors that were not disclosed to them in the admission process. Benika Matthis stated she contacted 911 because she needed to keep other residents safe and Resident A was not responding to her prompting and redirection. Benika Matthis stated she spoke to both Resident A's case manager and social worker at the hospital about Resident A's behaviors and the need for alternative placement if Resident A was going to continue to make attempts to physically assault direct care staff and residents. Benika Matthis stated Resident A's mental health case manager Kate Koyak approved for 1:1 staff supervision and arranged for Resident A to return to the facility however Resident A's mental health treatment team will be speaking to her management to determine if the facility remains a proper fit for Resident A and if his needs can still be met.

Direct care staff member Monica Lee stated Resident A has been exhibiting new behaviors that he did not demonstrate when he was admitted in July of 2023. Moncia Lee stated recently Resident A has exhibited self-injurious behaviors, property destruction, and has been acting out sexually in front of other residents. Moncia Lee stated she does not believe Resident A would have been admitted to the facility if his mental health provider would have disclosed Resident A's behaviors more accurately. Monica Lee further stated she has no knowledge of any staff member telling the hospital that Resident A could not return to the facility however it was discussed with the hospital and mental health providers that Resident A needed to be de-escalated before he returned, and it was recommended by staff members that psychiatric placement be considered.

Direct care staff member William Chesney stated that he facilitated Resident A's admission at the facility and there were behaviors of physical aggression not disclosed by the mental health provider when conducting Resident A's assessment to determine his care needs. William Chesney stated he has been working with Resident A's mental health providers and a 30-day discharge notice is being discussed as Resident A may not be compatible with the other residents due to his behaviors. William Chesney stated he is going to continue to closely monitor Resident A's behaviors and will work closely with his mental health treatment plan to determine if Beachfield AIS/MR is the best setting for him.

On 9/13/2023, I reviewed Resident A's *30-Day Discharge Notice* dated 9/12/2023. This notice stated that a discharge notice is being issued to Resident A due to ongoing physical aggression and sexual behaviors displayed.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.

ANALYSIS:	Based on my investigation which included interviews with social worker Sandrena Mathis, mental health case manager Kate Koyak, direct care staff members Benika Matthis, Monica Lee and Williams Chesney along with my review of Resident A's *30-Day Discharge Notice* there was no evidence direct care staff members did not allow Resident A to return to the facility after he was discharged from the hospital due to his behaviors. Sandrena Mathis stated she believes the referral to Licensing and Regulatory Affairs (LARA) was made prematurely as Resident A was discharged from the hospital last night back to the facility arranged by his mental health provider. Kate Koyak stated when Resident A went to the hospital, staff members discussed discharge with her and hospital staff, however, did not say Resident A was not allowed to return to the facility if alternative placement was not obtained. Staff members allowed Resident A back to the facility and stated they would work with Resident A's mental health providers to determine the best setting for Resident A. A few weeks after Resident A returned to the facility a 30-day written discharge notice was provided to Resident A on 9/12/2023 for ongoing physical aggression and sexual behaviors and sent to his designated representatives.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/11/2023, I conducted an exit conference with licensee designee Janice Hurst. I informed Janice Hurst of my findings and allowed her an opportunity to ask questions and make comments.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.

Ondrea Johnson
Licensing Consultant

10/11/2023
Date

Approved By:

10/17/2023

Dawn N. Timm
Area Manager

Date