GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 29, 2023

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

RE: License #: AS370413382
Investigation #: 2023A1029065
Beacon Home At Nottawa

Dear Roxanne Goldammer:

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370413382
Investigation #:	2023A1029065
Complaint Receipt Date:	09/28/2023
Investigation Initiation Date:	09/28/2023
Report Due Date:	11/27/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St. Suite 110, Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home At Nottawa
Facility Address:	7302 S Nottawa Rd, Mount Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/14/2022
License **Status:**	REGULAR
Effective Date:	05/14/2023
Expiration Date:	05/13/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was left without 1:1 staffing coverage on September 22, 2023, because Ms. O'Connor was spending time with Ms. O'Dell and her family in the driveway at Beacon Home at Nottawa.	Yes
On September 22, 2023 direct care staff members Kaylie O'Dell and Olivia O'Connor smoked marijuana in the driveway at Beacon Home at Nottawa.	No
Residents residing at Beacon Home at Nottawa are often found in the road or down the street without supervision.	Yes

III. METHODOLOGY

09/28/2023	Special Investigation Intake 2023A1029065
09/28/2023	Special Investigation Initiated – Letter to Sarah Watson ORR
09/29/2023	Contact - Telephone call made to Sarah Watson ORR
10/03/2023	Contact - Document Received -Additional concerns sent from BCHS complaints.
10/03/2023	Contact - Document Received from Sarah Watson ORR
10/06/2023	Contact - Document Received Email from Marlo Derry
10/06/2023	Inspection completed on-site - Face to Face with Naomi Vorhees, Roxanne Goldammer, Lauren Lora, Residents A, B, C, D, and E, Jamie Cooper
10/26/2023	Contact - Document Sent to Roxanne Goldammer and Marlo Derry
11/02/2023	APS Referral made to Centralized Intake
11/03/2023	Contact - Document Sent - Email to complainant regarding additional concerns.
11/03/2023	Inspection Completed On-site Face to Face with Naomi Vorhees, Resident A, Lauren Lora, Roxanne Goldammer at Beacon Home at Nottawa

11/03/2023	Contact - Document Received - Email from Marlo Derry and Roxanne Goldammer
11/03/2023	Contact – Email received and phone conversation with Luke Sawyer, Chief of Police
11/15/2023	Contact – Telephone call to direct care staff member Olivia O'Connor, can no longer accept calls at number, Email to Sarah Watson, Kaylie O'Dell
11/16/2023	Contact – Email from Emily Fairris, email to Chief Sawyer, Sarah Watson
11/17/2023	Contact – Telephone call to ORR Sarah Watson, sent additional concerns regarding supervision concerns to Recipient Rights, telephone call to Chief Sawyer
11/17/2023	Exit conference with licensee designee Roxanne Goldammer.

ALLEGATION: Resident A was left without 1:1 staffing coverage on September 22, 2023, because Ms. O'Connor was spending time with Ms. O'Dell and her family in the driveway at Beacon Home at Nottawa.

INVESTIGATION:

On September 28, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns that prior to starting her shift on September 22, 2023 direct care staff member Kaylie O'Dell smoked marijuana in the driveway at Beacon Home at Nottawa with direct care staff member Olivia O'Connor who was working her shift. While outside, Ms. O'Connor left Resident A unattended for 45 minutes while she was spending time in the driveway with Ms. O'Dell, her partner, and children. Office of Recipient Rights (ORR) Sarah Watson is also investigating the concerns.

On September 29, 2023, I interviewed ORR advisor, Ms. Watson who stated Ms. O'Connor advised her she was also at the facility in the driveway with her partner and children and at one point, she let her son use the restroom inside and he was found playing video games with Resident B. Ms. Watson stated Resident A and Resident B both require 1:1 staffing coverage at all times and this was not provided during this incident on September 22, 2023 because Ms. O'Connor was outside in the driveway. I reviewed the notes from Ms. Watson's interviews and noted Ms. O'Connor informed her there were approximately 5 minutes when she was not in sight of Resident A because she could not remember if there was any direct care staff member in the home when shift change occurred.

On October 4, 2023 I interviewed licensee designee Roxanne Goldammer. Ms. Goldammer stated Ms. O'Dell and Ms. Cooper resigned right after this incident. Ms. O'Connor is still an employee at Beacon Home at Nottawa. Ms. Goldammer stated Ms. Odell was outside talking to another coworker at the time Ms. Cooper was dropped off for her shift, however Ms. Odell did not recall if any of the residents were without supervision during Ms. Goldammer's interview with Ms. Odell. Ms. Goldammer stated direct care staff members were "hanging out in the driveway" while residents were in the home. Ms. Goldammer stated this included Resident A who was inside the home and requires 1:1 supervision, while his assigned 1:1 direct care staff member Ms. O'Connor was outside in the driveway not supervising him.

On October 6, 2023, I completed an on-site investigation and interviewed direct care staff member Lauren Lora. Ms. Lora stated she was working on September 22, 2023 and around 8:18 PM Ms. Odell arrived at the facility with her children and spouse. Ms. Lora stated she observed direct care staff members Ms. Cooper and Ms. O'Connor outside in the driveway with Ms. Odell. Ms. Lora stated during this time frame, Ms. Cooper and Ms. O'Connor were assigned to provide 1:1 supervision to Resident A and Resident B and the other three residents do not require 1:1 supervision however Resident A was sitting inside watching TV and Resident B was playing his game in his room so there was no way Ms. Cooper and Ms. O'Connor could see them while being outside in the driveway visiting with Ms. Odell. Ms. Lora stated she left work around 9:15 and they were still in the driveway so there was approximately one hour, Resident A did not have 1:1 staffing coverage as required.

On October 6, 2023, I interviewed Resident A, B, C, D, and E. Each resident recalled the incident when Ms. O'Dell, Ms. O'Connor, and Ms. Cooper were outside in the driveway on September 22, 2023 but none of them had any information regarding how long they were outside.

On October 6, 2023, I interviewed licensee designee Roxanne Goldammer. Ms. Goldammer the direct care staff members involved admitted to hanging out in the driveway for an unspecified amount of time while they were supposed to be working their shift and as a result leaving Resident A without 1:1 supervision as required.

During the on-site investigation, I reviewed the resident records and *Assessment Plan for AFC Residents* for Residents A, B, C, D, and E. Currently Resident A and Resident B are the only residents who require 1:1 supervision coverage. Resident A's *Assessment Plan for AFC Residents* dated February 2, 2023 for AFC Residents includes documentation he cannot move independently in the community and "Needs staff to monitor his behaviors and intervene when necessary."

Resident A's *Behavioral Treatment Plan* from CMH dated March 6, 2023 was also reviewed which included the following documentation:

"[Resident A] required 1:1 line of sight supervision 24 hours per day due to instances of property destruction and physical aggression. A designated staff member must be able to see [Resident A] in the home and in the community at a distance of several feet or more to provide support and safety. Staff may need to be closer and he may not leave the home without staff support."

Resident B's *Assessment Plan for AFC Residents* dated January 27, 2023 which includes documentation that he cannot move independently in the community and he "needs supervision" but the *Assessment Plan for AFC Residents* does not include documentation he needs 1:1 staffing. Resident B's resident record included a *Behavioral Treatment Plan* from CMH stating: "[Resident B] has a history of elopement, property destruction, and self-injury. He has enhanced supervision while in the home due to leaving the home's property and going to neighbor's homes and knocking on the doors and going in the woods behind the home, and while in the community due to increased anxiety, being overstimulated and not tolerating people he does not know."

On November 15, 2023, I interviewed former direct care staff member Kaylie O'Dell. Ms. O'Dell stated she showed up at work at 8:40 PM on September 22, 2023 and Ms. O'Connor was outside on the porch and she was outside for "about 5 minutes." Ms. O'Dell stated Resident B was on the porch during this time they were outside and during that time, she does not know if it was Ms. Cooper or Ms. O'Connor were responsible for him. Ms. O'Dell stated Resident A was also inside the house but she also did not know who was responsible for each resident because "they all worked as a team to keep an eye on all the residents." Ms. O'Dell did not recall if Resident A had a direct care staff member who was providing 1:1 supervision. Ms. O'Dell stated Resident A and Resident B both require 1:1 supervision. Ms. O'Dell stated she did not start her shift until 9 PM so she did not know where the other residents were when she arrived at 8:40 PM and saw Ms. O'Connor in the driveway however Ms. O'Dell stated there was no time they did not have 1:1 supervision for Resident A.

On November 17, 2023, I interviewed ORR Sarah Watson who stated she will be substantiating because Resident A did not receive 1:1 staffing coverage during this incident. Ms. Watson stated she did review the schedule with Ms. Goldammer and confirmed the direct care staff member assigned to Resident A on September 22, 2023 was Ms. O'Connor. Ms. Watson stated Ms. O'Connor admitted to leaving Resident A without supervision when she was in the driveway for at least a half hour.

APPLICABLE RULE	
R 400.14206	**Staffing requirements**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on the interviews from Residents A, B, C, D, and E, Ms. Goldammer, and Ms. Vorhees, Resident A and Resident B were not provided adequate 1:1 staffing coverage during the approximate time frame between 8:15PM-9:15PM on September 22, 2023 while Ms. O'Dell, Ms. O'Connor, and Ms. Cooper were in the driveway spending time with Ms. O'Dell's family when she was getting dropped off for work. Ms. Cooper and Ms. Lora confirmed Resident A was not within line of sight supervision while they were out in the driveway, therefore Resident A was not receiving the required 1:1 staffing coverage.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On September 22, 2023 direct care staff members Kaylie O'Dell and Olivia O'Connor smoked marijuana in the driveway at Beacon Home at Nottawa.

INVESTIGATION:

On September 28, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns that prior to starting her shift on September 22, 2023 direct care staff member Kaylie O'Dell smoked marijuana in the driveway at Beacon Home at Nottawa with direct care staff member Olivia O'Connor who was working her shift.

On September 29, 2023, I interviewed ORR advisor, Ms. Watson who stated she completed a visit to Beacon Home at Nottawa and after she completed her interviews, Ms. O'Dell had terminated her employment because she claimed she was insulted by the allegations of her smoking marijuana. Ms. Watson stated Resident B informed her during the interviews that he knew Ms. O'Dell was using marijuana because the smell was making him sick, but that he could not remember which direct care staff members were outside at the time of the incident. Ms. Watson stated she interviewed Resident C who advised he recalled Ms. Cooper using marijuana outside in the front of the building using a vape. Ms. Watson stated Resident C informed her he went for an outing with other residents on September 23, 2023 and he went to Ms. O'Dell's apartment with Ms. Cooper and Ms. O'Dell and their boyfriends and they went into the bedroom for about 12-20 minutes to smoke marijuana. Ms. Watson stated Resident B also confirmed this story but stated he did not know which direct care staff members were at her house.

On October 4, 2023 I interviewed licensee designee Roxanne Goldammer. Ms. Goldammer stated she cannot prove if they were using marijuana during this incident because all direct care staff members interviewed by Ms. Goldammer denied using marijuana while working. Ms. Goldammer stated only Complainant reported the allegation however Complainant was not suspicious or smelled it. Ms. Goldammer stated the employees were not drug tested after the incident.

On October 6, 2023, I interviewed direct care staff member whose current role is home manager, Naomi Vorhees, and licensee designee Roxanne Goldammer at Beacon Home at Nottawa. Ms. Vorhees stated there is a rule regarding confidentiality that prohibits their families from spending time with the residents as well as prohibiting substance use on the property. Ms. Vorhees stated she did not know if there was marijuana use on the property.

On October 6, 2023, I interviewed direct care staff member Lauren Lora at Beacon Home at Nottawa. Ms. Lora stated Ms. Cooper, Ms. O'Connor, and Ms. O'Dell were smoking marijuana by the truck for about an hour around 8:20 PM-9:15 PM. Ms. Lora stated she observed the marijuana use and smelled marijuana while they were using. Ms. Lora stated she left work around 9:15 and they were all still out there in the driveway.

On October 6, I interviewed Residents A, B, C, D, and E at Beacon Home at Nottawa. Resident A, Resident D, and Resident E all stated they could smell the marijuana so they knew Ms. O'Dell and Ms. O'Connor were smoking in the driveway. Resident B stated he knew it was marijuana use because he could smell it and the smell was bothering him. Resident C stated he knew they were using marijuana in the driveway because he was also smoking with them but later in the interview denied marijuana use or having further details. Resident D stated one time a month ago he saw Ms. Cooper and Ms. O'Dell passing a marijuana joint back and forth on the porch while they were working in September 2023 and the last two Sundays they both worked Ms. Cooper and Ms. O'Dell were using marijuana on the porch.

On October 6, 2023, I interviewed direct care staff member Jamie Cooper. Ms. Cooper stated she was not aware of anyone using marijuana on the property, only regular cigarettes. Ms. Cooper stated she would never do this as it would jeopardize her job. Ms. Cooper stated sometimes when she is smoking Resident D will joke around and ask if it's a marijuana cigarette but it has never been one. Ms. Cooper denied seeing any other drugs on the property and knows this is against facility policies.
On October 6, 2023, I interviewed licensee designee Roxanne Goldammer. Ms. Goldammer stated she was unsure if anyone was smoking marijuana on the property because the stories are not consistent. Ms. Goldammer denied ever smelling marijuana on any of the direct care staff members or having a suspicion anyone was under the influence of drugs or alcohol while they were working.

On November 15, 2023, I interviewed former direct care staff member Kaylie O'Dell. She stated there was no marijuana use but they were both smoking a cigarette around 8:40 PM on September 22, 2023 and denied she has ever seen any other drugs or alcohol on the property.

I reviewed the Beacon Specialized Living policy regarding "Use of alcohol and Drugs Policy" which states the following:

> *"The Organization does not allow the use or possession of alcohol, illegal drugs, or medications not prescribed to the individual possessing them on its premises.*

This includes any illegal or controlled drug or other substance which 1) is not legally obtainable, or 2) which is legally obtainable but has not been legally obtained. The term includes prescription drugs which have not been properly prescribed by a licensed physician or are not being used for prescribed purposes or in a prescribed manner. It also includes marijuana, even if the individual has a valid medical marijuana registry card."

On November 17, 2023, I completed an exit interview with licensee designee Roxanne Goldammer. Ms. Goldammer stated if there is a suspicion they can do a drug test, however, if they are smoking marijuana on their personal time, it will come back positive which does not tell them if they are under the influence at work, however typically an employee will admit if they are sent for a drug screen and they are terminated on the spot. Ms. Goldammer stated now all three of the employees involved in this incident Ms. O'Dell, Ms. O'Connor, and Ms. Cooper are no longer employees at Beacon Home at Nottawa.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Although there was speculation that Ms. O'Dell, Ms. Cooper, and Ms. O'Connor were under the influence in the driveway, there was no proof they were smoking marijuana and not cigarettes. Both Ms. O'Dell and Ms. Cooper denied smoking marijuana on the property or with the residents at any time. There are no reports of Ms. O'Dell, Ms. O'Connor, or Ms. Cooper acting like they are under the influence or not being able to meet resident needs and the licensee designee did not have them submit to a drug test regarding these concerns.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents residing at Beacon Home at Nottawa are often found in the road or down the street without supervision.

INVESTIGATION:

On October 3, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with additional concerns that residents from Beacon Home at Nottawa have been found in the road or down the street by neighbors because they are not supervised according to their *Assessment Plan for AFC Residents*.

On October 6, 2023, I interviewed direct care staff member whose current role is home manager, Ms. Vorhees who stated there has been instances of residents wandering around neighborhood however, right now, Resident B is the only resident who will roam the neighborhood. Ms. Vorhees stated in the beginning of September 2023 Resident B had Ms. Lora assigned to him as his 1:1 direct care staff member and he left the facility; however, he was within her eyesight the whole time. Ms. Vorhees stated during this incident Resident B was lying in the yard and it scared the neighbor's daughter. Ms. Vorhees stated that is the only time a resident has wandered the neighborhood.

On October 6, 2023, I interviewed direct care staff member Ms. Lora. Ms. Lora stated she has never observed any resident wandering recently however in the past, Resident B has wandered down the road and visit the police officer who resides down the street. Ms. Lora stated the officer will tell Resident B he needs to listen to direct care staff member so he does not get put in the back of his police car, however this has not deterred Resident B because he thinks the officer is his best friend and he continues to want to visit that home.

I interviewed Residents A, B, C, D, and E. All the residents stated being aware of several times when Resident A and/or Resident B have left the facility to wander down the street. Resident A stated sometimes direct care staff members have "chased me down" when he leaves but sometimes they do not. Resident A stated he went into the camper down the street because he wanted to "sit all over it." Resident B stated he walked "ten miles away" from the home and went all over the neighborhood and "sometimes does and sometimes does not" have a direct care staff member with him when he leaves the facility. Resident C stated Resident A broke into a camper and wanders so much the other neighbors are upset. Resident C stated sometimes there is a direct care staff member providing 1:1 supervision and following him and sometimes not. Resident E stated Resident A is the only resident who goes down the road and knocks on neighbors' doors and he has been in trouble for this in the past because the police bring him back to the house. Resident E stated sometimes there are direct care staff members with Resident A when he leaves, but many times they are not following him. Resident E could not recall exact dates when this occurred because this behavior has stopped lately because Resident A is not feeling well.

On October 6, 2023, I interviewed direct care staff member Jamie Cooper. Ms. Cooper stated Resident A and Resident B both require 1:1 supervision but Resident C does not require this any longer. Ms. Cooper stated there are a minimum of three direct care staff members on at all times which includes the DMA who is responsible for passing medications and preparing meals and a 1:1 staff member assigned to Resident A and Resident B. The "DMA" staff member is responsible for Residents C, D, and E since they do not require 1:1 staffing coverage. Ms. Cooper stated she has observed Resident B leave the facility and walk down the road both supervised and unsupervised and the policy is to follow him when he does this to try and encourage him to come back to the home, however, they cannot force him. Ms. Cooper stated in the past Resident A tried to elope at night but she did not recall what day this occurred. Ms. Cooper stated

the neighbors have called the police before and sometimes Resident B will walk to the police officer's home and they will bring him back to the facility.

I reviewed an *AFC Incident / Accident Report* regarding an incident on February 24, 2023 which stated the following:

Describe the event:
"Staff member went downstairs into the basement to grab supplies for upstairs to restock closet. Staff came back upstairs went to use the restroom and home phone rang. Staff answered and it was the Sheriff Department calling the resident was down in the neighbor's yard. Police officer brought resident back to house.
***Action taken by staff**:*
Talked to the police. Staff could not leave the home because there was only one staff on at night. Staff reassured resident that they were here to help.
Corrective action:
Two staff working on nights to help prevent him from elopement."

I reviewed an AFC Incident / Accident Report regarding an incident on September 9, 2023 which stated the following:

Describe the event:
"[Resident B] and another resident got into an argument over milk and he started walking down the driveway and staff tried to verbally redirect him to stay on the property. [Resident B] walked down to the neighbor's home who is the Chief of Police and he walked [Resident A] home.
***Action taken by staff**:*
Staff was on the phone with Ms. Vorhees when the Chief of police arrived back to the home with Resident B. Ms. Vorhees talked with the Chief of Police and agreed it was dangerous for Resident B to be out walking at night and something needs to be done to try to keep Resident B on the property.
Corrective action:
Management will work with staff on changing the hours Resident B has his 1:1 in the home so he will have 1:1 when he is having more agitations."

During the on-site investigation, I reviewed the *Assessment Plan for AFC Residents* for Residents A, B, C, D, and E. According to Ms. Goldammer and Ms. Vorhees, currently Resident A and Resident B are the only residents who require 1:1 staffing coverage. Resident A's *Assessment Plan for AFC Residents* dated February 2, 2023 for AFC Residents includes documentation he cannot move independently in the community and "Needs staff to monitor his behaviors and intervene when necessary."

Resident B's *Assessment Plan for AFC Residents* dated January 27, 2023 which includes documentation that he cannot move independently in the community and he "needs supervision" but the *Assessment Plan for AFC Residents* does not include documentation he needs 1:1 staffing. Resident B's resident record included a Behavioral Treatment Plan signed June 20, 2023 from CMH stating:

"[Resident B] has a history of elopement, property destruction, and self-injury. He has enhanced supervision while in the home due to leaving the home's property and going to neighbor's homes and knowing on the doors and going in the woods behind the home, and while in the community due to increased anxiety, being overstimulated and not tolerating people he does not know." [Resident B] will be provided with line of sight 1:1 supervision in the community."

Resident A's Behavioral Treatment Plan from CMH dated March 6, 2023 was also reviewed which included the following documentation:

"[Resident A] required 1:1 line of sight supervision 24 hours per day due to instances of property destruction and physical aggression. A designated staff member must be able to see [Resident A] in the home and in the community at a distance of several feet or more to provide support and safety. Staff may need to be closer and he may not leave the home without staff support."

On November 3, 2023, I received documentation from Village of Shepherd Chief of Police Luke Sawyer regarding residents leaving the facility. I also interviewed Chief Sawyer who stated there have been several instances of residents leaving the AFC facility without direct care staff member supervision and walking down the street. Chief Sawyer stated he is familiar with these incidents professionally and because he resides nearby and has walked residents back to the facility and spoken to the direct care staff members on several occasions. Chief Sawyer stated he is worried residents will get hit by a car or harmed while walking down the street or going to neighbors' homes. Chief Sawyer stated direct care staff members do not have supervision of the residents because they are often in the road. Chief Sawyer stated sometimes the direct care staff members will be following the residents, however the residents are most often found alone with no supervision. Chief Sawyer stated he does not record the residents' names for each incident but knows he primarily deals with Resident A and Resident B.

Chief Sawyer sent documentation of the following incidents:

1. *02/24/2023 at 4:24AM – Resident left the home at 7302 South Nottawa Road, Beacon Specialized Living, and is walking around 7375 South Nottawa Road and eventually on the porch. He is taken back home by the Isabella County Sheriff's Office.*
2. *02/27/2023 at 3:56PM – Resident left the Beacon Home and is lying in the middle of South Nottawa Road. Police are not notified.*
3. *02/28/2023 at 2:26AM– Resident left the Beacon Home and is in the camper of the homeowner at 7375 South Nottawa Road. Returned home by the Isabella County Sheriff's Office.*
4. *02/28/2023 at 4:08AM – Resident left the Beacon Home and is back on the porch of 7375 South Nottawa Road. Neighborhood resident walks him back to the Beacon Home, the Isabella County Sheriff's Office meets him there.*

5. *03/04/2023 at 12:41AM – Resident left the Beacon Home and is on the porch at 7375 South Nottawa Road and then in the driveway at 7362 South Nottawa Road, the Isabella County Sheriff's Office responds, and is taken to the hospital.*
6. *03/04/2023 at 8:00AM – Resident left the home and is back on the porch at 7375 South Nottawa Road. the Isabella County Sheriff's Office responds and he is taken to the hospital.*
7. *07/28/2023 at 12:08AM – Resident is attacking staff. MSP responded.*
8. *08/02/2023 at 6:51PM – Resident walked into the woods.*
9. *08/03/2023 at 9:18AM – Resident needs to be removed from home per staff. ICSO advises he is blacklisted from Gratiot and McClaren due to past behavior.*
10. *8/30/2023 – Resident is being disorderly and law enforcement is called.*
11. *9/8/2023 – Resident found walking down Nottawa Rd in the dark. Police called.*
12. *9/9/2023 – Resident is walking down the road with staff. Neighborhood resident helps them get him back. Staff says he already walked away earlier in the day.*
13. *9/15/2023 – Resident leaves the home and lays in the ditch. Police are called.*
14. *9/21/2023 – Resident leaves the home, staff isn't aware, 911 is called. ICSO and MSP on scene.*
15. *9/22/2023 – Resident walks away down road, staff is with him.*
16. *10/17/2023 – [Resident A] called 911 and left the home. ICSO was called and found [Resident A] walking in the road.*

On November 3, 2023, I interviewed direct care staff member Ms. Lora. Ms. Lora stated she has not observed Resident A leaving the home lately because he has not been feeling well and is now receiving services from Hospice.

On November 15, 2023, I interviewed former direct care staff member Kaylie O'Dell. Ms. O'Dell stated Resident A and Resident B both have severe behaviors. Ms. O'Dell stated Resident A had worse behaviors after refusing to take his medications including running down the road screaming rape and on at least one occasion she was shoved out of the way so he could get down the road. Ms. O'Dell stated Resident A destroyed the RV down the road. Ms. O'Dell stated Resident A also ran down the street and talked to the neighbor and her children which scared them. Ms. O'Dell stated Resident A she believed this facility was not a good fit for Resident A as he needed more services than could be provided. Ms. O'Dell stated Resident A left at least 50 times including some incidents when he was unsupervised and went down the road while she worked at Beacon Home at Nottawa. Ms. O'Dell stated Chief Sawyer who walked Resident A down to the home several times and he has brought him back to the house before. Ms. O'Dell stated some of the parents in the neighborhood were scared to let their kids play outside. Ms. O'Dell stated Resident A would bolt out the door from sitting at the table and they could not force him to stay in the home and the only thing they could do is follow him. Ms. O'Dell stated there was an incident where she was left home alone with the other five residents because Resident A had taken off. Ms. O'Dell stated when this occurred Resident A did not have a 1:1 supervision so she was watching him from the side of the house going down the road. Resident A took off to the camper several times when direct care staff members were following him. Ms. O'Dell stated, there was no stopping him when he wanted to go down the road and she would try to bribe him with some pop to get him to go back to the home. Ms. O'Dell stated the

staff members started buying items to convince him to have a good behavior because it was a “reward system.” Ms. O’Dell stated this was not put in writing but something the staff members put in place to make it easier to work with him. Ms. O’Dell stated she was not sure how long he had a 1:1 direct care staff member but it was after he ran away 4-5 times that this was implemented.

Ms. O’Dell stated Resident B started having more behaviors due to a medication change around 4-5 months ago. Ms. O’Dell stated those serious behaviors have included Resident B leaving the home multiple times unsupervised, getting upset with people in his personal space, and one time tried to hit another direct care staff member with a board in the backyard.

Ms. O’Dell stated in general direct care staff members follow residents when they walked away from the home especially if they had a 1:1 however if they refuse to come back to the home within 10-15 minutes the policy was to call the on-call manager and 911 to assist. Ms. O’Dell stated there were times the residents were not followed when they left the home because it was “too hard because of low staffing and other residents having behaviors which required the assistance of two direct care staff members and not being able to leave the facility.”

On November 17, 2023, I completed an exit interview with licensee designee Roxanne Goldammer. Ms. Goldammer stated on September 9, 2023 Ms. Cooper was the direct care staff member assigned to Resident B and she told Ms. Goldammer she could not follow him because Resident B was belligerent. Ms. Goldammer stated Resident A has required 1:1 staffing coverage since February 2023 after the incident of him going to the camper. Resident B now has 12 hours of 1:1 staffing instead of 24 hours however the times are not specified and since he received a Nintendo Switch he is no longer wandering. Ms. Goldammer stated Resident A is now in Hospice and has not been leaving home. Ms. Goldammer stated Resident A’s 1:1 supervision is noted in the *Plan of Service* and the *Person Centered Plan* through Community Mental Health.

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:	Resident A and Resident B were not provided supervision according to their *Assessment Plan for AFC Residents* and *Behavior Treatment Plans.* Chief Sawyer sent documentation of 16 instances between the dates of February 24, 2023 and October 17, 2023 of either Resident A or Resident B walking through the neighborhood and disrupting the neighborhood residents. Some of the instances include a direct care staff member following behind, but several of them indicated direct care staff members were not aware the resident had eloped from the facility. Direct care staff member Ms. O'Dell admitted there were times Resident A and Resident B eloped down the road and would not be followed due to low staffing and other resident behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning _____11/17/2023_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 11/29/2023

_____

Dawn N. Timm Date
Area Manager