GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 4, 2023

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

RE: License #: AS370413382
Investigation #: 2024A1029003
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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370413382
Investigation #:	2024A1029003
Complaint Receipt Date:	10/10/2023
Investigation Initiation Date:	10/10/2023
Report Due Date:	12/09/2023
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?
On October 6, 2023, direct care staff member Apryl Long did not provide personal care to Resident A after he had a bowel movement accident and he had to wait between 30 minutes to 3 hours to receive toileting assistance.	Yes
On October 6, 2023, direct care staff member Apryl Long left Resident A unattended while she went to the gas station during her shift. During this timeframe, Ms. Long was the assigned 1:1 direct care staff member for Resident A.	No
Direct care staff member Lauren Lora told Resident A that he was a “pain in the ass” and “I don’t care, I am done.”	No

III. METHODOLOGY

10/10/2023	Special Investigation Intake 2024A1029003
10/10/2023	Special Investigation Initiated – Email to Katie Hohner ORR
10/10/2023	APS Referral sent to Centralized Intake
10/26/2023	Contact - Telephone call made to Roxanne Goldammer, sent email to Ms. Goldammer and Marlo Derry requesting documents.
11/03/2023	Inspection Completed On-site – face to face with Roxanne Goldammer, Resident A, Lauren Lora, Naomi Vorhees
11/03/2023	Contact - Document – Sent Email from Marlo Derry
11/15/2023	Contact - Telephone call made to direct care staff member Kaylie O'Dell
11/17/2023	Contact - Telephone call made from Roxanne Goldammer
11/20/2023	Contact - Document Received Emily Fairris, compliance director.
11/29/2023	Contact - Telephone call made to direct care staff members Apryl Long (Left message) and Eva Haack
11/29/2023	Contact - Document Sent to Katie Hohner ORR
11/30/2023	Exit conference with licensee designee Roxanne Goldammer.

ALLEGATION: On October 6, 2023, direct care staff member Apryl Long did not provide personal care to Resident A after he had a bowel movement accident and he had to wait between 30 minutes to 3 hours to receive toileting assistance.

INVESTIGATION:

On October 10, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with concerns that on October 6, 2023, direct care staff member Apryl Long did not assist Resident A after he had a bowel movement accident. Resident A was not provided personal care toileting for at least 30 minutes to 3 hours after the bowel movement accident occurred.

On October 26, 2023, I interviewed licensee designee Roxanne Goldammer who stated Resident A requires assistance at times with personal care and he requires 1:1 supervision 24 hours a day. Ms. Goldammer stated when Resident A is in the bathroom a direct care staff member needs to be by the door in case he needs assistance. Ms. Goldammer stated Ms. Long was supposed to be providing assistance, including assistance with toileting, and did not do this and while Resident A waited for assistance, another direct care staff member Lauren Lora monitored the situation, timed it, and reported the incident instead of providing personal care assistance to Resident A. Ms. Goldammer stated direct care staff member Eva Haack, who is a new night shift direct care staff member, stepped in and took care of Resident A after she realized he was left for over an hour needing assistance. Ms. Goldammer stated Ms. Long is no longer an employee of Beacon Specialized Living Services.

On November 3, 2023, I completed an unannounced on-site investigation at Beacon Home at Nottawa and interviewed Resident A. Resident A was unable to remember details of when he received personal care or if he ever needed care and did not receive it. Resident A is now enrolled in Hospice services due to his failing health and his speech was difficult to understand. Resident A stood up and walked out of the interview after my attempts to ask him questions.

During the on-site investigation, I reviewed Resident A's resident record. Resident A's *Assessment Plan for AFC Residents* dated February 2, 2023 includes the following documentation:

> *"Under B. Toileting: Yes, needs assistance because at times will have bowel accidents. History of using a urinary catheter due to difficulty urinating. Under C. Bathing: At times will need assistance with showering due related to bowel issues. Under F. Personal Hygiene: Needs cuing and reminders for personal hygiene. Sometimes needs some physical assistance if he has a bowel accident."*

I reviewed the staffing schedule for October 6, 2023:

<u>Day shift 9 AM- 9 PM:</u>
Lauren Lora- assigned as the DMA.
Apryl Long: Assigned as the 1:1 for [Resident B]
Jamie Cooper: Assigned as the 1:1 for [Resident A]

<u>Night shift 9 PM- 9 AM:</u>
Eva Haack: assigned as the 1:1 for [Resident A]
Naomi Vorhees

Ms. Goldammer confirmed Ms. Cooper and Ms. Long switched and Ms. Long was the 1:1 for Resident A and Ms. Cooper was the 1:1 for Resident B on October 6, 2023 according to the 1:1 documentation completed by the direct care staff members. Ms. Cooper is no longer an employee and her last day was October 6, 2023.

On November 3, 2023, I interviewed direct care staff member Lauren Lora. Ms. Lora stated there was an incident on October 6, 2023 when Resident A did not receive personal care because direct care staff member Ms. Long did not provide personal care to him as required. Ms. Lora stated this was in the evening around shift change and Ms. Long was his 1:1 assigned and Ms. Lora was the DMA who is the direct care staff member responsible for meals, charting, and supervision of the residents who do not require 1:1 supervision. Ms. Lora stated she realized Resident A needed personal care assistance and prompted Ms. Long three times that he needed assistance and Ms. Long responded with "Oh." Ms. Lora stated she did not provide personal assistance to Resident A because she had three other residents to look after and was completing her book work. Ms. Lora stated she was upset she was told by management she should have provided personal care because then she would have let the other three residents to be unsupervised. Ms. Lora stated Resident A had a bowel movement that was not changed for 1.5 hours until direct care staff member Ms. Haack arrived who was the third shift staff member. Ms. Lora stated when she arrived she assisted Ms. Haack with bathing and toileting Resident A. Ms. Lora stated they often provide assistance with toileting to Resident A now that his health is declining.

On November 3, 2023, I interviewed direct care staff member whose current role is home manager, Naomi Vorhees. Ms. Vorhees stated she came in around 1 AM to relieve a direct care staff member and she was told what occurred on October 6, 2023 Ms. Vorhees stated they said it was a ½ hour-3 hours because when third shift came in at 9 PM is when Ms. Lora and Eva provided personal care to him.

On November 15, 2023, I interviewed direct care staff member Kaylie O'Dell. Ms. O'Dell stated direct care staff members assist with toileting assistance for Resident A because he was having accidents on himself and on furniture so they were providing hands on care. Ms. O'Dell was not familiar with any incident where Resident A needed personal care and it was not provided to him.

On November 29, 2023, I interviewed direct care staff member Eva Haack. Ms. Haack stated she arrived to work at 9 PM for her shift on October 6, 2023 and she entered the home and she could smell feces when she walked in and asked the other direct care staff members and they all pointed to Resident A. At that point, she observed he was covered in feces and it was coming out of his pant legs. Ms. Haack stated the feces was on him at least three hours because of the condition she saw him in when she arrived.

Ms. Haack stated Ms. Long was his 1:1 that day and she was sitting on her phone in front of a space heater and the other two staff members were sitting at the table. Ms. Haack stated she took Resident A immediately into the shower to assist him. Ms. Haack stated Resident A is dying and most times he won't get dressed or take his meds unless it's for "Big Mama" which is what he calls her. Ms. Haack stated after she cleaned Resident A, she noticed he had a rash on his buttock and where his legs met his body. Ms. Haack stated Resident A now wears adult incontinence briefs but at the time, he was wearing underwear and regular pants. Ms. Haack stated Resident A will likely pass away this weekend and she plans to be with him when he passes. Ms. Haack stated she was upset with the direct care staff member and she asked them why they would leave him sitting in feces for 3 hours. Ms. Long would not answer her because she was always playing on her phone and Ms. Lora stated she knew that he needed care. Ms. Haack stated she told Ms. Lora she should have stepped in much earlier to assist him. Ms. Haack stated he is usually covered in urine when she comes to the home to work her shift and sometimes direct care staff members will say that he won't let them and change them. Ms. Haack stated she will roll him around and change him to provide personal assistance. Ms. Haack stated she will tell him she loves him, make jokes, and try to make him as comfortable as possible while she is doing this because she knows he does not like it. Ms. Haack stated Resident A is still not receiving personal care timely because direct care staff member Veronica Gammage will leave him now in his urine soaked clothes all day, wait for Ms. Haack to come in so she can change him, and then tell Ms. Hack she did not do it because Resident A did not allow her to do so.

Special Investigation Report # 2023A1029065 dated November 29, 2023 cited Rule 400.14303 (2) because residents were not receiving the required 1:1 staffing coverage as needed according to their *Assessment Plan for AFC Residents*. A Corrective Action Plan is due on December 14, 2023.

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 did not receive care according to his *Assessment Plan for AFC Residents.* Resident A's *Assessment Plan for AFC Residents* dated February 2, 2023 under the section titled "B. *Toileting"* documented the following*: "Yes, needs assistance because at times will have bowel accidents. History of using a urinary catheter due to difficulty urinating. Under C. Bathing: At times will need assistance with showering due related to bowel issues. Under F. Personal Hygiene: Needs cuing and reminders for personal hygiene. Sometimes needs some physical assistance if he has a bowel accident."* Based on interviews with licensee designee Roxanne Goldammer and direct care staff members Ms. Lora and Ms. Haack, direct care staff members Ms. Long and Ms. Lora did not provide personal care assistance to Resident A on October 6, 2023 after he had a bowel accident and he was left in this condition for almost three hours.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SIR# 2023A1029065 DATED NOVEMBER 29, 2023. CAP DUE ON DECEMBER 14, 2023.]**

ALLEGATION: On October 6, 2023, direct care staff member Apryl Long left Resident A unattended while she went to the gas station during her shift. During this timeframe, Ms. Long was the assigned 1:1 direct care staff member for Resident A.

INVESTIGATION:

On October 9, 2023 a complaint was received via the online Bureau of Community and Health Systems complaint system with concerns on October 6, 2023, direct care staff member Ms. Long left Resident A unattended while she went to the gas station during her shift. According to the complaint allegations, during this timeframe, Ms. Long was the assigned 1:1 direct care staff member for Resident A.

On October 26, 2023, I interviewed licensee designee, Roxanne Goldammer. Ms. Goldammer stated direct care staff member Ms. Long left Resident A while she went to the gas station and was gone for 15 minutes. Ms. Goldammer stated she was gone long enough to go to the Winn gas station. Ms. Goldammer stated Ms. Long drove the company van to the gas station and did not fill out the mileage log. Ms. Goldammer stated she checked the log and the geo-tab on the vehicle and she noticed Resident A was left alone for at least 15 minutes. Ms. Goldammer she would forward a schedule to review for October 6, 2023 but she knew there was at least three direct care staff members working at the time because Resident A and Resident B both require 1:1 staffing coverage and there is the DMA who is responsible for the other residents, medications, and meal preparation. Ms. Goldammer stated the DMA, who was Ms. Lora, did step in and kept an eye on Resident A when Ms. Long went to the store when she realized that she was gone but she did not ask her to do so.

On November 3, 2023, I completed an unannounced on-site investigation at Beacon Home at Nottawa and attempted to interview Resident A. Resident A is now enrolled in Hospice services due to his failing health and his speech was difficult to understand. Resident A stood up and walked out of the interview after my attempts to ask him questions.

During the on-site investigation, I reviewed Resident A's resident record. Resident A's *Assessment Plan for AFC Residents* dated February 2, 2023 includes documentation he cannot move independently in the community and "Needs staff to monitor his behaviors and intervene when necessary." There is no documentation on his *Assessment Plan for AFC Residents* indicating 1:1 staffing coverage is necessary, however it is it noted in the *CMH Behavioral Treatment Plan* dated March 6, 2023 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."*

I reviewed the staffing schedule for October 6, 2023:

<u>Day shift 9 AM- 9 PM:</u>
Lauren Lora- assigned as the DMA.
Apryl Long: Assigned as the 1:1 for [Resident B]
Jamie Cooper: Assigned as the 1:1 for [Resident A]

<u>Night shift 9 PM- 9 AM:</u>
Eva Haack: assigned as the 1:1 for [Resident A]
Naomi Vorhees

Ms. Goldammer confirmed Ms. Cooper and Ms. Long switched and Ms. Long was the 1:1 for Resident A and Ms. Cooper was the 1:1 for Resident B on October 6, 2023 according to the 1:1 documentation completed by the direct care staff members.

On November 3, 2023, I interviewed direct care staff member Lauren Lora. Ms. Lora stated Ms. Long did leave Resident A on October 6, 2023 without supervision during the day when she went to the gas station to get cigarettes. Ms. Lora did not recall what time of day this occurred or how long he was left for. Ms. Lora stated she did step in to provide 1:1 supervision to Resident A once she realized Ms. Long had left, however, Ms. Long did not inform her she was leaving or ask her to provide supervision to Resident A.

On November 3, 2023, I interviewed direct care staff member whose current role is home manager, Naomi Vorhees. Ms. Vorhees stated she is not aware of Ms. Long

leaving the building while she was working on October 6, 2023. Ms. Vorhees stated the policy is that if they are assigned to supervise a resident who requires 1:1 supervision they do not leave unless they know that someone else can supervise the resident.

On November 29, 2023, I interviewed direct care staff member Eva Haack. Ms. Haack stated Ms. Long was providing 1:1 supervision to Resident A on October 6, 2023 around 6 PM and Ms. Long wanted Resident A to drive to the store with her but he did not want to go. Ms. Haack stated she could have asked another resident if they wanted to go and she could have switched 1:1 resident and sign the switch sheet.

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:	Although Ms. Long did leave the facility for 15 minutes and drove to the gas station, there is no indication Resident A was not supervised during this time. While she was gone, Ms. Lora stated she provided 1:1 supervision for Resident A. When Ms. Long went to the store, there were still two other direct care staff members providing supervision to the five residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff member Lauren Lora told Resident A that he was a "pain in the ass" and "I don't care, I am done."

INVESTIGATION:

On November 3, 2023, additional concerns were received via the Bureau of Community and Health Systems online complaint system stating an Anonymous caller reported to the Office of Recipient Rights (ORR) that during first shift today Ms. Lora said in front of Resident A that he was a "pain in the ass" and 'I don't care I am done" when caring for Resident A.

On November 3, 2023, I completed an unannounced on-site investigation at Beacon Home at Nottawa and interviewed Resident A. Resident A was unable to remember details of when he received personal care or if he ever needed care and did not receive it. Resident A nodded his head yes when I asked if the direct care staff members were kind to him and again nodded yes when I asked if he felt safe residing at Beacon Home at Nottawa. Resident A is now enrolled in Hospice services due to his failing health and his speech was difficult to understand. Resident A stood up and walked out of the interview after my attempts to ask him questions.

On November 3, 2023, I interviewed licensee designee Roxanne Goldammer. Ms. Goldammer stated she has never had concerns regarding Ms. Lora saying anything disrespectful to the residents and is concerned these allegations are a result of disagreements between the direct care staff members.

On November 3, 2023, I interviewed direct care staff member Ms. Lora at Beacon Home at Nottawa. Ms. Lora stated she has never made a disrespectful comment to Resident A or told him he was “pain in the ass” or stated that she was “done” while caring for him. Ms. Lora stated she would never speak to a resident in that manner and feels this is retaliation from the other direct care staff members due to conflicts between them. Ms. Lora stated if she made a comment like that to a resident, she would be upset with herself.

On November 3, 2023, I interviewed direct care staff member whose current role is home manager, Naomi Vorhees. Ms. Vorhees stated she has never heard Ms. Lora make a negative comment about any of the residents. Ms. Vorhees stated Ms. Lora can have a “mom voice” with the residents when she is trying to get their attention however, she has always observed her to be respectful of the residents.

On November 29, 2023, I interviewed direct care staff member Eva Haack. Ms. Haack stated she has never heard Ms. Lora say anything negative. Ms. Haack stated she will rub his head and is always very loving to the residents. Ms. Haack stated she would “give up her job in order to protect [Resident A].” Ms. Haack stated she is protective of him and since he cannot defend herself she would have defended him if she ever heard a statement like this made to Resident A. Ms. Haack stated sometimes she would sound stern with the residents but has never been disrespectful.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	There is no indication Ms. Lora did not treat Resident A with dignity and respect while working with him at Beacon Home at Nottawa. Ms. Lora denied she made these comments regarding Resident A and based on interviews with Ms. Goldammer, Ms. Vorhees, Ms. Haack, there is no indication she has spoken to him in a negative manner. Resident A denied any of the direct care staff members were mean to him and stated he felt safe residing at Beacon Home at Nottawa.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Jennifer Browning 11/30/2023_____
Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 12/04/2023
_____
Dawn N. Timm Date
Area Manager