GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 10, 2024

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

RE: License #: AM030402101
Investigation #: 2024A0581010
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030402101
Investigation #:	2024A0581010
Complaint Receipt Date:	11/15/2023
Investigation Initiation Date:	11/17/2023
Report Due Date:	01/14/2024
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
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?
The facility's direct care staff were sleeping during the overnight shift on 11/13/2023.	Yes

III. METHODOLOGY

11/15/2023	Special Investigation Intake 2024A0581010
11/16/2023	Referral - Recipient Rights
11/17/2023	Special Investigation Initiated - Telephone Interview with Allison Kridler, OnPoint RRO
11/17/2023	Contact - Document Received Email from Ms. Kridler.
11/20/2023	Contact - Face to Face Interview with Kim Scott, direct care staff.
11/21/2023	Contact - Document Received Emails from Ms. Scott
11/29/2023	Contact - Telephone call made Interview with licensee designee, Ramon Beltran
11/29/2023	Exit conference with the licensee designee, Ramon Beltran.
12/05/2023	Inspection Completed On-site Interview with staff and residents
01/05/2024	Contact - Telephone call made Left voicemail with former direct acre staff, Annette Reeber
01/05/2024	Contact - Telephone call made Left voicemail with former direct care staff, Jessica Zuniga.
01/05/2024	Inspection Completed-BCAL Sub. Compliance
01/05/2024	APS Referral No referral needed due to complaint not alleging abuse or neglect.

ALLEGATION:

The facility's direct care staff were sleeping during the overnight shift on 11/13/2023.

INVESTIGATION:

On 11/15/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged direct care staff Annette Reeber and Jessica Zuniga, were sleeping on 11/13/2023 during the overnight shift at the facility. The complaint alleged Resident A observed both staff sleeping.

On 11/17/2023, I confirmed OnPoint Recipient Rights Officer (RRO), Allison Kridler, had also received the allegation and was investigating. She stated upon reviewing the ORR complaints, it was her understanding that sometime during the overnight shift starting on 11/13/2023 through 11/14/2023, Resident A and Resident B attempted to wake up direct care staff, Annette Reeber and Jessica Zuniga, but were unable. Ms. Kridler stated Resident C, who is an OnPoint recipient, requires awake staff during the overnight shift. She stated despite residents not being able to wake staff up during the overnight shift, Ms. Kridler was not aware of any residents being harmed, eloping, or needing assistance (and not receiving it) while staff were sleeping.

Ms. Kridler forwarded me Resident B's, Resident C's, and Resident D's *OnPoint Assessment Plans* and their corresponding *OnPoint Community Living Supports (CLS) Addendum*s. According to my review of these documents, Resident B, C, and D all require direct care staff support during sleeping hours, but only Resident C requires direct care staff being awake during that time.

On 11/20/2023, I interviewed direct care staff, Kim Scott, who later identified as the facility's Program Manager. Ms. Scott stated Resident A reported to her on 11/14/2023 she was incontinent during the overnight shift because Ms. Reeber and Ms. Zuniga didn't prompt to her to get up. Ms. Scott stated direct care staff prompt Resident A to get up once per night around 12 am to use the bathroom to prevent incontinence.

Ms. Scott stated on 11/14/2023, Resident A was eventually able to get Ms. Reeber up who helped her, but then went back to bed. Ms. Scott stated Resident A reported Ms. Reeber woke up back up around 5 am while Ms. Zuniga didn't wake up until 6 am. Ms. Scott stated Resident A reported to her both direct care staff members were sleeping on the couch. Ms. Scott stated Resident B also reported to her she tried waking both direct care staff. Ms. Scott stated she intended to stop by, unexpectedly, at the facility during the overnight shift to ensure direct care staff were awake.

Ms. Scott stated Resident A and Resident B are the only two residents who stay up later in the facility or who may get up in the middle of the night. She stated only Resident A and Resident B reported staff sleeping during the overnight shift. Ms. Scott stated staff should be conducting hourly checks on all residents throughout the day and night, as well.

Ms. Scott provided me with copies of the Recipient Rights Complaints Resident A and Resident B submitted to OnPoint. According to Resident A's complaint, she woke up at approximately 3:30 am on 11/14/2023 with a "wet bed". She documented in the complaint she went to get both night direct care staff members Ms. Reeber and Ms. Zuniga and attempted to wake them up by calling their names and shaking them. The complaint documented Ms. Reeber woke up, but Ms. Zuniga did not. The complaint documented Ms. Reeber assisted Resident A with changing her bedding; however, Ms. Reeber then went back to bed until 5 am. The complaint documented Ms. Zuniga did not wake up until 6 am.

Resident B's Recipient Rights Complaint was consistent with Resident A's complaint.

I reviewed Resident A's *Person Centered Plan* (PCP), dated 10/24/2023, which was created by the licensee's clinical department. According to this plan, from 10 pm until 6 am "staff will perform eyes on checks every 30 minutes overnight."

I reviewed the remaining residents *Assessment Plans for AFC Residents*; however, none of the plans documented additional monitoring of residents, specific care, or enhanced supervision of residents during the overnight shift.

On 11/21/2023, I received an email from Ms. Scott at 4:23 am documenting she conducted an unannounced visit at the facility at 2:25 am and "caught both Annette Reeber and Jessica Zuniga sleeping." She documented Ms. Zuniga was "sleeping in a chair covered in a blanket." She also documented she discovered Ms. Reeber "cuddled up in a ball on couch." Ms. Scott documented she sent both staff home after contacting her program director. Ms. Scott documented in her email only one resident was awake during her visit. She did not document any additional issues or concerns in her email to me.

Ms. Scott sent a follow up email at 9:24 am documenting the licensee's Human Resource Department received the approval to terminate both Ms. Reeber and Ms. Zuniga.

On 11/29/2023, I interviewed the facility's licensee designee, Ramon Beltran, via telephone who stated both staff were terminated upon Ms. Scott discovering them sleeping during the overnight shift. He confirmed both staff were terminated from employment and would not be transferred to a different facility under the licensee. Mr. Beltran stated he spoke to Ms. Reeber, but not to Ms. Zuniga. He stated Ms.

Reeber reported to him she had “a lot going on” personally and between that and working several days per week she was falling asleep.

Mr. Beltran stated he didn't recall a resident being injured, eloping, or not receiving significant care while staff slept. He stated none of the residents required enhanced staffing during the overnight either. Mr. Beltran stated moving forward, upper management would conduct unannounced visits during the overnight shifts to tighten up the overnight issues.

On 12/05/2023, I conducted an unannounced inspection at the facility with Adult Foster Care consultant, Amanda Blasius. I interviewed direct care staff, Alexis Crowe, who stated she’d been working in the facility since August 2023. She stated she primarily works the day shift, which is 7 am until 7:30 pm. She stated when she relieved Ms. Reeber and Ms. Zuniga at 7 am both have been awake. Ms. Crowe denied observing either Ms. Reeber or Ms. Zuniga sleeping in the facility while they were working.

I interviewed Resident A and Resident B during the inspection. Resident A’s statement to me was consistent with the allegations and with her Recipient Rights complaint. She stated both Ms. Reeber and Ms. Zuniga occasionally slept on the facility’s couch and were hard to wake up when found sleeping. She stated she would wake up and need their help with changing her bedding if she experienced incontinence, but they wouldn’t help her because they’d be sleeping. She stated she would shake them and call their names, but they wouldn't wake up. Resident A stated Resident B also tried waking up staff.

I interviewed Resident B whose statement to me was consistent with Resident A’s statement to me and her Recipient Rights complaint. Resident B stated Ms. Reeber and Ms. Zuniga would fall sleep in the facility around 1 am or 2 am after all the residents went to the bed. She stated both staff still completed their duties like laundry, mopping, and taking the trash out. Resident B stated sometimes she would wake staff up and sometimes she wouldn’t. She stated she was not aware of any incidences of residents leaving the facility or being injured in the home because both staff was sleeping during the overnight shift.

On 01/05/2024, I interviewed direct care staff, Annette Reeber. Her statement to me was consistent with what she reported to licensee designee, Ramon Beltran. Ms. Reeber stated staff are expected to be awake during the overnight shift and confirmed she was terminated by the licensee for sleeping. Ms. Reeber stated when she’d “doze off” while working it would only be for approximately one hour. She stated Ms. Zuniga also feel asleep while working, but only “once or twice”.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based on my investigation, which included interviews with the facility's current identified Program Director, Kim Scott, direct care staff, Annette Reeber and Alexis Crowe, the licensee designee, Ramon Beltran, OnPoint Recipient Rights Officer, Allison Kridler, Resident A and Resident B, and my review of resident documentation, including Resident A's Person Centered Plan, dated 10/24/2023, Resident C's OnPoint Community Living Supports (CLS) Addendum, and emails from Ms. Scott, there is evidence both Ms. Reeber and Ms. Zuniga were sleeping during the overnight shifts at the facility on multiple occasions, including 11/14 and 11/21. Resident A's Person Centered Plan documents staff are expected to perform 30 minute checks on her during the overnight shift while Resident C's CLS Addendum documented staff are required to be awake during the overnight shift. Subsequently, resident's plans of service were not implemented by staff, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/29/2024, I conducted my exit conference with the licensee designee, Ramon Beltran, via telephone. Mr. Beltran stated upon discovering the two staff sleeping, they were both terminated. He stated Mr. Beltran stated moving forward, upper management would conduct unannounced visits during the overnight shifts to ensure staff were not sleeping.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

01/08/2024

Cathy Cushman — Date
Licensing Consultant

Approved By:

01/10/2024

Dawn N. Timm — Date
Area Manager