GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 3, 2024

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

RE: License #: AM030402101
Investigation #: 2024A0464027
Beacon Home at Hammond

Dear Mr. 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 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,

Megan Aukerman, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030402101
Investigation #:	2024A0464027
Complaint Receipt Date:	03/06/2024
Investigation Initiation Date:	03/06/2024
Report Due Date:	05/05/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Ramon Beltran
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:	01/26/2024
Expiration Date:	01/25/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident C has been left lying in urine-soaked briefs and soiled linens.	Yes
Staff are not administering Resident C's prescribed medications.	No
Staff are refusing to assist Resident C with showers.	No
Resident C's bedroom is dirty with trash all over the floor.	Yes

III. METHODOLOGY

03/06/2024	Special Investigation Intake 2024A0464027
03/06/2024	Special Investigation Initiated - On Site Elena Tricoci, Kalamazoo County ORR
03/06/2024	Inspection Completed On-site Elena Tricoci (ORR), Kim Scott (Manager), Britini Smith (Manager), Tanya Klifman (Staff), and Resident C
03/06/2024	Contact - Document Received Facility Records
04/10/2024	APS Referral Centralized Intake, DHHS
04/10/2024	Contact-Teams Meeting Elena Tricoci (ORR), Britini Smith (Manager), Casey Bosse (Staff) and Kristy Penny (Staff)
04/19/2024	Inspection Completed-Onsite Elena Tricoci (ORR), Britini Smith (Manager), and Residents C, D, E and F
05/03/2024	Exit Conference Ramon Beltran, Licensee Designee

ALLEGATION: Resident C has been left in urine-soaked briefs and soiled linens.

INVESTIGATION: On 03/06/2024, I received a complaint from Kalamazoo County Office of Recipient Rights (ORR), which alleged Resident C is frequently left in urine-soaked briefs and dirty linens. Resident C's bedroom is dirty and there is trash all

over the floor. Facility staff refuse to assist Resident C with showers. There is also concern that staff are not adequately administering Resident C's prescribed medications. Similar investigations exist under SIR #2024A0464026 and SIR #2024A0464025).

On 03/06/2024, I met with ORR worker, Elena Tricoci to coordinate the investigation.

On 03/06/2024, Ms. Tricoci and I completed an unannounced, onsite inspection at the facility. We interviewed facility managers, Britini Smith, and Kim Scott. Ms. Smith and Ms. Scott stated Resident C likes to confine herself to her bedroom, rarely wanting to come out. Staff are to prompt Resident C to get up and come out of her bedroom. Both Ms. Smith and Ms. Scott stated they witnessed residents not being toileted, changed or groomed. Both Ms. Smith and Ms. Scott stated they have come into the facility and found Resident C lying in urine-soaked clothes and linens. Ms. Scott stated the previous facility manager, Chelsea Hernandez has been suspended due to not ensuring residents were properly cared for.

Ms. Tricoci and I then made face-to-face contact with Resident C. An interview was not completed as Resident C was observed to be asleep, in her bed. Resident C was dressed in clean clothing and lying on clean linens.

Ms. Tricoci and I interviewed staff, Tanya Klifman. Ms. Klifman stated she has only worked at the facility for 90 days. Ms. Klifman denied the allegations that staff do not properly care for Resident C. Ms. Klifman stated when she works, she will change Resident C's adult briefs and linens when they get wet. Ms. Klifman stated Resident C will refuse to get out of bed, but Ms. Klifman will try to prompt her to do so. She stated Resident C also has a bad habit of picking sores on her legs, causing them to bleed; Therefore, Ms. Klifman makes sure the sores are cleaned and bandaged.

On 03/06/2024, I received and reviewed Resident C's facility records, specifically her Assessment Plan. Under the Social/Behavioral Assessment section, it states Resident C prefers to be along and can become verbally aggressive towards others. Under the Self Care Skills Assessment section, it states Resident C is incontinent and needs assistance with changing her adult briefs. Resident C uses a wheelchair to ambulate.

On 04/10/2024, I spoke with Allegan County Adult Protective Services worker, Kathleen Woodward to coordinate the investigation.

On 04/10/2024, Ms. Tricoci and I completed a Microsoft Teams meeting to interview staff. Facility manager, Britini Smith was also present. We interviewed staff, Kristy Penny. Ms. Penny stated she works third shift at the facility. Ms. Penny denied witnessing Resident C being left in soiled briefs and linens. Ms. Penny admitted there have been incidents when she has fallen asleep for a brief period of time during her shift, but there were two other staff present, taking care of the residents.

On 04/19/2024, Ms. Tricoci and I completed an unannounced onsite inspection at the facility. We interviewed Residents D, E and F. All three residents stated staff provide adequate care when needed. They denied having any concerns. Face-to-face contact was made with Resident C. An interviewed was not completed as she was asleep. Attempts were made to wake Resident C; however, she wanted to sleep.

Ms. Tricoci and I then interviewed staff, Justice Brunn. Ms. Brunn stated she has worked for Beacon Homes for four years. She typically works third shift. Ms. Brunn stated when she comes in for her shift, often times Resident C is lying in a urine-soaked brief and soiled linens. Ms. Brunn stated day shift staff refuse to provide care to the residents as evident by the fact that she frequently has to clean and change the residents who are incontinent. Ms. Brunn stated there have also been incidents when she was working and observed two other staff sleeping on shift.

We then interviewed staff, Casey Bosse. Ms. Bosse stated she has only worked at the facility for two months. Ms. Bosse denied witnessing Resident C, or other residents not being changed.

On 05/02/2024, I completed an exit conference with licensee designee, Ramon Beltran. He was informed of the investigation findings and recommendations. Mr. Beltran stated a corrective action plan would be submitted.

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:	On 03/06/2024, a complaint was received alleging Resident C is often left in urine-soak briefs and soiled linens. On 03/06/2024 and 04/19/2024, unannounced, onsite inspections were completed at the facility. Face-to-face contact was made with Resident C on both occasions; however, she was not interviewed as she was sleeping. Facility staff, Britini Smith, Kim Scott, and Justice Brunn all reported Resident C is often left in urine-soaked briefs and dirty linens. Resident C's Assessment Plan was reviewed and reflected Resident C is incontinent. She requires staff assistance with changing her adult briefs.

	Based on the investigative findings, there is sufficient evidence to support a rule violation that staff are not providing adequate care for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff are not administering Resident C's prescribed medications.

INVESTIGATION: On 03/06/2024, Ms. Tricoci and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Smith and Ms. Scott. Both stated they were not aware of any medication errors with Resident C; however, Resident C had several empty, paper medication cups on her bedroom floor. They were not sure if this is related to Resident C "hording" behaviors.

Ms. Tricoci and I then interviewed Ms. Klifman. Ms. Klifman stated Resident C is administered medications as prescribed. She was not aware of any medication errors.

On 03/06/2024, I received and reviewed Resident C's medication administration record (MAR). The MAR reflected Resident C is prescribed the following medications: Aspirin 81 mg, Breo Ellipta 100-25mcg, Calmoseptome .44%, Celebrex 200mg, Clopidogrel 75mg, Duoneb .5 mg, nasal spray, Hydroxyzine 25mg, Lipitor 10mg, Lisinopril 5mg, Metoprolol succinate 50mg, Miralaz 17-gram, Nystatin powder, Prilosec OTC 20mg, Deroquel XR 150mg, Trazadone 50mg and Trintellix 10mg. The MAR reflects Resident A was administered her medications as prescribed.

On 04/19/2024, Ms. Tricoci and I completed an unannounced, onsite inspection at the facility. We interviewed Residents D, E and F, individually. All three residents stated staff administer their medications as prescribed.

We then interviewed Ms. Brunn. Ms. Brunn stated staff are to have Resident C come out of her bedroom and then administer her medications. Ms. Brunn stated before, staff would bring Resident C's medication to her bedroom to administer them. Ms. Brunn denied being aware of any medication errors.

On 05/02/2024, I completed an exit conference with Mr. Beltran. He was informed of the investigation findings and recommendations.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	On 03/06/2024, a complaint was received alleging facility staff are not administering Residence C's prescribed medications. On 03/06/2024 and 04/19/2024, unannounced, onsite inspections were completed at the facility. Facility staff, Britini Smith, Kim Scott, Tonya Klifman and Justice Brunn denied any knowledge of medication issues concerning Resident C. Face-to-face contact was made with Resident C during onsite inspections; however, interviews were not completed as Resident C was asleep. Residents D, E and F all stated they receive their medications as prescribed. Resident C's Medication Administration Record was reviewed and reflected staff administer her medications as prescribed. Based on the investigative findings, there is insufficient evidence to support a rule violation that staff to not properly administer Resident C's medication.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff refused to assist Resident C with showers.

INVESTIGATION: On 03/06/2024, Ms. Tricoci and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Smith and Ms. Scott. Both staff stated Resident C will often times refuses to be showered; however, it depends on staff's approach. Both staff stated often times they are successful at getting Resident C to shower, but other staff have a difficult time prompting Resident C.

Face-to-face contact was made with Resident C. An interview was not completed, as Resident C was asleep. Resident C was observed to be clean and appropriately dressed.

On 03/06/2024, I received and reviewed Resident C's Assessment Plan. Under the Self Care Skill Assessment Section of the plan it stated Resident C has limited mobility and requires staff assistance with showering.

On 04/10/2024, Ms. Tricoci and I interviewed Ms. Penny, using Microsoft Teams. Ms. Penny stated often times staff will prompt Resident C to get in the shower, but she frequently refuses.

On 04/19/2024, Ms. Tricoci and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Brunn. Ms. Brunn stated Resident C frequently refuses showers. Ms. Brunn stated she will try to prompt Resident C three separate

times, during a day to shower and then if she continues to refuse, she will not force Resident C.

On 05/02/2024, I completed an exit conference with Mr. Beltran. He was informed of the investigation findings and recommendations.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	On 03/06/2024, a complaint was received alleging staff refuse to assist Resident C with showers. On 03/06/2024 and 04/19/2024, unannounced, onsite inspections were completed at the facility. Facility staff, Britini Smith, Kim Scott, Tonya Klifman and Jutice Brunn each reported Resident C frequently refuses showers. On 03/06/2024 and 04/19/2024, face-to-face contact was made with Resident C; however, interviews were not completed as she was sleeping. Resident C was observed to be clean and appropriately dressed. Based on the investigative findings, there is insufficient evidence to support a rule violation that staff do not assist Resident C with showers.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident C's bedroom is dirty with trash all over the floor.

INVESTIGATION: On 03/06/2024, Ms. Tricoci and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Smith and Ms. Scott. Both staff stated Resident C's bedroom is often dirty with soiled linens, briefs, medication cups and trash on the floor. Both Ms. Smith and Ms. Scott stated they believe staff are not cleaning Resident C's bedroom.

Ms. Tricoci and I then made face-to-face contact with Resident C. An interview was not conducted as Resident C was observed to be asleep. Resident C presented clean and appropriately dressed but laying on stained linens. There were also small

stains observed on Resident's C wall, next to her bed. Resident C's trash was observed to be overflowing and her room was cluttered with various belongings. Ms. Tricoci and I then interviewed Ms. Klifman. Ms. Klifman stated she cleans the facility, including Resident C's bedroom during her shift. Ms. Klifman reported Resident C likes to collect things and has a hard time letting them go. Resident C does not like things thrown away.

On 04/19/2024, Ms. Tricoci and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Brunn and Ms. Bosse individually. Ms. Brunn and Ms. Bosse both stated they typically work third shift. Each time they come in for their scheduled shifts, the facility is messy, including Resident C's bedroom. Often times they have to clean Resident C's bedroom and change her soiled linens.

Ms. Tricoci and I then made face-to-face contact with Resident C, who was observed to be asleep. Resident C room was observed to be cluttered with belongs; however, the floor was clean. The wall, next to Resident C's bed, still had small red stains.

On 05/02/2024, I completed an exit conference with licensee designee, Ramon Beltran. He was informed of the investigation findings and recommendations. Mr. Beltran stated a corrective action plan would be submitted.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On 03/06/2024, a complaint was received alleging Resident C's bedroom is dirty with trash all over the floor. On 03/06/2024, an unannounced, onsite inspection was completed at the facility. Face-to-face contact was made with Resident C. An interview was not completed as Resident C was observed to be asleep. Resident C's room was dirty, with trash overflowing and stains on the wall. Facility staff, Britini Smith, Kim Scott, Justice Brunn and Casey Bosse each reported staff are not cleaning Resident C's room as they should. Often times the bedroom is messy, trash all over and Resident C is lying on soiled linens. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff are not keeping Resident C's bedroom clean.

CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/03/2024

Megan Aukerman Date
Licensing Consultant

Approved By:

05/03/2024

Jerry Hendrick Date
Area Manager