GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 3, 2024

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

RE: License #: AM030402101
Investigation #: 2024A0464059
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 #:	2024A0464059
Complaint Receipt Date:	09/16/2024
Investigation Initiation Date:	09/16/2024
Report Due Date:	11/15/2024
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?
Facility staff are giving Resident A marijuana. Marijuana is also left out and accessible to other residents.	Yes
Resident A requires a 1-to-1 staff supervision. Staff have been caught sleeping when they are supposed to be supervising Resident A.	Yes

III. METHODOLOGY

09/16/2024	Special Investigation Intake 2024A0464059
09/16/2024	APS Referral Referral came from APS
09/16/2024	Special Investigation Initiated-Telephone Michael McClellan, Allegan County APS
09/16/2024	Contact-Document sent Elena Tricoci, ORR
09/16/2024	Contact-Document received Kathleen Woodworth, Allegan APS
09/19/2024	Inspection Completed-Onsite Elena Tricoci (ORR), Kathleen Woodworth (APS), Ann Wiley (Facility Manager), Madelyn Maxwell (Staff) & Madison Motter (Staff)
09/19/2024	Contact-Document Received Facility Records
10/03/2024	Exit Conference Ramon Beltran, Licensee Designee

ALLEGATION: Facility staff are giving Resident A marijuana. Marijuana is also left out and accessible to other residents.

INVESTIGATION: On 09/16/2024, I received an online BCAL complaint from Adult Protective Services (APS). The complaint stated Resident A suffers from schizophrenia. There are concerns that while residing in the facility, staff gave Resident A marijuana vapes, which she had access to on multiple occasions. The staff are also allegedly giving Resident A the marijuana.

On 09/16/2024, I spoke to Allegan County APS worker, Michael McClellan. He stated he was the APS worker on call, but the complaint would be assigned to Kathleen Woodworth.

On 09/16/2024, I sent a copy of the referral to Kalamazoo County Office of Recipient Rights (ORR) investigator, Elena Tricoci to coordinate the investigation.
On 09/16/2024, I exchanged emails with Allegan County APS worker, Kathleen Woodworth. Ms. Woodworth stated she interviewed Resident A at Borgess Inpatient Behavioral Health Hospital. Resident A reported facility staff have been smoking marijuana with her. Resident A did not want to provide names, as she did not want to get into trouble. Resident A stated she believes some of the staff that were giving her marijuana quit or were fired. She stated there is still one staff person working at the facility who smokes marijuana with her. Ms. Woodworth stated that during the interview Resident A became visibly upset and was shaking.

On 09/19/2024, Ms. Tricoci, Ms. Woodworth and I completed an unannounced, onsite inspection at the facility and interviewed facility manager, Ann Wiley. Ms. Wiley stated she has been the facility manager since June 24,2024. Ms. Wiley explained Resident A requires constant, one-on-one staff supervision due to her self-harming behaviors. Ms. Wiley stated Resident A was admitted into the hospital due to attempting to run in front of a moving vehicle and banging her head on the cement. Ms. Wiley stated Resident A remains in the hospital and she is not sure when she will be returning. Ms. Wiley denied witnessing or hearing of any staff giving Resident A marijuana.

We then interviewed staff, Madelyn Maxwell. Ms. Maxwell explained that Resident A called her into her bedroom and reported staff, Skyler Price let her hit a “dab pen”, which is a marijuana vape on more than one occasion. Resident A reportedly informed Ms. Maxwell Mr. Price gave her the pen, because he said it would help with her anxiety. Resident A stated it helped at first, but then it started to make her feel “funny”. Resident A stated she was too scared to tell Mr. Price she didn’t want to use marijuana anymore, because he would pressure her to do so. Ms. Maxwell stated there are other staff in the home who use marijuana while working. She has caught staff, Anastasia Lee leaving her “dab pen” out where residents had access. Ms. Maxwell provided a photograph of the “dab pen” being left out during a shift Ms. Lee worked. Ms. Maxwell stated she immediately reported the information to Ms. Wiley.

Ms. Tricoci, Ms. Woodworth and I then confronted Ms. Wiley. Ms. Wiley admitted to lying about being made aware of the marijuana incidents. Ms. Wiley denied witnessing the incidents but did acknowledge staff reported the incidents. Ms. Wiley stated she had a meeting with all of the staff and informed them marijuana is not allowed on facility premises.

We then interviewed staff, Madison Motter. Ms. Motter denied witnessing staff give Resident A marijuana. Ms. Motter stated she has seen staff “dab pens” left out,

where residents could access. She denied knowing if any residents had grabbed the “dab pen”.

On 10/03/2024, I completed an exit conference with licensee designee, Ramon Beltran. He was informed of the investigation findings and recommendations. Mr. Beltran stated the report will be sent to the compliance department and a corrective action plan will be submitted.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(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 09/19/2024, a complaint was received alleging facility staff gave Resident A marijuana. Allegan County Adult Protective Services worker Kathleen Woodworth interviewed Resident A at the hospital. Resident A disclosed staff have given her marijuana to calm her anxiety. Staff Madelyn Maxwell reported Resident A disclosed staff Skyler Price had given her marijuana on more than one occasion. Ms. Maxwell also disclosed witnessing staff Anastasia Lee leaving marijuana out, where it was accessible to residents. Staff, Madison Motter disclosed witnessing staff leave marijuana out in the open, where it was accessible to residents. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff were giving Resident A marijuana and left marijuana out in the open, where residents would have access.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A requires a 1-to-1 staff supervision. Staff have been caught sleeping when they are supposed to be supervising Resident A.

INVESTIGATION: On 09/19/2024, Ms. Tricoci, Ms. Woodworth and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Wiley, who explained Resident A requires constant, one-on-one staff supervision due to her self-harming behaviors. Ms. Wiley stated Resident A was admitted into the hospital

due to attempting to run in front of a moving vehicle and banging her head on the cement. Ms. Wiley denied witnessing staff sleeping while they were supposed to be supervising Resident A.

We then interviewed Ms. Maxwell. She reported Resident A requires one staff at all times for supervision. Ms. Maxwell stated she has caught Ms. Lee sleeping in a chair when she was supposed to be supervising Resident A. Ms. Maxwell reported the incident to Ms. Wiley.
Ms. Tricoci. Ms. Woodworth and I then interviewed Ms. Motter. Ms. Motter stated she came in one morning, towards the end of July, to relieve the night shift. When she arrived, she observed Ms. Lee asleep in the front living room chair, when she was scheduled to provide supervision of Resident A.

On 09/19/2024, I received and reviewed Resident A's facility records, specifically her Assessment Plan and Person-Centered Planning report (PCP). Resident A's Assessment Plan was completed and signed by Resident A's guardian, Stanley Learner. Under the Social/Behavioral Assessment section, it states, "(Resident A) requires one-to-one staff in the community".

Resident A's PCP was reviewed and completed on 01/08/2024. The PCP stated Resident A requires one-to-one staff ration, during waking hours (6:00 am to 10:00 pm), staff must be within an arm length reach. Resident A requires thirty-minute checks during sleeping hours (10:00 pm to 6:00 am). If Resident A is agitated, staff must contact the clinic, and a one-to-one ration is to be implemented during the night.

On 10/03/2024, I completed an exit conference with licensee designee, Ramon Beltran. He was informed of the investigation findings and recommendations. Mr. Beltran stated the report will be sent to the compliance department and a corrective action plan will be submitted.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(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:	On 09/16/2024, a complaint was received that Resident A requires one-to-one staff supervision. It was discovered staff were sleeping when they were supposed to be supervising Resident A. On 09/16/2024, an unannounced, onsite inspection was completed at the facility. Staff Madelyn Maxwell and Madison - Motter both stated Resident A requires one-to-one staff

	supervision. On two separate occasions staff, Anastasi Lee was caught sleeping during her shift, when she was supposed to be providing supervision to Resident A. Resident A's Assessment Plan and Person-Centered Planning reports were reviewed. Both stated Resident A requires a one-to-one staff supervision a majority of the time, at the facility as well as in the community. Based on the investigative findings, there is sufficient evidence to support the allegation that staff were sleeping when they were supposed to be providing supervision for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/03/2024

Megan Aukerman Date
Licensing Consultant

Approved By:

10/03/2024

Jerry Hendrick Date
Area Manager