RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

August 28, 2018

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

RE: License #: AS250387844
Investigation #: 2018A0501040
Beacon Home at Washburn

Dear Ms. Williams:

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 (810) 787-7031.

Sincerely,

Crecendra Brown

Crecendra Brown, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 931-0965

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250387844
Investigation #:	2018A0501040
Complaint Receipt Date:	06/28/2018
Investigation Initiation Date:	06/28/2018
Report Due Date:	08/27/2018
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Melissa Williams
Licensee Designee:	Melissa Williams
Name of Facility:	Beacon Home at Washburn
Facility Address:	8012 Washburn Rd. Goodrich, MI 48438
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	09/07/2017
License Status:	REGULAR
Effective Date:	03/07/2018
Expiration Date:	03/06/2020
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A laid in his bed for days receiving no medical attention and now he is in the hospital due to medical neglect.	No
Additional Findings	Yes

III. METHODOLOGY

06/28/2018	Special Investigation Intake 2018A0501040
06/28/2018	Special Investigation Initiated - Letter
06/28/2018	APS Referral Genesee County Adult Protective Services Kizzie Baker investigating.
07/12/2018	Inspection Completed On-site Staff Toni Little, Staff Katelyne Dobson, Staff Derrick Jones, Resident B, Resident C, and Home Manager Jennifer Stancroff.
07/20/2018	Contact - Telephone call made Guardian 1.
07/20/2018	Exit Conference Licensee Designee Melissa Williams.
08/02/2018	Exit Conference Licensee Designee Melissa Williams.
08/10/2018	Exit Conference Licensee Designee Melissa Williams.

ALLEGATION:

Resident A laid in his bed for days receiving no medical attention and now he is in the hospital due to medical neglect.

INVESTIGATION:

On July 12, 2018, I conducted an onsite investigation at Beacon Washburn. Staff Toni Little, Staff Katelyne Dobson, Staff Derrick Jones, Resident B, Resident C and Home Manager Jennifer Stancroff were interviewed.

Staff Toni Little stated that Resident A was admitted to the hospital in June 2018. Staff Little stated that the day Resident A went to the hospital he refused to take his medications and we knew something was wrong. Staff Little stated that the day before that Resident A was still taking his medications, eating and drinking, but he did mostly stay in the bed. Staff Little stated that she contacted the staff nurse and she said to take his vitals. Staff Little stated that Resident A's blood pressure was lower than usual and he had a temperature, but he said he was not in any pain so the nurse told staff to keep an eye on his vitals. Staff Little stated that as soon as they saw he was reacting different the next day he was sent to the hospital. Staff Little stated that Resident A was not medically neglected.

Staff Katelyne Dobson stated that Resident A would laid down in the bed often. Staff Dobson stated that when staff noticed a change in Resident A's behavior he was sent to the hospital. Staff Dobson stated that Resident A was not being medically neglected.

Staff Derrick Jones stated that he doesn't know about the allegation. Staff Jones stated that he is a fairly new employee. Staff Jones stated that when he started working at the home Resident A was already in the hospital.

Resident B stated that he thinks Resident A was sick for two days before he went to the hospital. Resident B stated that he remembers Resident A went to the hospital in June 2018 and he thinks staff could have sent him to the hospital sooner than they did. Resident B stated that Resident A would laid down a lot, but when he was sick he laid down more than usual.

Resident C stated that Resident A wasn't feeling good for a few days. Resident C stated that staff sent him to the hospital after he had been sick for a few days. Resident C stated that he almost called 911 himself.

Home Manager Jennifer Stancroff stated that one day Resident A said he wasn't feeling good, but he was still smoking, eating, and drinking so they called the staff nurse. Home Manager Jennifer Stancroff stated that they were told by the nurse to monitor Resident A's vitals. Home Manager Jennifer Stancroff stated that they decided to send Resident A to the hospital the next day. Home Manager Jennifer Stancroff stated that

Resident A was not medically neglected. Home Manager Jennifer Stancroff stated that Resident A is currently in rehab and not sure what the plans are for him after rehabilitation.

On July 20, 2018, I conducted a phone interview with Guardian 1. Guardian 1 is the guardian for Resident A. Guardian 1 stated that Resident A did go to the hospital in June 2018 and then on July 6, 2018 Resident A went into a rehabilitation center. Guardian 1 stated that he does not know anything about Resident A being medically neglected. Guardian 1 stated that Resident A was having kidney failure. Guardian 1 stated that on June 27, 2018 he signed consent for Resident A to have surgery and on June 28, 2018 Resident A had diverted colonoscopy surgery. Guardian 1 stated that Resident A has to have another surgery and more rehab. Guardian 1 stated that if all goes well, Resident A is supposed to return to Beacon Washburn.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Staff Toni Little, Staff Katelyne Dobson, Home Manager Jennifer Stancroff stated that Resident A was not medically neglected and he was sent to the hospital as soon as they noticed a change in his behavior. Guardian 1 stated that he doesn't know anything about Resident A being medically neglected. There is not enough evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On July 12, 2018, I conducted an onsite investigation at Beacon Washburn. Staff Toni Little, Staff Katelyne Dobson, Staff Derrick Jones, and Home Manager Jennifer Stancroff were interviewed.

Staff Toni Little stated that Resident A was admitted to the hospital in June 2018. Staff Little stated that she did not know if an incident report was completed. Staff Little was unable to find a copy of an incident report in the home.

Staff Katelyne Dobson stated that Resident A went to the hospital, but she was not aware if an incident report was completed. Staff Dobson stated that she thinks someone completed an incident report. Staff Dobson stated that Resident A is still in the hospital.

Staff Derrick Jones stated that he did not know if an incident report was completed. Staff Derrick Jones stated that when he started working at the home Resident A was already in the hospital.

Home Manager Jennifer Stancroff stated that Resident A went to the hospital in June 2018. Home Manager Jennifer Stancroff stated that she was not sure if an incident report was done. Home Manager Jennifer Stancroff was not able to locate an incident report on Resident A going to the hospital in June 2018 and one was not sent to the State of Michigan.

On July 20, 2018, I conducted a phone interview with Guardian 1. Guardian 1 is the guardian for Resident A. Guardian 1 stated that he was never called by the home about Resident A being sick or going to the hospital. Guardian 1 stated that he found out Resident A was in the hospital form the hospital on June 20, 2018.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(ii) Hospitalization.** **(2) An immediate investigation of the cause of an accident or incident that involves a resident, employee, or visitor shall be initiated by a group home licensee or administrator**

	and an appropriate accident record or incident report shall be completed and maintained. **(7) A copy of the written report that is required pursuant to subrules (1) and (6) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.**
ANALYSIS:	Staff Toni Little, Staff Katelyne Dobson, Staff Derrick Jones, and Home Manager Jennifer Stancroff stated that they do not know if an incident report was completed on Resident A going to the hospital in June 2018. Guardian 1 stated that Resident A was hospitalized June 20, 2018. No incident report was received at the State of Michigan office.
CONCLUSION:	**VIOLATION ESTABLISHED**

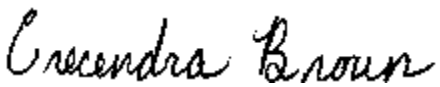
On July 20, 2018, I attempted to conduct a phone exit conference with Licensee Designee Melissa Williams. I left a voice message for her to call me back.

On August 2, 2018, Licensee Melissa Williams left me a voice message stating she received my message and I could call her back about the exit conference.

On August 10, 2018, I attempted to conduct a phone exit conference with Licensee Designee Melissa Williams. A man answered the phone and I asked to speak to Melissa Williams. The man wanted to know who I was, and I identified myself and where I worked at. The man kept saying “What do you want” and I told him I would like to speak to Melissa Williams. The man said, “For what” and I asked him if I could know who I was speaking to. The man said he was Melissa Williams husband and they were on vacation. I asked him if I could leave a message and he said she would be back to work sometime next week. I thanked him and he hung up. To date, I have not received a return phone call from Ms. Williams.

IV. RECOMMENDATION

Upon the receipt of an acceptable and approved corrective action plan, no change to the license status is recommended.

 August 28, 2018

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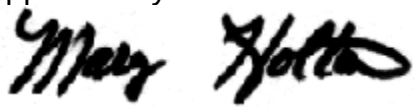
Crecendra Brown Date
Licensing Consultant

Approved By:

 August 28, 2018

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Mary E Holton Date
Area Manager