RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 9, 2019

Eric McBean
McBean Transitional Care, LLC
1410 Lynton Avenue
Flint, MI 48507

RE: License #: AS250315962
Investigation #: 2019A0779006
McBean Transitional Care - Lynton

Dear Mr. McBean:

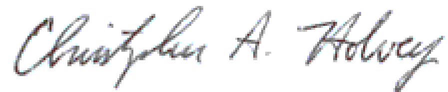
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 899-5659

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250315962
Investigation #:	2019A0779006
Complaint Receipt Date:	11/15/2018
Investigation Initiation Date:	11/16/2018
Report Due Date:	01/14/2019
Licensee Name:	McBean Transitional Care, LLC
Licensee Address:	1410 Lynton Avenue Flint, MI 48507
Licensee Telephone #:	(810) 877-1814
Administrator:	Eric McBean
Licensee Designee:	Eric McBean
Name of Facility:	McBean Transitional Care - Lynton
Facility Address:	1410 Lynton Ave Flint, MI 48507
Facility Telephone #:	(810) 820-0840
Original Issuance Date:	05/09/2012
License **Status:**	REGULAR
Effective Date:	11/14/2016
Expiration Date:	11/13/2018
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 11/9/18, residents were left unattended in the home when staff Major Beaugard left the home. Home owner, Eric McBean, was in the home but was asleep on the couch.	Yes
Resident medication was left out.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/15/2018	Special Investigation Intake 2019A0779006
11/15/2018	APS Referral Complaint was referred to AFC licensing by APS centralized intake.
11/16/2018	Special Investigation Initiated - Telephone Spoke to recipient rights investigator, Kim Nguyen.
11/27/2018	Inspection Completed On-site Interview conducted with licensee, Eric McBean and staff person, Christina McBean.
11/27/2018	Contact – Telephone call made Voicemail message was left for staff person, Major Beaugard
01/09/2019	Contact – Telephone call made Phone interview conducted with staff person, Major Beaugard.
01/09/2019	Exit Conference Conducted by phone with licensee designee, Eric McBean.

ALLEGATION:

On 11/9/18, residents were left unattended in the home when staff Major Beaugard left the home. Home owner, Eric McBean, was in the home but was asleep on the couch.

INVESTIGATION:

On 11/16/18, a phone conversation took place with Recipient Rights Investigator, Kim Nguyen-Forbes. Ms. Nguyen-Forbes stated that the licensee designee, Eric McBean, called recipient rights to report that one of his staff left the home during his shift and left residents unsupervised. She reported that Mr. McBean told her that he was asleep on the living room couch when the staff left and that the staff did not wake him before leaving. Ms. Nguyen-Forbes stated that Resident A requires line-of-sight supervision, was in the home at that time, and was not properly supervised for an unknown amount of time.

On 11/27/18, an on-site inspection was conducted. Licensee designee, Mr. McBean and staff person, Christina McBean, were interviewed.

According to Mr. McBean, his wife/staff person, Christina McBean, and staff person, Major Beaugard, were in the home when he laid down to take a nap on the couch. He stated that Mrs. McBean left the home at 5:00pm and left Mr. Beaugard in charge of supervising the residents. Mr. McBean reported that when he woke from his nap between 6:30-7:00pm, Mr. Beaugard was not anywhere inside the home. He stated that Mr. Beaugard left the home for some unknown reason and did not wake him before he left. Mr. McBean is not certain of the exact time that Mr. Beaugard left the home and exactly how long the residents were unsupervised. Mr. McBean stated that all six residents were home during that time and confirmed that Resident A requires line-of-sight supervision in the home and out in the community. He stated that when he woke up, Resident A was sitting in the living room chair. Mr. McBean reported that he has tried to get an explanation from Mr. Beaugard, but that Mr. Beaugard will not return his phone calls. He stated that he has terminated Mr. Beaugard's employment at this home.

Staff person, Christina McBean, stated that she left the home at 5:00pm. She claims that Mr. McBean was falling asleep on the couch and that Mr. Beaugard was there and knew he was in charge of supervising the residents. Mrs. McBean stated that she does not know what time Mr. Beaugard left the home.

During the on-site inspection on 11/27/18, an attempt was made to interview Resident A. Due to his mental illness and cognitive deficiencies, Resident A was not able to effectively communicate the events and/or details during the time frame in question.

Resident A's assessment plan and psychosocial assessment indicate that he suffers from schizophrenia. They also state that he has a peg tube for eating, requires assistance with walking long distances and requires line-of-sight supervision, both in the home and while out in the community.

On 1/9/19, a phone interview was conducted with staff person, Major Beaugard. Mr. Beaugard claims that he had permission to leave his shift early on 11/9/18. He stated that Mr. McBean was lying on the couch when he asked him if he could leave early and

that Mr. McBean told him he could. Mr. Beaugard reported that he believes Mr. McBean was awake when he left the home. He does not remember what time he left. Mr. Beaugard stated that there were a couple residents in the living room with Mr. McBean when he left the home.

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 was not provided the line-of-sight supervision specified in his written assessment plan when he was left unsupervised for an unknown amount of time on 11/9/18. Staff person, Major Beaugard, left the home sometime between 5:00-6:30pm, while licensee designee, Eric McBean, was asleep on the living room couch. There were no other staff present and/or awake to supervise Resident A or the other five residents, during Mr. Beaugard's absence and before Mr. McBean woke from sleep.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident medication was left out.

INVESTIGATION:

On 11/27/18, licensee designee, Mr. McBean, stated that on 11/9/18 he awoke from his nap and found that staff person, Mr. Beaugard, had left the home during his shift, he also noticed that Mr. Beaugard had left resident medications sitting on the kitchen counter. Mr. McBean stated that the pharmacy had dropped off the medications while he was sleeping and Mr. Beaugard did not lock them up and away from where the residents could get them. He stated that the medications were still in the pharmacy bag and that no residents handled the medications.

On 11/27/18, staff person, Mrs. McBean, stated that when she left the home, she passed the pharmacy person who was dropping off resident medications. She stated that when she left Mr. McBean was sleeping on the couch and Mr. Beaugard was in charge of supervising the residents.

On 11/27/18, an exit conference was conducted in-person with licensee designee, Eric McBean. At that time, Mr. McBean provided an acceptable corrective action plan addressing the rule violations in this report.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	On 11/9/18, resident medications were left sitting on the kitchen counter unattended by staff for an unknown amount of time. Staff failed to lock the medication in a locked cabinet or drawer and left them where residents had access to them.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/27/18, Mr. McBean confirmed that he had fallen asleep on the living room couch on 11/9/18. He stated that he was not sure exactly what time he fell asleep, somewhere around 5:00pm, and that he woke up between 6:30-7:00pm.

On 11/27/19, Mrs. McBean stated that when she left the home at 5:00pm, Mr. McBean was lying on the living room couch falling asleep.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally**
	(2) A living room, dining room, hallway, or other room that is not ordinarily used for sleeping or a room that contains a required means of egress shall not be used for sleeping purposes by anyone.

ANALYSIS:	Licensee designee, Eric McBean, admits to falling asleep on the living room couch on 11/9/18. Mr. McBean was sleeping on the couch for approximately 1-2 hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/19/2019, an exit conference occurred with Mr. McBean. Mr. McBean was informed of the findings of this investigation.

IV. RECOMMENDATION

Upon receipt of an approved written plan of correction, I recommend that the status of this home's license remain unchanged.

1/9/19

Christopher Holvey Date
Licensing Consultant

Approved By:

1/9/19

Mary E Holton Date
Area Manager