GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 13, 2020

Patricia Miller
Galesburg Retirement Home LLC
Suite #110
890 North 10th Street
Kalamazoo, MI 49009

RE: License #: AM390337021
Investigation #: 2020A0462007
Beacon Home at Stagecoach

Dear Ms. Miller:

Attached is the **AMENDED** Special Investigation Report for the above referenced facility. **Additional information for this special investigation was added to pages three and four of the report.** No substantial violations were found.

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,

Michele Streeter

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
322 E. Stockbridge Ave
Kalamazoo, MI 49001
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM390337021
Investigation #:	2020A0462007
Complaint Receipt Date:	11/13/2019
Investigation Initiation Date:	11/14/2019
Report Due Date:	01/12/2020
Licensee Name:	Galesburg Retirement Home LLC
Licensee Address:	11218 Miller Dr. Galesburg, MI 49053
Licensee Telephone #:	(269) 427-8400
Administrator:	Karla Averill
Licensee Designee:	Patricia Miller
Name of Facility:	Beacon Home at Stagecoach
Facility Address:	11218 Miller Dr. Galesburg, MI 49053
Facility Telephone #:	(269) 200-5174
Original Issuance Date:	01/23/2013
License Status:	REGULAR
Effective Date:	07/23/2019
Expiration Date:	07/22/2021
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The facility lacks the proper level of supervision and control of the residents who reside there, creating an unsafe and dangerous atmosphere throughout the neighborhood. Due to lack of supervision, residents misuse emergency response systems.	No

The written complaint included incidents of residents committing assault and battery, felony assault, damage to private property, operating under the influence of alcohol, obstructing justice, CSC 4th degree, weapon possession, breaking and entering, outstanding warrants and home invasion over the course of four years. However, the written complaint did not include specific dates and/or residents' and facility staff members' names. There is no record of the department receiving any complaints over the past four years regarding excessive 911 calls and/or excessive requests to respond to the facility. According to the Bureau's Internal Tracking Systems, two complaints were filed with the department in 2015, one in 2016, two in 2017, one in 2018 and one in 2019. None of these complaints, which resulted in investigations, included instances of felony assault, damage to private property, operating under the influence of alcohol, obstructing justice, CSC 4th degree, weapon possession, breaking and entering, outstanding warrants and home invasion.

To ensure an objective investigation to determine the facility's current compliance with AFC administrative licensing rules, all information gathered for this investigation, including but not limited to the review of relevant documents, records, etc., was for the period of no longer than one year.

III. METHODOLOGY

11/13/2019	Special Investigation Intake 2020A0462007
11/14/2019	Special Investigation Initiated – Request for KCSD police reports.
11/15/2019	Contact – Received KCSD police reports.
11/22/2019	Contact – Left voicemail for Complainant. Emailed Complainant.
11/26/2019	Contact- Telephone interview with Charleston Township Board Member Jerry Vander Roest.
12/04/2019	Contact- Requested information, via email exchange, from licensee designee Patricia Miller and administrator Karla Averill.

12/05/2019	Contact- Received requested documentation.
12/10/2019	Contact- Requested additional documentation from licensee designee Patricia Miller, administrator Karla Averill and home manager Amanda Wilson.
12/11/2019	Contact- Requested additional documentation from licensee designee Patricia Miller, administrator Karla Averill and home manager Amanda Wilson. Contact- Telephone interview with licensee designee Patricia Miller.
12/12/2019	Contact- Received requested documentation.
12/19/2019	Contact via Telephone with BFS' fire inspector Ken Howe and licensee designee Patricia Miller.
01/02/2020	Contact- Face to face interviews with licensee designee Patricia Miller and Chief Compliance Officer Nichole VanNiman. Exit conference with licensee designee Patricia Miller.
01/29/2020	Contact- Face-to-face meeting with Charleston Township individuals, AFC Division Director Jay Calewarts, AFC Area Manager Dawn Timm and AFC Consultant Michele Streeter. BSLS members declined this meeting.

ALLEGATION: The facility lacks the proper level of supervision and control of the residents who reside there, creating an unsafe and dangerous atmosphere throughout the neighborhood. Due to lack of supervision, residents misuse emergency response systems.

INVESTIGATION: On 11/12/2019 the Bureau of Community and Health Systems (BCHS) received this complaint, via the BCHS' on-line complaint system. The written complaint indicated 215 police complaints or service calls, regarding residents of the facility, were reported to the Kalamazoo County Sheriff's Department (KCSD) within the past four years. The written complaint indicated the types of police reports/complaints filed involved instances of residents committing assault and battery, felony assault, damage to private property, operating under the influence of alcohol, obstructing justice, CSC 4th degree, weapon possession, breaking and entering, outstanding warrants and home invasion. The written complaint did not include specific incidents, dates, and/or the names of the residents and/or facility staff members allegedly involved in these incidents.

According to the written complaint, the Township of Charleston averaged over one 911 call from the facility per week, over the past four years. The written complaint indicated the Township of Charleston's Fire Department had been called to the facility 16 times in 2019, at a cost of $8,592. According to the written complaint, a representative from the Township of Charleston attempted to contact Beacon Specialized Living Services, Inc. (BSLS), via telephone, over five times, and requested to meet with a representative of BSLS on at least three occasions, with no response. In the written complaint, Complainant requested the department change the licensed capacity of the facility from 12 residents to 6 residents.

On 11/22 I provided Complainant, via email exchange, the contact information for BSLS' Executive District Director and licensee designee Patricia Miller and BSLS' Chief Compliance Officer Melissa Williams. Via email exchange, I encouraged Complainant to reach out to Ms. Miller and Ms. Williams to discuss the allegations.

On 11/26 I conducted a telephone interview with Jerry Vander Roest, a board member with the Township of Charleston. Mr. Vander Roest confirmed the allegation the Township of Charleston board of representatives requested a meeting with Ms. Williams approximately five weeks ago. However, according to Mr. Vander Roest, he never heard back from Ms. Williams. I offered to schedule and facilitate a meeting between the AFC licensing division, Township of Charleston board members, KCSD and BSLS. Mr. Vander Roest declined this offer. On 01/29/2020, during a face-to-face meeting with Mr. Vander Roest, he clarified that he declined this offer only because he thought a meeting would be completed in lieu of a formal investigation. Mr. Vander Roest stated he was directed by the Charleston Township Board to assure an investigation was completed. Mr. Vander Roest stated by declining he did not intend to appear uncooperative or unwilling to meet with all parties, he simply wanted to assure a formal investigation was completed per the board members' instructions. AFC Consultant Michele Streeter acknowledged at no point was it communicated that a meeting would be held in lieu of a formal investigation. Ms. Streeter stated she offered the meeting as an opportunity to provide information to all involved education about adult foster care facilities, the residents who reside within them, and how best live in the community while in compliance with AFC rules/requirements.

For the purposes of this investigation, it is important to note residents of adult foster care facilities are afforded freedom of movement and are to reside in the least restrictive environment possible.

According to the facility's Program Statement, BSLS provided a specialized program that offers residential and crisis services to the mentally ill (MI) and developmentally disabled (DD) populations. According to the licensee's website, BSLS provided, in part, residential settings for residents who were unable to live without direct support, exhibited high risk behaviors, over utilized emergency departments, public safety

and/or other justice resources, and unsuccessfully responded to traditional services and benefits.

According to the Bureau's Internal Tracking System (BITS) the facility was licensed on 01/23/2013 and granted a certification to provide specialized programing to residents with a DD and/or MI diagnosis, who were also receiving services from a county community mental health board or contracting agency (responsible agency).

According to the *MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS) BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES ADMINISTRATION Standards for Behavior Treatment Plan Review Committees Revision FY17,* restrictive techniques are defined as those techniques which, when implemented, would result in the limitation of an individual's rights, as specified in the Michigan Mental Health Code and the federal Balanced Budget Act, and would include any limitations of the freedom of movement of an individual. Therefore, unless otherwise indicated in a resident's community mental health Behavior Treatment Plan (BTP), residents are to move freely within the community and are to be afforded the right of reasonable access to a telephone for private communications. BTPs that propose the use of restrictive or intrusive interventions are to be reviewed and approved by representatives from the residents' responsible agency, often referred to as a "behavior treatment plan review committee."

According to BITS, only one complaint was filed with the AFC licensing division in 2019. This complaint resulted in Special Investigation #2019A0462061 and did not include any incidents of assault and battery, felony assault, damage to private property, operating under the influence of alcohol, obstructing justice, CSC 4th degree, weapon possession, breaking and entering, outstanding warrants and home invasion.

On 12/05, home manager Amanda Wilson provided me with the facility's resident roster. According to the facility's resident roster, at the time of this investigation, eleven residents resided in the facility. Documentation on the resident roster indicated the facility currently held contracts with the following responsible agencies; Macomb County Community Health, Kalamazoo Integrated Health Services, Ottawa County Mental Health, Riverwood Center Mental Health Services, Van Buren County Community Mental Health, Saginaw Community Mental Health Authority and the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties.

I requested and reviewed every residents' *Assessment Plan for AFC Residents* (assessment plans) which appeared to be current, as evidenced by the dates and signatures indicated on each assessment plan. Documentation on the assessment plans indicated all 11 residents appeared to meet the department's compatibility requirements. According to documentation on each assessment plan, all residents were able to move independently within the community without supervision, except for Residents B, C, D and E. Documentation on each assessment plan indicated no residents had restrictions on the use of a telephone for private communications.

According to home manager Amanda Wilson, Residents B, C, D and E were the only residents with Community Mental Health BTPs. Ms. Wilson submitted to the department Resident B, C, D and E's BTPs. I reviewed the BTPs and confirmed Residents B, C, D and E had restrictions on their freedom of movement in the community.

I reviewed all 46 *AFC Licensing Division- Incident/Accident Reports* (IRs) submitted to the department in 2019. According to documentation on each IR received by the department, 911 was called 41 times by either facility direct care staff members or facility residents. According to these IRs, there were eight instances in which residents called 911 and reported either false incidents and/or incidents that were "non-life threatening" in nature. Documentation on the other 38 IRs indicated facility direct care staff members and/or residents called 911 following either a sudden adverse change in a resident's physical condition, to report a resident who was absent without notice and/or to assist with residents who were displaying acts of hostility and/or instances of facility property destruction. Documentation on these 38 IRs indicated facility staff members acted appropriately following each incident.
On 12/11, I conducted a telephone interview with licensee designee Patricia Miller. According to Ms. Miller, former Resident A moved into the facility in 2016. Within the past year, Resident A's medical needs and behavioral issues had increased significantly. Ms. Miller confirmed that due to behaviors associated with Resident A's mental and physical health conditions, as well as his inability to verbally communicate, Resident A frequently pulled the facility's fire alarm when frustrated, which caused the Township of Charleston Fire Department to respond to the facility on multiple occasions in 2019. According to Ms. Miller, this issue had been resolved, as Resident A was discharged from the facility in early September 2019, after it was established the facility was unable to manage his behaviors and physical health needs. Ms. Miller stated since Resident A's discharge in September, there had been no false alarms made to the Township of Charleston Fire Department.

Ms. Miller stated Resident B, who resided in the facility since 2016, previously had no restrictions independently accessing the community. Therefore, facility direct care staff members were unable to prevent Resident B from moving freely in the community without supervision. However, in 2019 Resident B began to drink alcohol more frequently, resulting in Resident B missing medications and engaging in negative behaviors at the facility and in the community, including sexually harassing a community member. Ms. Miller confirmed that while on community access unsupervised, Resident B engaged in one instance of breaking and entering, which ultimately lead to his arrest. According to Ms. Miller, due to Resident B's behavior, facility staff members requested Resident B's responsible agency approve a BTP that included a restriction on his independent access in the community, as well as the implementation of 1:1 enhanced staffing while at the facility. I reviewed Resident B's BTP, which was updated on 08/03/2019. Documentation on Resident B's BTP confirmed Ms. Miller's statements. Ms. Miller stated that since these interventions were added to Resident B's BTP, there had been a decrease in Resident B's

negative behaviors in the facility and no instances of Resident B engaging in criminal/negative behaviors in the community.

Documentation on all IRs submitted to the department in 2019 regarding incidents involving Resident B confirmed Ms. Miller's statements.

Documentation on an IR dated 02/07/2019 indicated that on 01/29/2019 Resident B signed out the facility at 2:30 PM and wrote down that he'd return to the facility at 5:00 PM. When Resident B didn't return by 5:00 PM, facility staff members went looking for Resident B. Resident B was located at 5:05 PM and returned to the facility.

Documentation on an IR dated 03/06/2019 indicated that on 03/06 Resident B signed out of the facility at 12:20 PM and wrote down that he'd return to the facility at 5:00 PM. However, according to the IR, Resident B did not return at 5:00 PM. Per the facility's policy, facility staff members notified the KCSD, and Resident B was transported back to the facility at 9:45 PM. Documentation on the IR indicated this incident was reported to Resident B's responsible agency and legal guardian.

Documentation on an IR dated 03/13/2019 indicated that on 03/13, while at a medication review, Resident B was "petitioned" for admission to a psychiatric hospital.

Documentation on an IR dated 05/30/2019 confirmed that on 05/26, Resident B left the facility on independent community access at 12:10 PM and was expected back by 6:00 PM. Facility staff members received a telephone call that Resident B was observed in the community stumbling around allegedly under the influence of alcohol and sexually harassing a member of the community. Facility staff members went looking for Resident B and located him at a local liquor store. Facility staff members made several unsuccessful attempts to convince Resident B to return the facility. Documentation on the IR indicated KCSD was notified and a police officer transported Resident B back to the facility at 5:45 PM. Resident B smelled strongly of alcohol and was verbally aggressive with facility staff members upon returning to the facility. Documentation on the IR indicated this incident was reported to Resident B's responsible agency and legal guardian. Documentation on the IR indicated I followed up with the facility's administrator Karla Averill regarding this incident on 06/04 and again on 06/11. Documentation on the IR indicated a request had been made to Resident B's responsible agency to update Resident B's BTP to include interventions to address Resident B's current negative behaviors.

Documentation on an IR dated 07/17/2019 confirmed that on 07/17, Resident B was in his bedroom at the facility at 11:00 PM. During hourly checks at 12:15 PM Resident B was not in his bedroom, nor was he in any other area in the facility. Documentation on the IR indicated facility staff members followed the facility's *Resident Absent Without Leave* policy. There was no documentation on the IR indicating when Resident B returned to the facility. Documentation on the IR

indicated facility staff members would continue to conduct routine checks on resident B during sleeping hours. According to the IR, this incident was reported to Resident B's responsible agency and legal guardian.

Documentation on an IR dated 07/28/2019 confirmed that on 07/27, while conducting 15-minute checks on Resident B, it was discovered Resident B had left the facility without notifying facility staff members. Documentation on the IR indicated facility staff members followed the facility's *Resident Absent Without Leave* policy, which included calling the police. Resident B returned to the facility on his own at 10:00 PM. Documentation on the IR indicated this incident was reported to Resident B's responsible agency and legal guardian.

Documentation on an IR dated 07/28 confirmed that on 07/28, after engaging in a verbal altercation with another resident, Resident B pushed a facility staff member down and left the facility. Documentation on the IR indicated facility staff members followed the facility's *Resident Absent Without Leave* policy, which included calling the police. Resident B did not return to the facility until the following morning. Documentation on the IR indicated this incident was reported to Resident B's responsible agency and legal guardian.

Documentation on an IR dated 07/30 confirmed that on 07/30, Resident B lit a recipient right's booklet on fire while at the facility. Facility staff members called 911 and evacuated the residents from the facility. Documentation on the IR indicated the fire department responded to the facility and gave facility staff members the "all clear". According to the IR, facility staff members continued conducting 15-minute checks on Resident B. Documentation on the IR indicated this incident was reported to Resident B's responsible agency and legal guardian.

Documentation on an IR dated 08/01/2019 confirmed that on 08/01, at approximately 9:00 AM, a KCSD police officer responded to the facility and arrested Resident B on outstanding warrants out of Kalamazoo County and Detroit, Michigan. According to the IR, the warrant from Detroit became "inactive." Facility staff members picked Resident B up from the jail at approximately 5:30 PM and transported him back to the facility. There was no documentation on the IR indicating what Resident B's warrants were about. Documentation on the IR indicated this incident was reported to Resident B's responsible agency and legal guardian.

There were no IRs submitted to the department after 08/01 regarding incidents involving Resident B, until 12/03. Documentation on an IR submitted to the department on 12/03 indicated that on 12/02, another resident punched Resident B while at the facility. According to the IR, Resident B did not react violently but instead called the police. Documentation on the IR indicated a KCSD police officer responded to the facility and spoke with both residents. However, no arrests were made.

I requested all KCSD's police reports for incidents involving facility residents in 2019 and received a total of nine police reports; five reports regarding lost/found persons, one report regarding "non-aggravated" assault and battery, one report regarding a welfare check, one report regarding a resident's court ordered treatment and one report regarding supplemental information. Documentation on these police reports did not indicate any incidents of felony assault, damage to private property, operating under the influence of alcohol, obstructing justice, CSC 4th degree, weapon possession, breaking and entering, and home invasion.

Documentation on three KCSD police reports, dated 07/17 (Case Number: 19-007884), 07/27 (Case Number: 19-008317) and 08/12 (Case Number: 19-007884) were consistent with the documentation on the 07/17, 07/28 and 08/01 IRs submitted to the department regarding incidents involving Resident B.

Documentation on a KCSD police report, dated 08/12 (Case Number: 19-007884), was also consistent with documentation on the 08/01 IR submitted to the department. According to documentation on the police report, on 08/01, a KCSD police officer responded to the facility and arrested Resident B on outstanding warrants, one out of the Kalamazoo County Sheriff's Department and one out of Detroit. There was no documentation in the police report indicating the nature of Resident B's warrants.

Documentation on a KCSD police report, dated 02/28 (Case Number: 19-002406), indicated that at 9:00 PM on 02/28, a KCSD police officer responded to the facility regarding a report of an altercation between Residents F and G. The police report indicate it was established Resident F was the aggressor. Documentation on the police report indicated Resident G requested charges be filed against Resident F. The police report indicated Resident G was transported to the hospital for an evaluation. There was no documentation on the police report indicated whether Resident F was arrested. According to documentation on the police report, a facility staff member by the name of "Anna" was the only staff member working at the facility at the time of the incident. "Anna" reported to the responding officer she was outside smoking a cigarette, and when she came back into the facility, Residents F and G told her what had occurred.

Documentation on a KCSD's police report, dated 05/07 (Case Number: 19-004918), indicated that on 05/06, a KCSD police officer was dispatched to the facility to conduct a welfare check on Resident H. It was established Resident H had called Borgess hospital and "rambled." The police report indicated Resident H referenced being suicidal and needing assistance. However, when an officer responded to the facility, Resident H denied ever calling Borgess hospital. Resident H also denied being suicidal and told the officer he just wanted to talk. Documentation on the police report indicated Resident H "rambled on" incoherently about the government and other world events.

Documentation on a KCSD's police report, dated 05/17 (Case Number: 10-005349), indicated that on 05/17, a KCSD police officer was dispatched to the facility to serve Resident H a court order for psychiatric evaluation.

Documentation on a KCSD's police report, dated 07/24 (Case Number: 19-008168), indicated that on 07/24, facility staff members contacted the KCSD when Resident B left the facility without signing out, per the facility's policy. Resident B was eventually located at Borgess hospital. According to documentation on Resident B's assessment plan and BTP, at the time of this incident, Resident B had independent access into the community.

Documentation on a KCSD's police report, dated 09/23 (Case Number: 19-010768), on 09/23, facility staff members contacted the KCSD when Resident I left the facility without signing out, per the facility's policy, and didn't return at curfew. A KCSD police officer located Resident I at a gas station and transported him back to the facility. According to Resident I's assessment plan, Resident I had independent access in the community.

Documentation on a KCSD's police report, dated 10/17 (Case Number: 19-011838), on 10/17, a KCSD officer was dispatched to the facility when Resident E did not return to the facility by 5:00 PM. The police report indicated Resident E was located on 10/18 at his sister's house. Resident E's assessment plan, dated 10/10, indicated Resident E was allowed five hours of unsupervised independent community access per day. Documentation on Resident E's BTP, last updated on 10/15, was consistent with the documentation on Resident E's assessment plan. According to Resident E's BTP, Resident E was to sign out and sign back in when leaving/returning to the facility, per BSLS' policy. Therefore, when Resident E did not return by 5:00 PM on 10/17, facility staff members acted appropriately by notifying the KCSD.

There was no documentation on any of the nine police reports received and reviewed indicating specific incidents of felony assault, damage to private property, operating under the influence of alcohol, obstructing justice, CSC 4th degree, weapon possession, breaking and entering or home invasion.

I requested copies of the facility's direct care worker (DCW) schedules, as actually worked, for the past 90 days, and a copy of the facility's "*Resident Absent Without Leave*" policy, as well as a copy of the facility's emergency fire drill records for 2019. Documentation on the DCWs' schedules submitted indicated the facility scheduled enough DCWs on each shift to provide for the supervision, personal care, and protection of the residents, as specified in their assessment plans and in Resident B, C, D and E's BTPs. Documentation on the DCWs' schedules and fire drill records submitted indicated the facility scheduled enough DCWs on each shift to effectively implement the facility's "*Resident Absent Without Leave*" policy, and to safely evacuate the residents from the facility in the event of an emergency. According to this documentation, there was no evidence to suggest the residents were not provided with adequate supervision while at the facility.

On 12/18, via telephone, I spoke with fire inspector Ken Howe, who worked for the Bureau of Fire Services (BFS). Mr. Howe stated it was his understanding there were some township ordinances that allowed for fire departments to charge an individual, or in this case a business, for every false fire alarm made. According to Ms. Howe, there was nothing in the BFS's rules preventing a township from taking this action, if they had the correct ordinance to do so.

I spoke with Ms. Miller, via telephone. According to Ms. Miller, BSLS was in the process of contacting a professional fire protection services company to install protective covers on all the facility's fire alarm pull stations, to prevent accidental and/or improper discharge. According to Ms. Miller, when these protective covers were lifted to gain access to the actual alarm, they would first sound an internal alarm, which would be auditable throughout the facility. Ms. Miller stated facility staff members would be trained to respond immediately to the internal alarm, in an effort to prevent the actual alarm from being discharged when there is no fire emergency. According to Ms. Miller, Facility staff members would be trained to access the situation to determine whether there is an actual fire emergency.

On 01/02 I conducted face to face interviews with Ms. Miller and Ms. VanNiman at BSLS' main office. Ms. VanNiman denied the allegation BSLS failed to respond to the Township of Charleston regarding the allegations. Ms. VanNiman stated she personally communicated with Mr. Vander Roest. However, according to Ms. VanNiman, Mr. Vander Roest only wanted to discuss the allegations at a public Kalamazoo County Community Mental Health board meeting and refused to speak with BSLS regarding the allegations via a telephone conference and/or a private meeting. Ms. VanNiman stated because these board meetings were open to the public, she did not believe it was appropriate to discuss the allegations in that forum, due to possible PHI and HIPAA violations. Ms. VanNiman also stated that while Mr. Vander Roest made several allegations of residents displaying negative behaviors in the community, he was unable to provide specific dates and residents' names in connection with those allegations. Therefore, Ms. VanNiman stated it was unclear whether some of the allegations even involved residents of the facility.

Ms. Miller and Ms. VanNiman both stated they were unaware of any incidents involving residents engaging in felony assault, significant damage to private property, operating under the influence of alcohol, obstructing justice, CSC 4th degree and weapon possession. According to Ms. Miller and Ms. VanNiman, they were also unaware of BSLS ever receiving complaints from the KCSD regarding excessive 911 calls and/or excessive requests to respond to the facility. Ms. VanNiman stated that due to the population BSLS served, similar concerns were raised in BSLS facilities located in other counties. Ms. VanNiman stated BSLS met with emergency responders in these other counties, and together, were able to come up with a proactive plan to respond to residents' misuse of emergency response systems. Ms. VanNiman stated Mr. Vander Roest refused to discuss any of these possible solutions. According to Ms. VanNiman, Mr. Vander Roest stated the Township of Charleston Fire Department did not have time to follow up, via telephone, every time a pull station in the facility was activated, prior to responding to the facility.

According to Ms. Miller, Resident B was currently doing so well at the facility, Resident B, facility staff members and Resident B's case manager were discussing the possibility of decreasing the time Resident B received 1:1 enhanced staffing.

On 01/03 Mr. VanNiman forwarded me an email she sent to Mr. Vander Roest on 10/23/2019, which read;

"Jerry-

I wanted to reach out to you because I had not heard when you wanted to meet and discuss the concerns you had that were discussed at the last IKS meeting. If you would like to give me a call so we can set up some time for us to meet, that would be great. Please remember that what I can discuss will be related to our organizational policies and procedures. I cannot discuss an individual consumers as this would be a PHI and HIPAA violation.

I look forward to talking with you"

According to Ms. VanNiman, she never received a response from Mr. Vander Roest.

On 01/03 Ms. Wilson confirmed, via email exchange, Resident B was arrested on 08/01/2019 for breaking into a home on 06/17, while on unsupervised community access. According to Ms. Wilson, Resident B was released that same day on a PR bond. Ms. Wilson informed me Resident B was hospitalized at a psychiatric unit from 06/18 to 07/16, and facility staff members implemented 1:1 enhanced staffing for Resident B on 08/02. According to Ms. Wilson, Resident B was officially charged with Home Invasion 3rd degree and will be sentenced on 01/27.

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:	Residents of adult foster care facilities are afforded freedom of movement and are to reside in the least restrictive environment possible. Unless otherwise indicated in a resident's assessment plan and/or BTP approved by their responsible agency, facility staff members cannot prevent residents from moving freely within the community unsupervised, nor can they prevent residents from using a telephone for private communications. Based upon my investigation, there is no evidence to support the allegation residents engaged in incidents of felony assault, significant damage to private property, operating under the influence of alcohol, obstructing justice, CSC 4th degree and weapon possession in 2019. While it has been established that in 2019 residents, who had no restrictions on the use of a telephone for private communications, called 911 to report allegations that were found to be false and/or "non-life threatening" in nature, pulled the fire alarm multiple times, and engaged in criminal/negative behavior while on independent community access, resulting in the arrest of Resident B, there is not enough evidence to support the allegation this was because the facility did not provide adequate supervision and protection. There is enough evidence to establish the facility took the appropriate steps necessary to address negative behaviors displayed by residents, due to symptoms related to their MI and DD diagnosis.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	According to documentation reviewed, it has been established the facility provided adequate staffing to meet the needs of the residents as specified in their assessment plans and BTPs.

CONCLUSION:	VIOLATION NOT ESTABLISHED

On 01/02 I conducted a face-to-face exit conference with licensee designee Patricia Miller and Chief Compliance Officer Nichole VanNiman and shared with them the findings of this investigation. Ms. Miller and Ms. VanNiman expressed their desire to further discuss a possible plan to respond to residents' misuse of emergency response systems with the Township of Charleston, in an appropriate setting. Both Ms. Miller and Ms. VanNiman stated they understood the facility could possibly be fined for every instance the Township of Charleston Fire Department responded to the facility when there was no fire emergency, should the Township of Charleston Fire Department have the correct ordinance to do so.

IV. RECOMMENDATION

I recommend that the current license status continue.

01/03/2020

Michele Streeter — Date
Licensing Consultant

Approved By:

01/09/2020 and 04/13/2020

Dawn N. Timm — Date
Area Manager