GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2021

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

RE: License #: AM390337021
Investigation #: 2021A0462015
Beacon Home at Stagecoach

Dear Ms. Miller:

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 (616) 356-0183.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
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 #:	2021A0462015
Complaint Receipt Date:	12/17/2020
Investigation Initiation Date:	12/18/2020
Report Due Date:	02/15/2021
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 Miler
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

	TRAUMATICALLY BRAIN INJURED AGED

II. ALLEGATION(S)

	Violation Established?
On 11/27/2020 direct care worker Montiece Sanders prevented Resident A from leaving the property with his legal guardian to go to the emergency room to be examined.	No
Resident A was not allowed to have his personal television in the facility.	No
Direct care worker Montiece Sanders would not allow Resident A to launder his dirty clothing.	No
Resident A's legal guardian was not notified before a facility staff member transported Resident A to the doctor, where Resident A was prescribed prescription medication.	Yes
According to his Community Mental Health Plan of Service, Resident A was to be supervised while out in the community. Facility staff members allowed Resident A to access the community unsupervised.	Yes

III. METHODOLOGY

12/17/2020	Special Investigation Intake 2021A0462015
12/18/2020	Special Investigation Initiated - Requested documentation from licensee designee Patricia Miller and home manager Amanda Wilson. Contact – Attempted to contact Complainant via telephone.
12/21/2020	Contact - Requested documentation from licensee designee Patricia Miller and home manager Amanda Wilson.
12/22/2020	Contact – Separate telephone interviews with Resident A, assistant home manager Suzanne Street, and Case Management of Michigan Case Manager Arriel Ampey.
12/23/2020	Contact- Received documentation from District Director-Southwest District Navi Kaur.
01/19/2021	Contact- Separate telephone interviews with Direct Care Worker Montiece Sanders and home manager Amanda Wilson.
01/27/2021	Contact- Received documentation.

02/02/2021	Exit conference with licensee designee Patricia Miller.

ALLEGATION: On 11/27/2020 direct care worker Montiece Sanders prevented Resident A from leaving the property to go with his legal guardian to the emergency room to be examined.

INVESTIGATION: On 12/17/2020 the Bureau of Community and Health Systems (BCHS) received this complaint via the BCHS' on-line compliant system. According to the written complaint, "the day after Thanksgiving" (11/27), Relative A1, Resident A's mother and legal guardian, visited Resident A at the facility and noticed Resident A was having what appeared to be an allergic reaction. The written complaint indicated direct care worker Montiece Sanders informed Relative A1 she could not take Resident A to the emergency room (ER) unless Resident A was discharged from the facility. According to the written complaint, Mr. Sanders would not allow Relative A1 to stay with Resident A at the facility and threatened to call the police if Relative A1 did not leave the property.

On 12/18 I attempted to conduct a telephone interview with Complainant. However, the telephone number listed in the written complaint for Complainant was not a working telephone number.

On 12/22 I conducted separate telephone interviews with Resident A and assistant home manager Suzanne Street. Resident A denied the allegations and stated, "I don't remember a time when I wasn't allowed to leave with [Relative A1]". Resident A reported no complaints regarding the facility and stated he was treated "well."

Ms. Street stated that "the day before Thanksgiving" (11/25), Resident A moved out of Relative A1's home and was admitted into the facility. Ms. Street reported Resident A was adjusting well to his new residence and was a "model resident." Ms. Street stated this was the first time she was made aware of allegation. According to Ms. Street, Relative A1 made several false allegations against facility staff members, including allegations staff members yelled at her and hung up on her during telephone conversations. Ms. Street stated facility staff members had been instructed to refer Relative A1 to facility employee Navi Kaur, whose title was District Director-Southwest District. According to Ms. Street, due to emergency orders related to the COVID 19 pandemic, the facility was currently prohibited from allowing visitors at the facility.

I requested and received all facility case notes written for Resident A on 11/27. Documentation on a case note written by Mr. Sanders on 11/27 read, "[Resident A] had minor swelling in his eye lids and some shakiness. Staff contacted the nurse on-call and took the proper steps. Staff will continue to prompt and document."

On 01/19 I conducted separate telephone interviews with Mr. Sanders and home manager Amanda Wilson. Mr. Sanders stated that on 11/27, Relative A1 came to the

facility and demanded facility staff members transport Resident A to the ER, due to minor swelling on his eye lids. However, Resident A did not want to go to the ER. According to Mr. Sanders, he explained to Relative A1 that he could not just transport Resident A to the ER, as he had to follow the proper facility protocols. Mr. Sanders stated he informed Relative A1 she could take Resident A to the ER, showed Relative A1 how to sign Resident A in and out, and denied ever telling Relative A1 this would require Resident A be discharged from the facility. According to Mr. Sanders, Relative A1 decided not to take Resident A to the ER and the incident caused Resident A anxiety. Mr. Sanders stated Resident A's symptoms were minor and he did not appear to require outside medical treatment. Mr. Sanders denied ever threatening to call the police on Relative A1. According to Mr. Sanders, on one occasion Relative A1 stopped at the facility and gave Resident A a bottle of Benadryl. Mr. Sanders stated Relative A1 became irate when he informed her resident medication could not be administered without a written physician's order.

Ms. Wilson stated she had no information regarding the allegation. Ms. Wilson's statements were consistent with the statements Ms. Street provided to me on 12/22.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	I was unable to interview Complainant, as the telephone number listed in the written complaint was not a working telephone number. Based upon my investigation, which included interviews with Resident A and multiple facility staff members, other than what was alleged in the written complaint, there is no evidence to support the allegation that on 11/27 direct care worker Montiece Sanders prevented Resident A from leaving the property to go with his legal guardian to the emergency room to be examined.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was not allowed to have his personal television in the facility.

INVESTIGATION: This allegation was also indicated in the written complaint.

On 12/18 I attempted to conduct a telephone interview with Complainant. However, the telephone number listed in the written complaint for Complainant was not a working telephone number.

During my telephone interview with Resident A on 12/22, Resident A stated he was not aware of the allegation. According to Resident A, he regularly watched a television located in his bedroom, which he shared with his roommate.

During my telephone interview with Ms. Street on 12/22, Ms. Street stated this was the first time she had been made aware of this allegation. Ms. Street confirmed Resident A's roommate had a television in their shared bedroom. According to Ms. Street, residents were encouraged to bring their own personal belongings with them upon admission into the facility. Ms. Street stated Resident A was welcomed to bring his personal television into the facility if he wanted.

The statements Mr. Sanders and Ms. Wilson provided to me during my telephone interviews with them on 01/19 were consistent with the statements Ms. Street provided to me.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	I was unable to interview Complainant, as the telephone number listed in the written complaint was not a working telephone number. Based upon my investigation, which included interviews with Resident A and multiple facility staff members, other than what was alleged in the written complaint, there is no evidence to support the allegation that Resident A is not allowed to have his personal television in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care worker Montiece Sanders would not allow Resident A to launder his dirty clothing.

INVESTIGATION: This allegation was also indicated in the written complaint. According to the written complaint, Mr. Sanders would not allow Resident A to launder his clothing on his assigned laundry day, because another resident had an accident and needed to use the washer and dryer. The written complaint indicated Resident A had to wait until the following week to launder his dirty clothing.

On 12/18 I attempted to conduct a telephone interview with Complainant. However, the telephone number listed in the written complaint for Complainant was not a working telephone number.

During my telephone interview with Resident A on 12/22, Resident A stated Thursdays were his assigned "laundry day." According to Resident A, last Tuesday he requested to launder his dirty clothing. However, Mr. Sanders told him he could not, as it was someone else's assigned "laundry day." Resident A stated he had enough clean clothing to wear until Thursday. According to Resident A, on Thursday he laundered his dirty clothing. Resident A stated he had "no issues" regarding his ability to launder his dirty clothing in the facility.

During my telephone interview with Ms. Street on 12/22, Ms. Street stated this was the first time she had been made aware of this allegation, Ms. Street confirmed each resident was assigned a specific day to launder their clothing. According to Ms. Street, residents were welcomed to launder their dirty clothing on days not assigned to them, as long as the washer and dryer were available.

During my telephone interview with Mr. Sanders on 01/19, Mr. Sanders denied the allegation. Mr. Sanders' statements were consistent with the statements Resident A and Ms. Streets provided to me during my interviews with them. Mr. Sanders admitted to telling Resident A he could not launder his clothing on one occasion. However, this was because at the time Resident A made this request, the facility's washer and dryer were in use by the resident assigned to launder his clothing that day.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(5) A licensee shall afford a resident with opportunities, and instructions when necessary, to routinely launder clothing. Clean clothing shall be available at all times.
ANALYSIS:	I was unable to interview Complainant, as the telephone number listed in the written complaint was not a working telephone number. Based upon my investigation, which included interviews with Resident A and multiple facility staff members,

	other than what was alleged in the written complaint, there is no evidence to support the allegation that direct care worker Montiece Sanders would not allow Resident A to launder his dirty clothing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's legal guardian was not notified before a facility staff member transported Resident A to the doctor, where Resident A was prescribed medication.

INVESTIGATION: This allegation was indicated in the written complaint.

On 12/18 I attempted to conduct a telephone interview with Complainant. However, the telephone number listed in the written complaint for Complainant was not a working telephone number.

During my telephone interview with Ms. Street on 12/22, Ms. Street stated that on 12/06, without notifying Relative A1 first, a facility staff member transported Resident A to the local Urgent Care after Resident A's mouth was observed to be swollen and Resident A complained of mouth pain. Ms. Street confirmed that while at Urgent Care, Resident A was prescribed and administered medication. According to Ms. Street, Relative A1 was upset she was not notified prior to Resident A being transported to Urgent Care. Ms. Street explained that upon every residents' admission, Ms. Wilson was to obtain from their legally appointed guardians, if applicable, signed facility forms titled "authorizations". Ms. Street further explained signed authorization forms were to be obtained for every licensed medical professional Resident A would potentially receive services from while residing at the facility. According to Ms. Street, it was established Ms. Wilson failed to obtain signed authorization forms from Relative A1 upon Resident A's admission on 11/25. Ms. Street stated Ms. Wilson had since received disciplinary action, in the form of a "write up".

On 12/23, Ms. Kaur emailed me a copy of a facility form titled, Provided Contact Sheet. Documentation on this form confirmed direct care worker Miranda Gould transported Resident A to Urgent Care for "swelling of the mouth." According to documentation on this form, Resident A was prescribed as needed Motrin, the antibiotic Augmentin, and warm compresses, as needed.

During my telephone interview with Ms. Wilson on 01/19, Ms. Wilson's statements regarding this incident were consistent with the statements Ms. Street provided to me. According to Ms. Wilson, she was uncertain as to why the incident upset Relative A1. However, since this incident, Relative A1 had signed all required authorization forms.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(l) The right to employ the services of a physician, psychiatrist, or dentist of his or her choice for obtaining medical, psychiatric, or dental services.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	I was unable to interview Complainant, as the telephone number listed in the written complaint was not a working telephone number. Based upon my investigation, which included interviews with multiple facility staff members, as well as a review of pertinent documentation relevant to this investigation, it has been established that on 12/06 direct care worker Miranda Gould transported Resident A to the local Urgent Care when it was discovered there was an adverse change in Resident A's physical condition, causing swelling and pain in his mouth. Assistant home manager Suzanne Street and home manager Amanda Wilson confirmed Relative A1, who was Resident A's legally appointed guardian, was not notified prior to Ms. Gould transporting Resident A to Urgent Care, where Resident A was prescribed medication. It has been established that on 12/06, Relative A1, on behalf of Resident A, was not given an opportunity to employ the services of a medical provider of her choice for Resident A before Resident A was examined and treated at Urgent Care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: According to his Community Mental Health Plan of Service, Resident A was to be supervised while out in the community. Facility staff members allowed Resident A to access the community unsupervised.

INVESTIGATION: This allegation was indicated in the written complaint. According to the written complaint, facility staff members allowed Resident A to leave the facility unsupervised even though he had an "EPOS" preventing him from doing so. The written complaint indicated that on one occasion Resident A left the facility unsupervised on foot. Resident A got lost and tried to call the facility. However, nobody at the facility would answer the telephone. The written complaint indicated Relative A1 located Resident A by using an application on her cellular telephone,

and Resident A was almost an hour away from the facility when located. The written complaint also indicated that while in the community unsupervised Resident A went fishing with another resident. According to the written complaint, Resident A was allergic to fish.

On 12/18, via email exchange, I requested and received from Ms. Wilson a copy of Resident A's written *Health Care Appraisal* (HCA), *Assessment Plan for AFC Residents* (assessment plan) and Macomb County Community Mental Health (CMH) Personal Care Plan (PCP). According to documentation on Resident A's written HCA, Resident A was a 26-year-old male diagnosed with Schizoaffective disorder, IDD, Intermittent Explosive disorder, seizures, celiac disease, GERD, and ADHD with hyperactivity.

As evidenced by her signature on Resident A's assessment plan, Relative A1 gave her permission to release information on 11/09 (VI. RELEASE OF INFORMATION-RESIDENT OR LEGAL GUARDIAN SIGNTURE ONLY). However, she did not sign the last page of assessment plan (X. SIGNATURES). As indicated by Macomb County CMH employee Britney Hunt's signature, Ms. Hunt completed Resident A's assessment on 11/17. Documentation on Resident A's assessment plan indicated Resident A had independent community access.

I established Resident A's PCP went into effect on 12/01/2019 and expired on 11/30/2020, five days after Resident A's admission into the facility. Documentation on Resident A's PCP read, per Relative A1, "[Resident A] is not able to care for himself and has behavioral issues I can't control, it is best for [Resident A] to live in a residential setting". According to documentation on Resident A's PCP, Resident A was to be monitored 24 hours per day. Resident A was not to be left alone in his home or in the community for any period of time, due to health and behavioral concerns.

Via email exchange, facility employee Nichole VanNiman, whose title was Vice President of Operations-South Region, informed me Resident A was admitted into the facility on 11/25. According to Ms. VanNiman, prior to his admission, Resident A's assessment plan was completed by Macomb CMH and Relative A1. Ms. VanNiman stated that, per Relative A1, the restrictions to Resident A's independent community access that were indicated in Resident A's PCP "were from where he was living before which was at home and at another placement". Ms. VanNiman informed me that on 12/08, Macomb County CMH transferred Resident A's case to the local agency Case Management of Michigan (CMM). According to Ms. VanNiman, Resident A's new case manager was currently working on a behavioral treatment plan (BTP) for Resident A and "addressing the discrepancies in the information that was sent over."

During my telephone interview with Resident A on 12/22, Resident A stated he occasionally went for walks in the community unsupervised. Resident A also confirmed that on at least one occasion, he went fishing with another facility

resident. However, according to Resident A he was only allergic to shellfish. Resident A did not report having any issues regarding his unsupervised time in the community.

During my telephone interview with Ms. Street on 12/22, Ms. Street stated Resident A had no restrictions to his community but rarely left the facility. Ms. Street confirmed Resident A had gone on a few unsupervised walks. According to Ms. Street, she recalled one occasion shortly after Resident A moved into the facility, when Resident A went for an unsupervised walk. Prior to leaving, facility staff members gave Resident A directions. Ms. Street stated Relative A1 called the facility "freaking out." According to Ms. Street, Resident A was "fine." Ms. Street stated she was not aware Resident A had a current PCP.

On 12/22 I conducted a telephone interview with Resident A's new case manager Arriel Ampey, who worked for CMM. Ms. Ampey confirmed that approximately one week ago, she was assigned to manage Resident A's case. According to Ms. Ampey, prior to his admission into the facility, Resident A had never resided in an AFC setting. Ms. Ampey confirmed Resident A's last PCP was written based on his previous placement, which was with Relative A1. Ms. Ampey acknowledged restrictions to residents' independent movement in the community were typically outlined in a BTP and not a PCP. According to Ms. Ampey, she was currently working on an updated PCP for Resident A, which was due on or before 02/01. Ms. Ampey stated until that time, facility staff members were to follow the restrictions outlined in Resident A's last PCP, which had expired on 11/30/2020. According to Ms. Ampey, this was especially important given Resident A's mental health diagnoses, the fact she and facility staff members were just getting to know Resident A, the fact he was new to an AFC setting, and because he was unfamiliar with the surrounding area.

I emailed Ms. Wilson, Ms. Kaur, Ms. VanNiman, and licensee designee Patricia Miller and informed them of Ms. Ampey's expectations. I suggested they reach out to Ms. Ampey should this not be their understanding.

On 12/23, via email, I requested and received from Ms. Kaur a copy of a facility form, titled *Resident Sign In & Out Sheet*. According to documentation on this form Resident A signed out of the facility on his own on 11/27, 11/28, 12/13, and 12/15.

During my interview with Ms. Wilson on 01/19, Ms. Wilson stated Resident A's independent access in the community was currently restricted and Resident A continued to do "really well." According to Ms. Wilson, she met with Relative A1 and Ms. Ampey on 01/12. During this meeting, Relative A1 requested Resident A be able to take unsupervised walks. Ms. Wilson and Ms. Ampey asked that Relative A1 put her request in writing. However, as of 01/19 neither Ms. Wilson nor Ms. Ampey had received this written request from Relative A1. I reminded Ms. Wilson Resident A's assessment plan also needed to be updated to reflect his current care and supervision needs.

On 01/27, upon my request, Ms. Wilson emailed me a copy of Resident A's new PCP, which went into effect on 01/25. There were no restrictions to independent community access indicated in Resident A's updated PCP. Documentation in Resident A's PCP indicated Resident A would be referred for a BTP to access target behaviors, as well as safety within the facility and community, to determine if a BTP was required to ensure safety with or without restrictions.

Per email, Ms. Wilson informed me facility staff members had been instructed to continue supervising Resident A in the community until he received his BTP assessment.

On 01/28, per email, I reminded Ms. Wilson to update Resident A's assessment plan to reflect his current care and supervision needs.

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:	I was unable to interview Complainant, as the telephone number listed in the written complaint was not a working telephone number. Based upon my investigation, which included interviews with multiple facility staff members, as well as a review of pertinent documentation relevant to this investigation, it has been established that upon Resident A's admission into the facility on 11/25, Resident A had a CMH PCP indicating he was not to be left alone in his home or in the community for any period of time, due to health and behavioral concerns. However, according to documentation on Resident A's assessment plan, allegedly completed by Macomb County CMH employee Britney Hunt and Relative A1 on 11/09 and 11/17, Resident A had independent access in the community. On 12/18, via email exchange, facility employee Nichole VanNiman informed me Resident A's new CMM case manager Arriel Ampey was

	currently working on a BTP for Resident A and "addressing the discrepancies in the information that was sent over." On 12/22 I contacted Ms. Ampey who stated she was currently working on an updated PCP for Resident A. Ms. Ampey stated until a new PCP was completed, facility staff members were to follow the restrictions outline in Resident A's last PCP, which had expired on 11/30/2020. According to Ms. Ampey, this was especially important given Resident A's mental health diagnoses, the fact she and facility staff members were just getting to know Resident A, the fact he was new to an AFC setting, and because he was unfamiliar with the surrounding area.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/02 I conducted an exit conference with licensee designee Patricia Miller and shared with her the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

Michele Streeter 01/27/2021

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 02/01/2021

Dawn N. Timm Date
Area Manager