STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

October 27, 2021

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

RE: License #: AS380392702
Investigation #: 2022A0122001
Beacon Home at Jackson

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 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 (517) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380392702
Investigation #:	2022A0122001
Complaint Receipt Date:	10/06/2021
Investigation Initiation Date:	10/06/2021
Report Due Date:	12/05/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Shelly Keinath
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Jackson
Facility Address:	7014 DeWeese Road Jackson, MI 49201
Facility Telephone #:	(517) 769-6053
Original Issuance Date:	05/14/2018
License **Status:**	REGULAR
Effective Date:	11/13/2020
Expiration Date:	11/12/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct care staff did not follow physician orders regarding Resident A's dialysis treatment.	No
Additional Findings	Yes

III. METHODOLOGY

10/06/2021	Special Investigation Intake 2022A0122001 APS Referral
10/06/2021	Special Investigation Initiated - Telephone Completed interview with Complainant 1.
10/07/2021	Inspection Completed On-site Resident A file review. Received information pertaining to Resident A. Completed interview with Ryanna Hardman, Home Manager. Shelly Keinath, Administrator, was present. Received staff information.
10/12/2021	Contact – Telephone calls made and received Completed interviews with direct care staff, Thomas Anderson, and Kim McCleary. Case Manager Bobby Coleman.
10/12/2021	Contact – Telephone call made Shelly Keinath, Administrator. Requested information from Resident A's primary care physician.
10/19/2021	Exit Conference Discussed findings with Ramon Beltran, Licensee Designee
10/26/2021	Contact – Telephone call made ORR Referral

ALLEGATION: Direct care staff did not follow physician orders regarding Resident A's dialysis treatment.

INVESTIGATION: On 10/06/2021, I completed an interview with Complainant 1. Complainant 1 reported that Resident A was admitted to Henry Ford Hospital on 09/14/2021. Complainant 1 stated that prior to Resident A being admitted he resided at the Beacon Home at Jackson adult foster care group home. Per Complainant 1, Resident A missed two dialysis appointments which meant that direct care staff of the facility did not follow physician orders.

On 10/07/2021, I completed an onsite inspection and completed an interview with Home Manager, Ryanna Hardman. Ms. Hardman confirmed that Resident A was admitted to the Beacon Home at Jackson adult foster care facility in June 2021 with medical orders that included dialysis treatment of three sessions per week. Ms. Hardman stated that Resident A often refused some of his dialysis sessions on a weekly basis which would result in staff members making a notation of the missed appointment in his file and contacting the dialysis center to reschedule the appointment.

Resident A's file was reviewed on 10/07/2021. A Provider Contact Sheet completed on 06/08/2021 by a representative of the Fresenius Kidney Care documents that Resident A should have received "dialysis treatment Tue, Thurs, Sat." Reviewing Resident A's Provider Contact Sheets completed by representatives of the Fresenius Kidney Center from 06/15/2021 through 09/14/2021 shows that Resident A did not complete his dialysis sessions as ordered. The sheets document that he completed dialysis sessions approximately 2 days per week.

Provider Contact Sheets dated 08/03/212021 and 08/19/2021 completed by representatives of Fresenius Kidney Care documented that Resident A had issues completing his dialysis sessions. On 08/03/2021 the Provider Contact Sheet states, "Pt (patient) left the facility as soon as RN turned his back, please have sitter stay til patient is through the treatment. Pt was verbally vulgar and very agitated." Provider Contact Sheet dated 08/19/2021 states, "no new orders, try to stay for full dialysis treatment."

Staff notes were reviewed. On 08/07/2021 and 09/14/2021 there were notations in the staff notes that Resident A did not attend his dialysis appointments, but nothing showed that the sessions were rescheduled for another date. The staff notes do not document that Resident A refused treatments, only stating on the above dates that he did not go to his scheduled sessions. Resident A was admitted to the hospital on 09/14/2021 and is still there to this date. There are no notation(s) in staff notes that document direct care staff contacted Resident A's primary care physician to notify him/her of missed dialysis' sessions.
Resident A's Medical Intensive Care Unit History and Physical dated 09/14/2021 documents that he was admitted due to "shortness of breath." It states that he was diagnosed with "end-stage renal disease on hemodialysis (T, Th, Sat) …was known

to have missed his last 2 dialysis sessions although he was later thought that he may have last dialysis on 09/11/2021…patient was reported to be noncompliant with his hemodialysis and apparently had missed his last 2 hemodialysis sessions."

On 10/12/2021, I completed an interview with Bobby Coleman, Case Manager for Resident A. Mr. Coleman confirmed that Resident A refused dialysis treatments every so often and direct care staff informed him when this decision was made by Resident A. Mr. Coleman reported that he "feels like staff did all that they could to get him to go to dialysis treatments, but he refused." Mr. Coleman stated he had no complaints regarding the care Resident A received by direct care staff of Beacon at Jackson adult foster care group home.

On 10/12/2021, I completed interview with direct care staff, Kim McCleary. Ms. McCleary reported that she was familiar with Resident A and his dialysis regimen. She stated that she had observed incidents when he refused to go to dialysis treatment. Per Ms. McCleary, stated protocol for when Resident A refused to go to a dialysis treatment was as following: verbally encourage him to go if he still refused then contact the dialysis center to inform them and a representative usually stated they would see him at the next scheduled session. Ms. McCleary reported that Resident A typically never refused sessions twice in a row.

Direct care staff, Thomas Anderson, stated he worked night shift from 7:30 a.m. – 7:00 p.m. Mr. Anderson stated he never assisted Resident A with his dialysis appointments.

On 10/12/2021, I spoke with Shelly Keinath, Administrator, requesting documentation from Resident A's primary care physician that staff members had notified physician of missed appointments. As of 10/20/2021, I have received no contact from Ms. Keinath, nor have I received a statement from Resident A's physician.

On 10/19/2021, I completed an exit conference with Ramon Beltran, Licensee Designee. Mr. Beltran was in agreement with my findings.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**

ANALYSIS:	On 10/06/2021, allegations were made stating that direct care staff did not follow physician orders regarding Resident A's dialysis treatment. Resident A's Provider Contact Sheet documents that he is to receive dialysis treatment Tue, Thurs, Sat. Three sessions per week. On 10/07/2021, Home Manager, Rayanna Hardman reported that Resident A refused to complete dialysis treatments on a weekly basis. Provider Contact Sheets dated 08/03/2021 and 08/19/2021 document that Resident A did not complete dialysis treatments – he voluntarily left the sessions before they were completed. Resident A's Medial Intensive Care Unity History and Physical dated 09/14/2021 documents that Resident A "was reported to be noncompliant with his hemodialysis and apparently had missed his last 2 hemodialysis sessions." On 10/12/2021, both Bobby Coleman, Case Manager for Resident A and direct care staff, Kim McCleary confirmed that Resident A refused dialysis treatments. Based upon my investigation there is evidence to support that the licensee followed the instructions of Resident A's physician when Resident A cooperated and completed his dialysis treatments. However, there were occasions when Resident A refused to participate in his dialysis treatments.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Resident A's file was reviewed on 10/07/2021. A Provider Contact Sheet completed on 06/08/2021 by a representative of the Fresenius Kidney Care documents that Resident A should have received "dialysis treatment Tue, Thurs, Sat." Reviewing Resident A's Provider Contact Sheets completed by representatives of the Fresenius Kidney Center from 06/15/2021 through 09/14/2021 shows that Resident A did not complete his dialysis sessions as ordered. The sheets document that he completed dialysis sessions approximately 2 days per week.

Staff notes were reviewed. On 08/07/2021 and 09/14/2021 there were notations in the staff notes that Resident A did not attend his dialysis appointments, but nothing showed that the sessions were rescheduled for another date. The staff notes do not document that Resident A refused treatments, only stating on the above dates that he did not go to his scheduled sessions. Resident A was admitted to the hospital on 09/14/2021 and is still there to this date. There are no notation(s) in staff notes that document direct care staff contacted Resident A's primary care physician to notify him/her of missed dialysis' sessions.

On 10/19/2021, I completed an exit conference with Ramon Beltran, Licensee Designee. Mr. Beltran was in agreement with my findings and stated that a corrective action plan would be submitted to address rule violations.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**

ANALYSIS:	On 10/07/2021, Home Manager, Ryanna Hardman reported that Resident A refused to complete his dialysis treatments on a weekly basis. On 10/07/2021, I reviewed Resident A's file. Staff notes were reviewed and showed that there was no documentation that direct care staff contacted Resident A's primary care physician to notify him/her of missed dialysis treatments nor Resident A refused treatments, only stating that he did not go to scheduled treatments on two occasions. Shelly Keinath, Administrator, failed to provide documentation that Resident A's primary care physician had been notified that he was refusing his ordered dialysis treatments. Based upon my investigation there is evidence to support that direct care staff failed to notify Resident A's primary care physician of missed dialysis treatments. There is evidence to support that direct care staff failed to record Resident A's refusal to complete his dialysis treatments on scheduled dates.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a Corrective Action Plan I recommend no change to the status of the license.

Vanita C. Bouldin
Licensing Consultant

Date: 10/26/2021

Approved By:

Ardra Hunter
Area Manager

Date; 10/27/2021