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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 7, 2021

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

RE: License #: AS390406162
Investigation #: 2022A0581003
Beacon Home at Sprinkle

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406162
Investigation #:	2022A0581003
Complaint Receipt Date:	10/19/2021
Investigation Initiation Date:	10/20/2021
Report Due Date:	12/18/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Ramon Beltran
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Sprinkle
Facility Address:	6457 N. Sprinkle Rd. Kalamazoo, MI 49004
Facility Telephone #:	(269) 488-8118
Original Issuance Date:	02/18/2021
License Status:	REGULAR
Effective Date:	08/18/2021
Expiration Date:	08/17/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On or around 10/14/2021, the facility was left unstaffed for approximately 1 hour.	Yes
Additional findings.	Yes

III. METHODOLOGY

10/19/2021	Special Investigation Intake 2022A0581003
10/20/2021	Referral - Recipient Rights Kalamazoo recipient rights received the allegations and is investigating.
10/20/2021	Special Investigation Initiated - Telephone Interviewed direct care staff via MiTeams with RRO.
10/21/2021	Contact - Telephone call made Interviewed Resident A via MiTeams
10/29/2021	Contact - Telephone call made Left message with direct care staff, Ernie Tigues
10/29/2021	Contact - Telephone call made Attempted to contact direct care staff, Aamani Spivey
10/29/2021	Contact - Telephone call made Interview with direct care staff, Ernie.
11/04/2021	Contact – Document Received Staff schedules
11/04/2021	Contact - Document Received Received Ms. Tigues' handwritten timesheet from Beacon HR.
11/04/2021	Contact - Telephone call made Interview with Beacon HR, Michelle Tuyls
11/15/2021	Contact - Telephone call made Interview with ISK, Michelle Schieble.

11/22/2021	Inspection Completed-BCAL Sub. Compliance
11/30/2021	Contact – Document Received Email from licensee's Human Resources
12/03/2021	Exit conference with licensee designee, Ramon Beltran.

ALLEGATION:

On or around 10/14/2021, the facility was left unstaffed for approximately 1 hour.

INVESTIGATION:

On 10/20/2021, I received this complaint through the Bureau of Community Health Systems (BCHS) on-line complaint system. The complaint alleged direct care staff, Aamani Spivey came into work at approximately 8:30 am on 10/14/2021 and found the facility without any staff. The complaint alleged direct care staff, Earnie Tigues, who had been working the overnight shift from 10/13/2021 through 10/14/2021 was the direct care staff who left the residents unattended. The complaint also alleged the facility's stove was on when Ms. Spivey arrived.

On 10/20/2021, I confirmed with Integrated Services of Kalamazoo (ISK) Recipient Rights Officer, Michelle Schiebel, her agency had received the allegations and was investigating.

On 10/20/2021, I interviewed Ms. Schiebel via MiTeams. She indicated she had conducted a Microsoft MiTeams interview with direct care staff, Ms. Spivey, prior to me joining the MiTeams interview. She stated Ms. Spivey reported to her she had arrived at the facility between 8 am and 8:30 am to Resident A on the facility's porch, requesting a light for his cigarette. Ms. Spivey reported to Ms. Schiebel Resident B was on the couch. Ms. Spivey also reported to Ms. Schiebel Resident B told her the overnight staff had been gone for at least an hour. Ms. Spivey reported to Ms. Schiebel she looked around the facility but was unable to find any direct care staff. Additionally, Ms. Spivey reported to Ms. Schiebel that direct care staff, Ms. Tigues was supposed to be working at the facility until 8:30 am that day rather than her regularly scheduled time of 7:30 am because Ms. Spivey wasn't able to get to the facility until later. Ms. Spivey also stated to Ms. Schiebel that while the stove had been turned on there was nothing in the stove and none of the residents indicated they had turned it on.

Ms. Schiebel and I interviewed direct care staff, Briyonna Green, via Microsoft MiTeams. Ms. Green stated she had worked at the facility for approximately two weeks working the overnight shift from 7:30 pm until 7:30 am. She stated on

10/13/2021, she was only supposed to work until 11 pm; however, in order to get her 40 hours in for the week she worked until 5 am. She confirmed she also worked with Ms. Tigues that overnight. Ms. Green indicated Ms. Tigues only works until 7 am, which is when she was scheduled to leave on 10/14/2021. Ms. Green stated all staff are expected to stay at the facility until their relief staff arrives. Ms. Green stated that even though she and Ms. Tigues worked together on the overnight shifts they didn't communicate much to one another.

Ms. Green stated she left the facility at approximately 5:20 am on 10/14/2021. She stated most of the residents were in their bedrooms, but Resident C was in the shower. Ms. Green denied turning the facility stove on before she left. She stated she had no information for why the stove would have been left on.

On 10/21/2021, Ms. Schiebel and I interviewed Resident A and Resident B via Microsoft MiTeams. Resident A was asked if he had ever woken up and not had staff in the facility. He indicated there had been a night when he woke up and Ms. Tigues was not in the facility when she was working the overnight shift; however, he was unable to provide additional details. During Resident A's interview he also provided conflicting information by stating he had also never been left alone in the facility.

Resident B was also interviewed via Microsoft MiTeams. He recalled an instance where had woken up and staff wasn't around. He stated he had needed "a light" and staff wasn't there to provide one for him as staff keep his lighter for him. Resident B was unable to recall any additional information pertaining to Ms. Tigues not being there when he woke up.

On 10/29/2021, I interviewed direct care staff, Ernie Tigues, via telephone. Ms. Tigues recalled a morning around the incident date where she worked with Ms. Green and Ms. Green left the facility at approximately 5:15 am; however, Ms. Tigues indicated she did not know Ms. Green had left the facility that early until after the fact. Ms. Tigues stated she normally works until 7 am, but there had been one day she stayed at the facility until 8:30 am because she attended a MiTeams meeting. Ms. Tigues denied knowingly leaving the residents unattended or without supervision. Ms. Tigues also denied ever turning the facility stove on and then leaving the facility.

On 11/03/2021 and 11/04/2021, the facility's licensee designee, Ramon Beltran, sent me documentation showing Ms. Tigues had been terminated effective 10/03/2021 and was no longer employed with the licensee. He provided documentation showing Ms. Tigues had been on the schedule to work from 11 pm until 7 am on 10/13/2021 through 10/14/2021, but there was no indication Ms. Tigues had clocked in or out that evening/morning.

Mr. Beltran also sent via email the facility's staff schedules for the week of 10/11/2021 through 10/17/2021. According to this schedule, Ms. Green was

scheduled to work at the facility from 5 pm until 11 pm on 10/13/2021 and Ms. Spivey was expected to arrive at 7 am on 10/14/2021. The schedule did not indicate any additional staff was scheduled to work at the facility from 11 pm until 7 am.

Mr. Beltran also provided Ms. Spivey's time sheet indicating she had logged into work at the facility on 10/14/2021 at 8:11 am.

On 11/04/2021, Ms. Schiebel and I interviewed the licensee's vice president of human resources, Michelle Tuyls. Ms. Tuyls also provided me with Ms. Tigues paperwork timesheet indicating Ms. Tigues was handwriting the hours she worked at the facility. According to this handwritten timesheet, Ms. Tigues left the facility on 10/14/2021 at 7:02 am. Ms. Tuyls indicated previous home managers were allowing Ms. Tigues to handwrite her hours on a paper timesheet because Ms. Tigues was not able to operate the facility's computer to clock in and out.

On 11/30/2021, I received and reviewed Resident A's, Resident B's, Resident C's, Resident D's, Resident E's, and Resident F's *Assessment Plans for AFC Residents* and their respective community mental health (CMH) plans, if applicable. Based on these assessments and CMH plans, I determined Resident B can be difficult to understand due to verbal difficulties and Resident C is legally blind. None of the resident's assessment plans indicated any of the residents required increased supervision from direct care staff at any point during the day. The remaining assessment plans did not indicate any other residents were nonverbal or unable to communicate their needs.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Based on my investigation, there was evidence indicating direct care staff, Ernie Tigues, left the residents of the facility with insufficient staff on 10/14/2021 at approximately 7 am when she left before 1st shift staff, Aamani Spivey, relieved her of her duties. Ms. Spivey did not come into work until 8:11 am, therefore, the facility was insufficiently staffed, with no direct care staff members present, for approximately 1 hour and 11 minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

During the on-site inspection, I requested to review the facility's staff schedule; however, one was not available. The facility's licensee designee, Ramon Beltran, provided a staff schedule on 11/04/2021; however, this schedule did not reflect direct care staff, Ernie Tigues, working the 3rd shift at the facility from 10/13/2021 through the morning of 10/14/2021. Additionally, the schedule did not reflect direct care staff, Briyonna Green, working until 5 am on 10/14/2021 or direct care staff, Aamani Spivey, coming into work at approximately 8:30 am on 10/14/2021. Subsequently, the staff schedule provided did not accurately reflect the staff working at the time or the changes in staff's schedules.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	There was no staff schedule when I conducted my on-site inspection and when one was requested, it was not an accurate depiction of the staff schedule for October 2021 as direct care staff, Ernie Tigues, was not on it. The licensee's human service personnel, Michele Tuyls, indicated once staff are deleted from the licensee's time tracking system then they are deleted from online schedules. Due to Ms. Tigues having been deleted from the time tracking system, she was subsequently deleted off the facility's online schedule; therefore, the staff schedule did not accurately reflect the names of staff on duty or scheduling changes.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/03/2021, I attempted to conduct the exit conference with licensee designee, Ramon Beltran, via telephone; however, I was unable to contact him, but left a voicemail message.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

12/03/2021

Cathy Cushman Date
Licensing Consultant

Approved By:

12/07/2021

Dawn N. Timm Date
Area Manager