STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

December 3, 2021

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

RE: License #: AS390406165
Investigation #: 2022A0462003
Beacon Home at Richland

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,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406165
Investigation #:	2022A0462003
Complaint Receipt Date:	10/18/2021
Investigation Initiation Date:	10/18/2021
Report Due Date:	12/17/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Navi Kaur
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Richland
Facility Address:	9445 N. 24th St. Richland, MI 49083
Facility Telephone #:	(269) 488-0024
Original Issuance Date:	01/11/2021
License Status:	REGULAR
Effective Date:	07/11/2021
Expiration Date:	07/10/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility's home manager Cassandra Pueblo did not adequately address and/or "handle" Residents B and C when they verbally and physically abused Resident A.	No
On 09/16/2021 facility staff members failed to transport Resident A to his prescheduled doctor's appointment and then lied about why.	No
Resident A and Resident C broke into each other's locked bedrooms on several occasions, which caused conflict between Resident A and Resident C. Facility staff members did not address this issue in a timely manner.	Yes
Resident A's legally appointed guardians were not notified of a physical altercation between Resident A and Resident D on 01/28/2021, which resulted in police contact.	Yes
Additional findings.	Yes

Via an email to Kalamazoo County Adult Protective Services Specialist Gene Coulter on 11/01/2021, Resident A's sibling, Relative A1, made several allegations against both the facility and a Kalamazoo County sheriff deputy. All complaints that were not Adult Foster Care administrative licensing rule violations were not investigated by this department.

III. METHODOLOGY

10/18/2021	Special Investigation Intake 2022A0462003 Special Investigation Initiated- Email to APS Specialist Gene Coulter.
10/27/2021	Unannounced investigation onsite. Face-to-face interviews with Resident A, Resident B, and Resident C, home manager Cassandra Pueblo, DCW Jessica Gales, and DCW Nikkole Hegler. Requested and received documentation.
10/29/2021	Contact- Telephone interview with DCW Tiffany Sanders.
11/02/2021	Contact- Email from APS Specialist Gene Coulter received.
11/05/2021	Contact- Telephone interview with APS Specialist Gene Coulter.

11/09/2021	Contact- Separate telephone interviews with Ottawa County CMH Contracts Coordinator Leah Brink and Resident A's CMH case manager Katlyn Johns.
11/10/2021	Contact- Requested and received documentation via email.
11/17/2021	Contact- Telephone interview with home manager Cassandra Pueblo.
11/18/2021	Contact- Received email from home manager Cassandra Pueblo.
12/03/2021	Exit conference with licensee designee Ramon Beltran, via telephone.

ALLEGATION: The facility's home manager Cassandra Pueblo did not adequately address and/or "handle" Residents B and C when they verbally and physically abused Resident A.

INVESTIGATION: On 10/18/2021 Kalamazoo County Adult Protective Services (APS) referred the above allegation, via a written complaint, to the Bureau of community and Health Systems (BCHS) through the BCHS online complaint system. According to the written complaint, Resident A instigated the abuse by yelling and cursing at Residents B and C, which led Residents B and C to "act out" verbally and physically.

On 10/27 I conducted an unannounced investigation on-site. I requested and received a copy of Resident A's, B's and C's *Assessment Plan for AFC Residents* (assessment plans). Documentation on Resident A's, B's, and C's assessment plans indicated Residents A, B and C all had a history of uncontrollable aggressive behaviors.

I conducted separate face-to-face interviews with Ms. Pueblo and Resident A. Ms. Pueblo denied the allegation. Ms. Pueblo stated Residents A and B previously had a close friendship. According to Ms. Pueblo, Residents A and B spent a significant amount of time together, often in each other's private bedrooms, and facility staff members suspected Residents A and B were in a romantic relationship. Ms. Pueblo described the relationship between Residents A and B as unhealthy, as evidenced by Resident A "doing everything" for Resident B. According to Ms. Pueblo, Resident A would often get jealous when Resident B talked to other residents, which resulted in Residents A and B engaging in arguments. According to Ms. Pueblo, sometime in August, while Resident A was visiting family members, Resident A disclosed he was bitten by Resident B. Resident A showed his family members several bite marks located on his back and shoulders. Ms. Pueblo stated facility staff members were not aware this occurred until Resident A's family members notified them of the incident.

According to Ms. Pueblo, Resident A's family members expressed their concerns regarding Resident A's and B's relationship and ultimately, Resident A's safety. Subsequently, Ms. Pueblo stated facility staff members closely monitored Residents A and B and did their best to keep them separated. According to Ms. Pueblo, this was sometimes challenging as it appeared Resident A wanted to continue his friendship with Resident B. Ms. Pueblo stated Residents A and C engaged in what she described to be several "minor incidents". Ms. Pueblo stated Residents A and C had a history of going into each other's bedrooms uninvited. According to Ms. Pueblo, Resident A also had a history of hoarding facility items, such as all the facility's bowls and cups, and locking them in his bedroom, which made Resident C angry. Ms. Pueblo stated that on one occasion, Resident C accused Resident A of stealing all of his underwear. According to Ms. Pueblo, she and other facility staff members always intervened and provided redirection whenever there were conflicts between Residents A and C.

During my interview with Resident A, I did not observe any visible injuries on any exposed parts of his body. Resident A confirmed that sometime in May or June, Resident A bit him on his back and shoulders while they were in Resident A's bedroom. According to Resident A, he immediately reported this to direct care workers (DCW) Nikkole Hegler and Tiffany Sanders. Resident A confirmed that while visiting his parents, he also disclosed the incident to them. According to Resident A, he had not been verbally and/or physically abused by Resident B since this incident. Resident A stated, "staff keep us apart". According to Resident A, "my stress is coming down". Resident A stated it was often a challenge to keep him and Resident B separated, as they frequently wanted to be in the same area of the facility, at the same time. According to Resident A, he believed he was being treated unfairly, as facility staff members requested he leave areas of the facility instead of making Resident B leave. Resident A stated, "I used to be scared of Resident B but now I am scared of Resident C". Resident A stated Resident C recently broke his bedroom door. Without explanation, Resident A stated, "I don't have a lot of chairs". According to Resident A, besides a physical altercation between him and Resident C back in 2019, he had not been physically assaulted by Resident C. Resident A stated facility staff members "tried the best they could" to keep him safe from Resident C. Resident A stated that earlier that morning, Resident C "kept following me". Resident A stated he reported this to Ms. Hegler, who appropriately addressed the situation. During my interview with Resident A, Resident A did not allege Ms. Pueblo inadequately addressed and/or "handled" Residents B and C when there were conflicts. According to Resident A, he was planning to move out of the facility soon.

I conducted separate face-to-face interviews with Ms. Hegler and DCW Jessica Gales, who both denied the allegation Ms. Pueblo, and/or other facility staff members, ignored conflicts between residents, including conflicts between Residents A, B, and C. According to Ms. Helger, she did not believe Resident A was unsafe in the facility, as Ms. Pueblo and other facility staff members redirected Residents A, B, and C and assisted them in resolving their conflicts. Ms. Helger denied Resident A's statement that he reported being bitten by Resident B to her, immediately following

the incident. According to Ms. Helger, she became aware of the incident after Resident A reported it to his parents sometime in August 2021. Ms. Helger stated Residents A and B “argued and antagonized each other”. According to Ms. Gales, who was a newly hired facility staff member, she had never witnessed any verbal and/or physical altercations between Residents A and B. Ms. Gales stated that as part of her training, Ms. Pueblo and other facility staff members instructed her to closely monitor Residents A and B and keep them separated. According to Ms. Gales, Resident B was “doing well”. However, Resident A would often get mad when asked to separate from Resident B, as it appeared Resident A wanted to continue his friendship with Resident B. Ms. Helger stated Resident A’s bedroom was located next to Resident C’s bedroom and they often accused one another of taking each other’s personal items. Ms. Gales stated she recently intervened when Resident A took all of the chairs in the facility and locked them in his bedroom, causing Resident C to get angry and punch Resident A’s door. According to Ms. Gales, this was the only conflict she witnessed between Residents A and C while working at the facility.

I conducted separate face-to-face interviews with Residents B and C, who both denied the allegation Ms. Pueblo, and/or other facility staff members, ignored conflicts between them and Resident A. Resident B confirmed he and Resident A were “good friends”. Resident B stated he had “anger issues” and admitted to taking his issues out on Resident A by biting him on the back and shoulders. According to Resident B, he “respected” Resident A’s parents’ request that he and Resident A remain separated. Resident B stated, “staff has been doing a good job at keeping us separated but (Resident A) wants to hang out with me bad”. Resident B stated he got along well with Resident C. According to Resident B, Resident C occasionally “picked on” Resident A but Resident A always “started it”. Resident B stated the conflicts between Residents A and C were “not major”. Resident B described Resident A and Resident C’s conflicts as “bickering”. According to Resident B, he never witnessed Resident C physically assault Resident A. Resident B stated, “staff would never just let us fight”. Resident C stated, “(Resident A) is weird, but we get along ok”. Resident C admitted to recently punching Resident A’s bedroom door after Resident A took all of the chairs in the facility and locked them in his bedroom. According to Resident C, on one occasion Resident A locked him outside. Resident C stated that on both occasions, facility staff members intervened.

On 10/29 I conducted a telephone interview with DCW Tiffany Sanders, who denied Resident A’s statement that he reported being bitten by Resident B to Ms. Sanders, immediately following the incident. According to Ms. Sanders, “he never said a word to me”.

On file with the department was an *AFC Licensing Division-Incident/Accident Report* (IR) written by Ms. Pueblo and submitted to the department on 08/09. Documentation on the IR indicated that on 08/09, upon returning from a visit with his family members, Resident A’s father informed facility staff members Resident A reported Resident B had bitten him on his back and shoulders. The IR indicated Resident A disclosed not reporting the incident to facility staff members because he

didn't want Resident B to get in trouble. According to documentation on the IR, facility staff members reported the incident to Resident A's Community Mental Health treatment team and APS, and discussed the possibility of an alternative residential placement for Resident A. The IR indicated facility staff members encouraged Resident A to engage in healthy boundaries and appropriate forms of communication.

On 11/02 APS Specialist Gene Coulter forwarded a picture, via email, of Resident A's back and shoulders. The picture was initially provided to him on 11/01, via email, from Resident A's sibling, Relative A1. According to Relative A1, the picture was taken in August while Resident A was visiting with family. In the picture I observed several healing bite marks on Resident A's back and shoulders.

On 11/05 I conducted a telephone interview with APS Specialist Gene Coulter. Mr. Coulter informed me Resident A's parents, who were also his legally appointed guardians, were currently looking for an alternative residential placement for Resident A. According to Mr. Coulter, given Resident A's family members' concerns regarding Resident A's safety in the facility, he suggested Resident A stay with his parents until alternative placement could be located.

On 11/09 I conducted separate telephone interviews with Ottawa County Community Mental Health Contracts Coordinator Leah Brink and Resident A's Community Mental Health case manager Katlyn Johns, who worked for the agency Case Management of Southwest Michigan. Ms. Brink stated she had a "solid lead" on a new residential placement for Resident A. Ms. Johns stated she had no concerns regarding the AFC services provided to Resident A at the facility.

Based upon additional information indicated in Relative A1's 11/01 email to Mr. Coulter, via an email to Ms. Pueblo, facility administrator Navi Kaur, and licensee designee Ramon Beltran on 11/10, I requested a copy of several pieces of facility documentation. Mr. Beltran provided most of the requested documentation to me, via email.

On 11/15, via email, Mr. Beltran informed me Ms. Kaur was no longer employed at Beacon Specialized Living, Inc. and subsequently no longer employed at the facility.

Via Relative A1's 11/01 email to Mr. Coulter, Relative A1 reported that on 08/09, after discovering Resident B had bitten Resident A on the back and shoulders, Ms. Pueblo offered to transfer Resident A to another licensed adult foster care facility owned and operated by the licensee. However, Resident A's parents declined this offer, as they did not feel "moving the victim at this time was appropriate".

On 11/17 I conducted a telephone interview with Ms. Pueblo, who stated she had a recent meeting with Resident A's parents on 10/08. According to Ms. Pueblo, during this meeting Resident A's parents called her a liar, told her she "had it out for (Resident A)", and expressed their distrust of Ms. Pueblo. Ms. Pueblo stated she

suggested that given their concerns, Resident A's parents move Resident A from the facility, as they had the legal authority to do so. According to Ms. Pueblo, Resident A's parents refused to move Resident A and requested Resident B be discharged from the facility. During our interview, Ms. Pueblo agreed Resident A's and B's relationship was unhealthy and stated there was no excuse for Resident B biting Resident A. However, according to Ms. Pueblo, Resident A often instigated and/or contributed to the many conflicts between him, Resident B, and other residents in the facility. Ms. Pueblo stated Resident B was not legally guarded and did not want to move out of the facility. According to Ms. Pueblo, Ms. Kaur, who was her direct supervisor, informed Ms. Pueblo the licensee did not have "grounds" to issue 30 day discharge notices to either Resident A or Resident B. Subsequently, Ms. Pueblo informed Resident A's parents she could not force Resident B to leave the facility. I provided Ms. Pueblo with technical assistance on adult foster care (AFC) administrative licensing discharge rules.

Via Relative A1's 11/01 email to Mr. Coulter, Relative A1 reported that on 09/07 "[Resident A] was beaten up by [Resident B] again". According to Relative A1, Resident A called her and reported he had bruises on his face and was hit in the stomach multiple times. Via this email, Relative A1 informed Mr. Coulter she spoke to "Des", a facility staff member who worked at the time of the assault. According to Relative A1, "Des" informed Relative A1 he used approved physical restraint to hold Resident B back and told Resident A to "run to your room and lock the door." Via this email, Relative A1 informed Mr. Coulter "Des" said "he (Resident A) was hit pretty good."

According to two separate IRs Mr. Beltran emailed to me on 11/10, both written by DCW Desmond Whitley on 09/08, at 9:13PM on 09/07 Resident A called Resident B a "bitch". Resident B responded by punching and kicking Resident A. According to documentation on the IRs, Mr. Whitley used "body positioning" and stepped in-between Residents A and B. Mr. Whitley separated Residents A and B and reminded Resident B of proper ways to handle his anger. The IRs indicated Resident B went to his bedroom, where he stayed for the remainder of the evening. According to the IRs, Mr. Whitley asked Resident A if he could check him for injuries. Resident A declined and stated he was "fine". Documentation on the IRs indicated Mr. Whitley continued to monitor Residents A and B for health and safety. This documentation was inconsistent with Resident A's statements to me on 10/27, that he had not been physically abused by Resident B since Resident B bit him on his back sometime in May or June.

Via Relative A1's 11/01 email to Mr. Coulter, Relative A1 reported that on 10/16, Resident A kept the facility's folding chairs in his bedroom because he was afraid other residents were going to pee on them. According to Relative A1, Resident C broke Resident A's door and cracked it, trying to get into Resident A's bedroom for the chairs.

Via an email to me on 11/10, Mr. Beltran stated he could not locate an IR and/or any other facility documentation regarding an incident between Resident A and Resident C on 10/16.

During my telephone interview with Ms. Pueblo on 11/17, Ms. Pueblo stated that upon her return to the facility on 10/27 following a weeklong vacation, facility staff members verbally reported to her that while she was gone, Resident A collected all the facility chairs and locked them in his bedroom. Facility staff members intervened when Resident C punched Resident A's door, causing a crack to form in the door. Ms. Pueblo stated she believed the incident occurred on 10/14 and not 10/16. However, Ms. Pueblo was unable to locate an IR and/or any other facility documentation regarding this incident. Ms. Pueblo's statements regarding this incident were consistent with the statements Ms. Gales provided to me during my interview with her on 10/27.

Via Relative A1's 11/01 email to Mr. Coulter, Relative A1 reported that while at a doctor's appointment on 10/19, Resident A's doctor discovered bruises and scratch marks on Resident A's back. According to Relative A1, Resident A reported his jaw and cheeks hurt from being pinched. There was no information in Relative A1's email indicating who did this to Resident A and when. This information was inconsistent with the statements Resident A provided to me during my interview with him on 10/27. Resident A reported to me he had not been verbally and/or physically abused by Resident B since Resident B bit him sometime in May or June. Resident A also reported that besides a physical altercation between him and Resident C back in 2019, he had not been physically assaulted by Resident C.

During my telephone interview with Ms. Pueblo on 11/17, Ms. Pueblo stated she was on vacation when Resident A's parents took him to a doctor's appointment on 10/19. According to Ms. Pueblo, this was the first she had heard of this information.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It had been established Residents A and B engaged in an unhealthy relationship, which resulted in abusive behavior. Resident B admitted to taking his anger issues out on Resident A by biting him on the back and shoulders sometime in May or June 2021. Facility staff members, who were not aware of the incident until it was reported to them on 08/09, closely monitored Residents A and B and did their best to keep them separated after learning this information, which was sometimes challenging. During separate interviews with Residents A and B, they both stated facility home manager Cassandra Pueblo

	and/or other facility staff members did their best to keep them separated. It has also been established Residents A and C had a history of engaging in conflict. During separate interviews with Residents A and C, both Resident A and Resident C stated facility staff members intervened and assisted in resolving their conflicts. Licensee designee Ramon Beltran submitted sufficient documentation to the department confirming Ms. Pueblo's, Ms. Hegler's, and Ms. Gales' statements that Resident A often instigated and/or contributed to the many conflicts between him, and Residents B and C. This documentation also verified Ms. Pueblo, and/or other facility staff members, intervened during several incidents between Residents A, B and C. There is not enough evidence to substantiate the allegation Ms. Pueblo did not adequately address and/or "handle" Residents B and C when they verbally and physically abused Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 09/16/2021 facility staff members failed to transport Resident A to his prescheduled doctor's appointment and then lied about why.

INVESTIGATION: This allegation was also indicated in the email Relative A1 sent to Mr. Coulter on 11/01. According to Relative A1's email, Relative A1 reported that nobody from the facility informed Resident A's doctor's office he would not be at his prescheduled appointment on 09/16. When Resident A's parents asked Ms. Pueblo why Resident A missed his appointment, they were told Resident A refused to go when the doctor changed the appointment time. According to Relative A1's 11/01 email to Mr. Coulter, Relative A1 reported Resident A's parents later learned Resident A's doctor never changed the time of Resident A's appointment on 09/16. According to Relative A1's 11/01 email to Mr. Coulter, it took Ms. Pueblo three weeks to reschedule Resident A's doctor's appointment.

On 11/09 Ms. Johns emailed me a copy of Resident A's Community Mental Health *Individual Plan of Service* (IPOS). Documentation on Resident A's IPOS indicated facility staff members were to provide Resident A with transportation, complete medical appointment records, and provide a copy of these records to Resident A's case manager.

On 11/10, per my request, Mr. Beltran emailed me a copy of Resident A's written *Resident Care Agreement* (RCA). According to documentation on Resident A's RCA, transportation was included in the basic fee for adult foster care services.

Additional documentation on Resident A's RCA was confusing, as it also indicated Resident A would be charged the "current mileage rate plus staff wage" for transportation.

During my telephone interview with Ms. Pueblo on 11/17, Ms. Pueblo confirmed facility staff members provided Resident A with transportation to his medical appointments. Ms. Pueblo denied Relative A1's allegation. According to Ms. Pueblo, prior to 09/16, the facility received a telephone call from Resident A's doctor's office reminding them of Resident A's prescheduled doctor's appointment on 09/16. However, the reminder call from Resident A's doctor's office indicated an appointment time that was different than what Ms. Pueblo had previously written down on her schedule and appropriately staffed for. According to Ms. Pueblo, she assumed she had made a mistake. Subsequently, she rearranged facility staff members' schedules to accommodate the appointment time indicated by the reminder telephone call. Ms. Pueblo stated that on 09/16, either she or another facility staff member, called Resident A's doctor's office to inform them Resident A would be 10 minutes late to his appointment. At this time they were informed Resident A's doctor's appointment was actually scheduled at the time Ms. Pueblo previously wrote down on her schedule, and not at the time mistakenly indicated by the doctor's office reminder telephone call. According to Ms. Pueblo, it was too late to rearrange facility staff members' schedules to transport Resident A to his appointment. Subsequently, Ms. Pueblo rescheduled the appointment. According to Ms. Pueblo, Resident A's parents did not like the date of Resident A's rescheduled appointment. Therefore, Resident A's parents changed the appointment to 10/19. Ms. Pueblo stated she explained the entire situation to Resident A's parents, who refused to listen to her and called her a liar.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: **(d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost.**
ANALYSIS:	It has been established facility staff members were to provide Resident A with transportation to his medical appointments. While facility staff members failed to transport Resident A to his prescheduled doctor's appointment on 09/16, there is not

	enough evidence to support the allegation the facility was at fault and then lied about it.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R330.1805	**Accessibility.**
	Common use areas of the facility are accessible to all clients in residence or an individual plan of service addresses the removal of imposed restrictions. *<u>The facility shall be capable of meeting the transportation needs of all clients the facility accepts for service.</u>*
ANALYSIS:	It has been established facility staff members were to meet the transportation needs of Resident A. While facility staff members failed to transport Resident A to his prescheduled doctor's appointment on 09/16, there is not enough evidence to support the allegation the facility was at fault and then lied about it.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A and Resident C broke into each other's locked bedrooms on several occasions, which caused conflict between Resident A and Resident C. Facility staff members did not address this issue in a timely manner.

INVESTIGATION: During my interview with Ms. Pueblo on 10/27, Ms. Pueblo stated Residents A and C had a history of going into each other's bedrooms uninvited. According to Ms. Pueblo, Resident A also had a history of hoarding facility items, such as all the facility's bowls and cups, and locking them in his bedroom, which made Resident C angry. Ms. Pueblo stated that on one occasion, Resident C accused Resident A of going into his bedroom and stealing all of his underwear.

During my interview with Resident A on 10/27, Resident A stated Resident C recently broke his bedroom door. Without explanation, Resident A stated, "I don't have a lot of chairs".

During my interviews with Ms. Helger and Ms. Gales on 10/27, Ms. Helger stated Resident A's bedroom was located next to Resident C's bedroom and they often accused one another of going into each other's bedrooms and taking each other's personal items. Ms. Gales stated she recently intervened when Resident A took all of the chairs in the facility and locked them in his bedroom, causing Resident C to get angry and punch Resident A's door.

During my interview with Resident C on 10/27, Resident C admitted to recently punching Resident A's bedroom door after Resident A took all of the chairs in the facility and locked them in his bedroom.

Via Relative A1's 11/01 email to Mr. Coulter, Relative A1 confirmed Residents A and C had a history of going into one another's bedrooms, which caused conflicts. According to Relative A1, on 03/25 Resident C went into Resident A's bedroom uninvited to collect multiple facility cups Resident A had taken and kept in his bedroom. Relative A1 informed Mr. Coulter that at this time, Resident A's parents requested Ms. Pueblo change the locks on both Resident A's and C's bedroom doors, as the current locks were able to be "jimmied opened". However, this was never done. According to Relative A1, sometime in early June Resident C "ransacked and destroyed" Resident A's bedroom. Via Relative A1's 11/01 email to Mr. Coulter, Relative A1 reported that on 06/07 Resident A's parents eventually had to contact facility management staff member Patricia Miller, who ensured a new lock was installed on Resident A's door, within a week.

According to two separate IRs Mr. Beltran emailed to me on 11/10, both written by Ms. Pueblo on 03/23, at 10:14AM on 03/23 Resident B came upstairs with six facility cups he retrieved from Resident A's bedroom. Resident A was upset, as his bedroom door was locked. The IRs indicated Resident A yelled at Resident B and told him to stay out of this bedroom. According to documentation on the IRs, Resident B asked Resident A to stop stealing the facility cups. Resident B put the cups away and apologized to Resident A. Documentation on the IRs indicated Resident B then asked Resident A for an apology. The IRs indicated Resident A refused to apologize. As Resident B walked away, Resident A called Resident B a "B**ch". According to the IRs, Resident B turned around and hit Resident A. Ms. Pueblo and DCW "Margo" stepped in between Residents A and B. However, Resident A was able to reach around them and hit Resident B back. According to documentation on the IRs, Margo requested Resident B step outside with her to "cool off" and Resident A went to his bedroom. Documentation on the IR indicated facility staff members continued to monitor Residents A and B for safety and "encouraged proper social interactions with others".

According to a copy of an electronic case note Mr. Beltran emailed to me on 11/10, which was written by Beacon Specialized Living Services, Inc. Clinician Joel Parish on 03/25, Mr. Parish visited Resident A in the facility on 03/25. During this visit, Resident A informed Mr. Parish of his 03/23 altercation with Resident B. Resident A indicated he discussed with his father getting a bolt for his bedroom door. According to documentation in this case note, Mr. Parish also discussed the possibility of placing a metal plate on Resident A's bedroom door to prevent Resident B from opening the door with a credit card.

According to an IR Mr. Beltran emailed to me on 11/10, written by Ms. Hegler on 06/06, at 4:30PM on 06/06 Resident B went into Resident A's bedroom uninvited to search for personal belongings be believed Resident A had stolen from him.

Resident B told facility staff members he used his bedroom key to unlock Resident A's bedroom door. While searching for his missing items, Resident B knocked over a glass, which broke. The IR indicated facility staff members were able to get Resident B to leave Resident A's bedroom. According to documentation on the IR, facility staff members cleaned up the broken glass and "placed a work order to replace door locks". This documentation was not consistent with Relative A1's allegation that Resident C "ransacked and destroyed" Resident A's bedroom.

During my telephone interview with Ms. Pueblo on 11/17, Ms. Pueblo stated that even though Residents A and C kept their bedroom doors locked, they both broke into each other's bedrooms on several occasions. According to Ms. Pueblo, neither Resident A nor Resident C would admit to facility staff members how they were able to do this. Ms. Pueblo stated that while it was unknown at the time, facility staff members later discovered the keys to Resident A and C's bedroom doors worked on both doors. Ms. Pueblo denied the allegation that following the incident on 03/23 Resident A's parents requested a new lock be installed on Resident A's bedroom door. According to Ms. Pueblo, Resident A's parents first made this request on 06/07. Ms. Pueblo stated that upon receiving the request, she immediately placed a "work order" with the facility's maintenance team. According to Ms. Pueblo, Ms. Miller instructed her to continue to follow up with the maintenance team to ensure the work order was completed. Ms. Pueblo stated she later reached out to Ms. Miller to seek permission to purchase a new lock and install it on Resident A's bedroom door herself, as the facility's maintenance team was taking too long. According to Ms. Pueblo, she installed a new lock on Resident A's bedroom door on 06/11. Ms. Pueblo stated there was no need to install a new lock on Resident C's door, as once a new lock was installed on Resident A's bedroom door, Resident A provided facility staff members with the key that opened Resident C's bedroom door.

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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	It has been established Resident A and Resident C went into each other's locked bedrooms, uninvited, on several occasions which resulted in conflict. According to the facility's home manager Cassandra Pueblo, neither Resident A nor Resident C

	would admit to facility staff members how they were able to "break" into each other's locked bedrooms. Ms. Pueblo stated facility staff members later discovered the keys to Resident A and C's bedroom doors worked on both doors. On 03/23 Resident C "broke" into Resident A's locked bedroom, resulting in a verbal and physical altercation between Residents A and C. Following this incident, facility staff members did not implement adequate corrective measures to prevent the incident from reoccurring, such as changing the locks on the bedroom doors. Approximately two months later, following an incident on 06/07 when Resident C "broke" into Resident A's locked bedroom again, causing conflict between Residents A and C, Ms. Pueblo installed a new lock on Resident A's bedroom door, per Resident A's parents' request. Had adequate corrective measures been implemented in a timely manner, the 06/07 incident, which resulted in further conflict between Residents A and C, may have been prevented.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's legally appointed guardians were not notified of a physical altercation between Resident A and Resident D on 01/28/2021, which resulted in police contact.

INVESTIGATION: This allegation was indicated in the email Relative A1 sent to Mr. Coulter on 11/01. According to Relative A1's 11/01 email to Mr. Coulter, Resident A disclosed to family members he had been physically assaulted by Resident D. However, since Resident A's parents had not received any reports of this from facility staff members, they were not sure if this information was true. According to Relative A1's 11/01 email to Mr. Coulter, Relative A1 reported that on 01/28 Sheriff Deputy Douglas C Fuentes reported to the facility after Resident D called the police on Resident A. According to Relative A1, facility staff members never notified Resident A's parents, who were also his legally appointed guardians, of this incident. Per Relative A1's 11/01 email to Mr. Coulter, Relative A1 reported that on 02/03, Resident A's father requested the written IR regarding the 01/28 incident between Residents A and D. According to Relative A1, Ms. Pueblo responded by informing Resident A's father the incident did not involve Resident A. According to Relative A1's 11/01 email to Mr. Coulter, Relative A1 reported Resident A was subsequently arrested at the facility on 02/24 by Deputy Fuentes following an incident with Resident D. According to Relative A1, a copy of the police report regarding Resident A's 02/24 arrest referenced a previous incident of alleged "domestic violence" between Residents A and D that occurred at the facility on 01/28.

During my interview with Resident A at the facility on 10/27, Resident A did not report any issues with Resident D and/or incidents where he was verbally and/or physically abused by Resident D.

There was no IR on file with the department regarding an incident between Residents A and D on 01/28, resulting in police contact.

On 11/10, per my request, Mr. Beltran emailed me a copy of an IR written by Ms. Sanders on 01/28. According to Ms. Sander's documentation, at 10:48PM on 01/28 Resident D reported being hit and choked by Resident A. Resident D called the police and reported the allegation. According to documentation on the IR, Ms. Sanders informed the 911 operator that everything was "fine". However, Resident D requested a police officer respond to the facility to take a report, as he wanted Resident A to go to jail. The IR indicated a police officer responded to the facility and interviewed both Residents A and D. According to documentation on the IR, the incident was "dismissed" and the officer advised Residents A and D to stay away from each other. There was no documentation on the IR indicating this incident was reported to Resident A's parents.

On file with the department was an IR written by Ms. Sanders and submitted to the department on 02/25. Documentation on this IR indicated that at 8:37PM on 02/24, Resident D came inside from smoking and alleged Resident A had kicked him in the leg. Subsequently, Resident D called the police, who responded to the facility approximately 20 minutes later. According to documentation on the IR, after taking both Resident A and D's statements, Resident A was arrested and taken to jail. The IR indicated Resident A's father was notified of the incident at 1:00AM on 02/25.

During my interview with Ms. Pueblo on 11/17, Ms. Pueblo denied telling Resident A's father the 01/28 incident between Resident A and Resident D did not involve Resident A and subsequently, he could not have a copy of the written IR regarding the incident. However, Ms. Pueblo acknowledged the 01/28 incident between Resident A and Resident D, resulting in police contact, was not reported to Resident A's parents. According to Ms. Pueblo, she did not know why the incident wasn't reported to Resident A's parents, as required by AFC administrative licensing rules. Ms. Pueblo stated she believed it was an oversight.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:

	(a) The death of a resident. **(b) Any accident or illness that requires hospitalization.** ***<u>(c) Incidents that involve any of the following:</u>*** ***<u>(i) Displays of serious hostility.</u>*** **(ii) Hospitalization.** ***<u>(iii) Attempts at self-inflicted harm or harm to others.</u>*** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	Facility home manager Cassandra Pueblo admitted an incident on 01/28 between Resident A and Resident D, resulting in police contact, was not reported to Resident A's parents, who were also his legally appointed guardians.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Upon review of Resident A's and B's assessment plans, I discovered their assessment plans had not been updated at least annually, as evidenced by the dates listed on their assessment plans.

Documentation on Resident A's, B's, and C's assessment plans indicated Residents A, B, and C were unable to control their aggressive behaviors. There were no methods of services to address Resident A's, B's, and C's uncontrolled aggressive behaviors documented on Resident A, B, and C's assessment plans.

In August of 2021, it was established Residents A and B were engaging in an unhealthy relationship, which resulted in abusive behavior. Resident A's parents, who were also Resident A's legally appointed guardian, expressed to facility staff members their concerns regarding Resident A's safety and requested Resident A and Resident B be closely monitored and separated. However, according to documentation on Resident A's and B's assessment plans, neither assessment plan was updated to include additional documentation instructing facility staff members to closely monitor Residents A and B and encourage them to stay away from each other.

Resident C's assessment plan, which was last updated on 02/10/2021 was missing Resident C's signature, and/or the signature of Resident C's responsible person. Subsequently, there was no way to determine if Resident C's assessment was conducted with Resident C and/or his responsible person.

Per my request, on 11/10 Mr. Beltran emailed to me an IR written by Ms. Sanders on 01/28. This IR contained documentation regarding an alleged incident between

Residents A and D on 01/28 of serious hostility and harm to others, which resulted in police contact. This IR was not submitted to the department within 48 hours of the incident occurring.

Per my request, on 11/10 Mr. Beltran emailed to me two separate IRs written by Ms. Pueblo on 03/23. Both IRs contained documentation regarding an incident between Residents A and C on 03/23 of serious hostility and attempted harm to others. These IRs were not submitted to the department within 48 hours of the incident occurring.

Per my request, on 11/10 Mr. Beltran emailed to me an IR written by Ms. Hegler on 06/06. This IR contained documentation regarding an incident of destruction of property at the facility on 06/06. This IRs was not submitted to the department within 48 hours of the incident occurring.

Per my request, on 11/10 Mr. Beltran emailed to me two separate IRs written by Mr. Whitley on 09/08. Both IRs contained documentation regarding an incident between Residents A and B on 09/07 of serious hostility and attempted harm to others. These IRs were not submitted to the department within 48 hours of the incident occurring.

During my telephone interview with Ms. Pueblo on 11/17, Ms. Pueblo stated that upon her return to the facility on 10/27 following a weeklong vacation, facility staff members verbally reported to her that while she was gone, Resident A collected all the facility chairs and locked them in his bedroom. Facility staff members intervened when Resident C punched Resident A's door, causing a crack to form in the door. Ms. Pueblo stated she believed the incident occurred on 10/14 and not 10/16. However, Ms. Pueblo was unable to locate an IR and/or any other facility documentation regarding this incident. Subsequently, this incident was not reported to the department within 48 hours of occurring. According to Ms. Pueblo, in her absence, former facility administrator Navi Kaur's was responsible for notifying the department of all reportable incidents.

Via Relative A1's 11/01 email to Mr. Coulter, Relative A1 reported Resident A's parents took him to a doctor's appointment on 10/19.

During my telephone interview with Ms. Pueblo on 11/17, Ms. Pueblo stated she was on vacation when Resident A's parents transported Resident A to his 10/19 doctor's appointment. I requested a copy of Resident A's medical paperwork from this appointment. According to Ms. Pueblo, she was not sure if Resident A's parents provided facility staff members with a copy of this paperwork.

On 11/18, via email, Ms. Pueblo provided me with a picture of Resident A's current bedroom door. The picture confirmed that sometime around 10/16, Resident C punched the door, creating a large vertical crack to form, large enough to see some light shine through. According to Ms. Pueblo's email, a "work order" had been placed with the maintenance team to either fix or replace Resident A's bedroom door.

Per Ms. Pueblo's email to me on 11/18, she was unable to locate any medical paperwork from Resident A's 10/19 doctor's appointment.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
R 400.14102	**Definitions.**
	(d) "Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services, taking into account the preferences and competency of the individual.
ANALYSIS:	It has been established Resident A's and Resident B's assessment plans had not been updated at least annually, as evidenced by the dates listed on their assessment plans. It has been established there were no methods of service provided to address Resident A's, B's, and C's aggressive behaviors on their assessment plans. Neither Resident A's nor Resident B's expired assessment plans included documentation instructing facility staff members to closely monitor Resident A and Resident B and encourage them to stay away from each other. It has been established Resident C's assessment plan was missing Resident C's signature, and/or the signature of Resident C's responsible person. Subsequently, there was no way to determine if Resident C's assessment was conducted with Resident C and/or his responsible person.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** ***(c) Incidents that involve any of the following:*** ***(i) Displays of serious hostility.*** **(ii) Hospitalization.** ***(iii) Attempts at self-inflicted harm or harm to others.*** ***(iv) Instances of destruction to property.*** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	It has been established the facility did not submit written reports to the department within 48 hours of several incidents of residents' displays of serious hostility, attempts at self-inflicted harms to others, and instances of destruction to property.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	It has been established that sometime around 10/16, Resident C punched Resident A's bedroom door, creating a large vertical crack to form, large enough to see some light shine through. According to facility home manager Cassandra Pueblo, a "work order" had been placed with the maintenance team to either fix or replace Resident A's bedroom door. However, as of 11/18, approximately one month after Resident C punched Resident A's bedroom door, Resident A's bedroom door had not been repaired or replaced.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including** **dietary supplements and individual special medical procedures.** ***(iv) A record of physician contacts.***
ANALYSIS:	On 10/19 Resident A's parents transported him to and from a doctor's appointment. On 11/18, it was established Resident A's facility record did not include a copy of the medical paperwork from this doctor's appointment. Subsequently, facility staff members did not know whether or not there were updates and/or changes to the health care needs that were to be provided to Resident A in the facility. While there is no way to determine whether Resident A's parents ever provided facility staff members with Resident A's paperwork from his 10/19 doctor's appointment, facility staff members did not attempt to collect a copy of this paperwork from Resident A's parents and/or Resident A's doctor's office to ensure Resident A's health care needs were being adequately met.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/03 I conducted an exit conference with licensee designee Ramon Beltran and shared with him 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.

11/19/2021

Michele Streeter — Date
Licensing Consultant

Approved By:

12/02/2021

Dawn N. Timm — Date
Area Manager