GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2021

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

RE: License #: AS390396198
Investigation #: 2022A0462005
Beacon Home At Augusta

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.

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

THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS390396198
Investigation #:	2022A0462005
Complaint Receipt Date:	10/26/2021
Investigation Initiation Date:	10/26/2021
Report Due Date:	12/25/2021
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 Augusta
Facility Address:	817 Webster St. Augusta, MI 49012
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/29/2018
License Status:	REGULAR
Effective Date:	05/29/2021
Expiration Date:	05/28/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 10/17/2021 Resident A eloped from the facility unsupervised.	Yes
On 10/31/2021 direct care worker Joshua Terpstra "kneed" Resident E in the face and "threw his feet into" Resident E while attempting to address Resident B's aggressive behavior.	No
On 10/31/2021 direct care worker Joshua Terpstra spoke inappropriately to Resident B.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/26/2021	Special Investigation Intake 2022A0462005 Inspection Completed On-site. Face-to-face interviews with DCWs Jessica Garten and Joshua Terpstra.
10/27/2021	Contact – received documentation.
11/09/2021	Contact – Telephone interview with Kalamazoo County Recipient Right's Officer Lisa Smith.
11/18/2021	Contact - Face to Face interview with Resident B, DCW Joshua Terpstra, and home manager Marie Ulrich via Microsoft Teams.
12/13/2021	Contact- Requested documentation.
12/14/2021	Contact- Telephone interview with Kalamazoo County Recipient Rights Officer Lisa Smith.
12/15/2021	Contact- Received documentation.
12/22/2021	APS Referral. Exit conference with licensee designee Ramon Beltran via telephone.

ALLEGATION: On 10/17/2021 Resident A eloped from the facility unsupervised.

INVESTIGATION: On 04/23/2021 I sent the following email to former licensee designee Patricia Miller and facility home manager Marie Ulrich;

“I am following up on a few IRs I received for (Resident A). It appears he has eloped a few times in April. Is this new behavior for him? According to documentation on one IR, the neighbors called the police on 04/16. Can you please give me an update on what additional corrective measures you’ve put in place besides what you were already doing? Thank you!”

On 04/23, Ms. Ulrich emailed the following response,

“We will conduct a CPRT meeting that will look into why these elopements are taking place. We will see if we need to address additional goals that will help him be successful. We will increase supervision until we have a more concrete plan and I will follow up with you on what that plan is after the meeting.”

On 10/18/2021 the facility submitted to the department an *AFC Licensing Division-Incident/Accident Report* (IR), written by direct care worker (DCW) Joshua Terpstra. According to Mr. Terpstra’s documentation on the IR, at 12:30PM on 10/17, Resident A was in the garage with staff. Staff went inside the facility to check on other residents. Five minutes later, staff went back to the garage to check on Resident A, and discovered Resident A was gone. Documentation on the IR indicated that “staff Sheila” searched the front yard and “garage areas”, “staff Jessica” searched the facility’s basement, and Mr. Terpstra searched the facility’s upstairs. According to Mr. Terpstra’s documentation, staff searched for five minutes before a police officer pulled into the driveway with Resident A in the backseat. Resident A was laughing and screaming loudly and could be heard from the outside the police car. The IR indicated Resident A had eloped to the neighbor’s house and banged loudly on their door, scaring the neighbor who then called the police. According to Mr. Terpstra’s documentation, because the village of Augusta was small, an officer was able to respond to the neighbor’s home quickly. Documentation on the IR indicated the responding officer recognized Resident A from previous visits to the facility and subsequently brought Resident A back. The IR indicated it took approximately 10 minutes to get Resident A out of the police car. Resident A was checked for injuries and none were found. The IR indicated Resident A was closely monitored for the rest of the day and there were no further incidents. According to Mr. Terpstra’s documentation on the IR, staff would continue to monitor Resident A to ensure he did not elope.

On 10/26 I conducted an unannounced investigation at the facility and interviewed DCW Jessica Garten and Mr. Terpstra separately. Ms. Garten confirmed she was working with Mr. Terpstra and DCW Shelia Evans on 10/17 at the time Resident A eloped from the facility. Both Ms. Garten’s and Mr. Terpstra’s statements were consistent with Mr. Terpstra’s documentation on the IR submitted to the department on 10/18.

I reviewed a copy of Resident A’s *Assessment Plan for AFC Residents* (assessment plan) and individual plans of service. According to documentation on Resident A’s

assessment plan, Resident A required staff supervision while in the community. Documentation on Resident A's *Behavior Treatment Plan* (BTP) indicated Resident A was diagnosed with a moderate developmental disability, ADHD-combined type, and Bi-polar disorder. Resident A's BTP indicated Resident A had limited expressive language, no safety skills, and a history of challenging and "attention seeking" behaviors such as outbursts, elopement, physical aggression, and masturbation both at home and while in public areas. Resident A's BTP included a "freedom of movement restriction", which indicated facility staff members were to follow and redirect Resident A when he left the property due to Resident A's lack of safety skills within the community. Resident A's BTP also included additional strategies for facility staff members to implement when they observed Resident A leave the property.

According to Special Investigation Report (SIR) #2019A0579040, dated 07/23/2019, the facility was in violation of AFC administrative licensing rule 400.14303(2) when it was established DCWs failed to provide a former resident (identified as Resident A in SIR #2019A0579040) line-of-sight supervision, per his assessment plan, while on an outing on 07/23/2019. The facility's approved corrective action plan (CAP), dated 08/01/2019, indicated the facility's home manager would conduct a training with all DCWs on resident elopements and "de-escalation of resident behaviors" by 08/18/2019 and DCWs would review all residents' BTPs to ensure residents were kept safe. The facility's CAP indicated the facility's former licensee designee, along with the area clinician, would discuss "alternatives" to residents' assessment plans when a resident showed signs and patterns of elopement.

According to SIR #2019A0462051, dated 09/05/2019, the facility was in violation of AFC administrative licensing rule 400.14303(2) again when it was established that on 05/10, 05/21, 05/29, 06/04, 06/27, 07/02, 07/04, 08/05 and 08/16 DCWs failed to provide line-of-sight supervision to a former resident (identified as Resident A in SIR #2019A0462051), as indicated in his assessment plan when he eloped from the facility. From 04/01 to 08/16, there were four occasions when the former resident ate out of garbage cans when leaving the facility unsupervised. Subsequently, the resident was transported to the emergency room (ER) for evaluation and then discharged. On four occasions this resident was transported to the ER and admitted into the hospital for further observation. The facility's approved CAP, dated 09/24/2019, indicated this former resident, along with the resident's responsible agency, was issued a 24-hour discharge notice. Alternative placement for this resident was offered in a more secured setting. According to the facility's CAP, DCWs were provided additional training on providing enhanced and line-of-sight supervision to residents, and if necessary, further staff disciplinary action would be taken.

According to Special Investigation Report (SIR) #2020A0462058, dated 10/1/2020, it was established the facility was in violation of certification of specialized programs rule 330.1806(1) when it was established a former resident (identified as Resident A in SIR #2020A0462058) was to be supervised by DCWs while away from the facility.

The former resident eloped from the facility unsupervised on 09/15/2020 and again on 09/24/2020. According to the facility's approved CAP, dated 10/15/2020, the facility's former licensee designee ensured the following actions we taken:

- The topics of "resident supervision and completing appropriate checks" were reviewed by the facility's home manager and former administrator at a facility staff meeting on 10/06/2020.

- Pending Community Mental Health and legally appointed guardian approval, the former resident would be transferred to a more appropriate setting by 10/23/2020. Until that time, the former resident would receive 1:1 enhanced supervision by one DWC.

- Moving forward, facility staff members would receive training on residents' BTPs.

- Facility leadership would continue to explore additional staffing and placing options for the former resident.

According to SIR #2021A0462046, dated 10/08/2021, the facility was in violation of certification of specialized programs rule 330.1806(1) again when it was established that two residents (identified as Residents A and B in SIR #2021A0462046) were not provided with their required 1:1 enhanced supervision, per their BTPs, during the facility's first shift. According to SIR #2021A0462046, it was established the facility did not consistently schedule a sufficient number of DCWs to provide this enhanced supervision, and also provide for the supervision, personal care, and protection of the facility's other residents. The facility's approved CAP, dated 10/22/2021, indicated the facility's home manager received written "progressive disciplinary action" for not maintaining appropriate staffing ratios in the facility.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and specified in the resident's written assessment plan.
ANALYSIS:	Based upon my investigation, it has been established DCWs did not provide Resident A with supervision and protection as specified in his assessment plan when on 10/17, Resident A eloped from the facility unsupervised, went to the neighbor's home, and was subsequently transported back to the facility by a police officer.

CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2019A0579040, DATED 07/23/2019, AND CAP, DATED 08/01/2019]** **SEE SIR #2019A0462051, DATED 09/05/2019, AND CAP, DATED 09/24/2019]**

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:	Resident A's BTP included a "freedom of movement restriction". Based upon my investigation, it has been established that DCWs did not implement the supervision and protection protocols as specified in Resident A's BTP when on 10/17, Resident A eloped from the facility unsupervised, went to the neighbors' home, and was transported back to the facility by a police officer.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2020A0462058, DATED 10/01/2020, AND CAP, DATED 10/15/2020]** **SEE SIR #2021A0462046, DATED 10/08/2021, AND CAP, DATED 10/22/2021]**

ALLEGATIONS:

- **On 10/31/2021 direct care worker Joshua Terpstra "kneed" Resident E in the face and "threw his feet into" Resident E while attempting to address Resident B's aggressive behavior.**

- **On 10/31/2021 direct care worker Joshua Terpstra spoke inappropriately to Resident B.**

INVESTIGATION: On 11/09 Kalamazoo County Recipient Rights Officer Lisa Smith informed me, via telephone, the Kalamazoo County Office of Recipient Rights (KCORR) received the above allegations. According to Ms. Smith, the allegations occurred on 10/31 when former facility employee Robert Lovely and Mr. Terpstra took Residents B, C, D, and E trick-or-treating in the facility van. Ms. Smith stated that due to Resident E's autism diagnosis and symptoms related to his mental illness and a developmental disability, Resident E was unable to conduct an interview.

Ms. Smith shared with me, via email, an *AFC Licensing Division Incident/Accident Report (IR)* regarding the allegations, written by Mr. Lovely on 11/02 and submitted to KCORR on 11/03. Documentation on the IR indicated that at 5:30PM on 10/31, about a half an hour into trick-or-treating, Resident B began displaying negative behaviors and requested to go home. Mr. Terpstra directed Mr. Lovely to transport Resident B back to the facility in the facility's van. According to the IR, Resident E sat in the passenger seat, while Resident B sat in the "very back" of the facility van. Resident B attempted to climb over the back seat and refused to put his seatbelt on. Mr. Lovely's documentation on the IR indicated Mr. Terpstra "began to have a fit of anger". Upon being unable to swiftly open the sliding door of the van, Mr. Terpstra "hastily and forcefully" climbed over Resident E in the passenger seat. In the process, Mr. Terpstra kneed Resident E in the face and "threw his feet into" Resident E's body. The IR indicated Resident E repeated what Mr. Lovely interpreted as the word "upset" and buried his face in his hands. Mr. Terpstra than began shouting at Resident B "loudly and aggressively." According to Mr. Lovely's documentation on the IR, Mr. Lovely assessed Resident E, and determined he sustained no injuries from the incident. Mr. Lovely transported Residents B and E back to the facility. The IR indicated Mr. Terpstra would no longer be permitted to "run outings" until facility management staff members could determine their next steps.

On 11/18 Ms. Smith, Shiawassee County Recipient Rights Officer Andrea Andrykovich, and I conducted separate face-to-face interviews with Resident B and Mr. Terpstra via Microsoft Teams. Initially, Resident B was unable or unwilling to provide us with any details regarding the 10/31 incident in the van and/or the allegation. When asked if Resident B liked Mr. Terpstra, he answered "yes". Resident B then stated, "he tried to choke me in the van on Halloween". Following this statement, Resident B was either unable and/or unwilling to provide any additional information. According to Resident B, he liked Mr. Terpstra because Mr. Terpstra was "nice". Resident B stated, "he talks nice to me".

Mr. Terpstra's statements were inconsistent with Mr. Lovely's documentation on the IR submitted to the KCORR. According to Mr. Terpstra, he and Mr. Lovely took Residents B, C, D, and E trick-or-treating at 6:00PM on 10/31, along with a resident of an non-licensed facility also owned and operated by the licensee. Mr. Terpstra stated that at 6:45PM, Resident B started displaying negative behaviors and requested to go home. According to Mr. Terpstra, 15 minutes later Resident B "lost it" and attempted to hit Mr. Terpstra. Mr. Terpstra stated Resident E then expressed also wanting to go home. Subsequently, Mr. Terpstra buckled Resident E into the passenger seat of the facility van, sat Resident B in the very back seat of the van and requested Mr. Lovely transport Residents B and E back to the facility. According to Mr. Terpstra, as Mr. Lovely pulled away, Mr. Terpstra heard Resident B "pounding" on the walls in the inside of the van. Mr. Terpstra stated he yelled for Mr. Lovely to stop the van. Mr. Lovely stopped the van and unlocked the van's sliding side door. According to Mr. Terpstra, he entered the van, sat in the middle row, and attempted to calm Resident B down, as he was very upset. Mr. Terpstra stated he exited the van once Resident B appeared to be ok. However, the van had only

moved 15 feet when Mr. Terpstra observed through the van window that Resident B had gotten out of his seat, moved to the front of the van, and was attempting to hit Mr. Lovely and Resident E. According to Mr. Terpstra, he yelled for Mr. Lovely to stop the van again and Mr. Lovely stopped. However, this time Mr. Lovely was unable to figure out how to unlock the van's sliding side door. Mr. Terpstra stated he yelled multiple times for Mr. Lovely to unlock the van. According to Mr. Terpstra, the passenger side window was open. Subsequently, he was able to open the passenger side door by reaching his hand through the open window and unlocking the door. Mr. Terpstra stated he requested Resident E move his legs so that he could enter the van through the passenger door. According to Mr. Terpstra, his main priority was to get to Resident B before Resident B hurt himself or others.
Mr. Terpstra stated he did not recall "bumping into" Resident E but acknowledged "it could have happened" on accident. Mr. Terpstra denied Resident B's allegation he ever choked Resident B. According to Mr. Terpstra, he used body positioning and a physical intervention technique on Resident B called a "one arm hold." Mr. Terpstra stated he also briefly placed his hand over Resident B's mouth because Resident B was spitting on him. According to Mr. Terpstra, he was eventually able to convince Resident B to sit down so that he could be transported back to the facility.

Mr. Terpstra denied ever shouting "loudly and aggressively" at Resident B. Mr. Terpstra described his voice as "escalated" and his tone with Resident B as "firm." Mr. Terpstra admitted to using inappropriate language when speaking to Resident B in the van. According to Mr. Terpstra, he told Resident B, "calm the fuck down" and "I am not the ass hole".

I reviewed an IR Mr. Terpstra wrote regarding the 10/31 incident, which was written on 11/08 and submitted to the department on 11/09. Besides a few missing details, Mr. Terpstra's documentation was mostly consistent with the statements he provided to me, Ms. Smith, and Ms. Andrykovich during our interview with him.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	Based upon my investigation, there is not enough evidence to substantiate the allegation that on 10/31, Mr. Terpstra intentionally “kneed” Resident E in the face and “threw his feet into” Resident E while getting into the facility van to address Resident B’s aggressive behavior.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	During our interview with Mr. Terpstra on 11/18, Mr. Terpstra described his voice when speaking to Resident B in the van on the evening of 10/31 as “escalated” and his tone with Resident B as “firm”. According to Mr. Terpstra, he told Resident B, “calm the fuck down” and “I am not the ass hole.” Based upon Mr. Terpstra’s admission of using inappropriate language with Resident B while in the van on the evening of 10/31, in an “escalated” voice and “firm” tone, there is enough evidence is to substantiate the allegation Mr. Terpstra spoke inappropriately to Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 10/26 I conducted an unannounced investigation onsite at 10:30AM and discovered Ms. Garten and DCW Jackie Corbitt were the only two facility staff members present at the facility. According to Ms. Garten, Residents A, B, C and D were present at the facility. Ms. Garten and Ms. Corbitt stated Mr. Terpstra was also working. However, Mr. Terpstra was not present in the facility, as he had taken Resident E for a ride in the facility van. Either Ms. Garten or Ms.

Corbitt called Mr. Terpstra's cellular telephone to inform him of my arrival, and approximately 5 minutes later, Mr. Terpstra returned to the facility with Resident E.

I reviewed Resident B, C, D and E assessment plans and individual plans of service. Documentation on Resident B's and Resident D's assessment plans indicated Residents B and D required "line of sight" supervision while in the community. Resident C's and Resident E's assessment plans indicated they required staff supervision while in the community. Resident B's BTP indicated Resident B was to receive 1:1 enhanced supervision by one DCW during "target hours." According to Documentation in Resident C's BTP, Resident C was to be provided 1:1 enhanced supervision for 16 hours a day. During this time, facility staff members were to provide Resident C with "continuous attention."

On 11/18, Ms. Smith, Ms. Andrykovich, and I conducted a face-to-face interview with facility home manager Marie Ulrich, via Microsoft Teams. Ms. Ulrich explained Resident B was to be provided with 1:1 enhanced supervision during daytime hours, ending at 6:00PM (target hours).

During Ms. Smith, Ms. Andrykovich, and I's interview with Mr. Terpstra on 11/18 via Microsoft Teams, Mr. Terpstra confirmed Resident B's 1:1 enhanced supervision was to end at 6:00PM. Subsequently, at approximately 6:00PM on 10/31, Mr. Terpstra and former facility employee Robert Lovely took Residents B, C, D, and E trick-or-treating in the facility van. This information was not consistent with Mr. Lovely's documentation on an IR submitted to KCORR on 11/3, which indicated Mr. Lovely, Mr. Terpstra, and Residents B, C, and D were already trick-or-treating off-site at 5:30PM.

Mr. Terpstra confirmed Resident C was to be provided with 1:1 enhanced supervision at the time of their outing on 10/31. Subsequently, he was assigned to provide Resident C with his 1:1 enhanced supervision while Mr. Lovely provided supervision and protection to Residents B, D, and E. Mr. Terpstra stated that at approximately 7:00PM, Residents C and D stood by a nearby tree or mailbox approximately 30 feet away from the facility van, for 20 minutes while Mr. Terpstra addressed Resident B's aggressive behaviors inside the van. According to Mr. Terpstra, during this time Mr. Lovely sat in the driver's seat of the van, while Resident E sat in the passenger seat. Mr. Terpstra initially stated that while he was "de-escalating" Resident B in the van, Residents C and D began walking away from the tree or mailbox and towards nearby houses. When Ms. Smith questioned Mr. Terpstra further about this, Mr. Terpstra changed his statements. Mr. Terpstra then stated Resident C stayed by the nearby tree or mailbox, while Resident D walked away from the tree or mailbox and towards nearby houses, along with a resident of an non-licensed facility, also owned and operated by the licensee, who was trick-or-treating with the group. According to Mr. Terpstra, Resident D walked "several houses ahead." Mr. Terpstra stated that once Resident B calmed down, Mr. Lovely transported Residents B and E back to the facility and returned approximately 30-40 minutes later to assist Mr. Terpstra.

On 12/14 I conducted a telephone interview with Ms. Smith who stated she had spoken to Mr. Lovely, who confirmed his documentation on the IR submitted to KCORR on 11/03 was accurate. According to Ms. Smith, it was Mr. Lovely's recollection that he, Mr. Terpstra, and Residents B, C, and D left the facility to go trick-or-treating at approximately 5:30PM on 10/31, 30 minutes before Resident B's 1:1 enhanced supervision was to end for the day.

I reviewed Mr. Terpstra's written IR regarding the 10/31 incident with Resident B in the van, which was written on 11/08, 10 days prior to our interview with him on 11/18. Besides a few missing details, Mr. Terpstra's documentation was mostly consistent with the statements he provided to me, Ms. Smith, and Ms. Andrykovich, with the exception of the time the incident occurred. According to Mr. Terpstra's documentation, the incident between him and Resident B in the van on 10/31 occurred at 5:22PM, and not at 7:00PM as he reported during our interview with him.

On 12/15, via email, Ms. Ulrich informed me Resident C received 1:1 enhanced supervision by one DCW every day from 6:00AM to midnight (16 hours a day).

According to Special Investigation Report (SIR) #2019A0579040, dated 07/23/2019, the facility was in violation of AFC administrative licensing rule 400.14303(2) when it was established DCWs failed to provide a former resident (identified as Resident A in SIR #2019A0579040) line-of-sight supervision, per his assessment plan, while on an outing on 07/23/2019. The facility's approved corrective action plan (CAP), dated 08/01/2019, indicated the facility's home manager would conduct a training with all DCWs on resident elopements and "de-escalation of resident behaviors" by 08/18/2019 and DCWs would review all residents' BTPs to ensure residents were kept safe. The facility's CAP indicated the facility's former licensee designee, along with the area clinician, would discuss "alternatives" to residents' assessment plans when a resident showed signs and patterns of elopement.

According to SIR #2019A0462051, dated 09/05/2019, the facility was in violation of AFC administrative licensing rule 400.14303(2) again when it was established that on 05/10, 05/21, 05/29, 06/04, 06/27, 07/02, 07/04, 08/05 and 08/16 DCWs failed to provide line-of-sight supervision to a former resident (identified as Resident A in SIR #2019A0462051), as indicated in his assessment plan when he eloped from the facility. From 04/01 to 08/16, there were four occasions when the former resident ate out of garbage cans when leaving the facility unsupervised. Subsequently, the resident was transported to the emergency room (ER) for evaluation and then discharged. On four occasions this resident was transported to the ER and admitted into the hospital for further observation. The facility's approved CAP, dated 09/24/2019, indicated this former resident, along with the resident's responsible agency, was issued a 24-hour discharge notice. Alternative placement for this resident was offered in a more secured setting. According to the facility's CAP, DCWs were provided additional training on providing enhanced and line-of-sight supervision to residents, and if necessary, further staff disciplinary action would be taken.

According to Special Investigation Report (SIR) #2020A0462058, dated 10/1/2020, it was established the facility was in violation of certification of specialized programs rule 330.1806(1) when it was established a former resident (identified as Resident A in SIR #2020A0462058) was to be supervised by DCWs while away from the facility. The former resident eloped from the facility unsupervised on 09/15/2020 and again on 09/24/2020. According to the facility's approved CAP, dated 10/15/2020, the facility's former licensee designee ensured the following actions we taken:

- The topics of "resident supervision and completing appropriate checks" were reviewed by the facility's home manager and former administrator at a facility staff meeting on 10/06/2020.

- Pending Community Mental Health and legally appointed guardian approval, the former resident would be transferred to a more appropriate setting by 10/23/2020. Until that time, the former resident would receive 1:1 enhanced supervision by one DWC.

- Moving forward, facility staff members would receive training on residents' BTPs.

- Facility leadership would continue to explore additional staffing and placing options for the former resident.

According to SIR #2021A0462046, dated 10/08/2021, the facility was in violation of certification of specialized programs rule 330.1806(1) again when it was established that two residents (identified as Residents A and B in SIR #2021A0462046) were not provided with their required 1:1 enhanced supervision, per their BTPs, during the facility's first shift. According to SIR #2021A0462046, it was established the facility did not consistently schedule a sufficient number of DCWs to provide this enhanced supervision, and also provide for the supervision, personal care, and protection of the facility's other residents. The facility's approved CAP, dated 10/22/2021, indicated the facility's home manager received written "progressive disciplinary action" for not maintaining appropriate staffing ratios in the facility.

APPLICABLE RULE	
R 400. 14303	**Resident care; licensee responsibilities**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and specified in the resident's written assessment plan.
ANALYSIS:	Documentation on Resident D's assessment plan indicated Resident D was to be provided "line of sight" supervision while out in the community. Based upon both Mr. Terpstra's statements and Mr. Lovely's documentation regarding the incident inside the van between Mr. Terpstra and Residents B and E on the evening of 10/31, there is enough evidence to

	determine that during this time neither Mr. Terpstra nor Mr. Lovely were able to provide Resident D with "line of sight" supervision as specified in his assessment plan. Subsequently, Resident D walked away from the tree or mailbox he was standing by with Resident C, and along with a resident of a non-licensed facility, made it "several houses ahead" of where the van was located, in the dark.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2019A0579040, DATED 07/23/2019, AND CAP, DATED 08/01/2019]** **SEE SIR #2019A0462051, DATED 09/05/2019, AND CAP, DATED 09/24/2019]**

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:	Based upon the residents' care needs, there should have been at least three facility staff members at the facility upon my arrival at 10:30AM on 10/26; two DCWs to provide 1:1 enhanced supervision to Residents B and specifically 1:1 enhanced supervision with "continuous attention" to Resident C, and at least one additional DCW to provide personal care, supervision, and protection to Residents A, D, and E. Due to DCW Joshua Terpstra's decision to leave the facility and take Resident E for a van ride on the morning of 10/26, upon my arrival to the facility I established there were not enough facility staff members onsite to adequately implement Resident B's and C's BTPs and also provide personal care, supervision, and protection to Residents A and D. Based upon Mr. Terpstra statements, Mr. Terpstra was assigned to provide Resident C with his required 1:1 enhanced supervision on the evening of 10/31. According to Mr. Terpstra, while trick-or-treating, Resident C stood by a tree or mailbox with Resident D approximately 30 feet away from the facility van, without his required 1:1 enhanced supervision and "continuous attention" for 20 minutes while Mr. Terpstra and former facility employee Robert Lovely addressed Resident B's disruptive behavior inside the van. Subsequently, it has been established that neither Mr. Terpstra nor Mr. Lovely provided Resident C with his required 1:1 enhanced supervision and

	“continuous attention”, as indicated in his BTP, for approximately 20 minutes. There is enough evidence to determine Mr. Lovely, Mr. Terpstra, and Residents B, C, D, and E left the facility to go trick-or-treating before Resident B’s required 1:1 enhanced supervision ended at 6:00PM. Based upon this information, there should have been at least three facility staff members with Residents B, C, D and E when leaving the facility; two DCWs to provide 1:1 enhanced supervision to Residents B and enhanced 1:1 supervision with “continuous attention” to Resident C, and at least one additional DCW to provide supervision and protection to Residents D and E. It has been established that when Mr. Lovely, Mr. Terpstra, and Residents B, C, D, and E left the facility to go trick-or-treating on 10/31, there was not a sufficient number of facility staff members to implement the supervision protocols indicated in Resident B’s and C’s BTPs, and to provide supervision and protection to Residents D and E. According to Mr. Terpstra statements, Mr. Lovely transported Residents B and E back to the facility per their request, leaving Mr. Terpstra with Residents C and D for 30-40 minutes before returning. According to the residents’ care needs, there should have been at least two facility staff members with Residents C and D at this time; one DCW to provide 1:1 enhanced supervision and “continuous attention” to Resident C, and one additional DCW to provide supervision and protection to Resident D. It has been established that while Mr. Lovely was gone, there was not a sufficient number of DCWs present to provide Residents C and D with their required protection and supervision.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2020A0462058, DATED 10/01/2020, AND CAP, DATED 10/15/2020]** **SEE SIR #2021A0462046, DATED 10/08/2021, AND CAP, DATED 10/22/2021]**

ADDITIONAL FINDINGS:

INVESTIGATION: On 11/09 the facility submitted an IR, written by Mr. Terpstra, regarding the incident with Resident B on 10/31. According to Mr. Terpstra’s documentation, while in the van on the evening of 10/31, Resident B displayed

serious hostility and attempted to harm others, resulting in Mr. Terpstra having to use a physical intervention technique on Resident B to keep him and others safe.

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: **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility** **(iii) Attempts at self-inflicted harm or harm to others.**
ANALYSIS:	Based upon my investigation, it has been established the facility did not submit a written report to the department regarding Resident B's display of hostility and attempt to harm others while in the van on the evening of 10/31, within 48 hours of the incident occurring.
CONCLUSION:	**VIOLATION ESTABLISHED.**

On 12/22 I conducted an exit conference with licensee designee Ramon Beltran via telephone and shared with him the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, no change in the status of the license is recommended.

Michele Streeter 12/15/2021

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 12/17/2021

Dawn N. Timm Date
Area Manager