GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 14, 2021

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

RE: License #:	AS700297560
Investigation #:	2021A0356035
	Beacon Home at Trolley Center

Dear Mr. Kalinowski:

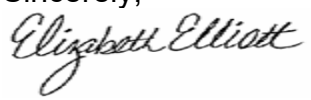
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700297560
Investigation #:	2021A0356035
Complaint Receipt Date:	07/07/2021
Investigation Initiation Date:	07/07/2021
Report Due Date:	09/05/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kevin Kalinowski
Licensee Designee:	Kevin Kalinowski
Name of Facility:	Beacon Home at Trolley Center
Facility Address:	320 64th Ave. North Coopersville, MI 49404
Facility Telephone #:	(616) 384-3141
Original Issuance Date:	02/25/2009
License Status:	REGULAR
Effective Date:	08/25/2019
Expiration Date:	08/24/2021
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED, AGED DEVELOPMENTALLY DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility while staff Joeyshaw John was sleeping on duty.	Yes
Staff Joeyshaw John yelled at Resident A.	No
Resident A's medication Nystatin is not administered as prescribed and staff Joeyshaw John is documenting that the medication is administered.	No
Resident A's room has urine puddled on the floor.	Yes
Resident A's medical care needs are not followed up on by staff at the facility.	No
Staff Jessica Griswold pushed Resident B.	No

III. METHODOLOGY

07/07/2021	Special Investigation Intake 2021A0356035
07/07/2021	Special Investigation Initiated - Telephone APS, TJ Cannon and ORR, Michele Scheibel.
07/07/2021	APS Referral TJ Cannon, Ottawa County APS, open investigation.
07/07/2021	Contact - Document Received IR-dated 06/22/2021.
07/08/2021	Contact - Face to Face Felisha Battice, home manager, TJ Cannon, APS worker, Kelly Blanchard, DCW.
07/12/2021	Contact - Face to Face Interviews with Michelle Scheibel, ORR Kalamazoo Co. CMH. Interviewed Felisha Battice, Halle Holmes, Kelly Blanchard, Resident A.
07/12/2021	Contact-Document Received New complaint filed and added to this special investigation.

07/12/2021	Contact - Document Sent FOIA request made to Ottawa County Sheriff's Dept. for police report(s).
07/13/2021	Contact - Face to Face DCW Joeyshaw John.
07/19/2021	Contact - Face to Face Na-Kingi Allen, DCW.
07/23/2021	Contact - Document Received Ottawa Co. sheriff's dept. police report.
07/27/2021	Contact - Telephone call made Julie LeClair, former DCW.
07/27/2021	Contact - Document Received
08/13/2021	Contact - Document Received Facility documents received.
08/16/2021	Contact-Document Received Facility documents/MAR.
09/08/2021	Contact-Telephone call made DCW Jessica Griswold. Suzy Hunter, Program manager.
09/14/2021	Exit Conference-Licensee Designee, Kevin Kalinowski.

ALLEGATION: Resident A eloped from the facility while staff Joeyshaw John was sleeping on duty.

INVESTIGATION: On 07/07/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported direct care worker (DCW) Joeyshaw John was asleep and snoring in the facility on 07/05/2021. The complainant reported it was suspected for quite some time but the manager, Felisha Battice could not catch Ms. John sleeping. The complainant reported during the 3rd shift hours when Ms. John was working, Resident A eloped twice. This facility requires staff to be awake during 3rd shift hours. Thomas Cannon, Ottawa County, Department of Health and Human Services (DHHS), Adult Protective Service Worker (APS) has an open investigation.

On 07/08/2021, Mr. Cannon and I conducted an unannounced inspection at the facility. Mr. Cannon and I interviewed home manager, Felisha Battice in the office. Ms. Battice stated other staff reported that Ms. John was sleeping while working 3rd

shift and she (Ms. Battice) has gone to the facility at different times, 2:00a.m., 5:00a.m. to see if Ms. John was sleeping and never found Ms. John sleeping, she was always cleaning or doing other household duties. Ms. Battice stated Resident A did leave the facility twice during Ms. John's shifts at night, both occurred on dates during the end of June 2021. Ms. Battice stated one-time Resident A exited the facility, made it to the courtyard and did not go beyond the facility fence before Ms. John's was able to get Resident A back into the facility. Ms. Battice stated Ms. John immediately called to inform her that Resident A eloped. Ms. Battice stated the other elopement, Resident A made it to the neighbor's house, rang their doorbell, then returned to the facility on her own but the neighbor called the police and the police stopped at the facility to check on Resident A. Ms. Battice stated the policy is to follow a resident if they leave the facility, if staff are able to, redirect the resident, and call the police if staff loses sight of the resident. Ms. Battice stated with three staff on during the daytime shifts and one staff on at night, Ms. John's was unable to follow Resident A because that would leave the other residents alone in the facility. Ms. Battice stated Resident A does not have a court appointed guardian, is able to be independent in the community and does not have a history of elopement from the facility.

On 07/12/2021, Michele Schiebel, Recipient Rights Officer with Kalamazoo Community Mental Health and I interviewed DCW Halle Holmes via video on Teams. Ms. Holmes reported that she heard from several staff who have caught her sleeping, that Ms. John's sleeps while on 3rd shift. Ms. Holmes stated staff, Shelby Snyder, Julie LeClair and Nikingi Allen all have firsthand accounts of Ms. John's sleeping during her shift at the facility. Ms. Holmes stated she expressed her concern over so many reports of Ms. John sleeping to the home manager, Ms. Battice. Ms. Holmes stated Ms. Battice told her that she (Ms. Battice) has to have proof, such as finding Ms. John sleeping when she pops in at random times throughout the night. Ms. Holmes stated Ms. Battice has not caught her and therefore, Ms. John continues to work at the facility on 3rd shift. Ms. Holmes confirmed that Resident A left the facility two times the end of June 2021 during the nighttime hours. Ms. Holmes stated she does not know Resident A to be an elopement risk.

On 07/12/2021, Ms. Schiebel and I interviewed DCW Kelli Blanchard via Teams. Ms. Blanchard stated she has not seen Ms. John sleeping during 3rd shift but has heard from other staff that Ms. John has been seen sleeping during her shift. Ms. Blanchard stated Resident A did elope from the facility twice during the month of June 2021 during 3rd shift hours and was still close to the facility, within the fence one of those times and the other elopement, Resident A went to the house next door and then returned on her own. Ms. Blanchard stated Resident A does not attempt to elope from the facility often and this is out of the ordinary for her.

On 07/12/2021, Ms. Schiebel and I attempted to interview Resident A via Teams. Resident A is not able to provide information pertinent to this allegation due to cognitive deficits.

On 07/13/2021, Ms. Schiebel and I interviewed Ms. John via Teams. Ms. John stated she does not sleep while on shift at the facility. Ms. John stated she was "charting" at the table in the dining room at the facility facing the window when Resident A woke up at midnight and wanted breakfast. Ms. John stated she told Resident A she could have some fruit or veggies to snack on, but it was not time for breakfast. Ms. John stated Resident A must have walked out the front door rather than going back to her bedroom. Ms. John stated she did not hear Resident A leave, the alarm on the door did not go off and she never knew Resident A was gone. Ms. John stated she then heard the door open and Resident A told her "I just ran down the road." Ms. John reported shortly after Resident A returned to the facility, the police arrived and conducted a welfare check. Ms. John stated Resident A went to the neighbor's house and they had a picture of Resident A on their porch ringing their doorbell. Ms. John stated the next time Resident A left the facility, she was mopping in the dining room, and she heard Resident A leave the facility and was able to get to the door and talk Resident A into coming back into the facility before she got beyond the front gate. Ms. John stated these incidents did not occur because she was sleeping on duty.

On 07/19/2021, Ms. Schiebel and I interviewed DCW NaKingi Allen via Teams. Ms. Allen stated she has heard from other staff that Ms. John is sleeping during 3rd shift and that is why she is just getting to her nightly duties such as mopping, cooking, and passing medications because she sleeps during her shift and does not get things done until she wakes up. Ms. Allen stated she has never seen Ms. John sleeping while on shift and heard about Resident A leaving the facility at night but has never had an issue with Resident A leaving the facility while she worked 1st shift.

On 07/23/2021, I received and reviewed the Case Report Compact from the Ottawa County Sheriff's Department dated 06/19/2021, written by Deputy Stariha. The report documents the following information, *'On 06/19/2021 at 0313 hours, I responded to 380 N. 64th Ave., in Coopersville for the report of someone knocking at the door. I checked the area first and nothing was located. I responded to the residence and contacted Geraldine Bacon. Geraldine stated she was in bed and heard someone knocking at the door and trying to turn the handle. Geraldine called 911 but the noise stopped. Geraldine had video footage from her ring camera at the front door. The video showed a heavy-set female in a looney tunes shirt at the door. The demeanor of the female you could tell she had impairment of some sort. I am familiar with an assisted living home at 320 N. 64th St., two houses to the north. I contacted employees there who did advise they had an escapee for a short minute. They stated (Resident A) ran out the front door on them because she was upset breakfast was not ready. They gave chase and lost her at the road. After a short search (Resident A) returned on her own. They showed me (Resident A) and she was the one in the video footage from the ring camera. Geraldine was advised of my findings. Status: Closed.'*

On 07/27/2021, I interviewed former DCW Julie LeClair via telephone. Ms. LeClair stated Resident A eloped more than once during Ms. John's shift and she (Ms.

LeClair) suspected that Ms. John was sleeping but had no way to prove it. Ms. LeClair stated she reported her suspicions to Ms. Battice, by sending her (Ms. Battice) a picture of Ms. John on the couch, wrapped in a blanket sleeping. Ms. LeClair stated Ms. Battice went to the facility, Ms. John's cell phone alarm was ringing, she was under a blanket on the couch but because she responded to Ms. Battice's question, Ms. Battice could not say Ms. John was actually sleeping and therefore, nothing ever happened. Ms. LeClair stated she worked with Ms. John during daytime shifts and Ms. John constantly fell asleep during the day shift and she (Ms. LeClair) woke Ms. John up. Ms. LeClair stated she has seen Ms. John asleep with her head down at the dining room table wrapped in a blanket with the cell phone alarm ringing. Ms. LeClair has a picture of Ms. John asleep on the couch at the facility wrapped in a blanket.

On 07/27/2021, I received and reviewed a picture of Ms. John asleep, wrapped in a blanket in a facility couch. The picture is undated, but I am able to see that the picture is Ms. John, and she is on a couch I know to be in this facility.

On 08/13/2021, I received and reviewed Resident A's Assessment Plan for AFC Residents. the assessment plan is dated 07/20/2021 and signed by Resident A, Steve Crotser, supports coordinator, and Licensee Designee Ramon Beltran (Beacon Home Licensee for Southwest Michigan). The assessment plan documents that Resident A is not able to move independently in the community and explains that Resident A has 8 hours of enhanced staffing each day to work with and support Resident A both in the home and in the community. *Note: Resident A does not have documented 1:1 staffing requirement at night but during the daytime hours.

On 08/27/2021, I reviewed Resident A's Behavioral Support Plan dated 09/23/2020, written by KCMH Psychologist Joyce Wilson. The plan describes *'elopement is defined (for Resident A) as leaving a designated area that could pose a potential risk to (Resident A's) health and safety (i.e., exiting the property at her home) without staff attendance or leaving staff when in the community without supervision. When elopement occurs, (Resident A) is typically dysregulated (upset about something).' The behavior plan documents an elopement protocol as follows, 'should (Resident A) leave the house alone (without staff supervision) staff will follow her by shadowing her, when possible. Upon approaching (Resident A) staff will ask her to return home. If she does not respond to staff's verbal request, staff will use their Mandt training, which emphasizes the use of gradual and graded non-physical techniques such as verbal re-direction, etc., while utilizing other proactive techniques, as appropriate for the situation. If (Resident A) leaves the house alone (without staff supervision) and staffing ratios do not allow a staff to shadow her (i.e., only one staff on for the overnight shift), staff (from the front doorway) will ask her to come back inside the house. The Service Team acknowledges the inherent risks in this plan for elopement.'*

On 09/08/2021, I interviewed DCW Jessica Griswold via telephone. Ms. Griswold stated Resident A told her she went out the side door of the facility on one of the

times she eloped. Ms. Griswold stated if staff were in the dining room doing paperwork, it is possible staff did not hear Resident A leave the facility as there is no alarm on that door. Ms. Griswold stated she has seen Ms. John sleeping while working at the facility and has had to wake her up on more than one occasion. Ms. Griswold stated she notified Ms. Battice that Ms. John was sleeping while on duty multiple times but when Ms. Battice would show up unannounced to try and catch Ms. John sleeping, she never could.

On 09/14/2021, I conducted an Exit Conference with Licensee Designee, Kevin Kalinowski via telephone. Mr. Kalinowski stated an acceptable corrective action plan will be submitted.

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 as specified in the resident's written assessment plan.
ANALYSIS:	The complainant reported Ms. John sleeps during 3rd shift hours and while sleeping, Resident A eloped from the facility on two different occasions. Ms. Battice acknowledged that Resident A eloped from the facility on two different dates in June 2021 but does not know if Ms. John was sleeping. Ms. Battice stated on one occasion, Ms. John called her while trying to verbally redirect Resident A back into the facility. Ms. Battice acknowledged that other staff have reported Ms. John sleeping on 3rd shift, but she was unable to catch her and therefore, Ms. John remained working 3rd shift. Ms. John stated she does not sleep while working 3rd shift and when Resident A eloped from the facility on two different occasions, it was not because she was sleeping. Ms. LeClair and Ms. Griswold reported they have seen Ms. John sleeping on duty. Ms. LeClair and Ms. Griswold stated they were aware that Resident A eloped from the facility on two different dates in June 2021 during 3rd shift hours while Ms. John was working. Resident A is not able to provide information pertinent to this allegation due to cognitive deficits. I received a photo of Ms. John wrapped in a blanket sleeping on a couch in the facility.

	An Ottawa County Sheriff's Department report written by Deputy Stariha documented Resident A's elopement from the facility on 06/19/2021 at 3:13a.m., knocking on a neighbor's door and then returning to the facility. The assessment plan documents that Resident A is not able to be independent in the community without staff supervision. The behavior plan documents elopement protocol for Resident A and defines elopement as Resident A leaving the property without staff attendance or supervision and that it could pose a potential risk to Resident A's health and safety. There is a preponderance of evidence to show that Resident A eloped from the facility twice during 3rd shift hours and while Ms. John may or may not have been sleeping during the times Resident A eloped, supervision and protection were not provided per Resident A's assessment plan. In addition, there is a preponderance of evidence to show that Ms. John has slept during her shifts at the facility based on staff reports and a picture of her sleeping on the couch at the facility. A violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff Joeyshaw John yelled at Resident A.

INVESTIGATION: On 07/07/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported Ms. John yelled at Resident A twice, once for leaving her walker in the living room and once for laughing.

On 07/08/2021, Mr. Cannon and I conducted an unannounced inspection at the facility. Mr. Cannon and I interviewed Ms. Battice in the office. Ms. Battice stated Ms. John is from the Caribbean and she has a naturally loud, boisterous voice that may be mistaken as yelling, but she is not yelling. Ms. Battice stated she was on the phone with Ms. John when she heard her say to Resident A, "what are you laughing about?" in a joking manner. Ms. Battice stated she has never heard Ms. John yell at Resident A about her walker. Ms. Battice stated she has not heard Ms. John yell at any of the residents in the facility including Resident A.

On 07/12/2021, Ms. Schiebel and I interviewed Ms. Holmes via Teams. Ms. Holmes reported that Ms. John yells at the residents, her voice is not loud naturally, she yells. Ms. Holmes stated she has not heard Ms. John yell at Resident A about her walker or about laughing but she has heard her yell at Resident B when it was time to eat. Ms. Holmes stated excuses are made for Ms. John that her voice is naturally loud, but really, she is yelling at the residents.

On 07/12/2021, Ms. Schiebel and I interviewed Ms. Blanchard via Teams. Ms. Blanchard stated Ms. John does not yell at the residents, her voice just sounds as though she is yelling. Ms. Blanchard stated Ms. John is “soft spoken” but her voice has some “umph” behind it. Ms. Blanchard stated Ms. John has a dry sense of humor and is hard to read when she is joking around, it may be misconstrued as yelling when she is not. Ms. Blanchard stated she has never heard Ms. John yell or be mean to the residents nor have any staff reported to her (Ms. Blanchard) that Ms. John yells or is mean to any of the residents including Resident A. Ms. Blanchard reported that Ms. John “does well with the residents.”

On 07/12/2021, Ms. Schiebel and I attempted to interview Resident A via Teams. Resident A is not able to provide information pertinent to this allegation due to cognitive deficits.

On 07/13/2021, Ms. Schiebel and I interviewed Ms. John via Teams. Ms. John stated no one has ever told her they think her tone of voice is harsh or sounds like she is yelling at the residents. Ms. John stated she knows exactly what this complaint is referencing, and she was not yelling at Resident A. Ms. John stated she took Resident A from the shower to her room and realized that Resident A had left her walker behind so she said to Resident A, “why would you leave your car in the middle of the road?” and Resident A smiled and said, “I’m sorry.” Ms. John stated she brought Resident A’s walker to her, it was a fun, kind exchange, not yelling at Resident A. Ms. John stated she does not know why she would yell at Resident A for laughing and does not recall any instance where this could have been misconstrued by staff as yelling at a resident. Ms. John stated at times, she uses her “mom voice” when she is firmer in her speech but stated she is never yelling at residents including Resident A. Ms. John explained that she uses her “mom voice” when she needs to be serious and safe with the residents, not joking around with them. Ms. John stated she does not yell at any of the residents including Resident A.

On 07/19/2021, Ms. Schiebel and I interviewed Ms. Allen via Teams. Ms. Allen stated Ms. John does not yell nor does she have an “attitude” with any of the residents including Resident A. Ms. Allen stated she heard Ms. John say to Resident A, “come get your walker” but she was not mean or yelling at Resident A. Ms. Allen stated Ms. John has an “aggressive voice” but does not “mean anything by it.” Ms. Allen stated it is “just her tone, that’s how she talks but the tone is not mean or demeaning, it’s just how she talks.”

On 07/27/2021, I interviewed Ms. LeClair via telephone. Ms. LeClair stated she has heard Ms. John yell at Resident A by saying things like, “what’d you leave this here for?” (talking about Resident A’s walker), “you expect me to take it to your room?” and “what are you laughing about?” Ms. LeClair stated Program Manager, Suzy Hunter was on the telephone at the time Ms. John was yelling at Resident A and heard the entire exchange.

On 09/08/2021, I interviewed DCW Jessica Griswold via telephone. Ms. Griswold stated she has never heard Ms. John speak in a harsh tone toward Resident A or any of the residents in the facility.

On 09/08/2021, I interviewed Ms. Hunter via telephone. Ms. Hunter stated she did not hear Ms. John yelling at Resident A over the telephone. Ms. Hunter stated staff reported that Ms. John yelled at them, but never did she hear or was she told that Ms. John was yelling at any of the residents. Ms. Hunter stated had she heard any yelling over the telephone by staff to resident(s), she would have immediately gone to the facility to find out what was going on and reported the incident to ORR, APS and Licensing.

On 09/14/2021, I conducted an Exit Conference with Licensee Designee, Kevin Kalinowski via telephone. Mr. Kalinowski stated he agrees with the information, analysis, and conclusion of this applicable rule.

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:	The complainant reported Ms. John yelled at Resident A. Ms. Battice, Ms. Hunter, Ms. Blanchard, Ms. Allen, and Ms. Griswold stated Ms. John does not yell at residents including Resident A. Ms. Holmes and Ms. LeClair reported that Ms. John yells at the residents including Resident A. Ms. John denied she yelled at any residents including Resident A. Resident A is not able to provide information pertinent to this allegation due to cognitive deficits. Based on investigative findings, there is not a preponderance of evidence to show that Ms. John is verbally aggressive with Resident A by yelling at her. A violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's medication Nystatin is not administered as prescribed and staff Joeyshaw John is documenting that the medication is administered.

INVESTIGATION: On 07/07/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported that Ms. John is not administering Resident A's peri-cream during 3rd shift but documenting on the MAR (medication administration record) that the medication is being administered.

On 07/08/2021, Mr. Cannon and I conducted an unannounced inspection at the facility. Mr. Cannon and I interviewed Ms. Battice in the office. Ms. Battice stated Resident A's "peri-cream" is called Nystatin and this medication is a PRN (as needed) medication. Ms. Battice stated the only time it is administered is if Resident A requests the medication or as staff see the need. Ms. Battice stated Resident A is prone to redness and irritation in the peri area so when staff notice this while assisting Resident A with bathing, they can apply it. Ms. Battice stated Resident A gets up around 5:00a.m. and sometimes she allows staff to clean her up and apply cream and sometimes she does not, it depends on if she likes the staff on duty at the time or not. Ms. Battice stated staff have until 9:30a.m. to complete 3rd shift personal care of residents and sometimes Resident A's cares are left to 1st shift to complete depending on if Resident A is agreeable with the care. Ms. Battice added, at one time the Nystatin cream was a daily medication to be administered on 3rd shift at 7:00a.m. but it was changed from 3rd shift to 1st shift at 9:00a.m. Ms. Battice stated the MAR reflects when the medication is administered and signed for by staff.

On 07/12/2021, Michele Schiebel, Recipient Rights Officer with Kalamazoo Community Mental Health and I interviewed Ms. Holmes via Teams. Ms. Holmes reported that Resident A's Nystatin cream used to be administered on a daily basis but now it is a PRN medication. Ms. Holmes stated she administers this medication as it is prescribed and documents it on the MAR after she administers it. Ms. Holmes stated she has never seen or heard of any issues with administering or documenting Resident A's Nystatin cream as prescribed.

On 07/12/2021, Ms. Schiebel and I interviewed Ms. Blanchard via Teams. Ms. Blanchard stated Resident A's Nystatin cream was changed to a PRN medication and a prescription for Diflucan was added which has been more effective than just the cream alone. Ms. Blanchard stated Resident A's medications are being properly administered and documented upon administration.

On 07/12/2021, Ms. Schiebel and I attempted to interview Resident A via Teams. Resident A is not able to provide information pertinent to this allegation due to cognitive deficits.

On 07/13/2021, Ms. Schiebel and I interviewed Ms. John via Teams. Ms. John stated Resident A's Nystatin cream recently became a PRN medication. Ms. John stated in order to administer the Nystatin cream staff look for redness or signs of

irritation and apply the cream as needed or Resident A was to request the cream be applied. Ms. John stated Resident A never requested the medication be administered so staff was to check just to make sure whether or not the medication was needed. Ms. John stated when Nystatin was a 7:00a.m. scheduled medication, she always attempted to apply the cream when Resident A showered however, she was not able to apply the cream every day during 3rd shift because Resident A would not always allow it and therefore, she would not mark the cream as applied if it was not applied. Ms. John stated she always squeezed the cream into a cup and took it into the shower when she assisted Resident A with her shower and tried to apply it. Ms. John stated Resident A took showers at different times, sometimes 3rd shift, sometimes 1st shift and therefore, the cream did not always get applied during 3rd shift and then 1st shift would then apply it.

On 07/19/2021, Ms. Schiebel and I interviewed Ms. Allen via Teams. Ms. Allen stated she is a newly trained staff on medications, so she has not administered medications yet but has never heard anyone complain about Resident A's Nystatin cream or that it was not administered properly and documented on the MAR system.

On 07/27/2021, I interviewed Ms. LeClair via telephone. Ms. LeClair stated staff are not applying Resident A's Nystatin cream and that she has "fought and fought" to get staff to apply the cream, but staff have put the cream in a med cup and leave it for the next shift to apply. Ms. LeClair stated then Ms. Battice changed the cream from a daily administration to a PRN, so staff did not have to apply the cream daily. Ms. LeClair stated the MAR is documented that the cream was applied when in fact, it was not.

On 08/16/2021, I received and reviewed Resident A's MARs for the months of April, May, June, and July 2021. The MAR documents the following:

- April 2021, Nystatin 100,000 unit/gm cream, PRN, no signatures, no administration as a PRN.
- April 2021, Nystatin 100,000 unit/gm cream, 8:00p.m. administration daily, signed as administered as prescribed.
- April 2021, Diflucan called Fluconazole on the MAR, 150 mg, 8:00p.m. one dose every 7 days, signed as administered as prescribed.
- May 2021, Fluconazole, 150 mg, 8:00p.m., one dose every 7 days, signed as administered as prescribed.
- May 2021, Nystatin 100,000 unit/gm cream, PRN, no signatures, no administration as a PRN.
- May 2021, Nystatin 100,000 unit/gm cream, 8:00p.m. administration daily, signed as administered as prescribed.
- June 2021, Fluconazole, 150 mg, 8:00p.m., one dose every 7 days, signed as administered as prescribed.
- June 2021, Nystatin 100,000 unit/gm cream, PRN, no signatures, no administration as a PRN.
- June 2021, Nystatin 100,00 unit/gm cream, changed from daily at 8:00p.m. to 9:00a.m. administration time and then discontinued on June 21, 2021. The

cream is documented as administered as prescribed prior to the discontinuation of the cream.

- July 2021, Fluconazole, 150 mg, 8:00p.m., one dose every 7 days, signed as administered as prescribed.
- July 2021, Nystatin 100,000 unit/gm cream, PRN, remains on the MAR with no signatures, no administration as a PRN.
- July 2021, Nystatin 100,00 unit/gm cream, continues to show on the MAR as discontinued.
- Throughout all of the MARs reviewed, Ms. Johns signature which is a "JJ" shows up very few times as being the staff that administered the Nystatin cream, and the MAR is signed by other staff as those who administered the cream during the time documented on the MAR.

On 09/08/2021, I interviewed DCW Jessica Griswold via telephone. Ms. Griswold stated Resident A used to have Nystatin cream daily but now it is a PRN. Ms. Griswold stated this all occurred back in May 2021 when the doctor prescribed Diflucan and made the cream a PRN, because the cream was not working that well and the Diflucan works much better. Ms. Griswold stated all of this was changed well before this complaint came in so staff should not still be concerned about the cream being applied to Resident A when the issue is being dealt with a new medication. Ms. Griswold stated she never signed the MAR if the cream had not been applied nor has she been aware that the MAR was signed with the cream not applied.

On 09/14/2021, I conducted an Exit Conference with Licensee Designee, Kevin Kalinowski via telephone. Mr. Kalinowski stated he agrees with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on investigative findings through there is no evidence that Ms. John is signing the MARs when the medication Nystatin is not being administered to Resident A. The initials of other staff members are documented on the MAR as administering the medication at the time it was prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on investigative findings through staff interviews and a review of Resident A's MARs, there is not a preponderance of evidence to show that Ms. John is not administering Resident A's Nystatin cream as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's room has urine puddled on the floor.

INVESTIGATION: On 07/07/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported staff found urine puddles on Resident A's bedroom floor and urine-soaked linens when 1st shift arrived over the weekend of 07/03/2021.

On 07/08/2021, Mr. Cannon and I conducted an unannounced inspection at the facility. Mr. Cannon and I interviewed Ms. Battice in the office. Ms. Battice stated over the weekend of 07/03/2021, Ms. Blanchard reported that when she came onto her shift, Resident A was up and clean but the sheets on her bed were wet and there was some urine on the floor in Resident A's bedroom. Ms. Battice stated Ms. Blanchard reported that Ms. John was on shift prior to this, and other staff asked Ms. John to clean it up before she left, and an argument ensued among the staff. Ms. Blanchard reported to Ms. Battice that Resident A was up and cleaned up, but that Ms. John probably did not get the room checked and cleaned prior to 1st coming on. Ms. Battice stated it is not unusual for Resident A to get up early, tell staff she is not wet, staff get her ready for the day and may not have gone into her room to make sure the room was clean. Ms. Battice stated this is something that happens but is not an ongoing issue.

On 07/08/2021, Mr. Cannon and I inspected Resident A's room at the facility. The linens on Resident A's bed were dry and appeared clean, Resident A's floor was freshly mopped and there was no smell of urine in the room.

On 07/12/2021, Michele Schiebel, Recipient Rights Officer with Kalamazoo Community Mental Health and I interviewed Ms. Holmes via Teams. Ms. Holmes reported when she came in on 1st shift, she found Resident A's linens on her bed and the floor urine soaked, 3 days in a row last week (week of 07/05/2021). Ms. Holmes stated she also found Resident A in urine-soaked pajama's as if the 3rd shift staff did nothing at all. Ms. Holmes stated 3rd shift is supposed to make sure Resident A's room is clean prior to 1st shift coming on duty. Ms. Holmes stated she emailed Ms. Battice and Ms. Hunter with no response.

On 07/12/2021, Ms. Schiebel and I interviewed Ms. Blanchard via Teams. Ms. Blanchard stated approximately 1-1 ½ weeks ago, she came in and found Resident A's bed linens and floor soaked with urine. Ms. Blanchard stated Resident A was clean, in dry clothes and showered. Ms. Blanchard stated 1st shift staff complained about Resident A's room, but they never cleaned it up themselves, so they are equally as guilty as the 3rd shift staff. Ms. Blanchard stated sometimes, things are busy and staff being on shift alone, just does not get to it. Ms. Blanchard stated this issue is not an ongoing problem but one that occurs from time to time and staff need to support one another and help.

On 07/12/2021, Ms. Schiebel and I attempted to interview Resident A via Teams. Resident A is not able to provide information pertinent to this allegation due to cognitive deficits.

On 07/13/2021, Ms. Schiebel and I interviewed Ms. John via Teams. Ms. John stated she recalls this incident and explained that when Resident A woke up, Ms. John asked her if her bed was wet, Resident A said it was not. Ms. John stated she was making breakfast and administering medications and did not go check Resident A's room and apparently Resident A's linens and floor had urine on them. Ms. John stated another time, she stripped Resident A's bed because there was urine on it, put it in the washer and left the bed unmade. Ms. John stated when 1st shift came in they were mad because Resident A's bed was unmade. Ms. John stated before tension between staff started, they would have made the bed and not made a big deal about it.

On 07/19/2021, Ms. Schiebel and I interviewed Ms. Allen via Teams. Ms. Allen stated she has not seen Resident A's bed or floor urine soaked. Ms. Allen stated if she came on shift and saw this, she would clean it up, it is part of the job. Ms. Allen stated she never has seen Resident A in urine-soaked clothing, her bed or floor urine soaked.

On 07/27/2021, I interviewed Ms. LeClair via telephone. Ms. LeClair stated she found urine puddles on Resident A's bedroom floor and urine-soaked linens when she arrived over the weekend of 07/03/2021. Ms. LeClair stated she suspects Ms. John of sleeping during 3rd shift and so she is unable to complete all the duties she should be getting done on her shift and this is why Resident A's room was in the state it was in on that weekend.

On 09/08/2021, I interviewed DCW Jessica Griswold via telephone. Ms. Griswold stated Resident A was doing really well and not wetting her bed, so staff were getting used to her bed being dry in the morning. Ms. Griswold stated Resident A tells staff her bed is dry when it is not. Ms. Griswold stated on this occasion, Resident A told Ms. John she was dry and Ms. John was busy and did not check Resident A's room. Ms. Griswold stated there have been 3 times she knows of that Resident A's linens have been left wet. Ms. Griswold stated she has had to clean urine off Resident A's floor that was left behind by previous staff, but the urine runs off Resident A's bed and puddles down under the bed so if you do not know it goes down the sides of the bed, you will not see it puddled under the bed. Ms. Griswold stated these are things that staff learn and Ms. John probably did not see it.

On 09/14/2021, I conducted an Exit Conference with Licensee Designee, Kevin Kalinowski via telephone. Mr. Kalinowski stated an acceptable corrective action plan will be submitted.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	Based on investigative findings, there is a preponderance of evidence to show that on more than one occasion, Resident A's floor and bed linens are soaked with urine, and it is left for an undetermined amount of time. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's medical care needs are not followed up on by staff at the facility.

INVESTIGATION: On 07/07/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported Resident A appears to be decompensating and management are ignoring it and not getting Resident A medical treatment.

*Note: On 01/12/2021, I conducted investigation SI2021A0356011 that Resident A's medical care needs were not followed up on by staff at the facility. The complainant reported Resident A was not able to stay awake, bruising easily, medical appointments were not followed up on, Resident A's blood draws were not followed up on and Resident A was not responding as she normally did to daily life. A thorough review of Resident A's medical records was completed along with a review

of the documented communication between facility staff and Dr. Holman's office, at the conclusion of the investigation on 02/04/201 no violations were found.

On 07/08/2021, Mr. Cannon and I conducted an unannounced inspection at the facility. Mr. Cannon and I interviewed Ms. Battice in the office. Ms. Battice stated Resident A's medical care needs are addressed continuously and medical appointments are followed up on. Ms. Battice stated Resident A loves to go to the hospital so she (Ms. Battice) refers often to Beacon's clinical staff to decipher what constitutes a need for Resident A to go to the hospital and what should be dealt with in house as a behavioral vs. medical need. Ms. Battice stated staff do not always understand that and therefore, may think Resident A's medical needs are not being attended to.

On 07/12/2021, Michele Schiebel, Recipient Rights Officer with Kalamazoo Community Mental Health and I interviewed Ms. Holmes via Teams. Ms. Holmes reported that Resident A's medical care needs are being attended to at the facility and Resident A is seen by her physician and taken to medical appointments and the hospital when needed.

On 07/12/2021, Ms. Schiebel and I interviewed Ms. Blanchard via Teams. Ms. Blanchard stated Resident A's medical care needs are addressed at the facility and Ms. Blanchard is the person who schedules and follows up on all of Resident A's treatments and appointments.

On 07/12/2021, Ms. Schiebel and I attempted to interview Resident A via Teams. Resident A is not able to provide information pertinent to this allegation due to cognitive deficits.

On 07/13/2021, Ms. Schiebel and I interviewed Ms. John via Teams. Ms. John stated Resident A receives medical care as needed at the facility.

On 07/19/2021, Ms. Schiebel and I interviewed Ms. Allen via Teams. Ms. Allen stated Resident A receives medical care as needed at the facility.

On 07/27/2021, I interviewed Ms. LeClair via telephone. Ms. LeClair stated no one would take Resident in for a full medical evaluation and getting management at the facility to make doctor's appointments for Resident A was difficult. Ms. LeClair stated Resident A was on Lithium and no one took her in for blood draws, so she became toxic and almost died. *Note: SI2021A0356011 medical notes dated 01/15/2021 addressed Resident A's blood draws that were completed at that time. Resident A is no longer on the medication Lithium and has not been since SI2021A0356011 was completed.

On 08/16/2021, I received and reviewed Next Step Note printout medical information dated 04/05/2021, 04/09/2021, 05/04/2021, 05/11/2021, 06/02/2021 and 08/06/2021 documenting various medical appointments with follow up for Resident A.

On 09/08/2021, I interviewed DCW Jessica Griswold via telephone. Ms. Griswold stated Resident A receives medical care as needed at the facility.

On 09/14/2021, I conducted an Exit Conference with Licensee Designee, Kevin Kalinowski via telephone. Mr. Kalinowski stated he agrees with the information, analysis, and conclusion of this applicable rule.

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:	Based on staff interviews and a review of Resident A's medical notes, there is not a preponderance of evidence to show that Resident A's medical care needs are not being met at the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff Jessica Griswold pushed Resident B.

INVESTIGATION: On 07/07/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported staff Jessica Griswold pushed Resident B and nothing was reported or documented about it.

On 07/08/2021, Mr. Cannon and I conducted an unannounced inspection at the facility. Mr. Cannon and I interviewed Ms. Battice and Ms. Blanchard in the office. Ms. Battice and Ms. Blanchard stated Resident B will pull you towards him and then pushes you away, that is something that he always does. Ms. Battice and Ms. Blanchard stated they were not present when Ms. Griswold allegedly pushed Resident B and have no knowledge of the alleged event until APS came to the facility on 06/21/2021 to investigate. Ms. Battice stated if anything occurred, it was without malice on Ms. Griswold's part, and she would have been just playfully talking to him and would never push Resident B.

On 07/08/2021, Mr. Cannon stated he interviewed two staff on duty with Ms. Griswold when the incident allegedly occurred on 06/21/2021. Mr. Cannon stated Ms. Allen acknowledged she was working and there was no intentional harm to Resident B from Ms. Griswold. Ms. Allen reported Resident B has a history of making a "high five" type motion with his hand and will open hand "pat" or "tap" staff, nothing hard but he will touch staff while doing this. Ms. Allen stated Ms. Griswold and Resident B were sitting at the dining room table and Resident B was tapping at

Ms. Griswold and she jokingly said, “you keep doing that and I’ll do it back to you,” Ms. Griswold did not push Resident B.

On 07/08/2021, Mr. Cannon stated he interviewed Shelby Snyder who reported Resident B pushed Ms. Griswold and Ms. Griswold said you push me, and I’ll push you back and then Ms. Griswold pushed Resident B. Ms. Snyder said they were both sitting at the dining room table.

On 07/08/2021, Resident B was not interviewed due to his inability to provide pertinent information regarding this allegation due to cognitive deficits.

On 07/08/2021, I reviewed the IR (incident report) received on 06/22/2021 written by Ms. Battice on 06/21/2021. The IR documented the following, *‘Adult Protective Services arrived at Trolley and stated they received a complaint that stated that staff Jessica Griswold stated if you push me I am going to push you back. (*Resident B*) pushed this staff and then staff pushed back. The home was not aware of the complaint being made. Home manager spoke to APS and informed Beacon’s compliance of the complaint that APS received and suspended staff in question pending the investigation.’*

On 07/08/2021, Resident B does not have a behavior plan so a review of Resident B’s assessment plan dated 06/11/2021 documents that Resident B is in control of aggressive behavior and *‘will “push” people if they are in his space but is not aggressive in general.’*

On 07/19/2021, I interviewed Ms. Allen via Teams. Ms. Allen stated Resident B pushes, pinches and can be aggressive. Ms. Allen stated Ms. Griswold was feeding Resident B and he pushed at her and Ms. Griswold re-directed Resident B by tapping his hand and in a playful nonaggressive way said, “you can’t push, if you push, I’ll push you back!”

On 08/16/2021, Mr. Cannon reported APS has closed this complaint as unsubstantiated.

On 09/08/2021, I interviewed DCW Jessica Griswold via telephone. Ms. Griswold stated Resident B pulls you in towards him and then pushes you away, he always does this. Ms. Griswold stated she and Resident B were sitting at the dining room table and he was doing this to her while Ms. Allen and Ms. Snyder were also working. Ms. Griswold stated she did not do anything back to Resident B, that she did not touch him, pull, or push him back and never said anything like “if you push, I’ll push you back.” Ms. Griswold stated she would not do anything like that to any resident including Resident B.

On 09/14/2021, I conducted an Exit Conference with Licensee Designee, Kevin Kalinowski via telephone. Mr. Kalinowski stated he agrees with the information, analysis, and conclusion of this applicable rule.

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 on investigative findings, there is not a preponderance of evidence to show that Ms. Griswold pushed Resident B.
CONCLUSION:	VIOLATION NOT ESTABLISHED

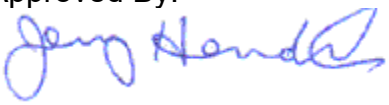
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

09/14/2021

Elizabeth Elliott Date
Licensing Consultant

Approved By:



09/14/2021

Jerry Hendrick Date
Area Manager