GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 11, 2022

Roxanne Goldammer
Loving Hands Adult Foster Home LLC
Suite 110
890 North 10th Street
Kalamazoo, MI 49009

RE: License #: AM210315739
Investigation #: 2022A0221007
Beacon Home at Sand Point

Dear Ms. Goldammer:

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 (906) 226-4171.

Sincerely,

Theresa Norton, Licensing Consultant
Bureau of Community and Health Systems
234 West Baraga
Marquette, MI 49855
(906) 280-2519

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM210315739
Investigation #:	2022A0221007
Complaint Receipt Date:	12/13/2021
Investigation Initiation Date:	12/15/2021
Report Due Date:	02/11/2022
Licensee Name:	Loving Hands Adult Foster Home LLC
Licensee Address:	555 Railroad Street Bangor, MI 49013
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home at Sand Point
Facility Address:	9284 Hwy M-35 Gladstone, MI 49837
Facility Telephone #:	(906) 420-8446
Original Issuance Date:	04/02/2013
License **Status:**	REGULAR
Effective Date:	01/13/2020
Expiration Date:	01/12/2022
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A repeatedly walks away from the facility and police pick him up and return him. Facility has it written in their policy that if there is not enough staff to call the police.	Yes
On 12/10/2021 and 12/12/2021 Resident B walked several miles and called a cab to go to Walmart. Concern for resident's safety due to repeated lack of supervision and dangerous exposure.	Yes
Complainant 2 reported that 'garbage blows in my yard all the time from the facility.'	
Additional Findings	Yes

III. METHODOLOGY

12/13/2021	Special Investigation Intake 2022A0221007
12/13/2021	Contact - Telephone call made Phone call to Complainant #2 (11/30/2021) Laura Mohrman.
12/15/2021	Special Investigation Initiated - On Site
12/15/2021	APS referral Email to Shawn Maki, Delta County APS.
12/15/2021	Contact – Face to Face Interviews with Home Manager Lee-Ellen Bailey and Asst. Home Manager Rebecca Kell.
12/15/2021	Contact - Telephone call made Email to Complainant 1.
12/17/2021	Contact - Document Received Police reports/records received.
12/20/2021	Contact - Telephone call made Email to/from Complainant #1.
12/28/2021	Contact - Telephone call received Texts and videos received from Complainant #2.

01/04/2022	Contact - Face to Face Interview with Home Manager Lee-Ellen Bailey.
01/05/2022	Contact - Telephone call received Phone call from Licensee Designee Roxanne Goldammer.
01/06/2022	Contact - Telephone call received Email from Complainant #1.
01/27/2022	Contact - Telephone call made Phone call to Complainant 2.
02/08/2022	Contact – Face to Face Interview with Assistant Home Manager Rebecca Kell. Elopement policy received.
02/11/2022	Exit Conference Exit interview with Licensee Designee Roxanne Goldammer.

ALLEGATION: Resident A repeatedly walks away from the facility and police pick him up and return him. Facility has it written in their policy that if there is not enough staff to call the police.

INVESTIGATION: Complainant 1 stated that Resident A has eloped from the facility several times and police are called to help assist. Complainant 1 stated the police have been called to the facility to assist/aid employees on several occasions. Complainant 1 stated an employee did tell her, “Our policy says if there’s not enough staff to go after a resident, we are to call the police.” Complainant 1 did not know the name of the employee that stated this. Complainant 1 produced a dispatch log of police calls to assist Sand Point. Police have been dispatched to assist staff at Sand Point/Saunders Point 43 times in the year 2021.

Complainant 1 states, “I feel staff are using police as additional staff when there are not enough staff to work at the facility.” This consultant made an APS referral on 12/15/2021 to Delta County DHS.

An unannounced onsite inspection was completed on 12/15/2021. Interviews were conducted with Home Manager Lee-Ellen Bailey and Assistant Home Manager Rebecca Kell.

The facility currently has 11 residents. Five of the eleven residents have elopement histories and four have successfully eloped from the facility in the last 6 months.

Plans of service were received for Resident A and Resident B along with staff schedules and the resident register.

Resident A and Resident B's plans of service both state they are elopement risks and cannot be in the community by themselves.

Ms. Bailey states that she is aware of the elopement risks of Resident A and B and also stated she is working with the case manager of Resident B to instate a one-to one or "eyes on" staff for him and Resident A is on the waiting list for a more secure facility.

The staff ratio for the facility is 2 staff to 11 residents from 8:30PM to 8:30AM. If a resident elopes and a staff member follows the resident, the home is not in compliance with their staff to resident ratio.

The Resident Absent Without Leave policy was received. The procedure when a resident has eloped without independent community access is: 1. Staff to contact the 'on-call person'. 2. Contact the police after you have searched the home and the grounds if it is felt the resident and/or staff may be at risk, or at the request of the on-call person. The procedure continues to state: "The staff must follow the resident on foot, **UNLESS** they are working the home alone. If you are the only staff working in the home, call for back-up and the on-call immediately for assistance. If another staff is working and they are not counted in the ratio, they can assist the staff on foot, by following the van."

APPLICABLE RULE	
R 400.14206	**Staffing requirements**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	The staffing ratio for the facility is 2 staff to 11 residents (2:11) from 8:30PM to 8:00AM. There are currently 5 residents that are high risk for elopement and 4 residents (Resident A, B, C, and D) have succeeded to elope from the facility on several occasions in the last 6 months. The staff to resident ratio is not sufficient to provide services for these residents as documented in their assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 12/10/2021 and 12/12/2021 Resident B walked several miles and called a cab to go to Walmart. Concern for resident's safety due to repeated lack of supervision and dangerous exposure.

INVESTIGATION: On 12/10/2021, Resident B had eloped from the facility and was found at WalMart in Escanaba. Resident B eloped again on 12/12/2021 and again was found at WalMart. Only one incident report was received for the elopement on 12/10/2021. Staff Khara Isotalo stated in the incident report on 12/10/2021, that staff were looking for Resident B around 6:30PM and could not find him in the home or the fenced-in yard. Staff found footprints in the snow, going through the gate (which was not functioning properly with a 15 second delay), and to the road. Staff then called 911. Resident A was returned to the facility and corrective measures included 15-minute checks. On 12/12/2021, Resident B eloped again and was found at WalMart again. Police brought him back to the facility again. No incident report was received for this elopement. (See Other Findings).

In a separate incident, an allegation from Complainant 2 involved residents outside of the facility with no staff present. Two videos were received in this office on 12/28/2021. One video was dated 11/23/2021 at 3:23AM. The video showed a woman wrapped in a blanket walking outside the facility, in the neighbor's yard, with no staff present. The other video dated 11/28/2021 at 10:00PM showed Resident A walking outside the facility with no staff present.

When questioned of these video incidents, Home Manager Lee-Ellen Bailey was not aware of either of these incidents and no incident reports were received in this office (See next allegation).

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 staff failed to protect Resident A from eloping on 12/12/2021 and also failed to protect residents on 11/23 and 11/28 when staff and management were not aware of the following: 11/23/21 – An unknown female resident from the facility was filmed walking outside the facility at 3:23 AM. 11/28/2021 – Resident A was filmed walking alone at 10:00PM outside the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Complainant 2 reported that 'garbage blows in my yard all the time from the facility.'

INVESTIGATION: During the on-site visits on both 12/15/2021 and 01/04/2022, the dumpster located in the front of the yard did not have a cover and garbage was overflowing onto the ground. Home Manager Lee-Ellen Bailey stated that trash is picked up on Wednesdays.

It was suggested to Ms. Bailey that a bigger, or second dumpster be provided or to increase the days trash is picked up.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(13) A yard area shall be kept reasonably free from all hazards, nuisances, refuse, and litter.
ANALYSIS:	The dumpster located in the front of the facility was overflowing with garbage during the on-site inspections conducted on 12/15/2021 and 01/04/2022. Complainant 2 stated that "garbage is always blowing in my yard from the facility."
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During the course of the investigation, it was discovered that the police had responded to several calls for residents eloping from the facility and licensing had not been notified of these incidents.

No incident reports were received in this office for the following incidents of eloping and/or when law enforcement was contacted for assistance:

09/04/21 – Resident A eloped. Police picked up Resident A running along road M-35 and returned him to the facility.
09/04/21 – Resident C eloped. Resident C was found at a private residence and the owner called the police.
11/13/21 – Resident A eloped. Resident A walked away from the facility and police were called to assist.
12/12/21 – Resident B eloped. Police were contacted and he was found at WalMart in Escanaba. (9 miles from the facility).

Ms. Bailey was instructed that all incidents involving contacting law enforcement or any resident eloping, needs to be reported to licensing.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: **(a) The name of the person who was involved in the accident or incident.** **(b) The date, hour, place, and cause of the accident or incident.** **(c) The effect of the accident or incident on the person who was involved and the care given.** **(d) The name of the individuals who were notified and the time of notification.** **(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **(f) The corrective measures that were taken to prevent the accident or incident from happening again.**

ANALYSIS:	No incident reports were received in this office for the following incidents of eloping when law enforcement was contacted for assistance: 09/04/21 – Resident A eloped. 09/04/21 – Resident C eloped. 11/13/21 – Resident A eloped. 12/12/21 – Resident B eloped.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: During the on-site visit on 02/08/2022, the gate lock on the outdoor fence was not working properly. There was no 15 second delay.

This issue was addressed in Special Investigation #2022A0221008. At that time, the gate was not able to be opened without a code. The Corrective Action Plan, dated 01/10/2022, stated the lock on the fence will be repaired.

During the onsite on 02/08/2022, the gate had been repaired with a green button to release the gate, however, no 15 second delay has been installed. Assistant Manager Rebecca Kell stated that residents do know there is no delay on the gate and freely walk out the gate.

The fence with a gate, and a 15 second delay on the gate, was part of a corrective action submitted years ago and is still in effect.

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 residents.
ANALYSIS:	The gate on the fence has been repaired to allow exit without entering a code, but there is no 15 second delay on the lock which is part of a previous corrective action plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was held with Licensee Designee Roxanne Goldammer on 02/09/2022 informing her of the findings of this report and the expectation of a corrective action plan.

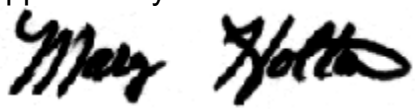
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

02/09/2022

Theresa Norton Date
Licensing Consultant

Approved By:



02/11/2022

Mary E Holton Date
Area Manager