GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 5, 2022

Ramon Beltran, II
Powell AFC Homes Inc
Suite #110
890 North 10th Street
Kalamazoo, MI 49009

RE: License #: AG030000010
Investigation #: 2022A0350015
Beacon Home at The Oaks

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (616) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AG030000010
Investigation #:	2022A0350015
Complaint Receipt Date:	02/28/2022
Investigation Initiation Date:	02/28/2022
Report Due Date:	03/30/2022
Licensee Name:	Powell AFC Homes Inc
Licensee Address:	555 Railroad Street Bangor, MI 49013
Licensee Telephone #:	(269) 685-7020
Administrator:	Melissa Williams
Licensee Designee:	Ramon Beltran, II
Name of Facility:	Beacon Home at The Oaks
Facility Address:	403 N. Main Plainwell, MI 49080
Facility Telephone #:	(269) 685-8724
Original Issuance Date:	06/01/1989
License Status:	REGULAR
Effective Date:	02/05/2022
Expiration Date:	02/04/2024
Capacity:	40
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
On 2/27/2022, Resident A was found hanging upside down by her right arm and left leg outside on a fire escape. There is a concern that the fire escape may have had ice or snow on it.	No
Resident A was supposed to have 1-to-1 supervision, but she was not receiving it, nor was she being monitored according to her Treatment Plan and Beacon's Bed Check policy.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/28/2022	Special Investigation Intake 2022A0350015
02/28/2022	Special Investigation Initiated - Telephone I spoke with Ramon Beltran, II, Licensee Designee
02/28/2022	Contact - Document Received I received a confirmation email from Mr. Beltran
03/02/2022	Contact - Face to Face I met Mr. Beltran, obtained documents and inspected room and fire escape
03/03/2022	Contact - Telephone call made I spoke with Nathan Fenner, staff member
03/04/2022	Contact - Telephone call made I spoke again with Nathan Fenner
03/04/2022	Contact - Telephone call made I spoke with Seth Brunn, staff member
03/04/2022	Contact - Telephone call made I spoke again with Mr. Beltran
03/04/2022	Contact - Telephone call made I spoke with Justice Keyzer, staff member
03/04/2022	Contact – Document sent I sent an email to Mr. Beltran

03/04/2022	Contact - Document Received I received a response email from Mr. Beltran
03/09/2022	Contact - Telephone call made I spoke further with Seth Brunn, DSP
03/09/2022	Contact - Telephone call made I spoke with April Snyder, DSP
03/09/2022	Contact - Telephone call made I spoke with Tori Wrobleski, Assistant Home Manager
03/10/2022	Contact - Telephone call made I spoke with Kaitylnn Taylor, company nurse
03/10/2022	Contact - Telephone call made I spoke with Marci Anderson, company nurse
03/10/2022	Contact - Telephone call made I spoke with Lenora Martin, DSP
03/15/2022	Contact – Document sent I sent an email to Melissa Williams requesting Beacon's Bed Check Policy
03/15/2022	Contact - Telephone call made I spoke with Nathan Fenner, DSP
03/15/2022	Contact - Telephone call made I spoke with Melissa Schmall, DSP
03/15/2022	Contact - Telephone call made I spoke with Latayvia Nelson, DSP
03/15/2022	Contact – Document sent I received an email from Melissa Williams, with the Beacon's Bed Check Policy attached
03/15/2022	Contact – Telephone call made I spoke with Darice Darby, onsite Program Director
03/16/2022	Contact – Telephone call made I spoke further with Mr. Beltran
03/17/2022	Contact – Telephone call made I spoke further with Ms. Wrobleski

03/17/2022	Contact – Telephone call made I spoke further with Ms. Snyder
04/05/2022	Exit conference – Held with Kevin Kalinowski, Executive Vice President, in Ramon Beltran, II, Licensee Designee's absence

ALLEGATION: On 2/27/2022, Resident A was found hanging upside down by her right arm and left leg outside on a fire escape. There is a concern that the fire escape may have had ice or snow on it.

INVESTIGATION: On 02/28/2022, I received a call from Ramon Beltran, II, Licensee Designee for The Oaks, informing me of Resident A's death and some brief details regarding what he knew up to this point. Mr. Beltran stated that on the morning of 02/27, Direct Care Worker (DCW), Nathan Fenner, found Resident A tangled up in the metalwork of the 2nd floor exterior fire escape staircase at about 8:20 a.m., but it could not be determined how long she had been out there. 9-1-1 was called, but Resident A died on route to the hospital of an apparent heart attack.

On 02/28/2022, I sent an email to Mr. Beltran requesting to meet me at The Oaks on 03/02/2022 at noon and to provide me with the Incident Report, police, fire, and medical reports, and Resident A's Assessment and Treatment Plans. I received an email response from Mr. Beltran on this same date stating that he would meet me as requested.

On 03/02/2022, I met Mr. Beltran at The Oaks. He had copies of all the documents I requested. Mr. Beltran informed me that the day before this incident, Resident A was dizzy and fell a couple of times, so she was taken to the hospital. However, she eloped from the hospital before being examined, receiving a diagnosis, or having a treatment plan established. I asked Mr. Beltran what the protocol was for cleaning snow and ice from the egresses of this building, including the fire escape. Mr. Beltran said that it is part of the staff's responsibilities to shovel snow, brush snow off stairs, and salt egress passages as needed. He stated, however, that it did not snow that morning or the night before. Mr. Beltran told me that Resident A was last seen alive between 6:45 and 7:00 a.m. that morning. Mr. Beltran said that after this incident, he found a patch of a mashed banana on Resident A's bedroom floor and on the fire escape. I inspected the fire escape and found it to be in good, sturdy condition and observed that it was free of ice and snow. I also noted that there was a sound-alarm on the door at this time, which went off when I opened the door. However, Mr. Beltran informed me that this sound-alarm was installed on the door after this incident.

On 03/03/2022, I reviewed the documents given to me by Mr. Beltran. The Incident Report (IR) read: *'At approximately 6:45am (Resident A) was seen downstairs before going to her bedroom by staff. After shift change staff around 8am (DSP Nate) went upstairs to clean upstairs bathrooms and prompt for 8am medications.,*

he noticed (Resident A) was not in her room or any of the upstairs bathrooms. (DSP Nate) then proceeded downstairs to inform other staff that (Resident A) was not in her room and that he could not find her in the house. At that point (DSP Seth) called 911 due to (Resident A) having history of eloping while other staff continued to search in the house and around the house for (Resident A). At 8:12am (DSP Nate) called (DSP Justice) and said he found (Resident A) on the stairs. (DSP Seth) called 911 and explained to them the situation and followed the orders from the dispatcher until the cops came. Other staff stayed near by watching over (Resident A) and asking her questions and she would not respond. The fire department came and was able to get (Resident A) down safely and brought her to Borgess to treat her. (DSP Nate) continued holding onto (Resident A's) leg and arm through the bars while (DSP Justice) was asking (Resident A) questions and she was not responding. Staff contacted the VP of Operations Ramon Beltran II to inform him of the situation. VP contacted another VP of Operations Nicole Vanniman and both responded to the home. Both VP went to Borgess, to check on the status of (Resident A). It was at this time, that Beacon was informed that (Resident A) had passed away [sic].'

Note: DSP stands for Direct Support Professional, which is Beacon's designation for Direct Care Worker.

The Incident Report by the police was written by Officer Pell and was three pages long. It described the incident and the responses by Beacon staff, the police, fire department, and Emergency Medical Service (EMS), as well as the Medical Examiner's findings. The report states that when the officer went to the fire escape he saw: *'a male subject, kneeling down, holding (Resident A) from falling to the ground. (Resident A's) left ankle was caught between two metal bars of the fire escape, her right elbow was around another metal bar. (Resident A) had her eyes open. You could see her breathing from her belly being exposed. She would occasionally move; however, she would not communicate at all. She was cold and may have been suffering from hypothermia; it was approximately 22 degrees.'*

According to Officer Pell's report, EMS arrived and he also contacted the fire department and advised them to bring a ladder to assist in getting Resident A down. The fire department personnel were able to lower Resident A to the ground and she was placed on a cot as they waited for the ambulance to arrive. Officer Pell wrote that The Oaks staff member Seth Brunn found two step ladders to try to get Resident A down before the fire department arrived, but the ladders were too short. Officer Pell's report states that he learned from speaking with staff members that Resident A was; *'acting tired and sleepy, and went back and forth; up to her room and back down that morning*.*'* A staff member (not identified in his report) reportedly informed Officer Pell that staff; *'never knew (Resident A) to use that back fire escape; it's labeled "Fire Escape Only" and you cannot get back inside when the door shuts behind you.'* Officer Pell noted in his report that; *'starting approximately half way down the stairs, there were chunks of banana wedged in the stairs.*' and he observed smeared banana on her bedroom floor. There was no mention of water, snow, or ice observed on the fire escape.

The medical report from Ascension Borgess Hospital states that Resident A; *'presented to the ED via EMS from AFC home in cardiac arrest. Initial report via EMS approximately 10 minutes prior to arrival stated that the patient was found hanging by her arms in a fire escape. Approximately 5 minutes before arrival to the ED EMS reported that the patient lost pulses and CPR was initiated. Upon arrival to ED the patient did have pulses but lost them again shortly after arrival.'* According to this report, the medical staff were not able to revive Resident A after that. The report also confirmed that Resident A was seen at this hospital the day before, on 02/26/22.

On 03/03/2022, I called and spoke with Nathan Fenner, the staff member who found Resident A the morning of this incident. Mr. Fenner reported that there was no water, snow, or ice on the fire escape when he found Resident A. He confirmed that he called another staff member for assistance and that 9-1-1 was called.

04/05/2022, I caled and held an exit conference with Kevin Kalinowksi, Executive Vice President, in Ramon Beltran, II, Licensee Designee's temporary absence. I informed Mr. Kalinowski that I was not citing violation of this rule. Mr. Kalinowski thanked me and had no further comment.

APPLICABLE RULE	
R 400.2447	**Safety, generally.**
	(3) Sidewalks, fire escape routes and entrances shall be kept free of any hazard such as ice, snow and debris.
ANALYSIS:	Ramon Beltran, Licensee Designee, informed me that staff members are instructed to clear snow and ice from all emergency egresses, including the fire escape where Resident A was located. Mr. Beltran stated that there was no snow or ice on the fire escape the morning of this incident. The staff member who was the first person to find Resident A on the fire escape, Nathan Fenner, reported that there was no snow, ice, or water on the fire escape when he found her. There was no mention of water, snow, or ice on the fire escape in Officer Pell's report. He was the first emergency responder to the scene. Officer Pell did state, however, that he observed pieces of a banana on the fire escape and smeared banana on Resident A's bedroom floor. The staff at The Oaks responded to this situation appropriately by trying to rescue Resident A, calling 9-1-1, and staying with her until the police, fire department, and EMS arrived.

	My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A was supposed to have 1-to-1 supervision, but she was not receiving it, nor was she being monitored according to her Treatment Plan and Beacon's Bed Check policy.

INVESTIGATION: On 02/28/2022, I sent an email to Mr. Beltran requesting to meet me at The Oaks on 03/02/22 at noon and to provide me with the Incident Report, police, fire, and medical reports, and Resident A's Assessment and Treatment Plan. I received an email response from Mr. Beltran on this same date stating that he would meet me as requested.

On 03/02/2022, I met Mr. Beltran at The Oaks. He provided me with copies of all the documents I requested.

On 03/03/2022, I reviewed Resident A's Assessment Plan and Behavior Assessment and Treatment Plan. Although it states in her Assessment Plan that Resident A required staff supervision while in the community, there is no mention in either document that she required 1-to-1 supervision. In addressing Resident A's elopement risk, her Treatment Plan states: *'If (Resident A) begins to walk away from the home, follow her (as staffing ratios allow) and verbally redirect her back to the home (or to the van if on an outing).'* The Treatment Plan states that Resident A's supervision requirements are that: *'Staff will know the general whereabouts of (Resident A) while in the home. Per Beacon Bed Check policy (#CTS-023) staff will do "bed checks" every 30 minutes during the day and every hour during the overnight.'* Further, it states in Resident A's Behavior Assessment that; *'She has been observed to have significant gait and balance issues and is a fall risk without assistance.'* The date this Behavior Assessment was prepared was 02/15/2022.

On 03/04/2022, I called and spoke with Nathan Fenner again, and asked him if he checked on Resident A anytime between 6:45 a.m. and 8:00 a.m.. Mr. Fenner stated he did not start his shift until 7:20 a.m. and that he did not attempt to check on her until about 7:50 a.m., which is when he noted that she was not in her room. He stated that he went looking for her and finally found her "tangled up" in the fire escape staircase at approximately 8:12 a.m.

On 03/04/2022, I called and spoke with Seth Brunn, DSP. Mr. Brunn stated that he worked 2nd shift on Saturday, February 26th until approximately 12:00 p.m. the next day. He said he stayed late because of this emergency situation. Mr. Brunn reported that he last saw Resident A at about 6:45 a.m. when she was on the main floor and then she went upstairs around that time.

On 03/04/2022, I called and spoke further with Mr. Beltran, who explained that the staffs' nighttime hourly checks end at 8:00 a.m., which is when staff begin checking on residents every thirty minutes.

On 03/04/2022, I called and spoke with Justice Keyzer, DSP, who also worked 2nd shift. Ms. Keyzer said that Resident A was on the main floor in the kitchen area most of the night, and that she last saw Resident A at about 6:45 a.m. when she headed up to her bedroom. Ms. Keyzer informed me that the other two staff members working at the time, Lenora Martin and Latayvia Nelson, were not assigned to check on Resident A that morning. Ms. Martin was on kitchen duty and Ms. Nelson was on medication administration duty.

On 03/15/2022, I called and spoke with staff members Nathan Fenner, Melissa Schmall, and Latayvia Nelson individually by phone. All three stated that staff members are assigned up to four residents to check-on during the first shift, and that they are to check on them every 30-minutes, starting at 8:00 a.m. They also each stated that staff are not required to document or keep a log of these checks.

On 03/15/2022, I called and spoke with Darice Darby, Program Director who works onsite. Ms. Darby informed me that 1st shift staff members are required to visually check on the residents every half hour, starting at 8:00 a.m. and 2nd shift staff members are to check on the residents every hour.

On 03/15/2022, I sent an email to Melissa Williams, Chief Administrative Officer, requesting Beacon's Bed Check Policy. That same day I received an email reply from Ms. Williams containing the Bed Check Policy which states; *'Daily awake hours (6 am - 9 pm), residents will be monitored at every 30 minutes or know the residents whereabouts. This is the policy unless otherwise stated in a PCP or Behavior Plan, or if an enhanced staffing (authorized one to one) form has been authorized.'*

On 04/05/2022, I called and held an exit conference with Kevin Kalinowski, Executive Vice President, as Ramon Beltran, II, Licensee Designee, was on vacation. I informed Mr. Kalinowski that I was citing a violation of this rule for the reasons stated above. Mr. Kalinowski stated that he did not dispute this finding as "The facts are the facts." Mr. Kalinowski informed me they (Beacon management and directors) have been looking into making improvements to their communication with staff and managers of The Oaks, as well as making improvements to their operating processes.

APPLICABLE RULE	
R 400.2412	**Care of residents.**
	(4) A resident shall be treated with dignity, and his personal needs, including protection and safety, shall be attended to at all times.

ANALYSIS:	Although Resident A's Assessment Plan and Behavioral Treatment Plan do not specify that she required 1-to-1 supervision while in the home, her Treatment Plan does state that; *'Staff will know the general whereabouts of (Resident A) while in the home.'* In addition, Beacon's policy, based upon the general supervision requirements of the residents served in this facility, does require staff to check on residents every 30 minutes beginning at 6:00 a.m.. On the morning of 02/27/2022, staff observed Resident A going up the stairs to the second floor of the home at approximately 6:45 a.m., Staff did not attempt to check on her until approximately 7:50 a.m., and did not ultimately locate her until she was discovered hanging from the 2nd floor exterior fire escape at 8:12 a.m. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: On 03/09/2022, I called and spoke with Seth Brunn, DSP. Mr. Brunn stated that he worked 2nd shift the night before and the morning of the incident regarding Resident A's falling down the fire escape. Mr. Brunn reported that he did not notice Resident A having any problems that shift. He said he did not have much contact with her, only that she asked for a cigarette. Mr. Brunn told me that he did call the Medical On-Call nurse, Kaitlynn Taylor, but only to inform her what happened with Resident A at the hospital the day before. Mr. Brunn stated that he had to leave a message for Ms.Taylor as she did not answer the phone.

On 03/09/2022, I called and spoke with April Snyder, who told me that Resident A was acting "off" the morning of 02/26/2022, so she called the Medical On-Call nurse, Ms. Taylor, but her call was not answered so she had to leave a message. When Ms.Taylor did not call her back after 10 minutes, she called Marci Anderson, the Medical On-Call back-up nurse, but that call was also not answered so she had to leave her a message as well. When Ms. Anderson did not call her back, Ms. Snyder said she called a third person, but didn't remember who, and still was not able to get ahold of anyone, so she finally called Tori Wrobleski, Assistant Home Manager, who advised her to take Resident A to the hospital, which she did.

On 03/09/2022, I called and spoke with Tori Wrobleski, Assistant Home Manager, and she confirmed that Ms. Snyder contacted her after failing to get ahold of either of the Medical On-Call nurses. Ms. Wrobleski stated that she advised Ms. Snyder to take Resident A to the hospital because she was unstable and had fallen a couple of times.

On 03/10/2022, I called and spoke with Kaitylnn Taylor, nurse, who stated that she was the Medical On-Call nurse the morning of 02/26/22, but she did not receive a

call, voicemail, or text message from Ms. Snyder, or anyone else from The Oaks that morning. Ms. Taylor informed me that they've been having problems with their call-forwarding system and are in the process of switching phone service providers.

On 03/10/2022, I called and spoke with Marci Anderson, back-up Medical On-Call nurse. I asked Ms. Anderson if she was working back-up on the morning of 02/26/22, and she stated that she is always the back-up. Ms. Anderson reported that she did not receive a call, voicemail, or text message from Ms. Snyder or anyone else from The Oaks that morning. Ms. Anderson said that all staff members have access to her cell phone number because it is posted in the medication room.

On 03/10/2022, I called and spoke with Lenora Martin, DSP, who said that she worked 2nd shift on 02/26-02/27 and observed that Resident A seemed "disoriented" and "lethargic." Ms. Martin told me that Resident A came to the medication room where Ms. Martin was working, several times, asking for a medication she had already given her. Ms. Martin said that she called Kaitlynn Taylor, Medical On-Call nurse, but had to leave her a message. She stated that she didn't get a call back from Ms. Taylor, so she called Marci Anderson, back-up Medical On-Call, but had to leave a message for her as well. Ms. Martin informed me that someone was going to take Resident A to the Emergency Room but she refused to go. Ms. Martin said that she last saw Resident A at around 6:45 a.m. the morning of 02/27/22 just before Resident A went upstairs, and she seemed to be doing better.

On 03/16/2022, I called and spoke with Ramon Beltran, II, Licensee Designee. In discussing this allegation and my investigation into it, Mr. Beltran asked me if I had asked either Ms. Snyder or Ms. Martin what times they made their calls to Medical On-Call and I told him I did not. I told Mr. Beltran that I was aware of Beacon's policy that if a staff member does not speak to the Medical On-Call nurse but has left a message, they are to wait 15-minutes and then call the back-up On-Call nurse. I said that I knew that this same process starts over again, with the staff member having to wait another 15-minutes before calling someone else. I explained that since Ms. Snyder and Ms. Martin both called both On-Call nurses, left messages, and did not get calls back, and because Ms. Taylor, one of the Medical On-Call nurses, informed me that there were problems with call-forwarding system used for the on-call procedure, it could have potentially made Resident A vulnerable to experiencing unnecessary harm. Mr. Beltran stated that he believed from the time Ms. Snyder made her first call to the Medical On-Call nurse to the time she spoke to Ms. Wrobleski and was advised to take Resident A to the hospital was within a reasonable period of time.

On 03/17/2022, I called and spoke with Tori Wrobleski, Assistant Home Manager, and she said that she received a call from April Snyder, DSP, at about 6:05 p.m. on 02/26. Ms. Snyder told Ms. Wrobleski about her concerns regarding Resident A (i.e., having several falls that day, elevated pulse) and Ms. Wrobleski instructed her to call 9-1-1. Ms. Wrobleski informed me that she also left a message for Ms. Taylor, the On-Call nurse, at about 6:10 p.m., but didn't get a response back until 7:17 p.m.. By

that time, Ms. Wrobleski had already instructed Ms. Snyder to call 9-1-1, which she did.

On 03/17/2022, I called and spoke with Ms. Snyder to obtain the timeframe of events on 02/26. Ms. Snyder reported that she first called Ms. Taylor, On-Call nurse, at about 10:30 a.m. She said she left a message for Ms. Taylor, but never got a call back from her. Ms. Snyder told me that Resident A then went up to her room and was there until about 4:30 or 5:00 p.m. when another resident let her know that Resident A had fallen again. At that time, Ms. Snyder asked two staff members to bring Resident A down to the main floor so she could check her vitals, and they brought her down. Ms. Snyder said that her vitals were within the normal range except her pulse was elevated. Ms. Snyder stated that she then called the back-up On-Call nurse, Marci Anderson, but had to leave her a message as well. This call was made at around 5:00 p.m. Ms. Anderson did not call Ms. Snyder back, and at about 6:00 p.m., Ms. Snyder contacted Ms. Wrobleski, who advised her to call 9-1-1, which she did, and Resident A was taken to the hospital. Ms. Snyder informed me that no other staff member contacted Ms. Wrobleski to seek direction on what to do about this matter.

On 03/17/2022, I spoke with Melissa Williams, Chief Administrative Officer, and informed her that, according to Ms. Snyder, it took about an hour to for Ms. Snyder to get direction on what to do about Resident A's falls and disoriented behavior, and that that sounded like an excessive amount of time to me.

On 03/21/2022, I received an email from Jerry Hendrick, Area Manager for the Adult Foster Care Licensing unit. Mr. Hendrick indicated that he had been contacted by Beacon leadership and they had requested an opportunity to provide additional information pertaining to this investigation which they felt would show there was not an excessive delay from when Resident A first began displaying concerning behaviors (including falls) and when medical attention was sought. Beacon leadership also reportedly expressed an opinion that Resident A's behaviors/falls did not warrant earlier medical attention and that a violation should not be substantiated.

On 03/23/2022, I received an email from Christopher Taylor, Chief Compliance Officer for Beacon Specialized Living Services, Inc. Attached to the email was a timeline produced by Beacon management regarding the events that took place on 02/26/2022 involving Resident A's change in health and the staff's response to it. The timeline they submitted includes the following information:

Preliminary Timeline

- *2/26/22 at 8:00am: (Resident A) was prompted to come down for meds three times but refused.*
- *2/26/22 10:14am: Staff heard (Resident A) fall in her room. She had tripped over her laundry basket. Staff checked (Resident A) for marks or injury but did not find any.*

- *2/26/22 10:30am: (Resident A) did come down for meds at 10:30am. Staff had reached out and obtained approval from the on-call nurse to pass medication at that time.*
- *2/26/22 at 3:30pm: (Resident A) fell in the bathroom when trying to get into the bathtub. Staff assisted her in the bathtub and out of the bathtub. When asked, (Resident A) stated that she was fine. Staff checked (Resident A) for marks or injury but did not find any.*
- *2/26/22 at 6:00pm: (Resident A) fell in the bathroom. Staff checked vitals and they were in normal ranges. Staff called on-call medical at 6:03pm, had technical difficulties with the call and immediately contacted the on-call manager at 6:04pm. The on-call manager recommended, as a precautionary measure, that (Resident A) be taken to the hospital. Staff were instructed to transport (Resident A) to the hospital upon the arrival of the evening shift at 6:30, since it was not an emergency situation.*
- *2/26/22 before 6:30pm: (Resident A) fell again in the hallway of the home. Staff examined (Resident A) for any sign of injury and no injury was found.*
- *2/26/22 at 6:30pm: (Resident A) was taken to the hospital upon the arrival of evening shift staff.*
- *2/26/22 at 7:25pm: Intake at the hospital emergency department, the emergency physician at the hospital saw (Resident A). (Resident A) was uncooperative with tests and labs, as was her typical demeanor when undergoing medical examination. A physician noted that the visit was due to "minor falls" that didn't result in unconsciousness. A physician noted that she was able "to ambulate without assistance" and "does have the capacity to refuse care." Doctor also noted that "if patient has any decline in mental status or other concerning symptoms that she should be brought by ambulance to an emergency department." (Resident A) refused to stay at the hospital any longer and walked away, accompanied by staff.*
- *2/26/22 evening/night: Staff continued to monitor (Resident A) closely throughout the evening and night. (Resident A) was active throughout the night, as was her pattern. She was walking up and down the stairs, went out to smoke, and asked for pancakes to be made up for her. There were no falls or other concerns noted during this period.*
- *2/27/22 6:45-7:00am: (Resident A) was seen downstairs before she went back up to her room, presumably to sleep.*
- *2/27/22 7:50am: Nathan Fenner walked by (Resident A)'s room and noticed she wasn't there and began to look for her. She was located entangled on the fire escape at 8:12am. 911 was called.*

Notes on on-call phone logs

- *Four calls logged in phone system to medical on-call from the home on the day of 2/26: 10:14 a.m., 10:23 a.m., 5:50 p.m., 6:03 p.m..*

- *An incident report related to approval to issue late medication to (Resident A), due to her not coming down from her room initially, indicates that staff connected with the on-call nurse at 10:23 from the house phone to approve the late medication pass. April Snyder indicated that she called the on-call system at 10:14 using her personal phone, but that the call did not go through. April Snyder confirmed that both calls at 10:14am and 10:23am were regarding the late medication pass.*

- *59 calls from all homes logged in phone system to medical on call on 2/26. No issues were noted with the phone system. No known concerns with accessing medical on call for the day at other homes.*

Standard of Care

- *Staff responded appropriately because (Resident A)'s falls did not rise to the level of a medical emergency. On 2/26/22, the emergency physician noted that (Resident A)'s falls were "minor falls," these were falls that didn't cause any type of injury. (Resident A) has a history of occasional minor falls. After the 6:00pm fall, it was determined to take (Resident A) to the hospital as a precautionary measure. However, (Resident A) did not cooperate with testing at the hospital.*

- *Upon returning to the home that evening, (Resident A) was up through the night, was monitored by staff, and did not have any additional falls.*

On 03/24/2022, I called and spoke again with April Snyder, DSP. Ms. Snyder informed me that she first called Medical On-Call about 10:30 a.m. on 02/26 to see if it would be alright to pass Resident A's morning medications late because Resident A did not get out of bed until about 10:30 a.m. Ms. Snyder said that she had to leave a message for Medical On-Call because no one answered. She said she waited about 15 minutes but didn't get a call back, so she called the back-up Medical On-Call person, but again had to leave a message because no one answered. Ms. Snyder told me that she then called an alternative number for Kaitlynn Taylor, the scheduled On-Call nurse, who gave her approval to pass Resident A's morning medications later than when prescribed. Ms. Snyder reported that about 1:30 p.m. that same day, she was informed that Resident A fell again, so Ms. Snyder called the Medical On-Call nurse, but again had to leave a message because she did not answer. She did not get a return call. Ms. Snyder stated that Resident A seemed to be doing alright after this point, so she did not make any more calls to Medical On-Call until later in the day, around 5:00 p.m., when Resident A had fallen again. Ms. Snyder stated that she then called Ms. Taylor, but had to leave a message because she did not answer. Ms. Snyder stated Ms. Taylor did not call her back, so she then called the back-up On-Call nurse, Marci Anderson, but had to leave her a message for her as well. This call was reportedly made at around 5:00 p.m. Ms. Snyder stated that Ms. Anderson also did not call Ms. Snyder back. Ms. Snyder informed me that another staff member, Melissa Schmall, DSP, also called Medical On-Call about this incident, but she, too, had to leave a message and didn't get a call back. At about 6:00 p.m., Ms. Snyder contacted Ms. Wrobleski, who advised her to call 9-1-1, which she did, and Resident A was taken to the hospital.

On 04/05/2022, I called and held an exit conference with Kevin Kalinowski, Executive Vice President, as Ramon Beltran, II, Licensee Designee, was on vacation. I informed Mr. Kalinowski that I was citing violation of this rule. Mr. Kalinowski made the point that although it did take staff about an hour to get Resident A to the hospital, it was not an emergency situation. I told him I appreciated his input and reiterated my concerns of the problems with their Medical On-Call system. Mr. Kalinowski added that they (management, directors, etc., of Beacon) have been and will continue to review their processes to find ways to make improvements.

APPLICABLE RULE	
R 400.2404	**Illnesses and accidents.**
	(1) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a congregate facility shall obtain needed care immediately and notify the responsible relative and the person or agency responsible for placing and maintaining the resident in the congregate facility.
ANALYSIS:	Beacon has a protocol in place in which if a staff member has a concern regarding the change in a resident's health, that staff person is to call the Medical On-Call nurse. If the assigned On-Call nurse does not answer, the staff member is to leave a message. If a message is left and the On-Call nurse does not call back within 15-minutes, the staff member is to call the back-up Medical On-Call nurse. On 02/26/22, staff member Lenora Martin had concerns about Resident A because she had fallen several times and was disoriented that day. Ms. Martin called Kaitlynn Taylor, the assigned Medical On-Call nurse for that day, but had to leave her a message. Ms. Martin said she did not receive a return call from Ms. Taylor within 15-minutes, so she made a call to Marci Anderson, the back-up Medical On-Call nurse, but had to leave a message for her as well. However, Ms. Anderson also did not call either of them back. On 02/26/22, staff member April Snyder also had concerns about Resident A because she had fallen several times that day. Ms. Snyder called the Medical On-Call nurse, Kaitlynn Taylor, at about 10:30 a.m. that morning, but had to leave a message as Ms. Taylor did not answer her phone. Ms. Snyder reported that Resident A went to her room at about this time, 10:30 a.m., and was there until about 4:30-5:00 p.m., when another resident told her that Resident A had fallen again. Ms. Snyder then called the

	back-up Medical On-Call nurse, Marci Anderson, at about 5:00 p.m., but had to leave her a message because she did not answer her phone either. Ms. Snyder said she waited until around 6:00 p.m. before she contacted the Assistant Home Manager, Tori Wrobleski, who advised her to call 9-1-1. On 02/26/22, Ms. Wrobleski also called and left a message for Ms. Taylor at about 6:10 p.m., and Ms. Taylor did not contact her back until 7:17 p.m. By that time, Ms. Wrobleski had already instructed Ms. Snyder to call 9-1-1, which she did. Ms. Taylor confirmed that she was the On-Call nurse on 02/26/2022, but said she did not receive any calls or messages from any staff member from The Oaks that day. Ms. Taylor reported that there have been problems recently with the call-forwarding system used by the On-Call nurses. Ms. Anderson confirmed that she was the back-up On-Call nurse on 02/26/22. Ms. Anderson denied receiving calls or messages from Ms. Snyder or Ms. Martin, or anyone else from The Oaks that day. Ms. Anderson said that all staff know that her cell phone number is posted in the medication room. Due to the Medical On-Call procedure not being properly followed and the reported technical problems with the call-forwarding system, Resident A's medical needs were not met in a timely manner. Ms. Snyder first had concerns regarding Resident A's change in health at around 10:30 a.m. and called Medical On-Call at that time but did not get a response. Later that day, sometime between 4:30 and 5:00 p.m., Ms. Snyder was made aware that Resident A had fallen again. She checked her vitals and found her pulse to be elevated, so she called Medical On-Call again, but again did not get a response. She finally spoke with Ms. Wrobleski shortly after 6:00 p.m. and was advised to call 9-1-1, which she did. More than an hour passed after Resident A's last fall and elevated pulse until a call to 9-1-1 was made and Resident A was taken to the hospital. My findings support that this rule was violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

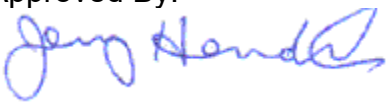
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that this facility's license be place on a six-month, 1st Provisional status.

April 5, 2022

Ian Tschirhart — Date
Licensing Consultant

Approved By:



April 5, 2022

Jerry Hendrick — Date
Area Manager