GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 25, 2022

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

RE: License #: AS810393269
Investigation #: 2022A0122036
Beacon Home At Ypsilanti

Dear Ms. Rawlings:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation?
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810393269
Investigation #:	2022A0122036
Complaint Receipt Date:	08/01/2022
Investigation Initiation Date:	08/01/2022
Report Due Date:	09/30/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Rawlings
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home At Ypsilanti
Facility Address:	7862 Tuttle Hill Road Ypsilanti, MI 48197
Facility Telephone #:	(734) 221-5424
Original Issuance Date:	05/24/2018
License Status:	REGULAR
Effective Date:	11/24/2020
Expiration Date:	11/23/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL TRAUMATICALLY BRAIN INJURED AGED

II. ALLEGATION(S)

	Violation Established?
Staff member, Brian Bradley, left the residents alone in the facility on 07/23/2022.	No
Resident A does not receive his prescribed diet.	No
On 07/23/2022, Resident A did not receive his medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/01/2022	Special Investigation Intake 2022A0122036
08/01/2022	Contact - Document Sent Email sent to Adult Protective Services Worker, Rita Sharma, Adult Protective Services Worker.
08/01/2022	Contact - Telephone call made Completed interview with Rita Sharma, Adult Protective Services Worker.
08/01/2022	Special Investigation Initiated - Telephone Completed interview with Rita Sharma, Adult Protective Services Worker.
08/01/2022	Contact - Telephone call made Jessica Krefman, ORR Representative. Unavailable - left voice message.
08/03/2022	Inspection Completed On-site Reviewed Resident A and B's files, Reviewed medication administration sheets for Resident A and medication. Assessed food in the facility. Completed resident interviews.
08/09/2022	Exit Conference Kim Rawlings, Licensee Designee

08/10/2022	Contact – Document received Resident Written Assessment Plans

ALLEGATION: Staff member, Brian Bradley, left the residents alone in the facility on 07/23/2022.

INVESTIGATION: On 08/01/2022, I completed an interview with Rita Sharma, Adult Protective Services Worker. Ms. Sharma reported that she had completed interviews with some of the residents, however, she did not receive a conclusive answer if they were left alone in the facility on 07/23/2022. I also completed an interview with Jessica Krefman, Office of Recipient Rights Representative. Ms. Krefman reported the same, that she was unable to receive a conclusive answer after interviewing the residents.

On 08/03/2022, I completed an interview with Brian Bradley, Home Manager. Mr. Bradley reported that he worked independently from Saturday, 7/23/2022, until Sunday, 07/24/2022 at the Beacon Home at Ypsilanti adult foster care group facility. Mr. Bradley stated he was responsible for 48 hours of assisting with the residents with following: bathing/grooming, medication administration, preparing/serving meals, transportation, behavior management, etc.

Mr. Bradley denied leaving the residents alone in the facility on 07/23/2022. He stated he had completed interviews with Ms. Sharma and Ms. Krefman, and it had been explained to him that allegedly he transported Resident C to a meeting and left the other residents alone. Mr. Bradley stated that did not happen and he did not leave the facility on 07/23/2022.

On 08/03/2022, I interviewed Residents A, B, C, D, and E. Residents B and D stated that a staff member is always present in the facility, and they have never been left alone. Residents A and C stated there have been incidents when they were left alone but neither could give specific dates or circumstances. I was unable to interview Resident E as he was delusional, I could hear him having an internal conversation with himself and he was agitated.

On 08/09/2022, I completed an exit conference with Kimberly Rawlings, Licensee Designee. Ms. Rawlings stated she understood my findings and would submit a corrective action plan to address all rule noncompliance's found.

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:	On 08/01/2022, both Rita Sharma and Jessica Krefman reported that they did not come to a conclusive resolution that residents were left alone in the facility on 07/23/2022. On 08/03/2022, Brian Bradley denied leaving the residents alone in the facility on 07/23/2022. On 08/03/2022, Residents B and D stated they are never left alone in the facility however Residents A and C stated they have been left alone in the facility but gave no specific date or time when they were left alone. Based upon my investigation I find there is no conclusive information to prove that residents were left alone in the facility on 07/23/2022, therefore, residents protection and safety have been attended to.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A does not receive his prescribed diet.

INVESTIGATION: On 08/02/2022, I completed interviews with Rita Sharma and Jessica Krefman. Ms. Sharma reported that Resident A was initially prescribed a soft diet, but he is currently prescribed a regular diet. Ms. Krefman reported that Resident A is on a soft diet but refuses to follow the diet.

On 08/03/2022, Brian Bradley confirmed that Resident A is on a soft diet, however, he will refuse meals when it is prepared this way. Per Mr. Bradley, if Resident A refuses a meal, he is offered another option, he will usually accept soup and crackers.

On 08/03/2022, Resident A stated he was not on a special diet. Resident A could not answer additional questions as he was unable to focus.

On 08/03/2022, I reviewed Resident A's Health Care Appraisal dated 06/28/2022. It states that Resident A is on a "soft mechanical diet." According to medical news today a mechanical soft diet "consists of any food that can be blended, mashed pureed, or chopped using a kitchen tool such as a knife, a grinder, a blender, or a food processor…"

On 08/03/2022 I observed enough food in the facility. There were options to provide Resident A with a soft diet. For lunch he was offered a hot dog and fruit, which he consumed. I also observed knives and a food processor in the facility kitchen.

On 08/09/2022, I completed an exit conference with Kimberly Rawlings, Licensee Designee. Ms. Rawlings stated she understood my findings and would submit a corrective action plan to address all rule noncompliance's found.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(b) Special diets.**
ANALYSIS:	On 08/01/2022, Rita Sharma reported that Resident A is not currently on a prescribed soft diet. Ms. Krefman reported that Resident A refuses to follow his prescribed soft diet. On 08/01/2022, Brian Bradley reported that Resident A is offered food options that consist of a mechanical soft diet however he refuses. On 08/01/2022, Resident A reported that he is not on a special diet. Resident A's Health Care Appraisal dated 06/28/2022 documents that he is prescribed a soft mechanical diet. On 08/03/2022, I observed that the food provided to Resident A is sufficient to meet the requirements of his prescribed soft mechanical diet. There were also kitchen tools observed to prepare the food to meet the requirement of Resident A's diet. Based upon my investigation I find there is evidence to support that the licensee, with the resident's cooperation is following the physician orders of Resident A's special diet of a mechanical soft diet.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 07/23/2022, Resident B did not receive his medication, Ritalin, as prescribed.

INVESTIGATION: On 08/02/2022, I completed interviews with Rita Sharma and Jessica Krefman. Both reported they had concluded that Resident B did not receive his medication, Ritalin, as prescribed on 07/23/2022.

On 08/03/2022, Brian denied giving Resident B an extra dose of medication. He stated he gave a total of 46 milligrams of the medication, Methylphenidate, which is a generic form of Ritalin on 07/23/2022.

I requested Resident B's medication administration records for July 2022. Brian reported that those records were on the computer, and he was unable to access them, however, he was able to submit a paper copy of the document. He stated that the administrative office may be able to submit a copy of the computer printout.

I reviewed printed copies of Resident B's medication administration records for July 2022. There is only a listing of Methylphenidate 10mg take one tablet by mouth daily at 4:30 p.m. listed on the sheet. Staff initials are listed on the following days only: 07/01, 07/03, 07/09, 07/13, 07/14, 07/24, 07/25 and 07/30. When questioned about the missing staff initials Brian stated that this form is not always completed by staff members, but the computer form is completed by them daily.

Resident B's prescription dated 05/31/2022, states that Resident B is to have Methylphenidate 10 mg one tablet by mouth once daily.

On 08/09/2022, I requested computer copies of Resident B's medication administration records. The forms were not submitted for my review.

On 08/09/2022, I completed an exit conference with Kimberly Rawlings, Licensee Designee. Ms. Rawlings stated she understood my findings and would submit a corrective action plan to address all rule noncompliance's found.

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:	On 08/02/2022, both Rita Sharma and Jessica Krefman reported that Resident B did not receive his medication, Ritalin, as prescribed on 07/23/2022. On 08/03/2022, Brian Bradley denied giving Resident B an extra dose of Methylphenidate, the genic form of Ritalin, on 07/23/2022. Resident A's prescription dated 05/31/2022 states that Resident B states is to have Methylphenidate 10 mg one tablet by mouth once daily. Resident B's medication administration record dated July 2022 documents that staff administered Methylphenidate 10mg one tablet by mouth daily at 4:30 p.m. on the following days of: 07/01, 07/03, 07/09, 07/13, 07/14, 07/24, 07/25 and 07/30. There were no staff initials documented administration of the medication for the remainder of the 23 days. Based upon my investigation, there are no records to document that Resident B received his prescribed medication, Methylphenidate 10 mg one tablet by mouth once daily for the month of July 2022, therefore Resident B did not receive his medication as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 08/03/2022, I completed an interview with Brian Bradley, Home Manager. Mr. Bradley reported that he worked independently from Saturday, 7/23/2022, until Sunday, 07/24/2022 at the Beacon Home at Ypsilanti adult foster care group facility. Mr. Bradley stated he was responsible for 48 hours of assisting with the residents with following: bathing/grooming, medication administration, preparing/serving meals, transportation, behavior management, etc.

I asked Mr. Bradley if he felt one staff member could give appropriate adult foster care to the residents of Beacon Home at Ypsilanti to which he replied no, however, he did the best that he could. Mr. Bradley stated that he was groggy from lack of sleep, and he felt overwhelmed with his job duties specifically with passing medications, preparing meals, etc.

On 08/03/2022, I requested written assessments plans to review from all residents. Mr. Bradley was unable to locate the requested documents but gave me behavior treatment plans for Residents B, C, D, and E.

On 08/08/2022, I reviewed the submitted resident behavior plans. Resident B's Plan dated 05/10/2022 documents that his targeted behaviors to be addressed are verbal aggression and sexual inappropriateness towards male and females. "Reactive strategies state staff members are to respond immediately and calmly when behaviors occur."

Resident C's Behavior Support Plan dated 04/22/2022 document his targeted behaviors are verbal aggression and inappropriate touching, and physical aggression. Staff members are to address behaviors using verbal redirection, engage in positive topics and activities, distance others from physical aggressive behaviors or call for assistance, and "follow him and verbally redirect him" during elopement attempts.

Resident D has a Safety Plan dated 04/15/2021 which outlines an incident when he was taken to a hospital in Pontiac Michigan to receive crisis care.

Resident E's Crisis Plan dated 07/23/2020 documents his targeted behaviors are elopement, destruction of property, and physical aggression. Staff members are to address his behaviors by making certain he attends all medical appointments, verbal redirect incidents of elopement, destruction of property and physical aggression. If Resident E escalates staff members are to call for assistance.

On 08/10/2022, I received written assessment plans for all residents of the facility. Five of the resident plans were outdated, the oldest completed on 10/04/2018. Some of the written assessment plans were not fully completed, missing information for example written assessment for Resident A documented that he does not communicate his needs but gave no explanation as to how this issue is addressed nor how staff assist him in this area.

On 08/09/2022, I completed an exit conference with Kimberly Rawlings, Licensee Designee. Ms. Rawlings stated she understood my findings and would submit a corrective action plan to address all rule noncompliance's found.

APPLICABLE RULE	
400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall

	maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	On 08/03/2022, I requested copies of resident written assessments for my review. On 08/10/2022, I received written assessment plans for all residents of the facility. Five of the resident plans were outdated, the oldest completed on 10/04/2018. Some of the written assessment plans were not fully completed, missing information for example written assessment for Resident A documented that he does not communicate his needs but gave no explanation as to how this issue is addressed nor how staff assist him in this area. Based upon my investigation I find that resident written assessments for all residents of Beacon Home at Ypsilanti are not being completed annually, one resident's current assessment was dated 10/04/2018.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
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:	On 08/03/2022, Brian Bradley, Home Manager, confirmed that he worked independently from Saturday, 7/23/2022, until Sunday, 07/24/2022 at the Beacon Home at Ypsilanti adult foster care group facility. Mr. Bradley stated he was responsible for 48 hours of assisting with the residents with following: bathing/grooming, medication administration, preparing/serving meals, transportation, behavior management, etc. Mr. Bradley stated he felt one staff member could not give appropriate adult foster care to the residents of Beacon Home at Ypsilanti. Mr. Bradley stated that he was groggy from lack of sleep, and he felt overwhelmed with his job duties specifically with passing medications, preparing meals, etc. Resident B did not receive his medication, Methylphenidate 10 mg one tablet bout mouth daily at 4:40 p.m. as prescribed according to his medication administration sheets dated July 2022. Resident B displays behaviors of verbal aggression and sexual inappropriate behaviors towards male and female. Resident C displays behaviors of verbal and physical aggression and inappropriate touching. Resident E displays behaviors of elopement, destruction of property, and physical aggression. All plans instruct staff to intervene either immediately via verbal redirection, offering different activities, distancing from other residents, etc. Based upon my investigation there was insufficient staffing to provide supervision and personal care as specified in the resident's written/behavior plans as Resident B did not receive his medication as prescribed and Residents B, C, E have behavior plans that call for staff intervention to address inappropriate behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan that specifically addresses have sufficient staffing scheduled for all shifts, I recommend no change in the status of the license.

Vanita C. Bouldin — Date: 08/16/2022
Licensing Consultant

Approved By:

Ardra Hunter — Date: 08/25/2022
Area Manager