GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 17, 2023

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

RE: License #:	AS700297560
Investigation #:	2023A0356016
	Beacon Home at Trolley Center

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 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 #:	2023A0356016
Complaint Receipt Date:	01/23/2023
Investigation Initiation Date:	01/23/2023
Report Due Date:	03/24/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St. Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Suzy Hunter
Licensee Designee:	Roxanne Goldammer
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:	08/25/2021
Expiration Date:	08/24/2023
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A sustained an injury at the facility while being supervised by staff, Deallen Walker.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/23/2023	Special Investigation Intake 2023A0356016
01/23/2023	Special Investigation Initiated - Telephone Emily Fewless, APS Ottawa County
01/23/2023	APS Referral From Emily Fewless, APS Ottawa County.
01/24/2023	Inspection Completed On-site
01/24/2023	Contact - Face to Face Emily Fairris, Felisha Battice, Resident A, Emily Fewless, APS worker.
01/24/2023	Contact - Document Received Facility documents, police report.
02/07/2023	Contact - Face to Face Deallen Walker, DCW, Lyric Foxx, DCW
02/07/2023	Contact - Telephone call made Emily Fairris and Felisha Battice.
02/17/2023	Exit Conference-Roxanne Goldammer, Licensee Designee.

ALLEGATION: Resident A sustained an injury at the facility while being supervised by staff, Deallen Walker.

INVESTIGATION: On 01/23/2023, I received a Centralized Intake Complaint through Adult Protective Services. The complainant reported that on 01/14/2023, Resident A sustained a black eye at the facility. There were two staff at the facility on duty at the home but one of the staff was out of the facility with another resident leaving Resident A at the facility with one staff member and two other residents. The complainant reported staff at the facility reported that Resident A has a behavioral

episode and that these episodes tend to occur when he wants something that does not belong to him. The complainant reported Resident A requires redirection and at times will hit himself or begin to throw things. The complainant reported Resident A took something belonging to staff Deallen Walker, the item was taken from Resident A, Resident A was sent to his room and Mr. Walker reported hearing Resident A throwing things in his room. The complainant reported per company policy, residents are not supposed to be sent to their rooms however, that is where Resident A usually went when upset. The complainant reported upon Mr. Walker checking on Resident A, discovered Resident A had a scratch near his eye and later this resulted in Resident A having a black eye. The complainant reported Resident A is not physically violent with staff or residents but when there has been an encounter, it is easy to diffuse the situation to minimize contact. Resident A can be physically violent with himself, however, he is not known to punch himself in the face but he will hit himself in the head or other body parts. The complainant reported it is not clear if Resident A had an altercation with another resident or staff to result in the injuries he sustained. Ottawa County APS (adult protective services) worker, Emily Fewless is assigned to investigate.

On 01/24/2023, I conducted an unannounced inspection at the facility with Ms. Fewless. Ms. Fewless and I interviewed Emily Fairris, corporate compliance officer for Beacon Specialized Living and Felisha Battice, home manager. Ms. Battice and Ms. Fairris stated Resident A moved into this facility on 09/15/2021 and has never self-harmed like this or given himself a black eye or engaged in self harm to this extent. Ms. Battice stated Resident A hits himself with an open hand, he hits himself in the head and/or bites his hand when he is frustrated or fixated on something. Ms. Battitse stated Resident A does not require 1:1 (one-on one) supervision. He throws items but does not throw things at staff or attempt to injure staff. Ms. Battice and Ms. Fairris stated staff do not tell the residents, “Go to your room,” but they re-direct them to their rooms. Once in his room, Ms. Battice stated Resident A may throw his totes first, hit windows next then push or rock his dresser back and forth and then throw the dresser to the ground. Ms. Battice and Ms. Fairris stated Mr. Walker was working with staff Lyric Foxx on 01/14/2023 and Ms. Foxx was on an outing with another resident who does require 1:1 supervision leaving Mr. Walker in the facility with three residents, one being Resident A and none of these residents require 1:1 supervision. Mr. Walker told Ms. Battice that Resident A took some of his (Mr. Walker’s) personal belongings, Tide pods. Ms. Battice and Ms. Fairris stated that is unusual for Resident A as he typically does not take other people’s things and they do not have Tide pods in the facility and all chemicals and cleaning agents are locked. Ms. Battice stated Mr. Walker did not report to her or document in staff notes that Resident A threw things around in his room or overturned his dresser. Ms. Battice stated Resident A sustained a black eye with scratches under his eye from the incident and staff Nakingi Allen took Resident A to Spectrum Urgent Care on Alpine Ave. N.W. for evaluation and treatment. Ms. Battice stated Ms. Allen reported urgent care staff said Resident A’s injury did not look like he injured himself but possibly hit his face on something. Ms. Battice stated Urgent Care staff took pictures

of Resident A's injuries and she (Ms. Battice) called and filed an APS referral and a report to the police.

On 01/24/2023, Ms. Fewless and I inspected Resident A's room. Resident A's room has a bed, a wooden dresser, and totes with toys in them. Ms. Fewless and I inspected the edges of the dresser and noted a rough edge to one of the dressers.

On 01/24/2023, Ms. Fewless and I attempted to interview Resident A at the facility. Resident A is unable to participate in an interview due to cognitive deficits.

On 01/24/2023, Ms. Fewless and I observed Resident A with a significant black and blue right eye and that same eye had a series of small cuts, scrapes under the eye.

On 01/24/2023, Ms. Battice stated she asked Resident B, the only verbal resident in the facility if she knew what happened to Resident A and Resident B told Ms. Battice she did not know what happened to his eye. Resident B was not present in the facility on this date for an interview.

On 01/24/2023, I reviewed the IR (Incident Report) dated 01/14/2023 signed by Mr. Walker and Ms. Goldammer, Licensee Designee. The IR documented the events occurred on 01/14/2023 at 4:02p.m., *'(Resident A) became upset because he wanted a staffs purse and started hitting himself and biting himself and had put a scratch under his eye. Staff reminded (Resident A) that he has his own bag and that he was ok. Staff talked with (Resident A) and was able to get him to use his coping skills such as taking a deep breath. All staff will continue to work with (Resident A) on having appropriate interactions and utilizing his coping skills when he does become upset. Home Manager will complete training with staff on keeping their personal belongings out if the common areas to prevent future incidents from occurring.'*

On 01/24/2023, I reviewed the IR dated 01/15/2023, written by Lyric Foxx. The IR documented the following information, *'(Resident A) woke up this morning with a black eye and could not open his eye all the way. It was reported yesterday that (Resident A) was hitting himself and scratched under his eye. Staff observed (Resident A's) left eye being black and blue and he had a small cut under his eye. Staff called Recipient Rights and attempted to leave a voicemail, but the box was full. Staff called Adult Protective Services to report, called the Police, and filed a report and took (Resident A) to Urgent Care to be checked out. Police Officer Dan Lewkowski (Deputy) Ottawa County Sheriff's office came to the home and spoke with staff and (Resident A).'*

On 01/24/2023, I received and reviewed the aftercare visit summary from Spectrum Health Urgent Care visit on 01/15/2023, Urgent Care Provider, Holly Mullin FNP (nurse practitioner). The summary documents Resident A's diagnosis as, Ecchymosis of right eye, initial encounter and abrasion of face, initial encounter. The

summary documented ‘follow up with APS as intended’ as one of the discharge plans.

On 01/24/2023, I received and reviewed the Ottawa County Sheriff’s Office Case Report. The report was taken on 01/15/2023 and investigated by Officer Lewkowski. Officer Lewkowski documented that he interviewed Ms. Foxx, Mr. Walker, Ms. Allen and attempted to interview Resident A. Officer Lewkowski reported, ‘*Foxx returned to the home and was informed by Deallen Walker, that* (Resident A) *took something of his, and when Walker took it back (*Resident A*) went into his room and had a behavior episode. Foxx stated she has witnessed (*Resident A’s*) episodes and he throws items and slaps himself when upset. Foxx advised Walker that (*Resident A*) hurt himself in his room and was not sure how it happened. Walker stated it did not appear that (*Resident A*) scratched himself, and it appeared he hit it on something.*’

Officer Lewkowski documented his attempt to interview Resident A and reported that he was not able to interview Resident A. Officer Lewkowski documented, *‘(Resident A) had a laceration below his right eye with that eye being black and blue.’*

Officer Lewkowski documented an interview with Na’Kingi Allen, *‘Allen arrived back at the home with (Resident A) as I spoke with Foxx. Allen stated she took (Resident A) to Alpine Spectrum Health Urgent Care. Allen stated the doctor, Holly Mollen, stated the injury did not appear to be caused from (Resident A) hitting himself, (Resident A) was cleared to return.’*

Officer Lewkowski documented an interview with Deallen Walker*, ‘I spoke with Walker on the phone. Walker stated he was doing laundry at the home when the container of laundry pods came up missing. Walker found (Resident A) to have them, he took the container back and asked (Resident A) to go to his room. (Resident A) had a behavioral episode in his room and threw down the dresser. Walker heard the commotion and when he went to check on (Resident A) he had blood under his eye and on his hand. Walker stated it appeared that (Resident A) hit his cheek on something in his room, like the corner of the bed or dresser. Walker stated he did not think (Resident A) scratched himself, and he reported the incident to Battice.’*

Officer Lewkowski documented additional information, *‘Walker’s statement of the incident was consistent of what he told Foxx. The injury to (Resident A) was consistent with striking the corner of furniture. There have been two other reports to Ottawa County Sheriff’s Office where (Resident A) has had out of control behavior, including assaulting other subjects. (Resident A’s) public guardian has been advised of the incident. I took a photograph of the injury and (Resident A’s) room. The status of the case is closed.’*

On 01/24/2023, I received and reviewed Resident A’s assessment plan for AFC residents dated 08/11/2022. A review of the assessment plan showed Resident A does not control aggressive behavior and documents, *‘(Resident A) does have*

history of aggression towards others, staff will verbally redirect and work with (Resident A) on developing some coping skills to use when he becomes upset.' The assessment plan documents Resident A exhibits self-injurious behavior and explains, '(Resident A) will engage in biting himself and hitting himself when he becomes upset. Staff will work with (Resident A) daily on developing his coping skills when he becomes upset and redirect as needed.'

On 01/24/2023, I received and reviewed Resident A's behavior support plan (BSP) dated 05/16/2022, written by Clara Lee, M. Ed., BCBA documents Resident A's behaviors as physical aggression, property destruction, self-injurious behavior, and stealing/theft. The BSP details several techniques such as listening to music with headphones (preferred activity), watching a movie (preferred activity), removing himself to a quiet spot-bedroom or sensory corner, utilizing white board or emotion cards, watching tv and deep breath exercises to work through episodes of behaviors.

On 02/07/2023, Ms. Fewless and I interviewed Mr. Walker via Face Time. Mr. Walker stated he brought his own laundry and container of Tide pods into the facility to wash during his shift. Mr. Walker stated the pods were in his basket of clothes. Mr. Walker stated he noticed some of the pods in the sink, so he called Ms. Foxx, who was working the same shift, but she was out of the facility at the time. Mr. Walker stated Ms. Foxx told him she did not touch his Tide pods but that she had seen them in his basket before she left the facility. Mr. Walker stated Resident B, C and D were all in their rooms resting and he saw that Resident A had his Tide pods tucked next to him while he was sitting in the dining room. Mr. Walker stated he prompted Resident A to go to his room, he (Mr. Walker) took the Tide pods away from Resident A and Resident A went into his room. Mr. Walker stated Resident A will do what you ask, he was cooperative and went to his room after prompting. Mr. Walker stated Ms. Battice taught staff to close the residents' door when they go into their rooms, so he closed Resident A's door once Resident A went into his room. Mr. Walker stated he heard a lot of banging, and "that's what (Resident A) does when he gets frustrated, he knocks things over. He knocked his dresser over, took the tote of toys and threw them all over and threw a bucket of urine he had in his room and threw that all over too." Mr. Walker stated he went to the room to check on Resident A and noticed he had scratches under his eye, and injury to the left corner of his right eye. Mr. Walker called Ms. Foxx as she was not back at the facility yet and talked to her about first aid for Resident A's eye injury. Mr. Walker stated it is not unusual for Resident A to hit himself in the face or dig at his face, he had a phone in his hand, and it appeared as though he hit his face on something sharp and pointed to cut his face as it was under his eye. Mr. Walker stated Resident A had blood on his hands and face. Mr. Walker stated Resident A's dresser was down, toys were all over, his phone was in his hand and, "I think he hit himself in the face." Mr. Walker stated he would never physically assault a resident. Mr. Walker stated he would never risk the safety of the residents or risk losing his job.

On 02/07/2023, I interviewed Lyric Foxx (former staff) via telephone. Ms. Foxx stated Mr. Walker called her and told her Resident A had taken his Tide pods, so he redirected him to his room after taking the Tide pods. Ms. Foxx stated Mr. Walker reported upon checking on Resident A, his eye had a scratch, and it was bleeding. Ms. Foxx stated she instructed Mr. Walker to clean the scratch and use the 1st aid kit. Ms. Foxx reported that Resident A takes things that are not his and once Mr. Walker redirected Resident A to his room, Mr. Walker informed Ms. Foxx that Resident A threw things around and knocked stuff down in his room. Ms. Foxx stated she was not at the facility when the incident occurred, and she does not remember what Resident A's room looked like when she got back. Ms. Foxx stated she has seen Resident A hit himself in the head, but she has never seen him hit himself in the eye. She added that he uses the palm of his hand, not fists and he bites himself. Ms. Foxx stated they close Resident A's door once he goes in his room because he likes to throw things out of his door at staff and other residents. Ms. Foxx stated Resident A flips his bookcase, takes his totes full of toys, buckets of urine that he has in the corner of his room (which he uses instead of going in the corner, in his totes filled with toys, or when he will not get up in the night to use the bathroom) and throws it aiming at other residents and staff, so they always close Resident A's door.

On 02/17/2023, I conducted an exit conference with Licensee Designee, Roxanne Goldammer. Ms. Goldammer stated she understands the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

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 01/14/2023, Resident A took Mr. Walkers Tide pods and after Mr. Walker retrieved the Tide pods from Resident A and redirected him into his room, Resident A began throwing items and knocking large pieces of furniture to the ground. As a result, Resident A sustained cuts to his face and a black eye. Based on the investigative findings, there is a preponderance of evidence to show that Resident A's protection and safety were not attended to on 01/14/2023 and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 02/07/2023, Ms. Fewless and I interviewed Mr. Walker via Face Time. Mr. Walker stated on 01/14/2023, he worked with Lyric Foxx at the facility, but that Ms. Foxx was not present during most of the shift. Mr. Walker stated he was alone from 2:00p.m. until he called Ms. Foxx at 6:30-7:00p.m. to talk to her about Resident A's injury. Mr. Walker stated Ms. Foxx was not at the facility and she was assigned as Resident B's 1:1 staff person yet Resident B, C & D were in the facility under his supervision when Resident A had a behavioral episode resulting in injury.

On 02/07/2023, I interviewed Lyric Foxx (former staff) via telephone. Ms. Foxx stated on 01/14/2023, she was assigned as Resident B's 1:1 staff, and she was working first shift (7:00a.m.-7: 00p.m) with Mr. Walker. Ms. Foxx stated she left the home and did not take Resident B with her. Ms. Foxx stated Resident B was sleeping and she did not want to wake her. In addition, Mr. Walker told her it was fine if she left the facility. Ms. Foxx acknowledged this was the day Resident A had an incident and an injury. Ms. Foxx acknowledged that she was not on a 1:1 outing with Resident B and that Mr. Walker called her for verbal assistance with first aid to Resident A as he had blood on his face and hands, and that she was not at the facility but at another unknown location without Resident B. Ms. Foxx stated she no longer works at the facility.

On 02/07/2023, I reviewed an IR dated 01/20/2023, written by Ms. Battice. The IR documented, *'While doing an interview with Kalamazoo Recipient Rights it was reported by the rights office that staff Lyric Foxx sent staff Deallen Walker a text message stating she was doing laundry at her mom's house. Lyric was scheduled to work at Trolley as (Resident B's) 1:1 staff and left the home leaving the home out of ratio. Staff Lyric that was accused of leaving her shift on 01/07/2023 was suspended pending the investigation.'*

On 02/15/2023, I received and reviewed Resident B's assessment plan for AFC residents. The assessment plan is dated 07/26/2022 and documents Resident A requires 1:1 staffing.

On 02/15/2023, I received and reviewed Resident B's behavior support plan (BSP) dated 02/09/2023. The BSP documents *'(Resident A) is unpredictable and impulsive and due to her target behaviors requires staff to be close by and available during all waking hours. (Resident A) also enjoys spending time in her room alone so the staff will check on her while she is in her room at least every 15 minutes. Staff do not need to be in her room with her but do need to check on her consistently while she is in her room.'*

On 02/15/2023, I received and reviewed Resident B's resident care agreement (RCA) dated 01/03/2023. The RCA documents Resident A shall be provided care and services as stated in this RCA and the resident assessment plan.

On 02/17/2023, I conducted an exit conference with Licensee Designee, Roxanne Goldammer. Ms. Goldammer stated she understands the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

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:	Mr. Walker and Ms. Foxx stated on 01/14/2023, Mr. Walker was supervising Resident A, B, C and D alone while Ms. Foxx was out of the facility. Resident B required 1:1 supervision and Ms. Foxx was assigned to Resident B which left the supervision of the residents at the facility out of ratio. During the time Ms. Foxx was out of the facility, an incident occurred and Resident A sustained injury during that incident. Based on my investigative findings, the facility did not have sufficient staff for the supervision, personal care and protection of residents and the services specified in Resident B's RCA, assessment plan and BSP were not met and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Elizabeth Elliott

02/17/2023

Elizabeth Elliott, Licensing Consultant Date

Approved By:

Jerry Hendrick

02/17/2023

Jerry Hendrick, Area Manager Date