GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 25, 2023

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

RE: License #: AM280299145
Investigation #: 2023A0230025
Beacon Home at Silverview

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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM280299145
Investigation #:	2023A0230025
Complaint Receipt Date:	03/03/2023
Investigation Initiation Date:	03/03/2023
Report Due Date:	05/02/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110, 890 N. 10th St., Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home at Silverview
Facility Address:	4024 Wyatt Road, Traverse City, MI 49684
Facility Telephone #:	(231) 922-9791
Original Issuance Date:	04/15/2010
License Status:	REGULAR
Effective Date:	10/16/2022
Expiration Date:	10/15/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A died unexpectedly at the facility.	No
Additional Findings	Yes

III. METHODOLOGY

03/03/2023	Special Investigation Intake 2023A0230025
03/03/2023	Special Investigation Initiated - On Site Interview with staff members Ashley Aho, Alicia Hallesy-Laford, Amber Starr, Roxanne Goldammer, GTSD Sergeant Wallace
03/08/2023	Contact - Telephone call made. Resident A's guardian/Mother
03/13/2023	Contact - Telephone call made. Brian Newcomb RRO
03/13/2023	Contact - Telephone call made. Dr Fellows-CMH
04/17/2023	Contact - Telephone call made. Staff member Marlo Derry
04/19/2023	Contact - Face to Face Alicia Hallesy-Laford and Amber Cowley
04/20/2023	Contact - Telephone call made. Administrator Roxanne Goldammer
04/21/2023	Contact- Telephone call made to Sergeant Wallace
04/21/2023	Inspection Completed On-site Med review with Alicia Hallesy-Laford and Marlo Derry
04/24/2023	Exit conference with Licensee Designee Roxanne Goldammer

ALLEGATION: Resident A died unexpectedly at the facility.

INVESTIGATION: On 03/3/2023, I arrived at the facility after being notified by Administrator Roxanne Goldammer that Resident A had passed away that morning

unexpectedly. I interviewed staff members Ashley Aho, Amber Cowley, and Home Manager Alicia Hallesy-Laford, and Administrator Roxanne Goldammer.

Ms. Goldammer stated she arrived at the home after the incident occurred. She contacted me immediately from the facility to inform me of what had happened.

Staff member Ms. Aho stated that she had given Resident A her medications at 8:45 a.m. on 03/03/2023. Resident A told Ms. Aho she had a nightmare and talked with Ms. Aho for a while. Resident A then thanked Ms. Aho for listening to her and Ms. Aho left Resident A's bedroom. Twenty minutes later Ms. Aho heard Resident A yelling from her bedroom. She went in to check on her and she talked more about nightmare and asked for help to go to the bathroom. After Ms. Aho helped Resident A stand up to go to the bathroom, she immediately went limp, and Ms. Aho called out for her coworker Dana Starr who immediately came into the bedroom. As Ms. Aho lowered Resident A to the floor both staff observed that Resident A's face and neck were turning blue. Ms. Aho began to perform CPR while Ms. Starr left the room to call 911 however the house phone was not working. Ms. Aho used her own phone which was in her back pocket to call 911. Ms. Aho stated she listened to the instructions from 911 and continued to perform CPR. A few minutes later the paramedics reportedly arrived and took over and Ms. Aho and Ms. Starr were asked to leave. Shortly thereafter the paramedics came out of the room and reported Resident A was deceased.

My interview with staff member Dana Starr revealed information that is consistent with what was reported by Ms. Aho. Ms. Starr stated she was called into Resident A's room by Ms. Aho and observed Resident A as she was falling. Ms. Aho began CPR and Ms. Starr attempted to call 911 on the house phone and could not get through. She took out her own phone and as she was running back into the room, she used her own phone, but Ms. Aho had already gotten through on her personal phone. Ms. Aho listened to 911 instructions While Ms. Starr had her hand on Resident A's leg and was holding her hand. The paramedics arrived and took over CPR. She and Ms. Aho left the room and a few minutes later the paramedics came out and pronounced Resident A's death.

Ms. Cowley stated she been downstairs in the facility in a meeting when a staff member stated there was an emergency and to come upstairs. When Ms. Cowley arrived upstairs, she observed paramedics and staff keeping residents clear of the west hallway. At this time, she was told by a staff member that Resident A had stopped breathing and paramedics were called. Ms. Cowley then went and contacted Resident A's guardian and let her know the paramedics were performing CPR. She also contacted the Beacon medical staff and Beacon Program Director. A short time later Sergeant Wallace came out and told the staff that Resident A had passed away. The police stated they would notify Resident A's guardian who was waiting for her at the hospital. Ms. Cowley stated the coroner came approximately an hour later and picked up Resident A.

Ms. Hallesy-Laford who is the facility manager stated she had been called to the facility by staff member Amber Cowley telling her that paramedics were on their way to attend to Resident A.

On 03/03/2023 while at the facility I interviewed Sergeant Jeff Wallace from the Grand Traverse County Sheriff's Department. He stated that he had requested an autopsy of Resident A's death as she was 39 years old. He added it was his opinion that there had been no foul play or harm caused to Resident A by the facility staff, but rather it is a matter of standard procedure to request an autopsy on a person of this age.

On 03/08/2023, I spoke with Resident A's mother who is also her guardian. She stated she did not know what happened to her daughter. She had been aware of a significant decline in her daughter's health since January. Resident A's mother stated she had been residing in Florida but had regular communication with facility staff and Community Mental Health regarding numerous psychological and physical health challenges her daughter had been experiencing. Including a weeklong hospital stay in February just prior to her death. She stated the staff sought medical and psychiatric help for her daughter.

On 03/13/2023, I spoke with Dr. Fellows who had been Resident A's psychiatrist through Community Mental Health. He noted a decline Resident A's health in the past two months. He stated he had been in regular contact with the facility staff and Resident A. He stated it was his opinion that the AFC staff sought medical and psychological help for Resident A whenever they observed a change.

On 04/17/2023, I conducted an on-site inspection and reviewed Resident A's file, physician contact logs and miscellaneous notes from 1/01/2023 through 03/03/2023.

Resident A had a diagnosis of ADHD, Bipolar Disorder, Cephalgia, Constipation, Developmental Delay, Gastroesophageal reflux disease, major depressive Disorder, schizoaffective disorder, seizure disorder, self-mutilation, sinus tachycardia, status epilepticus, tardive dyskinesia. Resident A's file also included numerous notes which are chronologically summarized below:

- On 01/04/2023, Dr. Fellows conducts medication review for Resident A and recommends discontinue medication Latuda and begin medication Vraylar.
- 01/09/2023 staff offered assistance with grooming, but Resident A refused and later had a verbal altercation with a peer.
- 01/12/2023 Resident A repeated a conversation three times with staff regarding hearing voices.
- 01/18/2023 Resident A woke up crying having a nightmare at 3:00 a.m. and tells staff she is hearing voices. At 3:30 a.m. Resident A begins singing.
- On 01/22/2023 Resident A threw up and told staff it may have been from eating too much dinner.

- On 01/23/2023 Resident A told staff at 5:00 a.m. she had diarrhea three times. Staff took her temperature and it was 98.8. Staff spent time talking with Resident A and she stated she felt better. (I confirmed with staff member Alicia Hallesy-Laford that a stomach virus had been going through the facility at this time and all residents had been ill.)
- On 01/26/2023, Resident A's medications were passed but the computer did not show.
- On 01/29/2023, at 10:30 p.m. Resident A became agitated with another resident but calmed down.
- On 01/31/2023, Resident A is yelling all day. Says she's hearing a lot of voices. At 4:00 p.m. she stated she had demons in her room and was talking to people who weren't there. Staff was unable to console her.
- On 02/01/2023 staff attempt to reach Resident A's psychiatrist Dr. Fellows but are able to only leave a message. Next, they contact Will Voleski who is a clinician for Beacon to seek advice on what to do for Resident A. He spoke with Resident A and observed unusual behavior and noted that she was wobbly and unsteady, she would stare off and mumble unintelligibly. He expressed concern for regressed behavior such as yelling and screaming at people. He wondered if the behavior was due to a change in medications but also possible Urinary tract infection (UTI).
- On 02/01/2023, Facility staff take Resident A to her primary Care physician where she was tested for a UTI and put on antibiotics. Hallucinations were also discussed at this visit with Dr. Dorman, Resident A's physician.
- On 02/02/2023, Dr. Fellow's nurse returns call to facility and stated they were increasing dosage of medication Vraylar from 3 milligrams to 6 milligrams to help with the auditory hallucinations.
- On 02/08/2023, The facility staff contact Dr. Dorman regarding UTI and a Resident A has a strained voice from yelling. Dr. Dorman recommends still continue with Bactrim antibiotic.
- On 02/08/2023, Facility staff contract Dr. Fellows to inform him that Resident A still has unstable mental state and she did not "seem like herself" Left message with nurse.
- On 02/13/2023, Resident A attended epilepsy appointment with Dr. Austin, who refilled medications and encouraged Resident A to stay active and follow up in six months.
- On 02/14/2023, Resident A refused gifts and communication with family. Her medication is reviewed by Dr. Fellows and he advised to discontinue Vraylar medication.
- On 02/16/2023, Facility staff attempt to help Resident A clean her room but she refused help. She is continuing with hallucinations, soiling herself but refusing to clean herself or receive help, she is barely verbal and not following commands. Resident A's mental state continuing to worsen. Facility staff talk with Resident A's mother about her current mental state and it is agreed that that Resident A be transported the Munson Medical Center for a psychiatric evaluation. Once there she is admitted to the inpatient psychiatric unit.

- On 02/24/2023, Resident A is discharged from Munson psychiatric unit. She is considered stable and it is recommended she continue with her medications with three adjustments that hospital physicians had made, and follow up with her psychiatrist Dr, Fellows. On 03/02/2023. When she arrives back at the facility, she tells staff that the “hospital didn’t help her and she still feels sad.”
- On 02/25/2023, at 5:12 p.m. Resident A refused to eat and seemed confused and tired. She refused to take her 2:00 p.m. medications. Facility staff called the Beacon nurse and she instructed to chart as refused and dispose of medication.
- On 02/26/2023, Resident A refused to shower 3 times.
- On 02/27/2023, Resident A refused to shower 3 times.
- On 03/01/2023, Resident A’s vital signs were taken and all were normal.
- On 03/02/2023, Resident A has follow up from hospital discharge with Dr. Fellows. He changes her dose of medication Zyprexa from 10 to 15 milligrams twice daily.

On 04/18/2023, I spoke with Community Mental Health Recipient Rights Officer Brian Newcomb. He stated he is still investigating the case but had not received word back regarding the autopsy for Resident A. He had not found any negligence on the part of Silverview in the cause of Resident A’s death.

On 04/21/2023, I spoke with Sergeant Wallace regarding an update on Resident A’s autopsy. He stated he had not received any conclusion back at this time and it could be another 4-6 weeks. He indicated he would inform LARA of the conclusion when it is released.

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:	Facility staff were in constant contact with medical staff, physicians, nurses, and psychiatrists for Resident A. They sought hospitalization when she declined in her mental status. All medical advice including physician orders were followed and medications were given as prescribed. When staff member Ashley Aho attended to Resident A to assist her to the bathroom, Resident A went limp, she immediately began administering CPR and called 911.

	Resident A was treated with dignity and her personal needs, including protection and safety were attended to at all times.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION: While at the facility only a partial health care appraisal was located for Resident A. This was dated 09/20/2022. The BCAL 3947 was used however only Resident A's name and height and weight were documented on the form. In the lines of diagnosis, medications, and allergies it read "see attached". It was signed by the physician, but no attachment could be located at the facility. In addition, the facility name, license number and licensee name were all blank.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	The annual written health care appraisal for Resident A was incomplete; missing diagnosis, medication list and allergies. Licensee name, facility name and license number all appeared blank.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 04/21/2023, I conducted an on-site inspection at the facility and reviewed all medication records for Resident A from 01/01/2023 through 03/03/2023. I reviewed these with home manager Alicia Hallesy-Laford and Beacon

Compliance Officer Marlo Derry. I found 18 medication doses that were not documented in the month of January. Three separate staff who did not document these medications were interviewed and stated they did indeed pass the medications, however there was often a problem with the computer system, so they were not always sure if the medications got logged.

On 04/24/2023, I spoke with home manager Alicia Hallesy-Laford who confirmed that there had been some difficulties with logging medications on the computer and sometimes the internet was not working. She stated staff had been instructed to use a paper log if the computer did not work. I confirmed that medications were logged on the paper but not on the computer numerous times however, there were still 18 undocumented medication doses.

On 04/24/2023, I conducted an exit conference with Licensee Designee Roxanne Goldammer and reviewed the findings of the investigation. Ms. Goldammer recognized that there were flaws in the medication logging system stated she has been working with the Beacon nursing team to educate and train staff on correcting this issue. She will provide a plan of correction.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	In January 2023 18 doses of Resident A's medications were not documented.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

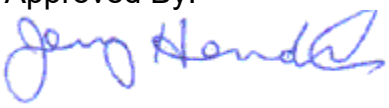
At this current time there have been no autopsy results for Resident A. Sergeant Wallace will inform LARA when results come in. At that time if there is something indicating the facility may have been negligent on the death of Resident A complaint

will be reopened. Upon receipt of an acceptable plan of correction I recommend the status of this license remain unchanged.

04/25/2023

Rhonda Richards Date
Licensing Consultant

Approved By:



04/25/2023

Jerry Hendrick Date
Area Manager