GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 21, 2023

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

RE: License #: AS370405093
Investigation #: 2023A1029025
Beacon Home At Mt Pleasant

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

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.

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,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370405093
Investigation #:	2023A1029025
Complaint Receipt Date:	02/22/2023
Investigation Initiation Date:	02/22/2023
Report Due Date:	04/23/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St., Suite 110, Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home At Mt Pleasant
Facility Address:	4659 S Leaton Rd, Mt Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/16/2020
License Status:	REGULAR
Effective Date:	05/16/2021
Expiration Date:	05/15/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was left without 1:1 staffing coverage on February 8, 2023 and February 10, 2023 because the direct care staff members assigned to provide supervision to him left their shifts early.	Yes

III. METHODOLOGY

02/22/2023	Special Investigation Intake 2023A1029025
02/22/2023	Special Investigation Initiated – Letter to Roxanne Goldammer
02/23/2023	Contact - Telephone call made Marlo Derry, Katie Hohner, ORR, email from Roxanne Goldammer
03/06/2023	Contact - Telephone call made to Dana Sprague
03/07/2023	Inspection completed on-site - Face to Face with direct care staff members Timothy Winkleman, Grace Lindauer, Veronica Nemetz, Joann Nappie, Jennifer Vincent, Resident A, B, and C
03/14/2023	Contact - Telephone call made licensee designee, Roxanne Goldammer
03/21/2023	APS Referral was not made due to no concerns of abuse or neglect.
04/04/2023	Contact - Document Sent Roxanne Goldammer and Marlo Derry with questions.
04/11/2023	Contact - Telephone call made to Kendra Pannill, Quantrelle Brown, and Arkeshia Foster
04/13/2023	Inspection completed – Face to face with Dana Sprague at Beacon Home at Mt. Pleasant, Resident A, and Veronica Nemetz
04/14/2023	Exit conference with licensee designee Roxanne Goldammer

ALLEGATION:

Resident A was left without 1:1 staffing coverage on February 8, 2023 and February 10, 2023 because the direct care staff members assigned to provide supervision to him left their shifts early.

INVESTIGATION:

February 8, 2023

On February 22, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system after licensee designee Roxanne Goldammer reported to the Office of Recipient Rights a concern on behalf of Resident A. According to the complaint, Ms. Goldammer stated she was informed that on February 8, 2023 direct care staff member, Ms. Foster was scheduled to provide 1:1 supervision to Resident A but she left at 9:30 p.m. instead of 11:00 p.m. without finding a replacement staff so Resident A was without 1:1 supervision.

On February 23, 2023, I spoke with Community Mental Health Office of Recipient Rights (ORR) advisor, Katie Hohner. Ms. Hohner stated Ms. Foster left the shift on the February 8, 2023, 1.5 hours early as well and she was also Resident A's 1:1 staffing because she had car problems and the other staff member who left was her ride.

I reviewed the staffing schedule for February 8, 2023 and determined there was adequate coverage to provide supervision to Resident A during the timeframe of 9:30-11 p.m. This was due to the requirement for Resident B's 1:1 supervision ending before 9:30 p.m. which freed up this direct care staff member to provide Resident A 1:1 supervision from 9:30 p.m.- 11 p.m. According to the staffing schedule I reviewed for February 8, 2023 there were still two direct care staff members scheduled during the 9:30-11:00 p.m. timeframe when Ms. Foster left at 9:30 p.m. I determined this was adequate staffing to meet the supervision needs of the four residents.

On March 6, 2023, I interviewed direct care staff member whose current role is home manager, Dana Sprague. Mr. Sprague stated on February 8, 2023 Ms. Foster did leave her shift without providing 1:1 supervision for Resident A however at that time he would still have a 1:1 supervision as required until 11:00 p.m. Since the other residents do not require 1:1 supervision after 9:30, the other direct care staff members working provided supervision to Resident A.

On April 11, 2023, I interviewed direct care staff member whose current role is assistant manager, Ms. Pannill. Ms. Pannill stated she found out Ms. Foster left early at 9:30 on February 8, 2023 because the other direct care staff member who was working was her ride. Ms. Foster was also Resident A's 1:1 during that time.

On April 11, 2023, I interviewed direct care staff member, Arkeshia Foster. Ms. Foster stated she did work on February 8, 2023 and she did leave early that day. Ms. Foster

stated she was scheduled to work until 11:00 p.m. but she left when midnight shift came in at 9:30 p.m. because she was having transportation concerns and the direct care staff member leaving was her ride home. Ms. Foster stated she did not notify anyone until she made it home that she left early. Ms. Foster stated there were no residents who required 1:1 supervision except for Resident A after 11:00 pm while Resident B's 1:1 supervision requirements ended at 9:00 p.m. so the other direct care staff members working provided Resident A with 1:1 supervision until 11p.m.

February 10, 2023

On February 22, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system there was another concern that direct care staff member Mr. Brown was scheduled to work on February 10, 2023 from 7 a.m. to 3 p.m. but the 3 p.m. to 11 p.m. person called in and Ms. Pannill "mandated" Mr. Brown to work until 7 p.m. when a replacement staff was available. According to the complaint, Mr. Brown was assigned to provide 1:1 supervision to Resident A but he left work four hours early.

On February 23, 2023, I spoke with Community Mental Health Office of Recipient Rights (ORR) advisor, Katie Hohner. Ms. Hohner stated all residents except for Resident D require 1:1 direct care staff member supervision for at least part of the day. Mr. Brown left at 3:00 p.m. on February 10, 2023 and there were three additional staff there however no one was providing 1:1 to Resident A. Ms. Hohner stated Mr. Brown did sign off on a document stating he understood that he could be mandated to stay at work if required.

Ms. Hohner also sent me copies of text messages from February 10, 2023 to review between Ms. Pannill and Mr. Brown. Ms. Pannill sent the original message to mandate Mr. Brown at 1:36 p.m. and he responded stating he could not stay until 7:00 p.m. Mr. Brown sent messages stating he could not work past 3:00 p.m. and sent a picture of the event he was hosting on campus and Ms. Pannill responded "OK" to that message.

On February 23, 2023 I receive an email from licensee designee Roxanne Goldammer. Ms. Goldammer broke down the scheduling system for Beacon Home at Mt. Pleasant. According to the documentation and schedules I reviewed, the following residents require these supervision needs:

- Resident A has 16 hours of 1:1 supervision.
- Resident B has 12 hours of 1:1 supervision.
- Resident C has 24 hours of 1:1 supervision. This is on the schedule as non-DMA.
- Resident D does not have any 1:1 staffing so the DMA is in charge of medications and monitoring Resident D.

According to the staffing schedule I reviewed for February 10, 2023 there were three direct care staff members working during the 3:00-7:00 p.m. timeframe when Mr. Brown

left leaving Resident A without 1:1 supervision or a direct care staff member unavailable to provide Resident D with assistance or complete other tasks.

On March 6, 2023, I interviewed direct care staff member whose current role is home manager, Dana Sprague. Mr. Sprague stated he does not know how one direct care staff member was able to provide 1:1 supervision of Resident A after Mr. Brown left the building at 3:00 p.m. Mr. Sprague stated Resident A is supposed to have 1:1 supervision provided to him which would have been Mr. Brown but when he left at 3:00 p.m. Resident A was without supervision other than the three direct care staff members who were working at the time. Two of those direct care staff members were assigned to provide 1:1 supervision to Residents B and C. Mr. Sprague stated the direct care staff member who is the "DMA" is "taxed on their day" and it would be hard to provide 1:1 supervision to Resident A and perform their other duties with meals and medications.

On March 7, 2023, I completed an unannounced on-site investigation at Beacon Home at Mt. Pleasant and reviewed all four resident records and confirmed that all residents require 1:1 staffing except for Resident D.

On March 7, 2023, I interviewed direct care staff member Grace Lindauer at Beacon Home at Mt. Pleasant. Ms. Lindauer stated she was there when Mr. Brown left his shift on February 10, 2023 and confirmed he was the 1:1 staff member for Resident A. Ms. Lindauer stated during the four hours the other direct care staff members provided 1:1 supervision for Resident A since he was primarily in the common area of the home. Ms. Lindauer stated she was a new direct care staff member at the time and she was not concerned with Mr. Brown leaving because he stated it was all confirmed with Ms. Pannill.

On March 14, 2023, I interviewed licensee designee, Roxanne Goldammer. Ms. Goldammer stated with the number of residents who require 1:1 supervision the direct care staff member assigned as the "DMA" will usually supervise Resident D who does not require 1:1 supervision. Ms. Goldammer stated if the direct care staff member is completing the DMA duties and monitoring Resident D, it is possible that direct care staff member could have also 'kept an eye on' Resident A however it is not what is required through the contract through Community Mental Health.

On April 11, 2023, I interviewed direct care staff member whose current role is assistant manager, Ms. Pannill. Ms. Pannill stated the earliest someone could relieve Mr. Brown from his mandated shift was 7:00 p.m. so she told Mr. Brown he needed to stay until 7:00 p.m. Ms. Pannill stated this led to Mr. Brown sending a picture of the event he needed to host and told her he could not stay. Ms. Pannill stated after that, she did not hear anything back from him other than a phone call from him but no voice mail and she called him back 30-45 minutes later and he did not answer, so she assumed that he was at the home working his shift as he was mandated. Ms. Pannill stated it was not until 9:00 p.m. that evening the direct care staff members working informed her that Mr. Brown left at 3:00 p.m. and Resident A was left without an assigned 1:1 direct care staff from 3:00-7:00 p.m. Ms. Pannill stated Mr. Brown received a write up and he was

suspended for three days for leaving his shift. Ms. Pannill stated no harm occurred to Resident A as a result of not having enough direct care staff members working.

On April 11, 2023, I interviewed direct care staff member Mr. Brown. Mr. Brown stated he left his shift early at 3:00 p.m. on February 10, 2023 because he could not stay. Mr. Brown stated he texted and called Ms. Pannill to tell her that he could not work the mandated shift and needed to leave work but he did not hear back from her. Mr. Brown stated one of the other direct care staff members said they would cover his 1:1 supervision of Resident A during the time. Mr. Brown stated he could not remember who covered Resident A's 1:1 supervision for him. Mr. Brown was not willing to elaborate on the concerns stating he already talked with Office of Recipient Rights regarding this issue.

On April 13, 2023 I interviewed direct care staff member Veronica Nemetz at Beacon Home at Mt. Pleasant. Ms. Nemetz stated she worked on February 10, 2023 when Mr. Brown left his shift after he was mandated to work. She was the direct care staff member assigned as to do the DMA tasks that day was also assigned to Resident D. Ms. Nemetz stated Mr. Brown left work at 3:00 p.m., so she was responsible for providing Resident A with 1:1 supervision along with monitoring Resident D and completing all other DMA related tasks. Ms. Nemetz stated none of the residents had any behaviors during that time, so she was able to complete all tasks and supervise both residents. Ms. Nemetz confirmed she supervised both Resident A and Resident D. Ms. Nemetz stated Resident D stayed in his room most of the time so she checked on him periodically and Resident A was in the living room while she cleaned the counters and swept.

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:	There were two occasions on February 8, 2023 and on February 10, 2023 when the direct care staff member assigned to provide 1:1 supervision to Resident A left their shift early leaving other direct care staff members to supervise Resident A. Based on the interviews with Mr. Sprague and Ms. Goldammer, there are currently four residents at Beacon Home at Mt. Pleasant and Resident A, Resident B, and Resident C all require some 1:1 supervision throughout the day for varying amounts of time. Mr. Sprague also stated Resident D does not require 1:1 supervision. I reviewed the staffing schedule for February 8, 2023 and there was adequate coverage to provide supervision to Resident A during the timeframe of 9:30-11 p.m. because the requirement for 1:1 supervision ending for Resident B during the evening hours after 9:30 p.m. allowed for adequate supervision of Resident A with two direct care staff members. However, on February 10, 2023, based on interviews with direct care staff members, licensee designee Ms. Goldammer, and reviewing the staffing schedule, there was not enough direct care staff members on February 10, 2023 to provide 1:1 supervision to Resident A from 3:00 -7:00 PM while also providing care to the remaining residents.
CONCLUSION:	**VIO/LATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

_____4/14/2023_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

04/21/2023

_____

Dawn N. Timm
Area Manager

Date