GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 10, 2023

Ramon Beltran
DuNord, Inc
Suite 110
890 North 10th Street
Kalamazoo, MI 49009

RE: License #: AM390259947
Investigation #: 2023A0581026
Beacon Home at River Run

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.
- 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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM390259947
Investigation #:	2023A0581026
Complaint Receipt Date:	03/21/2023
Investigation Initiation Date:	03/21/2023
Report Due Date:	05/20/2023
Licensee Name:	DuNord, Inc
Licensee Address:	555 Railroad Street Bangor, MI 49013
Licensee Telephone #:	(269) 344-7972
Administrator:	Aubry Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at River Run
Facility Address:	716 Leenhouts Kalamazoo, MI 49048
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	05/12/2006
License Status:	REGULAR
Effective Date:	01/20/2023
Expiration Date:	01/19/2025
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 03/17/2023, facility staff didn't provide Resident A with breakfast or lunch for her day program.	Yes
There's no food in the facility. Subsequently, Resident A hasn't eaten for days.	No
Additional Findings	Yes

III. METHODOLOGY

03/21/2023	Special Investigation Intake 2023A0581026
03/21/2023	Referral - Recipient Rights Macomb Co. CMH is investigating; therefore, no referral is necessary.
03/21/2023	Contact - Document Sent Email correspondence with Macomb Co. CMH
03/21/2023	Special Investigation Initiated - Letter Email correspondence with RRO
03/21/2023	Contact - Telephone call made Interview with MRC staff
03/22/2023	Contact - Telephone call received. Interview with MRC staff
03/23/2023	APS Referral APS received the allegations and investigated.
03/23/2023	Inspection Completed On-site Interviewed staff and residents
03/23/2023	Contact - Telephone call made Left voicemail with home manager, Brittany Miller.
03/23/2023	Contact - Document Sent Sent email to Ms. Miller and Administrator, Aubrey Napier.
03/27/2023	Contact – Face to face Interview with licensee designee, Ramon Beltran.

03/27/2023	Contact - Document Received Email from Ms. Napier.
04/06/2023	Inspection Completed On-site Interviewed Resident A.
05/10/2023	Exit conference with licensee designee, Ramon Beltran, via telephone.

ALLEGATION:

- **On 03/17/2023, facility staff didn't provide Resident A with breakfast or lunch for her day program.**

- **There's no food in the facility. Subsequently, Resident A hasn't eaten in days.**

INVESTIGATION:

On 03/21/2023, I received this complaint through the Bureau of Community Health System online complaint system. The complaint alleged that on 03/17/2023, Resident A did not have breakfast at her Adult Foster Care (AFC) facility prior to going to her scheduled day program/workshop because "there was no food in the house". The complaint alleged Resident A also did not have lunch sent with her that day, but eventually direct care staff and identified home manager, Brittany Smith, dropped off food for her around 2 pm. The complaint also alleged Resident A hadn't eaten in days.

On 03/21/2023, I interviewed Brittany Young, Supervisor at MRC Artworks, where Resident A attends a regular day program. Ms. Young stated Resident A has been attending the Artworks program since January 2023. She stated Resident A attends the program on Fridays from 9:30 am until 3:30 pm. She stated breakfast and lunch is not provided and residents are informed they need to bring a cold lunch when they attend. She stated snacks are not required but encouraged. Ms. Young stated that 03/17/2023 has been the only time Resident A hadn't brought a lunch with her.

On 03/22/2023, I interviewed Bridget Fox, Resident A's Artworks teacher. Ms. Fox stated she had been working the day Resident A came into the program without a lunch. She stated Resident A arrived at approximately 9:30 am on 03/17/2023. She stated at approximately 10:30 am all the students took their first break and had snacks, which is when Resident A reported she had no food, drinks, or snacks for the entire day. Ms. Fox stated she observed a clear bottle on Resident A's desk; however, she didn't ask Resident A where the drink came from. Ms. Fox stated

Resident A reported to her there was no food in the facility to eat and she hadn't eaten in days. Ms. Fox stated Artworks staff provided Resident A with snacks and water for her break.

Ms. Fox could not recall how Resident A normally brings her cold lunch into the program. Ms. Fox stated Resident A's personal bag was not checked by any staff to determine if she had a lunch bag in it, but she recalled Resident A putting her bag on her desk, checking it, and then reporting there wasn't anything in it. Ms. Fox stated the Artworks program staff provided snacks and water at lunchtime for Resident A. She stated direct care staff from the facility delivered Resident A "a lunchable" around 2 pm, as well. Ms. Fox stated she wasn't sure if any Artworks staff talked to whoever brought in the lunchable.

On 03/23/2023, I confirmed with Kalamazoo Adult Protective Services (APS) specialist, Gene Coulter, he had received the allegations and was investigating. He stated; however, he wasn't substantiating for abuse or neglect. He stated he had interviewed direct care staff, Arethia Dixon, who reported to him Resident A had woken up late on 03/17/2023, which is normal for her, and missed breakfast. He stated that it was reported to him her lunch hadn't been made, but food was brought to her at the Artworks program later in the afternoon. He stated he observed plenty of food in the facility and didn't have any concerns she wasn't able to access food or wasn't being offered food. He stated he would be closing his investigation.

On 03/23/2023, I conducted an unannounced inspection. I interviewed direct care staff, Arethia Dixon. Ms. Dixon's statement to me was consistent with her statement to APS specialist, Mr. Coulter. She stated Resident A is a "picky eater"; indicating Resident A will decline to eat breakfast if staff aren't making something she likes. Ms. Dixon stated Resident A also sleeps in on the day she attends Artworks and usually doesn't have time to eat breakfast. Ms. Dixon stated Resident A has asked staff if she can make her own lunches, which Ms. Dixon stated staff encourage her to do, as it assists her in being independent. Ms. Dixon stated if Resident A doesn't want to make her own lunch, then staff would be expected to make it for her. Despite also working on 03/16/2023, Ms. Dixon stated she could not recall if Resident A had prepared her own lunch for the following day or not. Ms. Dixon stated the facility's home manager, Brittany Smith, took Resident A lunch on 03/17/2023 when it was discovered Resident A hadn't taken one. Ms. Dixon denied the allegations of Resident A not eating for days. She stated residents, including Resident A, have plenty of options for food and food is always being prepared and served for breakfast, lunch and dinner.

I interviewed direct care staff, April Smith. She stated she came into work at 7 am on 03/17/2023. She stated direct care staff, Rebecca McAfee, was preparing breakfast that morning for residents which consisted of cereal. She stated Resident A woke up at approximately 8:20 am, took her morning medications and asked staff for cereal to go. Ms. Smith stated Resident A left the facility without eating or grabbing her cereal. Ms. Smith stated she was only aware of Resident A not taking a lunch with

her that day because she later heard the facility's home manager dropped one off to her later in the day. Ms. Smith stated she did not make Resident A's lunch that day and did not ensure she had a lunch to take. Ms. Smith stated both staff and Resident A can make Resident A's lunch when she attends the Artwork's program. She stated Resident A has a variety of food to take with her for lunch including, but not limited to, lunch meat, peanut butter and jelly, fruit, vegetables, and snacks including goldfish, Nutter Butter bars, and chips. Ms. Smith was able to show me all of these items in the facility.

Ms. Smith stated dinner is usually served to residents between 5 pm and 6 pm, whereas breakfast is served between 7 am and 8 am. She stated snacks are served whenever residents want them. Ms. Smith denied Resident A went for days without eating or not having food available to eat.

I interviewed direct care staff, Rebecca McAfee. Ms. McAfee stated she had also been working on 03/17/2023. Ms. McAfee stated Resident A had come into the kitchen that morning and wanted to prepare her own cereal, but Ms. McAfee told her she needed to do it because there needed to be enough cereal for all the residents. Ms. McAfee stated Resident A got upset, went to the fridge, grabbed a bag and then walked away. Ms. McAfee stated she believed the bag Resident A grabbed was Resident A's lunch bag. Ms. McAfee stated by the time she prepared cereal for Resident A and called for her to come get it, she determined Resident A had already walked out of the facility to get on the Artwork's bus. Ms. McAfee stated Resident A normally prepares her own lunch for the day she attends Artworks; which is what she assumed had occurred on 03/17/2023. Ms. McAfee's statement to me about the facility's mealtimes was consistent with Ms. Smith's statement to me.

During my inspection, I was unable to interview Resident A as she was sleeping.

I interviewed Resident B and Resident C. Both Resident B and Resident C had similar statements. They both stated breakfast is served around 7 am – 8 am, lunch around 12 pm – 1 pm and dinner around 5 pm – 6 pm with snacks served in the evening. They both stated Resident A goes to Artworks on Fridays and is supposed to take a lunch with her. Resident B stated Resident A usually makes her own lunch prior to going to Artworks, while Resident C stated staff usually prepare it for her. They both indicated "meat sandwiches" were available for Resident A to make on the days she prepares her own lunch. Neither Resident B nor Resident C could recall if Resident A took a lunch with her on 03/17/2023, but both Resident B and Resident C stated they recalled Resident A leaving the facility without having breakfast; despite it being available to her. They both stated she had woken up too late and didn't have time to eat any cereal.

Both Resident B and Resident C stated there is always food in the facility. They stated they are always provided with breakfast, lunch, and dinner, which Resident A has access too, as well. They stated none of the residents, including Resident A, go without eating unless one of the residents chooses not to eat.

I also interviewed Resident D and Resident E; however, they weren't able to provide as much information as Resident B and Resident C due to Resident D being focused on smoking and Resident E being newly admitted within the last couple of days. They both reported there is food available in the home, which they are able to access and is available to them daily for every meal.

On 04/06/2023, I completed a follow-up inspection to interview Resident A. Resident A stated she usually makes her own lunches when she's preparing to go to Artworks. She stated on 03/17/2023, she hadn't prepared her own lunch the night before, like normal, because there weren't ingredients to make anything. She stated staff didn't prepare her lunch either. Resident A stated her normal lunch on Artwork days consistent of snacks, peanut butter and jelly sandwich, or "sometimes bologna and mustard" or another type of lunch meat and canned beets. Resident A stated when she woke up the morning of 03/17/2023, she took a shower, took her medications, and got on the bus sometime between 8 am and 8:30 am. She stated she did not eat breakfast because she didn't have time to sit down and eat. She stated staff told her there weren't any bowls or plates for her to take with her on the bus. Resident A also stated she wasn't allowed to have food out in the open on the bus. Resident A denied having a lunchable dropped off to her at Artworks. She could not recall what she ate that day at the Artworks program.

Resident A stated not having lunch with her for her day program/workshop was a one-time incident. She stated there were no incidences prior to 03/17/2023, and there have been no additional issues since. She stated staff provide her with breakfast, lunch and dinner. Overall, Resident A stated she had no concerns.

During the inspection, I checked the facility's cupboards and refrigerator, which was consistent with the food items Resident A indicated she took for lunch.

I reviewed Resident A's *Assessment Plan for AFC Residents*, dated 11/14/2022. According to my review of this assessment plan, Resident A "requires reminders to maintain a healthy diet". Resident A's assessment plan did not identify her attending a day program or workshop.

I reviewed Resident A's Macomb County Community Mental Health Person Centered Plan (PCP), dated 09/20/2022. According to my review of this PCP, direct care staff are responsible for Resident A's meal planning and preparation. The PCP stated Resident A's is able to complete Activities of Daily Living (ADL's) including "grooming, hygiene, and dressing. However, currently needs several reminders or hands on assistance from staff to complete these tasks". The PCP identified an objective to her goal to be independent as "[Resident A] agrees to maintain a clean bedroom and engage in daily independent tasks (dishes, sweeping, laundry etc.) with less than three reminders from staff for thee[sic] consecutive months as exhibited by staff's documentation". There was also no indication Resident A was in

a day program or workshop or if Resident A was capable of preparing her own lunch or meals in preparation for her day program or workshop.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based on my review of Resident A's Macomb County Community Mental Health Person Centered Plan, dated 09/20/2023, facility direct care staff are responsible for meal planning and preparation for Resident A. Resident A's PCP did not indicate Resident A was responsible for preparing her own lunches on days when she was attending day program/workshop. The PCP indicates Resident A requires several reminders and assistance from direct care staff in completing her ADL's. Consequently, on 03/17/2023, direct care staff did not implement Resident A's plan of service by ensuring she had a lunch with her prior to her leaving for her Artwork day program/workshop.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	While there is no evidence indicating residents, including Resident A, are going without food on a regular and consistent basis, there is evidence that on 03/17/2023, Resident A woke up late, and didn't have time to eat breakfast despite it being available to her. Subsequently, staff did not ensure Resident A had breakfast to go with her upon her getting on the day program/workshop bus that day. Additionally, lunch was not prepared for Resident A prior to her leaving. Consequently, Resident A went approximately 20 hours without the licensee

	providing her with a regular and nutritious meal as the last meal provided to her would have been dinner on 03/16/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Direct care staff, Ms. McAfee, stated she purchased pizza for lunch and dinner on 03/17/2023; however, upon my review of the facility's menus it listed a ham sandwich, wheat crackers, an orange, and juice had been served for lunch while dinner was listed as Dijon baked turkey tenderloin, white rice, sauteed zucchini with herbs, nutmeg apples, vegetables, or a salad. There was no indication on the facility's menus pizza had actually been served to replace either of the meals. Ms. McAfee stated she ordered pizza twice that day because "sometimes I just do that". She indicated she may order pizza if the residents are "being good" or "want it".

Resident C confirmed eating pizza for lunch and dinner on 03/17/2023.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	After interviewing direct care staff, Ms. McAfee, I determined staff had served pizza for both lunch and dinner on 03/17/2023; however, this was not indicated on the facility's menu. Consequently, the facility's menu didn't reflect changes or substitutions, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Despite Resident A attending the MRC's Artwork day program/workshop since approximately January 2023, it was not identified in Resident A's *Assessment Plan for AFC Residents*.

APPLICABLE RULE	
R 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.
	"Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services, taking into account the preferences and competency of the individual.
ANALYSIS:	Resident A's participation in the MRC's Artwork day program/workshop was not identified in her *Assessment Plan for AFC Residents*, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/10/2023, I conducted the exit conference with licensee designee, Ramon Beltran, via telephone. Mr. Beltran acknowledged my findings. He stated he attributed many of the concerns at the facility with insufficient staff. He stated he would provide an acceptable corrective action plan upon receipt of the report.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

05/10/2023

Cathy Cushman — Date
Licensing Consultant

Approved By:

05/10/2023

Michele Streeter — Date
Section Manager