GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 28, 2023

Ramon Beltran II
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS390403155
Investigation #: 2023A0578021
Beacon Home At Ravine

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

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (517) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390403155
Investigation #:	2023A0578021
Complaint Receipt Date:	02/06/2023
Investigation Initiation Date:	02/06/2023
Report Due Date:	04/07/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubrey Napier
Licensee Designee:	Ramon Beltran II
Name of Facility:	Beacon Home At Ravine
Facility Address:	6595 Ravine Road Kalamazoo, MI 49009
Facility Telephone #:	(269) 488-3967
Original Issuance Date:	04/21/2020
License Status:	REGULAR
Effective Date:	10/21/2022
Expiration Date:	10/20/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was taken to the hospital with frostbite after being outside of this facility for an unknown time and was found by a passerby.	Yes

III. METHODOLOGY

02/06/2023	Special Investigation Intake 2023A0578021
02/06/2023	Special Investigation Initiated – Telephone call with Resident A.
02/06/2023	Inspection Completed On-site
02/06/2023	APS Referral Completed.
02/06/2023	Contact-Document Reviewed -*Incident Report* dated 02/03/2023.
02/06/2023	Contact-Telephone -Interview with Riverwood Center recipient rights advisor Tasha Stewart.
02/07/2023	Contact-Off-site -Interview with Bronson Hospital Registered Nurse Danielle Chappa, observations of Resident A.
02/13/2023	Contact-Telephone -Second request for AFC documentation.
02/14/2023	Contact-Document Reviewed -*Riverwood Center Behavior Treatment Plan* for Resident A, dated 03/29/2022.
02/14/2023	Contact-Document Reviewed -*Assessment Plan for AFC Residents* for Resident A, dated 01/19/2023.
02/14/2023	Contact-Document Reviewed -*After Visit Summary* for Resident A, provided by Bronson Hospital and dated 02/10/2023.
02/22/2023	Contact-Document Reviewed -Kalamazoo County Sheriff's Office *Case Report Summary #2023-3906.*

03/01/2023	Contact-Telephone -With adult protective services worker Lindsay Bickmeyer.
03/07/2023	Contact-Telephone -Interview with direct care staff Nichole Dickerson.
03/07/2023	Contact-Telephone -Interview with direct care staff Erica Bradford.
03/24/2023	Contact-Telephone -With Kalamazoo County Emergency Dispatch.
03/27/2023	Exit Conference. -With the licensee designee, Ramon Beltran.

ALLEGATION:

Resident A was taken to the hospital with frostbite after being outside of this facility for an unknown time and was found by a passerby.

INVESTIGATION:

On 02/06/2023, I received this complaint through the BCHS On-line Complaint System. Complainant reported Resident A is diagnosed with Schizophrenia and Bipolar Disorder. Complainant alleged that on 02/03/2023, Resident A was found by law enforcement unresponsive in the snow. Complainant reported Resident A was transported to Bronson Hospital for treatment. Complainant alleged Resident A's body temperature was in the low 80's. Complainant reported it was unknown how long Resident A was in the snow or how Resident A got out of the facility.

On 02/06/2023, I reviewed the details of the allegations with Riverwood Center recipient rights advisor Tasha Stewart. Ms. Stewart explained that a passerby driving past this facility observed what they thought was a "trash bag" in the snow. Ms. Stewart reported this passerby then notified law enforcement when this "trash bag" moved and it was later determined to be Resident A. Ms. Stewart reported Resident A was taken to the hospital and presented with a body temperature in the "low 80's" and provided with warm fluids intravenously. Ms. Stewart reported it was anticipated that Resident A would be at the hospital for a few days. Ms. Stewart denied that Resident A had any one-on-one supervision requirements and clarified Resident A has a behavior plan that allows her to walk to the end of the driveway of this facility. Ms. Stewart clarified Resident A was to be monitored by direct care staff members for elopement and have observations occurring on the hour. Ms. Stewart reported that when she was notified of the incident by direct care staff member Jamara White,

Ms. White acknowledged direct care staff working at the time of the incident may not have completed hourly observations of Resident A as required. Ms. Stewart added she was informed Resident A had open wounds on her hands and feet due to frostbite.

On 02/06/2023, I reviewed an *Incident Report* dated 02/03/2023 and related to the allegations. The *Incident Report* documented Resident A was transported to Bronson Hospital after law enforcement arrived and reported Resident A had been sitting outside for "a while" and they had received a call from someone in the community. The *Incident Report* documented Resident A was being seen at the hospital to rule out frostbite or hypothermia. The *Incident Report* documented that while at the hospital, Resident A had low temperature readings and provided with IV fluids to keep her warm as well as blankets. The *Incident Report* documented Resident A was to stay at the hospital for at least two or three days before being released.

On 02/06/2023, Riverwood Center recipient rights advisor Tasha Stewart reported that Resident A was still at the hospital and doing well but had wounds on her hands and feet due to frostbite. Ms. Stewart added that a nurse informed her Resident A will not need surgery to address complications from frostbite but will remain in the hospital until Resident A's wounds heal.

On 02/06/2023, I reviewed the searchable database on Weather.gov to determine weather temperatures on 02/03/2023 at this facility would have been a minimum of 11 degrees Fahrenheit and a maximum of 20 degrees Fahrenheit.

On 02/07/2023, I interviewed Bronson Hospital Registered Nurse Danielle Chappa regarding the injuries to Resident A. Ms. Chappa reported Resident A was currently sleeping and doing "okay" but had been verbally aggressive with hospital staff since her admission. Ms. Chappa reported Resident A had frostbite on her hands, knees, and feet, and this resulted in "big" blisters and burns. Ms. Chappa reported that because of Resident A's blisters and burns, it was difficult to determine the extent of the frostbite and it was unknown how long Resident A was exposed to cold air. While at Bronson Hospital, I attempted to interview Resident A. Resident A refused to be interviewed and refused to consent to the photographic documentation of her injuries. I observed the hands of Resident A and noted her entire hands and fingers were swollen, with sloughing and blistered skin across the length of each finger and palm. I noted the remaining skin on Resident A's hands were discolored with white and pink and purple tones. I did not visibly examine Resident A's feet to avoid having her socks removed from her visibly swollen feet.

On 02/14/2023, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 01/19/2023 and provided by staff member Jamara White. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A does not have independent community access and to refer to Resident A's *Behavior Treatment*

Plan. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A is not alert to surroundings and needs "staff supervision."

On 02/14/2023, I reviewed the *Riverwood Center Behavior Treatment Plan* for Resident A, dated 03/29/2022. The *Riverwood Center Behavior Treatment Plan* for Resident A identified Resident A's diagnosis as Schizoaffective Disorder, Depressive Type, Insomnia Disorder, Unspecified Mood Disorder and Other Medication Induced Movement Disorder. The *Riverwood Center Behavior Treatment Plan* for Resident A identified one of Resident A's "Challenging behaviors/Operational definitions" as elopement, and defined elopement as any time Resident A leaves the property of the facility she resides. The *Riverwood Center Behavior Treatment Plan* for Resident A documented that Resident A was allowed to walk around on the grounds of this property if she is upset. The *Riverwood Center Behavior Treatment Plan* for Resident A clarified that if Resident A leaves the end of the driveway, this results in being off property and direct care staff will actively pursue and redirect Resident A back to the facility. The *Riverwood Center Behavior Treatment Plan* for Resident A documented that Resident A's refusal to return to the property of the facility would result in contacting the home manager and law enforcement. The *Riverwood Center Behavior Treatment Plan* for Resident A documented that direct care staff will "keep checking" to see if Resident A is in line of sight when walking around the property of this facility. The *Riverwood Center Behavior Treatment Plan* for Resident A documented that when Resident A walks to the end of the driveway, direct care staff will keep monitoring her to see if she returns to the facility, and if she does not return or goes onto the street, direct care staff will start following Resident A on foot or in the van with the goal of redirecting Resident A back to the facility.

On 02/14/2023, I reviewed the *After Visit Summary* for Resident A, provided by Bronson Hospital and dated 02/10/2023. The *After Visit Summary* documented Resident A's primary diagnosis as "Frostbite Involving Multiple Body Regions." Additional diagnosis for Resident A documented on this After Visit Summary included "Hypothermia Due to Cold Environment" and "Hypothermia Due to Exposure, Undifferentiated Schizophrenia, Severe Malnutrition and Violent Behavior." The *After Visit Summary* for Resident A identified follow up orders for Resident A with Bronson at Home hospital services, a referral to the Burn and Wound Clinic, and continued treatments of Bacitracin and Xeroform to Resident A's bilateral hand and areas of frostbite daily.

On 02/22/2023, I reviewed Kalamazoo County Sheriff's Office *Case Report Summary #2023-3906* relating to the allegations. *Case Report Summary #2023-3906* documented Kalamazoo County Sheriff's Deputy (KCSD) Chad Deem completing a welfare check after a caller reported that Resident A was sitting on the ground at the end of the driveway and was afraid Resident A would be hit by a car. *Case Report Summary #2023-3906* documented KCSD Deem observed Resident A sitting on the ground at the end of the driveway, wearing wet leggings, shoes, and a jean jacket. The *Case Report Summary #2023-3906* documented that KCSD Deem

could not understand what Resident A was saying and when emergency medical services arrived, Resident A was placed in an ambulance. The *Case Report Summary #2023-3906* documented that KCSD Deem interviewed direct care staff Nichole Dickerson, who was not aware of the last time Resident A was seen inside the facility. The *Case Report Summary #2023-3906* documented that Ms. Dickerson informed KCSD Deem that Resident A usually goes outside to smoke but then usually comes right back inside. The *Case Report Summary #2023-3906* documented that KCSD Deem informed Ms. Dickerson that Resident A was being take to the hospital for further evaluation based on the temperature outside and being outside for an unknown amount of time.

On 03/07/2023, I interviewed direct care staff Nichole Dickerson regarding the allegations. Ms. Dickerson reported working at this facility for eight months. Ms. Dickerson acknowledged working on the day of the allegations with direct care staff Erica Bedford. Ms. Dickerson reported Resident A has a routine of frequently going in and out of the facility or sitting on the couch in the living room closest to the front door of the facility. Ms. Dickerson reported she did not hear Resident A exit the facility. Ms. Dickerson reported she did not know how long Resident A was outside, and when asked about hourly checks, Ms. Dickerson reported that the hourly checks of Resident A had not been completed prior or during this incident and “must have slipped” her mind.

On 03/07/2023, I interviewed direct care staff Erica Bradford regarding the allegations. Ms. Bradford reported working at this facility since January 15, 2023. Ms. Bradford acknowledged working on the day of the allegations with direct care staff Nichole Dickerson. Ms. Bradford also reported Resident A would frequently go in and out of the facility, but clarified on the day of the allegations, she had observed Resident A being outside in the cold and prompted Resident A to return to the facility around 3AM. Ms. Bradford reported that thirty minutes later, Resident A was found outside of the facility by law enforcement. Ms. Bradford clarified that when they initially returned to the facility, Ms. Bradford went to use the bathroom, and this must have been when Resident A went back outside. Ms. Bradford reported that she had completed hourly checks on Resident A, and that Resident A must have exited the facility and was found between one of these hourly checks. Ms. Bradford denied these hourly checks were documented in any way and reported that she just completes them as she was told to do by other staff. Ms. Bradford reported other direct care staff had told her Resident A just returns to the facility on her own and did not inform her Resident A is an elopement risk. Ms. Bradford reported Resident A usually goes outside to sit on a small bench, but clarified that as of late, Resident A had voiced wanting to wait for her daughter’s arrival at this facility.

On 03/24/2023, I contacted Kalamazoo County Emergency Dispatch and confirmed the time an unidentified passerby contacted the Kalamazoo County Emergency Dispatch regarding finding Resident A in the snow was 04:37AM.

On 03/01/2023, I reviewed the details of the allegations with adult protective services worker Lindsay Bickmeyer. Ms. Bickmeyer reported that based on her interview of direct care staff Nichole Dickerson, it was common for Resident A to go outside, and smoke and Ms. Dickerson did not “think much about it” and it must have “slipped her mind” to do hourly checks of Resident A. Ms. Bickmeyer reported that Ms. Dickerson was unaware that Resident A was outside until contacted by law enforcement. Ms. Dickerson reported that based on her interviews, she would be substantiating a violation of abuse and neglect.

According to SIR # 2022A0581048, dated 10/21/2022, the facility was in violation of rule 400.14305 (3) when it was established that on 08/31/2022, another resident was verbally and physically assaulted by direct care staff and home manager, Monique Johnson. Ms. Johnson was observed by direct care staff, Amaya Boehm, and Resident B, engaging in the assault, which included swearing at this resident and punching her in the face. Though videos did not show the actual assault, it provided evidence of Ms. Johnson verbally assaulting the resident and direct care staff could be heard yelling at Ms. Johnson to “stop” indicating Ms. Johnson was assaulting the resident. Subsequently, the resident was not provided with protection and safety on 08/31/2022, as required. The facility’s approved Corrective Action Plan (CAP) dated 10/25/2022 stated that Ms. Monique Johnson was no longer employed and that Ms. Johnson will not be eligible for rehire. The Corrective Action Plan documented that all staff would receive training on Beacon’s Emergency Medical Care/First aid Policy, Beacon’s Medical On-call Policy, and be retrained in Beacon’s Confidentiality, Abuse, Neglect and Mandatory Reporting Requirements Policy.

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 02/03/2023, Resident A was found outside of this facility at approximately 4:37AM in below freezing temperatures by law enforcement and transported to Bronson Hospital due to the temperature outside and Resident A being outside for an undetermined amount of time. *Case Report Summary #2023-3906* documented that Resident A was found wearing only leggings, shoes, and a jean jacket. *Case Report Summary #2023-3906* documented direct care staff Nichole Dickerson was interviewed at the time of the incident and was unaware of the last time Resident A was seen inside the facility. In an interview, direct care staff Nichole Dickerson confirmed that hourly checks had not been completed with Resident A and these hourly checks, “must have slipped” her mind despite being

	required per Resident A's *Riverwood Center Behavior Treatment Plan*. In an interview, direct care staff Erica Bradford reported that at 3AM, she returned Resident A to this facility but Resident A was found by law enforcement thirty minutes later. I reviewed *Case Report Summary #2023-3906* which established the time of this incident as 04:37AM, which I confirmed with Kalamazoo County Emergency Dispatch as the time a passerby had notified Kalamazoo County Emergency Dispatch. I reviewed the *After Visit Summary* for Resident A, which documented her treatment at Bronson Hospital for, "Frostbite Involving Multiple Body Regions" and an additional diagnosis of "Hypothermia Due to Cold Environment" and "Hypothermia Due to Exposure." As such, Resident A's personal need for protection and safety was not attended to at all times.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference SIR #2022A0581048 dated 10/21/2022 and CAP dated 10/25/2022].**

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:	During this investigation, I reviewed the *Riverwood Center Behavior Treatment Plan* for Resident A, which documented that Resident A would be allowed to walk around on the grounds of this property if she is upset, and that when Resident A walks to the end of the driveway, staff will keep checking and ensuring Resident A is within line of sight and monitoring Resident A to see if she returns to the facility, and if Resident A does not return or goes onto the street, staff will start following Resident A on foot or in the van with the goal of redirecting Resident A back to the facility. In an interview, Riverwood Center recipient rights advisor Tasha Stewart reported that Resident A was to be monitored for elopement and have observations occurring on the hour. I reviewed *Case Report Summary #2023-3906*, which documented that direct care staff Nichole Dickerson was interviewed at the time of the incident and was unaware of the last time Resident A was seen inside the facility. In an interview, direct care staff Nichole Dickerson confirmed that hourly checks had not been completed with Resident A and these hourly checks, "must have slipped" her mind. In an interview, direct

	care staff Erica Bradford reported that at 3AM, she returned Resident A to this facility and that Resident A was found by law enforcement thirty minutes later. Ms. Bradford added that other staff had told her that Resident A just returns to the facility on her own and did not inform her that Resident A is an elopement risk. I reviewed *Case Report Summary #2023-3906* which established the time of this incident as 04:37AM, which I confirmed with Kalamazoo County Emergency Dispatch as the time a passerby had notified Kalamazoo County Emergency Dispatch. As such, Resident A was able to exit the facility and walk to the end of the driveway without suitable clothing or being monitored by staff in below freezing temperatures and remained there without the knowledge of staff for at least 30 minutes to over one hour. Therefore, the *Riverwood Center Behavior Treatment Plan* for Resident A was not sufficiently implemented by direct care staff members at this facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.

03/28/2023

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Eli DeLeon Date
Licensing Consultant

Approved By:

03/28/2023

_____

Dawn N. Timm Date
Area Manager