GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 1, 2023

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

RE: License #: AM030402101
Investigation #: 2023A1024053
Beacon Home at Hammond

Dear Mr. Beltran:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030402101
Investigation #:	2023A1024053
Complaint Receipt Date:	09/05/2023
Investigation Initiation Date:	09/07/2023
Report Due Date:	11/04/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Hammond
Facility Address:	318 East Hammond Street Otsego, MI 49078
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	07/09/2020
License Status:	REGULAR
Effective Date:	01/26/2022
Expiration Date:	01/25/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

ALLEGATION(S)

	Violation Established?
Law enforcement has responded to the facility 13 times and there is concern protection and safety to residents is not provided.	No

II. METHODOLOGY

09/05/2023	Special Investigation Intake 2023A1024053
09/05/2023	APS Referral already involved
09/07/2023	Special Investigation Initiated – Telephone with Moncia Nagel-Otsego Police Department
09/07/2023	Contact - Document Received-Otsego Police Department-*Incident Reports*
09/08/2023	Contact - Document Received-Otsego Police Department-*Police Reports*
09/22/2023	Contact-Telephone call made with Guardian A1
09/26/2023	Contact - Telephone call made-with direct care staff member Sierra Cooper
10/17/2023	Inspection Completed On-site-with direct care staff members Hunter Dunklee, Rachel Cornell, Jaimie Goodacre and Resident A
10/17/2023	Contact - Telephone call made-with licensee designee Ramon Beltran
10/17/2023	Contact-Document Received-Email correspondence between Ramon Beltran, Guardian A1 and home manager Denise Rogers.
10/17/2023	Contact-Document Received- Resident A's *Assessment Plan for AFC Residents* and Behavior Treatment Plan (BTP)
10/25/2023	Exit Conference with licensee designee Ramon Beltran

ALLEGATION: Law enforcement has responded to the facility 13 times and there is concern protection and safety to residents is not provided.

INVESTIGATION:

On 9/5/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. According to this complaint, law enforcement has responded to the facility 13 times and there is concern protection and safety to residents is not provided. This complaint further stated Resident A frequently elopes from the facility. It should be noted the allegation regarding Resident A frequently eloping was investigated in SIR #2023A1024050.

On 9/7/2023, I conducted an interview with Monica Nagel from the Otsego Police Department. Monica Nagel stated that law enforcement has responded to multiple calls made from direct care staff members, neighbors, and residents for various reasons. Monica Nagel further stated there were only two calls made regarding this facility from January 2023 to May 2023.

On 9/7/2023 and 9/8/2023, I reviewed 17 *Incident Reports* from Otsego Police Department. I reviewed three Otsego Police Department *Incident Reports* dated 9/4/2023 involving Resident A. The first was regarding Resident A eloping from the facility, the second was called by a neighbor who witnessed Resident A yelling at the facility, and the third was called in by a staff member who was present with Resident A at the party store where he had eloped.

I reviewed two incident reports dated 8/26/2023 and one incident report dated 8/27/2023 involving Resident C who called 911 to report that she was having suicidal ideation and harming herself. Another Otsego Police Department *Incident Report* documented that a hospital staff member called 911 on 8/27/2023 trying to reach a staff member regarding Resident C who was a patient there.

I reviewed one Otsego Police Department *Incident Report* dated 8/24/2023 from a caller who requested a welfare check to be conducted on two individuals that were not residents at the facility. I reviewed two Otsego Police Department *Incident Reports* dated 8/21/2023 and 8/23/2023 involving Adult Protective Services (APS) placing a Law Enforcement Notification (LEN) referral requesting law enforcement to accompany APS in their investigation for alleged abuse/neglect. I reviewed four Otsego Police Department *Incident Reports* dated 8/18/2023, 7/25/2023, 7/26/2023, and 7/30/2023 involving calls made from Resident B requesting law enforcement to transport her to jail, prison, and/or the hospital which were determined to be non-medical issues.

I reviewed one Otsego Police Department *Incident Report* dated 7/22/2023 involving a neighbor calling who witnessed direct care staff members trying to de-escalate an upset resident outside the facility. I reviewed one Otsego Police Department *Incident Report* dated 7/25/2023 involving Resident D who called and stated that she wanted to go to a psychiatrist because she was having back issues and it was later determined there

were no medical issues. I reviewed two Otsego Police Department *Incident Reports* dated 2/23/2023 and 2/16/2023 involving APS requesting law enforcement to accompany APS in their investigation for alleged abuse/neglect.

On 9/22/2023, I conducted an interview with Guardian A1 who stated Resident A has a history of eloping from adult foster care facilities and she would like to see Resident A reside in a more secure fenced facility where he is not able to easily leave the property. Guardian A1 stated she has talked to Community Mental Health (CMH) about this however they have denied this request as Resident A only elopes during certain times of the year, generally when it is warmer outside, to seek alcohol and CMH believes this is a behavior Resident A can work on as part of his behavior support plan.

On 9/26/2023, I conducted an interview with direct care staff member Sierra Cooper who stated that she has worked with Resident A on numerous occasions, and he has only eloped once from the facility on 8/4/2023 at which time she had to contact law enforcement for assistance to locate Resident A because she was not able to go after him due to being the only staff member present at the facility with other residents. Sierra Cooper stated Resident A's normal routine is to sit on the porch, sleep in his bedroom for most of the day and come out to the common areas to eat meals. Sierra Cooper stated she has not had to call law enforcement for any other reason however was aware Resident B called law enforcement for non-emergencies when she wanted attention from others outside of the facility. Sierra Cooper stated direct care staff members have attempted to redirect Resident B however Resident B continues to make unnecessary calls to 911.

On 10/17/2023, I conducted an onsite investigation at the facility with direct care staff members Hunter Dunklee, Rachel Cornell, Jaimie Goodacre who all stated that Resident B often calls 911 when she is seeking to go to the hospital for attention or when she wants to be out in the community. Hunter Dunklee, Rachel Cornell, Jaimie Goodacre also all stated they have not had to call 911 for assistance with Resident A as they have been able to locate him and redirect him back to the facility. Hunter Dunklee stated that since June 2023, Resident A has left the facility without permission about five times to his knowledge to walk to the nearby party store to purchase alcohol. Hunter Dunklee stated majority of these times, direct care staff members have followed Resident A and have been able to redirect Resident A back to the facility without having police involvement.

Rachel Cornell stated she has never had to contact law enforcement when Resident A left the facility without permission to go to the nearby party store to purchase alcohol. She stated she can redirect Resident A back to the facility once he purchases alcohol which is being addressed with his mental health provider. Rachel Cornell stated Resident A tells staff that he believes he has an infection in his mouth and the only remedy is drinking alcohol. Rachel Cornell stated she has no knowledge of police involvement when Resident A leaves the facility without permission, however, believes alternative placement options are being explored for Resident A due to increased incidents in a short amount of time.

Jaimie Goodacre stated Resident A has never eloped while working with her as he prefers to elope during the late evening hours. Jaime Goodacre further stated to her knowledge direct care staff members follow Resident A when he leaves the facility without permission however have called law enforcement in the past to notify them that a vulnerable adult was out in the community without consent. Jaime Goodacre stated she does not believe law enforcement is called by direct care staff members routinely and has not been out to the facility that often.

While at the facility, I also conducted an interview with Resident A who stated that recently he has had to run away to the store to purchase alcohol because he has infection in his body and only alcohol can cure his infection. Resident A further stated he is not allowed to be out in the community therefore he must run away from the facility to go to the store as direct care staff will not allow him to purchase alcohol. Resident A stated he wants to move out of facility and live on his own and is working with his case manager to achieve this goal.

On 10/17/2023, I conducted an interview with licensee designee Ramon Beltran who stated he was not aware of any direct care staff members contacting law enforcement frequently however he was aware that one or two residents have made 911 calls for non-medical reasons causing law enforcement to come out to the facility. Ramon Beltran further stated Resident A has had increased elopements since June to seek alcohol at a nearby party store which was why Ramon Beltran contacted Resident A's mental health treatment team to discuss alternative placement options. Ramon Beltran stated when Resident A leaves the facility without permission, direct care staff members follow him on foot however will call 911 to notify them that a vulnerable adult is in the community without authorization. Ramon Beltran stated direct care staff members are usually able to redirect Resident A back to the facility with multiple prompts and verbal redirecting however alternative placement for Resident A is being explored as Resident A continues to leave the facility without permission to go to the nearby party story to purchase alcohol.

On 10/17/2023, I reviewed email correspondence dated 10/10/2023 between licensee designee Ramon Beltran and Guardian A1 which verified Ramon Beltran followed up with Guadian A1 regarding alternative placement options for Resident A.

On 10/17/2023, I reviewed Resident A's *Assessment Plan for AFC Residents* (assessment) dated 1/10/2023. According to this assessment, Resident A is required direct care staff monitoring while in the community however does not require 1:1 direct care staff supervision. I also reviewed Resident A's *Behavior Support Plan* (plan) dated 12/10/2022. According to this plan, Resident A has a history and target behaviors of eloping such as leaving the property without staff supervision, panhandling such as asking strangers in the community to give him preferred items and alcohol use. There is no mention in the report that Resident A requires 1:1 staff supervision.

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:	Based on my investigation which included interviews with direct care staff members Sierra Cooper, Hunter Dunklee, Rachel Cornell, Jaimie Goodacre, Monica Nagel from Otsego Police Department, licensee designee Ramon Beltran, Guardian A1 review of incident reports, and Resident A's *Assessment Plan for AFC Residents* and *Behavior Support Plan* there is no evidence law enforcement has responded to the facility due to direct care staff members not providing for the safety and protection of residents. According to staff members Sierra Cooper, Hunter Dunklee, Rachel Cornel, and Jaime Goodacre and my review of the Otsego Police Department Incident Reports, calls to 911 are often made by Resident B for non-medical reasons and misuse of 911. In addition, staff members have had police involvement for Resident A when he has left the facility without permission, however this is not a routine occurrence. It should be noted the allegation regarding Resident A eloping was also investigated in SIR # 2023A10124050 and there were no substantial findings regarding safety and protection provided to Resident A. Furthermore, based on the incident reports from Otsego Police Department, there is no indication that supervision and protection is not provided in the facility to residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/25/2023, I conducted an exit conference with licensee designee Ramon Beltran. I informed Mr. Beltran of my findings and allowed him an opportunity to ask questions and make comments.

III. RECOMMENDATION

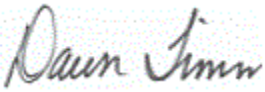
I recommend the current license status remain unchanged.

10/25/2023

Ondrea Johnson
Licensing Consultant

Date

Approved By:



11/01/2023

Dawn N. Timm
Area Manager

Date