GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 15, 2023

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

RE: License #: AS370405093
Investigation #: 2024A1029008
Beacon Home At Mt Pleasant

Dear Roxanne 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 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 (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 #:	2024A1029008
Complaint Receipt Date:	10/23/2023
Investigation Initiation Date:	10/24/2023
Report Due Date:	12/22/2023
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:	05/16/2023
Expiration Date:	05/15/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On October 14, 2023, direct care staff member Jennifer Vincent left her scheduled shift at Beacon Home at Mt. Pleasant and left Resident A unattended and without 1:1 supervision.	Yes
On October 20, 2023 direct care staff member Arden Pitts was not providing Resident B 1:1 staffing coverage when he left the facility and walked down the street approximately .5 mile to the church with no shoes on and covered in mud.	Yes

III. METHODOLOGY

10/23/2023	Special Investigation Intake 2024A1029008
10/24/2023	Special Investigation Initiated – Letter to Sarah Watson ORR
10/24/2023	APS Referral made to Centralized Intake
10/26/2023	Contact - Telephone call received - Text message from Roxanne Goldammer
10/26/2023	Contact - Telephone call made to direct care staff members Robb Lynch, Katie Hohner, Kendra Pannill (mailbox full), Dana Sprague
10/26/2023	Contact - Document Sent - sent an email requesting information to Marlo Derry, compliance officer.
10/26/2023	Contact - Telephone call made to licensee Designee Roxanne Goldammer
10/27/2023	Inspection Completed On-site-- Face to Face with Roxanne Goldammer, Arkeshia Foster, Resident B, ORR Katie Hohner, Arden Pitts, Alajah Carter at Beacon Home at Mt. Pleasant
12/07/2023	Contact – Text message sent to Roxanne Goldammer
12/08/2023	Contact – Telephone call to direct care staff member Jennifer Vincent, Robb Lynch (unavailable), Kendra Pannill, Citizen 1 (Left message)

12/13/2023	Contact – Telephone call to Mr. Miley (unavailable), Robb Lynch (unavailable), Citizen 1, Roxanne Goldammer (text)
12/13/2023	Exit conference with licensee designee Roxanne Goldammer. Left message for her.

ALLEGATION:

On October 14, 2023, direct care staff member Jennifer Vincent left her scheduled shift at Beacon Home at Mt. Pleasant and left Resident A unattended and without 1:1 supervision.

INVESTIGATION:

On October 23, 2023, a complaint was received via the Bureau of Community and Health Systems online complaint system with allegations that on October 14, 2023, direct care staff member Jennifer Vincent left her scheduled shift at Beacon Home at Mt. Pleasant and left Resident A without 1:1 supervision. According to the complaint, Resident A requires 1:1 direct care staff supervision and he did not have this when Ms. Vincent left her shift.

On October 26, 2023, I interviewed licensee designee Roxanne Goldammer. Ms. Goldammer stated Resident A requires 1:1 direct care staff supervision and did not receive this when Ms. Vincent walked off her shift at 2:30 PM. Ms. Goldammer stated Jennifer Vincent walked off at 2:30PM on October 14, 2023 because she did not want to stay any longer. Ms. Goldammer stated Ms. Vincent is no longer an employee for Beacon Specialized Living Services Inc. Ms. Goldammer stated direct care staff member, whose role is home manager, Kendra Pannill came to Beacon Home at Mt. Pleasant to relieve another direct care staff member who had been working longer and Ms. Vincent was upset she was not relieved and had to continue working. Ms. Goldammer stated Ms. Vincent had not done this before. Ms. Goldammer stated she did not know how long Resident A was without 1:1 staffing coverage after Ms. Vincent left the facility. Ms. Goldammer stated there were still three direct care staff members on at the time and there were no medications that needed administered or meals that needed to be prepared. Ms. Goldammer stated Resident A is the “higher functioning individual of the group who requires a 1:1.” Ms. Goldammer further explained of the four residents living at the facility, three require 1:1 direct care staff supervision and after Ms. Vincent left, three direct care staff members remained at the facility.

On October 27, 2023, Office of Recipient Rights (ORR) advisor, Katie Hohner and I completed an on-site investigation and met with Roxanne Goldammer at Beacon Home at Mt. Pleasant. Resident A was not present at the time of the on-site investigation.

I reviewed the *Staffing Schedule* and the *Resident Assignment Form* for the week of October 8, 2023- October 14, 2023. On October 14, 2023, the following direct care staff members were scheduled for 1st shift:

- Angie Himebaugh / Assigned as the DMA and supervising Resident D who does not require 1:1 staffing coverage.
- Kevin Miley / assigned as 1:1 staffing coverage to Resident C
- Robb Lynch / assigned as the 1:1 for Resident B
- Jennifer Vincent / assigned as the 1:1 for Resident A 9 AM-2:30 PM

I reviewed Resident A's *Assessment Plan for AFC Residents* and *Behavior Treatment Plan* which indicated he needs line of sight supervision in the community. I reviewed documentation which verified Ms. Vincent signed that she attended an in-service and understood the *Behavior Treatment Plan* for Resident A on September 24, 2023. I reviewed Resident A's *Behavior Treatment Plan* which stated the following:

> *"Due to these challenging behaviors, line of sight supervision in the community was approved by the Behavior Treatment Committee in May 2022 on an urgent basis, while a Behavior Assessment and Behavior Treatment Plan could be completed. [Resident A's] challenging behaviors has escalated and one-on-one staffing in his home was approved on January 10, 2023. After he moved to a new AFC home in January 2023, there was a reduction in challenging behaviors. In February 2023, the Behavior Treatment Committee clarified the 1:1 staffing as line of sight supervision outside of the restroom and bedroom areas."*

According to Resident A's *Health Care Appraisal* he has been diagnosed with autistic disorder, disruptive behavior disorder, OCD, unspecified intellectual disability, and speed impediment.

On October 27, 2023, I interviewed direct care staff member Arkeshia Foster at Beacon Home at Mt. Pleasant. Ms. Foster stated she was off the day Ms. Vincent left her shift however the direct care staff member cannot be mandated for more than 24 hours and the regular shift hours is 9 AM - 9:30 PM so they are working 12 hour shifts. Ms. Foster stated Resident B is the only resident who requires 1:1 staffing coverage at night but Resident A, Resident B, and Resident C all require 1:1 staffing coverage during the day shift.

On December 8, 2023, I interviewed direct care staff member Ms. Vincent at Beacon Home at Mt. Pleasant. Ms. Vincent stated none of the residents were left unsupervised when she left because there were still three direct care staff members there. Ms. Vincent stated she already worked 24 hours straight and she was ready to be done. Ms. Vincent stated Ms. Pannill waited until the last minute to find staffing coverage and stated, "someone needs to do their job right and make the schedule right, then maybe they would not have mandates each week." Ms. Vincent stated she has been in the field for 30 years and never had this many mandates. Ms. Vincent stated when she left

the facility the three direct care staff members working were Mr. Lynch, Ms. Himebaugh, and Mr. Miley. Ms. Vincent stated she was assigned as the 1:1 staffing coverage for Resident A. Ms. Vincent stated Ms. Pannill told her that she would have coverage for her at 1:00 PM and when it was after 2 PM and no one told her anything she had somewhere else to go. Ms. Vincent stated she was working at that home to help out. Ms. Vincent stated she was "fed up" and that's why she left. Ms. Vincent stated she quit the same day and was upset. Ms. Vincent stated she would not have walked out of the home if there were incapacitated adults that needed assistance but since there were three other direct care staff members she was sure everyone was safe there. Ms. Vincent stated she messaged Ms. Pannill, let her know she quit, and she left. Ms. Vincent stated she was not assigned to administer any medications and when she left Resident A was in the living room with Mr. Lynch and Ms. Himebaugh so he was not unsupervised. Ms. Vincent stated she felt it was the best decision to leave.

On December 8, 2023, I interviewed direct care staff member whose role is home manager, Ms. Pannill. Ms. Pannill stated she asked Ms. Vincent if she could stay over until 2:30 PM because she didn't have a vehicle at that time. Ms. Pannill stated a half hour before she went to Beacon Home at Mt. Pleasant, she received a call stating another direct care staff member was reaching her 24 hour mark at a different home so she needed to relieve her which meant Ms. Vincent needed to work longer. Ms. Pannill stated she told Ms. Vincent she needed to go to the other house and work before she could relieve her. Ms. Pannill stated she never gave Ms. Vincent permission to leave but she did hear after the fact that she had plans. Ms. Pannill stated this is the first time Ms. Vincent left her shift without notice. Ms. Pannill stated when she left, there would have been three direct care staff members supervising four residents. Ms. Pannill stated however three of those four residents required 1:1 staffing coverage, so technically four direct care staff members were needed to assure staffing needs were met for each resident. Ms. Pannill stated the direct care staff members who are on shift all agreed to supervise Resident A while also providing care and supervision to their assigned 1:1 resident. Ms. Pannill stated no one else came in for the rest of the shift. Ms. Pannill stated the next shift started over at 9 PM and at that point, he does not require 1:1 staffing supervision according to his plan. Ms. Pannill stated Resident A was fine during this time frame and did not have any behaviors or issues that needed additional attention.

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:	Ms. Vincent left her shift at 2:30PM leaving Resident A without direct supervision for the remainder of the shift on October 14, 2023. Resident A, Resident B, and Resident C all require 1:1 staffing supervision during daytime hours so the facility needs four direct care staff members each shift during daytime hours to meet the staffing needs which they did not have.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On October 20, 2023 direct care staff member Arden Pitts was not providing Resident B 1:1 staffing coverage when he left the facility and walked down the street approximately .5 mile to the church with no shoes on and covered in mud.

INVESTIGATION:

On October 25, 2023, additional concerns were received from the Bureau of Community and Health Systems online complaint system stating Office of Recipient Rights (ORR) Katie Hohner was notified by a community member that Resident B was outside of a church with no shoes on and without direct care staff supervision. According to the complaint allegations, the community member stated Resident B was covered in mud and the police were called. ORR contacted the group home and was told by direct care staff member Kevin Miley that Resident B was in the backyard and had "slipped away from his 1:1 staff." The complaint allegations also included information that direct care staff member Mr. Miley stated that was not sure how Resident B got away and he may have "hopped the fence."

On October 26, 2023, I interviewed licensee designee Roxanne Goldammer. Ms. Goldammer stated a meeting is scheduled for October 27, 2023, with direct care staff member Ms. Pitts to discuss this incident however, it appears at this point she was not paying attention. Ms. Goldammer stated Ms. Pitts was assigned to provide 1:1 supervision to Resident B on October 20, 2023 around 2 PM. Ms. Goldammer stated the other direct care staff members working were Kevin Miley who was assigned to another resident, Alashia Carter, and Arkeshia Foster who was assigned as the “DMA staff.” Ms. Goldammer stated according to Ms. Pitt’s report, Resident B was in the backyard and she asked direct care staff member Mr. Miley to keep an eye on Resident B while she went to the bathroom but no other direct care staff members were able to confirm this. Ms. Goldammer stated Resident B was found down the road at the church and he was gone long enough the neighbors called the police and they responded. Ms. Goldammer stated she does not know if there was a police report filed for this matter. Ms. Goldammer stated she did not know about this incident until ORR called her and Ms. Pitts did not do an *AFC Incident / Accident Report* until October 25, 2023, after she was directed to do so.

On October 27, 2023, Office of Recipient Rights (ORR) advisor, Katie Hohner and I completed an on-site investigation and met with Roxanne Goldammer at Beacon Home at Mt. Pleasant. Ms. Hohner and I attempted to interview Resident B however due to his autism diagnosis, he was unable to complete an interview regarding the incident.

I was informed by Ms. Goldammer that Resident B was found down the road at Countryside United Methodist Church which I calculated on Google Maps to be .6 miles down South Leaton Road north of Beacon Home at Mt. Pleasant.

I reviewed the *Staffing Schedule* and the *Resident Assignment Form* for the week of October 15, 2023- October 21, 2023. On October 20, 2023, the following direct care staff members were scheduled:

- Arkeshia Foster / Assigned as the DMA and supervising Resident D who does not require 1:1 staffing coverage.
- Kevin Miley / assigned as 1:1 staffing supervision for Resident C
- Arden Pitts / assigned as the 1:1 staffing supervision for Resident B
- Alajah Carter / assigned as the 1:1 staffing supervision for Resident A.

I reviewed Resident Bs *Assessment Plan for AFC Residents* which indicated he needs assistance to be aware of his surroundings and will attempt to escape or ignore direct care staff members if the activity being offered is not preferred. I reviewed documentation verifying Ms. Pitts signed that she attended an in-service and understood the *Behavior Treatment Plan* for Resident B on September 24, 2023. I reviewed Resident B's *Behavior Treatment Plan* which stated the following:

> *"[Resident B] will be provided 1:1 line of sight staffing for 16 hours during his waking hours when he is not in the bedroom. The designated staff should be able to see him, but maybe at a distance of several feet or more. Staff may need to be able to be closer to him to provide needed support and intervention for periods of time, but this is not required at all times. The 1:1 supervision must be provided by a designated staff member that does not have any other supervision responsibilities while providing support to him. [Resident B] Will be provided with one to one arms reach staffing when he is away from the AFC home during outings and appointments. When he is in the community, staff will provide arms, reach supervision in which they are within two feet of [Resident B]."*

On October 27, 2023, ORR Ms. Hohner and I interviewed direct care staff member Ms. Foster who was working on October 20, 2023 and was assigned as the 1:1 for a different resident. Ms. Foster stated she was sitting in the back den area with Resident A during that time frame when Ms. Pitts inquired if Resident B was back there too. Ms. Foster stated Resident B had not been in the den with her and Resident A. Ms. Foster stated this occurred between 3PM-4PM. Ms. Foster stated Ms. Pitts informed her Resident B was not in the facility nor in the backyard including his favorite area near the barn. Ms. Foster stated direct care staff member Alajah Carter drove the van down the

street and found Resident A at the park by the Countryside United Methodist Church. Ms. Foster stated Resident B stated he went down there because he wanted to carve a pumpkin. Ms. Foster stated she does not know how long he was gone for but the church is at least a ten minute walk. Ms. Foster stated there are four residents who reside at Beacon Home at Mt. Pleasant and three of them require 1:1 direct care staff supervision. Ms. Foster stated the last time she saw Resident B he was in the backyard but Ms. Pitts was not with him because she was sitting at the dining room table and he was on the back porch so she could see him but he was not within arm's reach of her. Ms. Foster stated Resident B needs to be within arm reach unless he is in the bedroom or bathroom. Ms. Foster stated Ms. Pitts told her she asked Mr. Miley to "keep an eye on him while she was in the bathroom" but she never heard this.

On October 27, 2023 ORR Ms. Hohner and I interviewed direct care staff member Ms. Pitts at Beacon Home at Mt. Pleasant. Ms. Pitts stated Resident B spent most of the morning in the backyard on the side of the house and she was with him outside. Ms. Pitts stated she had to use the bathroom so she asked Mr. Miley to keep an eye on Resident B. Ms. Pitts stated she saw that Mr. Miley was sitting in the living room on the couch after she went to the bathroom which took approximately three minutes. Ms. Pitts went to the back den and asked the other two direct care staff member if they knew where Resident B was because she did not see him. Ms. Pitts stated she went outside to look for him again while Ms. Foster drove the van down the street to look for him. Ms. Pitts confirmed Ms. Foster located Resident B down the street by the church. Ms. Pitts stated there is a side yard which is a fenced enclosure and that is where Resident B was outside in the yard. Ms. Pitts stated she used the bathroom outside in the porta-pottie in the driveway and did not see him leave either yard. Ms. Pitts stated Resident B was likely missing for around ten minutes. Ms. Pitts stated she did not call to report this to Ms. Goldammer, Ms. Pannill, or law enforcement. Ms. Pitts stated she wrote an *AFC Incident / Accident Report* after being directed to do so. Ms. Pitts stated neighbors contacted law enforcement who responded to determine if Resident B was okay. Ms. Pitts stated law enforcement was informed Resident B had been located and was unharmed. Ms. Pitts stated the typical procedure is to step away for the bathroom or a break during 1:1 supervision assignment, is for the DMA staff member to provide 1:1 supervision to the resident during that time. During this specific incident Ms. Pitts stated DMA Ms. Carter misunderstood who she should have been supervising and did not supervise Resident B.

On October 27, 2023, ORR Ms. Hohner and I interviewed direct care staff member Ms. Carter at Beacon Home at Mt. Pleasant. Ms. Carter was assigned DMA tasks that day while Ms. Pitts was assigned to provide1:1 supervision for Resident B. Ms. Carter stated she was sitting in the den with Ms. Foster and Resident A when Ms. Pitts inquired if Resident B was in the den with them. Ms. Carter said she went to go check the barn and looked outside but when she did not see him, she drove down the road and found Resident B at the church, picked him up, and drove him back. Ms. Carter stated she does not know how long Resident B was gone nor was aware of the reason Ms. Pitts was not providing 1:1 supervision as assigned. Ms. Carter stated last time she

saw Resident B he was outside and Ms. Pitts was back there with him. Ms. Carter stated it was 1.5 hours before Ms. Pitts came in and said she could not find him.

On December 8, 2023, I interviewed direct care staff member Ms. Vincent. Ms. Vincent stated Resident B flees the home quite often. Ms. Vincent stated it was not uncommon for him to walk down the road when he is upset.

On December 13, 2023, I interviewed Citizen 1 who stated she received the information because the neighbors across the road found Resident B barefoot, muddy, and picking up stones with no jacket on. Citizen 1 stated Resident B went around the church and tried all the doorknobs but they were all locked. Citizen 1 stated there was not a direct care staff member with him when he came down to the church. Citizen 1 stated not knowing how Resident B returned to the facility or how long he was at the church. Citizen 1 stated being concerned about the temperature getting colder and someone leaving the home unsupervised.

Special Investigation Report # 2022A0783035 dated March 29, 2022 cited rule 400.14303 (2) because a direct care staff member locked the bathroom doors to keep Resident B from having access to the shower. A Corrective Action Plan was received on May 10, 2022 and Mr. Sprague retrained all direct care staff member on dignity and respect during the May 11, 2022 staff meeting.

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.
ANALYSIS:	Resident B was not provided 1:1 direct care supervision on October 20, 2023, in accordance with his *Assessment Plan for AFC Residents* and his *Community Mental Behavior Treatment Plan.* Based on interviews with Ms. Pitts, Ms. Foster, and licensee designee Roxanne Goldammer, Resident B left the facility unsupervised, walked approximately .6 miles to Countryside United Methodist Church and was found covered in mud with no shoes on. Despite conflicting reports from direct care staff members regarding how long Resident B was missing from the facility, he was able to elope in the middle of the afternoon even though he was supposed to be receiving 1:1 direct care staff supervision and was gone from the facility for at least 15 minutes.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SIR # 2022A0783035 DATED MARCH 29, 2022. CAP SUBMITTED ON MAY 10, 2022.]**

IV. RECOMMENDATION

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

_____12/13/2023_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

12/15/2023

_____

Dawn N. Timm
Area Manager

Date