GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 1, 2024

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

RE: License #: AS380398558
Investigation #: 2024A0007011
Beacon Home at Sheffield

Dear Shelly Keinath:

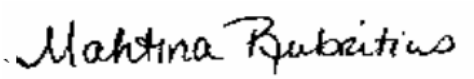
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9720.

Sincerely,



Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380398558
Investigation #:	2024A0007011
Complaint Receipt Date:	01/02/2024
Investigation Initiation Date:	01/03/2024
Report Due Date:	03/02/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Shelly Keinath
Licensee Designee:	Shelly Keinath
Name of Facility:	Beacon Home at Sheffield
Facility Address:	4162 Sheffield Drive Jackson, MI 49203
Facility Telephone #:	(517) 795-2004
Original Issuance Date:	02/05/2020
License Status:	REGULAR
Effective Date:	08/05/2022
Expiration Date:	08/04/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A, who has 1:1 staffing, was diagnosed with a fractured left arm shortly after Christmas Day 2023. Resident A had some bruising, was taken to the ER and will have surgery. Complainant is concerned Resident A was not properly supervised.	Yes
On 1/11/23, Employee #5, DCW, appeared to be smoking marijuana by the front door of the facility.	No

III. METHODOLOGY

01/02/2024	Special Investigation Intake - 2024A0007011
01/03/2024	Special Investigation Initiated - On Site - Unannounced - Face to face contact with Employee #1, Employee #2, and Resident A.
01/09/2024	Contact - Telephone call received from Ashlee Griffes, Office of Recipient Rights.
01/10/2024	Contact - Face to Face contact with Devin Pickett, APS. Discussion.
01/17/2024	Contact - Face to Face contact with Devin Pickett, APS. Discussion.
01/17/2024	Contact - Face to Face with Individual #1. Subsequent Allegations received.
02/20/2024	Contact - Face to Face contact with Devin Pickett, APS. Discussion. He plans to close his case.
02/21/2024	Contact - Face to Face contact with Devin Picket, APS. Joint phone call with Guardian A1.
02/23/2024	Contact - Telephone call made the facility, no answer.
02/23/2024	Contact - Telephone call made to Beth Pierce, Home Manager. Interview and documents requested.
02/27/2024	Inspection Completed On-site - Announced - on-site inspection. Face to face contact with Beth Pierce, Mickie Tingley, Nurse, Resident A, and direct care staff.

02/27/2024	Contact - Document Received - Provider Contact Sheet, After Visit Summary, Health Care Appraisal, Next Step Note, BTP, AFC Assessment Plan, Incident Report, Schedules, Emails.
02/27/2024	Contact - Face to Face - contact with Devin Pickett, APS. Discussion.
02/28/2024	Contact - Telephone call made to Employee #2. Interview (Follow-up).
02/28/2024	Contact - Telephone call made to Employee #5. Interview (Follow-up).
02/29/2024	Contact - Document Sent Email to Shelly Keinath, Licensee Designee. I requested a returned phone call to conduct the exit conference.
02/29/2024	Exit Conference conducted with Shelly Keinath, Licensee Designee.

ALLEGATION:

Resident A, who has 1:1 staffing, was diagnosed with a fractured left arm shortly after Christmas Day 2023. Resident A had some bruising, was taken to the ER and will have surgery. Complainant is concerned Resident A was not properly supervised.

INVESTIGATION:

On January 3, 2024, I conducted an unannounced on-site investigation and made face to face contact with Employee #1, Employee #2, and Resident A. I observed Resident A asleep in her bed. Due to Resident A's cognitive abilities and diagnoses, she was not interviewed during the investigation.

I interviewed Employee #1 and Employee #2 regarding Resident A's left arm and inquired about how the injury occurred. According to Employee #1, on December 19, 2023, Resident A was observed in the bathroom on the floor, next to the commode, with her elbows on her knees. The home nurse, Micki Tingly, was at the facility and checked Resident A over; there were no signs of injury, and her blood pressure was good. Per Employee #1, it was Christmas eve when staff noticed an issue with Resident A's arm and the injury was noticed. Employee #1 reported that she assisted and took Resident A to the doctor then to the emergency room (date unknown).

According to Employee #2, she was off for two days and when she came back, she observed the bruising on Resident A. On Christmas day, Employee #3, who quit, told her that Resident A had a small bruise in her armpit. Employee #2 stated that she noticed the bruise kept getting bigger. She observed Resident A slouched over in her chair and not moving her arm. According to Employee #2, she was assigned to be Resident A's 1:1 on Christmas day, and because of the injury to Resident A's arm, she needed Employee #3 to assist her with Resident A. Employee #2 stated, "You could look at it and tell it was broken." Employee #2 stated there was a knot on the left upper arm area, and between her shoulder and crease of armpit, there was nothing (as if the bone was not connected). Employee #2 described the bruise to be about the size of an orange, and it was purple and dark blue in color. According to Employee #2, the other staff told her Resident A fell. When asked when the fall occurred, she did not recall the specific dates but stated Resident A fell the day they had a meeting with ORR and then she fell the following day too.

On January 9, 2024, Office of Recipient Rights (ORR) Officer Ashlee Griffes stated she received additional information that Resident A fell four times between December 22, 2023, and December 25, 2023. It was alleged that Employee #1 was assigned as Resident A's 1:1 staff, but she had gone out to smoke, while Resident A took herself to the bathroom and appeared to have fallen while in the bathroom unsupervised.

On January 10, 2024, I spoke to Devin Pickett, Adult Protective Services. He reported that Resident A was found to have bruising and he will be investigating.

On January 17, 2024, I spoke to Devin Pickett, Adult Protective Services. He stated that he went to the facility and observed Resident A, who was sleeping at the time of his on-site visit. He observed the assigned 1:1 staff member sitting in the room with Resident A while she was asleep.

On February 21, 2024, Devin Picket, Adult Protective Services, and I spoke with Guardian A1, via telephone. According to Guardian A1, Resident A's other arm was broken (See SIR#2023A0007016) in the past, and it might have been due to her having osteoporosis. Resident A was supposed to be assessed for osteoporosis, but her other arm was broken before they could have the testing completed. Guardian A1 stated she did not know what happened, but questioned if the staff were "chatting," instead of paying attention to Resident A and had not noticed that she got up. According to Guardian A1, Resident A moves around quickly. They have installed handrails in the hallways to help eliminate falls.

Guardian A1 stated that when Resident A falls, staff should go with her, assisting and lowering her to the floor, instead of holding her to keep her from falling. Guardian A1 stated that even when staff are careful, when a resident has osteoporosis and falling, bones can break.

We inquired about her supervision level and Guardian A1 stated that she thinks Resident A's *Behavior Treatment Plan* (BTP) requires the 1:1 staff to be within arm's length.

On February 23, 2024, I interviewed Beth Pierce, whose role is home manager and direct care staff member, and we discussed Resident A's supervision requirements. Beth Pierce stated that sometimes Resident A will not let staff be around her when she's not happy. However, she stated that when Resident A gets up, staff should be there to assist her. In addition, she has a staff assigned to supervise her at night.

Regarding the injury, Beth Pierce stated that she came to the facility on December 24, 2023, to bring gifts for the residents. Employee #3 and Employee #4 reported that Resident A was not using her left arm as she normally does, and it was "weird." Employee #3 and Employee #4 reported that they checked for injuries and there were none. Beth Pierce stated she looked Resident A over, and observed a light purple bruise, about the size of a quarter, on the inside of Resident A's left armpit. She pointed the bruise out to the staff. Beth Pierce stated Employee #4 took Resident A's vitals, and they were within the normal range. Beth Pierce stated she had staff contact on-call medical, Nurse #1, who said to keep an eye on Resident A, because her vitals were normal and Resident A was not showing any signs of pain.

Beth Pierce stated she returned to the facility on December 26, 2023, and looked at the injury again, it was dark purple, and the bruise was larger. Beth Pierce stated she could not recall if she called Nurse Mickie Tingley or Medical Staff Member #1, from the Hybrid-Lifeways Clinic, but she knew Resident A had an appointment scheduled for either December 27th or December 28th. According to Beth Pierce, Nurse Mickie Tingley, stopped by the home to check on Resident A. Beth Pierce stated Nurse Mickie Tingley completed a medical note regarding the visit (on 12/26/23). According to Beth Pierce, Medical Staff Member #1 said if Nurse Mickie Tingley said it was okay, Resident A could wait to be seen at her PCP scheduled appointment on 12/27 or 12/28. Beth Pierce also informed me that on December 26, 2023, Mickie Tingley observed Resident A repositioning herself in the recliner, utilizing her left arm.

Beth Pierce informed me that when it was time for Resident A's appointment on 12/27/23 the doctor was late, so staff took Resident A to McDonald's (to help with anxiety issues). Once they returned to the doctor's office, Resident A would not let them look at her arm and Medical Staff Member #1 informed that Resident A would need to be seen at the hospital. The non-emergency medical personnel were contacted by staff, but Resident A refused to go in the ambulance. Staff then drove her directly to the hospital, but Resident A refused to get out of the car. Guardian A1 was contacted, and staff were instructed to go into the hospital, get medical staff, and do what was needed to have her arm examined.

According to Beth Pierce, Employee #1 then called and said the medical staff could not practice outside the hospital; and they were told to return to the home and call

911. Once they returned to the facility, they allowed Resident A to settle down and she was resting. Beth Pierce stated they contacted 911, and it took six medical personnel to get Resident A on the stretcher and into the ambulance. Resident A was fighting and resisting them.

Beth Pierce stated that once they were at the hospital, Resident A was given medication and placed into hard restraints. She was given an x-ray which showed she had a break on her left arm. Resident A was admitted into the hospital, and they performed surgery. Beth Pierce expressed concerns, as she stated that she was sad for Resident A, as Resident A is declining and when she goes into behaviors, it's very challenging. I inquired if staff reported how the injury could have occurred and Beth Pierce stated that the staff did not report anything out of the ordinary. Beth Pierce informed me that they were told by medical staff that the break could have happened any kind of way, from her running into the wall or her plopping in her chair. In addition, Beth Pierce stated Resident A rolls on the floor, during behaviors.

On February 27, 2024, I conducted an announced on-site inspection. I made face to face contact with Beth Pierce, Home Manager, Mickie Tingley, Nurse, Resident A, and direct care staff.

I spoke with Nurse Mickie Tingley, who informed me that Nurse #1, who was originally contacted about Resident A's condition, no longer works for the licensee. Mickie Tingley informed me that she saw Resident A on December 26, 2023, and completed documentation regarding her observations. In addition, Nurse Mickie Tingley stated Resident A was moving both of her arms that day.

While I was at the facility, Resident A was in a behavior and I observed her rolling around on the floor, kicking at staff, and screaming. Staff assisted Resident A back into her recliner once she accepted the help.

As a part of this investigation, I reviewed the note/observation completed by Mickie Tingley, RN, regarding Resident A, on December 26, 2023. Mickie Tingley noted that Resident A was resistive to allowing her to get a good visualization of the bruising to her left arm. It was noted that there was some swelling to Resident A's upper left arm and reddish-purple bruising that extended from her axilla to almost her elbow. Resident A's lower forearm had no bruising or swelling, and she had full range of motion to the fingers on that hand. It was noted, however, that Resident A would not use her left arm, as she would prior to that day. Direct Care staff reported to administer PRN medication for possible discomfort. Otherwise, Resident A presented at her baseline and did not appear painful during Mickie Tingley's visit that day. It was also noted that Beth Pierce reported that she spoke with Medical Staff Member #1 at PCP's office, who agreed to have Resident A evaluated at her PCP appointment the following day (12/27/23) at 8:30 a.m. instead of being seen in the emergency department. It was documented Nurse Mickie Tingley agreed to Resident A being seen by her primary care physician, as long as there were no other major changes or concerns that day. The observation note also documented that

Beth Pierce left a message for Guardian A1 and were awaiting a returned phone call. While at the home, the observation note documented Mickie Tingley and Beth Pierce observed Resident A use her left arm to readjust/reposition herself with her arm, in the recliner. Resident A was administered PRN ibuprofen and Vistaril, for occasional agitation and potential pain.

I reviewed Resident A's *Behavior Treatment Plan* which documented Resident A requires 1:1 eyes on supervision; she is to be within eye site and ear shot during all waking hours in the home and 15-minute checks are to be completed when she is sleeping. Staff are not to be within arm's length unless she is displaying unstable behavior that day. Resident A is also considered a high fall risk and requires 1:1 supervision per her OT Plan to prevent injury.

According to the *Assessment Plan for AFC Residents*, Resident A requires assistance with toileting. It was noted that "staff assistance/enhance staffing to prevent falls while in the restroom."

I reviewed the *Provider Contact Sheet*, which documented on December 27, 2023, Resident A was seen to have a Health care appraisal, diet order, PRN, renewal of all medications, and to check the bruising on her left arm. An x-ray and labs were also ordered.

The medical summary and discharge notes from Hospital #1 documented that Resident A was diagnosed with a "closed fracture of Proximal End of Left Humerus."

On February 27, 2024, I spoke with Devin Pickett, Adult Protective Services. He stated he interviewed Employee #1, who denied being outside smoking when Resident A fell. He stated that he substantiated the allegations for neglect against the facility.

On February 28, 2024, I spoke with Employee #2 who reported that she no longer works for Beacon. I inquired about Resident A falling four times between December 22, 2023, and December 25, 2023. She stated that she was not sure of the exact dates, but she had been off work for a couple of days and when she returned other staff were talking about Resident A having falls. Employee #2 stated that Resident A fell on a shift that she worked when Employee #1 was her assigned 1:1 staff. Employee #2 stated that she, and Employee #5 were also on duty that shift. Employee #2 stated that Employee #1 stepped outside to smoke. Resident A took herself to the bathroom. According to Employee #2, when Employee #1 came back in, Resident A was on the bathroom floor, like she had fallen, and was on her hands and knees. I inquired if anyone else was aware of this incident and she stated Employee #5.

On February 28, 2024, I interviewed Employee #5. He stated that Employee #1 was assisting Resident A in the bathroom, and she stepped out to get something. According to Employee #5, when Employee #1 returned, she said Resident A was

observed on her hands and knees. Employee #5 stated that he did not know if Resident A had fallen or not.

On February 29, 2024, I conducted the exit conference with Shelly Keinath, Licensee Designee. I discussed the investigation, the findings, and my recommendations. Shelly Keinath agreed to submit a written corrective action plan to address the establish violation.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**

ANALYSIS:	According to Beth Pierce, she went to the facility on Christmas Eve to deliver gifts when she was informed that Resident A was not using her left arm as she normally would. Staff reported that nothing out of the ordinary occurred. Staff reported that they checked for injuries and there were none. Beth Pierce looked Resident A over, and observed a light purple bruise, about the size of a quarter, on the inside of Resident A's left armpit. Resident A's vitals were taken, and on-call nursing was consulted. The nursing staff attempted to examine Resident A, as she was reluctant, and once she was examined at the hospital, she was diagnosed with a "closed fracture of Proximal End of Left Humerus." Resident A's *Behavior Treatment Plan* requires 1:1 eyes on supervision; she is to be within eye site and ear shot during all waking hours in the home and 15-minute checks are to be completed when she is sleeping. Staff are not to be within arm's length unless she is displaying unstable behavior that day. Resident A is also considered a high fall risk and requires 1:1 supervision per her OT Plan to prevent injury. According to Resident A's *Assessment Plan for AFC Residents*, Resident A requires assistance with toileting as follows: "staff assistance/enhance staffing to prevent falls while in the restroom." While it is unclear when and how Resident A sustained the injury to her left arm, staff reported at least one incident where Resident A was found to be on the floor in the bathroom, without an explanation as to what occurred prior to her being observed on the floor. Resident A is a high fall risk, and she requires 1:1 staff supervision during waking hours and while in the bathroom specifically. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that the amount of supervision and protection that Resident A required was not provided by the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On January 11, 2024, Employee #5, appeared to be smoking marijuana by the front door of the facility.

INVESTIGATION:

On January 17, 2024, I spoke to Individual #1. He stated that on January 11, 2024, around 12:15 p.m., when he arrived at the home, he observed Employee #5 smoking marijuana on the front porch of the facility. Individual #1 stated that he told Beth Pierce about the situation, and he would notify other officials as well.

On February 21, 2024, Devin Picket, Adult Protective Services, and I spoke with Guardian A1, via telephone. According to Guardian A1, she has not smelled marijuana in the home or on the staff.

On February 27, 2024, I conducted an announced on-site investigation and noted there were signs prohibiting drugs, alcohol, and weapons on the premises.

While at the facility, I spoke with Employee #5. He informed me that marijuana was not allowed on the premises and that he had not observed anyone smoking weed at the home. Employee #5 recalled that someone visited the home, he (Employee #5) was standing at the front door smoking; the person walked by, they spoke and that was it. Employee #5 stated that he was using his Breeze vape, not marijuana. Employee #5 informed me that he has been told a couple times that his vape smells like marijuana but it's not. Employee #5 stated that Individual #1 spoke to his lead staff (Employee #6), because she asked him what he said to Individual #1.

I interviewed Employee #6 who reported that Individual #1 asked who Employee #5 was and if he worked at the home. Employee #6 reported that Employee #5 did not appear to be under the influence of marijuana on the day in question. Employee #6 reported that Employee #5 was a "pretty good" worker, and he did well around the facility. She reported that she has smelled marijuana on his clothes but has not observed him smoking marijuana at the home.

I spoke with Beth Pierce who informed me that Individual #1 did speak to her about the allegations. I inquired if he was drug tested and she stated "No" because it's a legal substance that people can utilize outside of work. She stated that on the day in question, she made face to face contact with Employee #5 within a couple of hours and she did not smell any marijuana on his person, and he did not appear to be under the influence.

During my on-site investigation, I did not smell any marijuana in the home or on the staff.

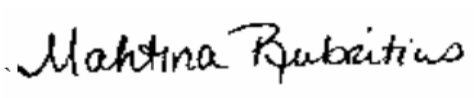
On February 27, 2024, Devin Pickett, Adult Protective Services, informed me that they were aware of these allegations, and they were not investigated by APS. Appropriate officials have been notified.

On February 29, 2024, I conducted the exit conference with Shelly Keinath, Licensee Designee, and she agreed with the conclusion of the investigation.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual and social needs of each resident.**
ANALYSIS:	Based on the information gathered during this investigation and provided above there is not enough evidence that direct care staff members, including Employee #5, were smoking marijuana on the premises affecting their ability to meet resident needs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of a detailed and acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.



02/29/2024

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

03/01/2024

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Dawn N. Timm Date
Area Manager