GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 3, 2024

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

RE: License #: AM030402101
Investigation #: 2024A0464026
Beacon Home at Hammond

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 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 (616) 356-0183.

Sincerely,

Megan Aukerman, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030402101
Investigation #:	2024A0464026
Complaint Receipt Date:	03/06/2024
Investigation Initiation Date:	03/06/2024
Report Due Date:	05/05/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Ramon Beltran
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:	01/26/2024
Expiration Date:	01/25/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff refused to assist Resident B with toileting and changing.	Yes
Staff did not administer Resident B's prescribed medications.	Yes
Staff refused to assist Resident B with showers.	No

III. METHODOLOGY

03/06/2024	Special Investigation Intake 2024A0464026
03/06/2024	Special Investigation Initiated - On Site Elena Tricoci, Kalamazoo ORR
03/06/2024	Inspection Completed On-site Elena Tricoci (ORR), Kim Scott (Manager), Britini Smith (Manager), Chelsea Roblyer (Staff), Tonya Klifman (Staff), Resident A & Resident C
03/06/2024	Contact - Document Received Facility Records
04/10/2024	APS Referral Kathleen Woodward, Allegan County APS
04/10/2024	Contact-Face to Face Elena Tricoci (ORR), Britini Smith (Manager), & Kristy Penny (Staff)
04/19/2024	Inspection Completed-Onsite Elena Tricoci (ORR), Britini Smith (Manager), Justice Brunn (Staff), Residents D, E & F
05/02/2024	Exit Conference Ramon Beltran, Licensee Designee

ALLEGATION: Staff refused to assist Resident B with toileting and changing.

INVESTIGATION: On 03/06/2024, I received a complaint from Kalamazoo County Office of Recipient Rights (ORR). The complaint alleged facility staff refused to provide basic care to Resident B and often refuse to assist Resident B with toileting. The complaint also alleged that facility staff refused to assist Resident B with

showers. There was also concern that staff were not administering Resident B's medications as prescribed. Resident B passed away, under the care of hospice, on 03/04/2024.

On 03/06/2024, I met with Office of Recipient Rights (ORR) worker, Elena Tricoci to coordinate the investigation. Ms. Tricoci and I completed an unannounced, onsite inspection at the facility. We interviewed staff Kim Scott and Britini Smith. The reported that Resident B had been diagnosed with lung cancer and was receiving palliative care through hospice (Elara Caring). Both staff confirmed Resident B passed away on 03/04/2024. Prior to Resident B passing, hospice informed facility staff Resident B was no longer independent and able to do things on her own, requiring staff assistance. Resident B also required the use of oxygen. When Resident B would get up for transfers or to use the toilet, her oxygen levels would significantly decline. Staff would have to put Resident B back in bed and make sure she had her oxygen on correctly. Ms. Smith and Ms. Scott reported often times, Resident B would move her oxygen tube and staff would have to readjust it, to ensure it was on Resident B's face correctly. Even though Resident B required staff assistance, certain staff would refuse to provide care to Resident B. Ms. Scott stated staff Justice Brunn had stated to her that she "wasn't going to deal with (Resident B)". Ms. Scott stated she also recently became aware that the facility manager, Chelsea Marie Hernandez was not adequately caring for residents or ensuring other staff were meeting resident care needs. Ms. Scott learned Resident B would yell for assistance with changing and toileting, but staff would refuse to assist. Ms. Scott and Ms. Smith reported that when they would come into the facility, residents were often discovered to have been left in urine-soaked clothing and linens. Ms. Scott stated Ms. Hernandez's employment has been suspended pending the investigation.

Ms. Tricoci then interviewed staff, Chelsea Roblyer. She stated she has worked at the facility for ninety days. She denied refusing to provide care to any resident. Ms. Roblyer denied witnessing any other staff refuse to provide care to Resident B or any other resident.

Ms. Tricoci and I then interviewed staff, Tonya Klifman. Ms. Klifman reported she has only been working at the facility for one month. Klifman denied refusing to provide care to Resident B. She denied witnessing other staff refuse to provide care to Resident B. Ms. Klifman reported Resident B required the use of oxygen but would often move the oxygen hose from her face. Ms. Klifman stated Resident A would also make herself fall out of her wheelchair to get attention from staff.

I then interviewed Resident A privately. Resident A stated she enjoys residing at the facility and staff take good care of her. Resident A denied observing staff refuse to provide care for any resident.

Face-to-face contact was made with Resident C. An interview was not completed as Resident C was observed to be sleeping.

On 03/06/2024, I received and reviewed Resident B's Assessment Plan. Under the Self Care Assessment section, it states staff will assist Resident B with dressing, hygiene and grooming when needed. The assessment states hospice comes to the facility to shower Resident B.

On 03/06/2024, I received and reviewed Resident B's Health Care Appraisal (HCA) which was completed and signed by nurse, Marci Villeneuve on 06/20/2023. The HCA states Resident B was diagnosed with lung cancer and was receiving hospice services through Elara Caring.

On 04/10/2024, Ms. Tricoci and I completed a Microsoft Teams meeting with Ms. Smith and staff, Kristy Penny. Ms. Penny stated she has worked at the facility since November 2023. She denied witnessing or observing Resident B not being appropriately cared for, specifically toileted or changed.

On 04/19/2024, Ms. Tricoci and I completed an onsite inspection at the facility. We interviewed staff, Justice Brunn. She stated she has worked for Beacon Homes for four years and typically works third shifts. Ms. Brunn stated first shift staff are not properly caring for residents, including Resident B. She stated that often times when she has come in for her scheduled shift, she has discovered that residents had been left in urine-soaked clothes and linens. Ms. Brunn stated when this has occurred, she would then be left to take care of them. Ms. Brunn denied there has ever been an incident where she stated and refused to provide care to Resident B.

We then interviewed Residents D, E and F, individually. All three residents stated facility staff provide care when needed. They denied having any concerns.

On 05/02/2024, I completed an exit conference with licensee designee, Ramon Beltran. He was informed of the investigation findings and recommendations. Mr. Beltran stated that a corrective action plan would be submitted within the next few days.

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:	On 03/06/2024, a complaint was receiving alleging facility staff refused to provide care to Resident B. Facility staff Kim Scott, Britini Smith, and Justice Brunn all reported that facility staff do not always assist, toilet or change residents, including Resident B.

	Facility staff Chelsea Roblyer and Tonya Klifman denied refusing to provide care for Resident B. Both denied witnessing other staff refuse to provide care. Resident B's Assessment Plan and Health Care Appraisal stated Resident B requires staff assistance with toileting and personal care. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff did not consistently provide needed care for Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff did not administer Resident B's prescribed medications.

INVESTIGATION: On 03/06/2024, Ms. Tricoci and I completed an unannounced, onsite inspection at the facility. We interviewed facility managers, Ms. Scott, and Ms. Smith. Both stated Resident B ran out of her Ativan (Lorazepam 1mg) prescription on 03/03/2024.

Ms. Tricoci and I then interviewed Ms. Roblyer. She stated she is trained in administering resident medications. Ms. Roblyer stated she has administered Resident B's medications. Ms. Roblyer stated she was not aware that Resident B's medication ever ran out, except for one weekend when Resident B was out of her Flonase spray (Fluticasone propionate). Ms. Roblyer stated when she noticed Resident B ran out of her Flonase, she documented it in the medication administration record (MAR) so that the facility manager would know to order a refill.

On 03/06/2024, I received and reviewed Resident B's Medication Administration Record (MAR) for the months of February 2024 and March 2024. The MAR reflected Resident B was prescribed loratadine 10mg, aspirin 81mg, bumetanide 81mg, docusate sodium .5mg, Fluticasone propionate nasal spray, klonopin 2mg, levothyroxine 25mg, lisinopril 10mg, lorazepam 1mg, Oxcarbazepine 300mg, Pulmicort inhaler, risperidone .5mg, and tamsulosin .4mg. The MAR reflected Resident B was supposed to be administered lorazepam every six hours. The MAR reflects Resident B was administered her medications, including the lorazepam as prescribed, until 03/03/2024 at 8:00 pm.

On 03/06/2024, I received and reviewed the facility's-controlled substance medication log. The log reflects Resident B's lorazepam was counted during every shift change. The log reflects Resident B ran out of the lorazepam on 03/03/2024 at 2:00 pm.

On 05/02/2024, an exit conference was completed with Mr. Beltran. He was informed of the investigation findings and recommendations.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 03/06/2024, a complaint was received alleging facility staff were not administering Resident B's prescribed medications. Facility managers, Kim Scott and Britini Smith both acknowledged that Resident B ran out of her lorazepam 1mg. Staff, Chelsea Roblyer also acknowledged there was an incident when Resident B ran out of her Fluticasone propionate. Resident B's medication administration record (MAR) was reviewed for the months of February 2024 and March 2024. The MAR reflects staff initialed all medications administered as prescribed. The facility's-controlled substance log was reviewed and reflected Resident B ran out of her lorazepam 1mg on 03/03/2024 at 2:00 pm, which contradicts Resident B's MAR. Based on the investigative findings, there is sufficient evidence to support a rule violation that facility staff did not ensure Resident B was administered her prescribed lorazepam 1mg.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff refused to assist Resident B with showers.

INVESTIGATION: On 03/06/2024, Ms. Tricoci and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Smith and Ms. Scott. Both stated Resident B often refused showers from staff. Once Resident B began receiving services through Elara Caring, hospice staff would come to the facility twice per week and shower Resident B.

Ms. Tricoci and I then interviewed Ms. Roblyer and Ms. Klifman individually. Both staff reported Resident B often refused showers. Both staff stated hospice started showering Resident B.

On 03/06/2024, I received and reviewed Resident B's Assessment Plan signed by court appointed guardian, Molly Chase. Under the Self Care Skill Assessment section, it states that hospice assists with showers during the week.

On 04/19/2024, Ms. Tricoci and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Brunn. She stated Resident B often refused showers, even when staff would try to prompt her. Ms. Brunn stated once Resident B began receiving hospice services, hospice staff would shower Resident B on a weekly basis.

On 05/02/2024, I completed an exit conference with licensee designee, Ramon Beltran. He was informed of the investigation findings and recommendations.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	On 03/06/2024, a complaint was receiving alleging facility staff refused to assist Resident B with showering. Facility staff Kim Scott, Britini Smith, Chelsea Roblyer, Tonya Klifman, and Justice Brunn all reported Resident B was receiving showers from hospice staff. Resident A's Assessment Plan was reviewed and reflected hospice staff come to the facility, to assist Resident B with showers. Based on the investigative findings, there is insufficient evidence to support a rule violation that staff are not showering Resident B.
CONCLUSION:	VIOLATION NOT ESTABLISHED

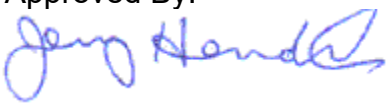
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the licensing status remain unchanged.

Megan Aukerman, MSW 05/02/2024

Megan Aukerman Date
Licensing Consultant

Approved By:



05/03/2024

Jerry Hendrick Date
Area Manager