GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 17, 2024

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

RE: License #:	AS250413017
Investigation #:	2024A0872057
	Beacon Home At Lennon

Dear Ramon 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 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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250413017
Investigation #:	2024A0872057
Complaint Receipt Date:	08/27/2024
Investigation Initiation Date:	08/27/2024
Report Due Date:	10/26/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At Lennon
Facility Address:	5328 Lennon Rd Swartz Creek, MI 48473
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/29/2022
License Status:	REGULAR
Effective Date:	05/29/2023
Expiration Date:	05/28/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 08/22/24, Resident A was yelling for help all night and staff would not help her. Resident A was observed “covered head to toe in urine.”	Yes

III. METHODOLOGY

08/27/2024	Special Investigation Intake 2024A0872057
08/27/2024	Special Investigation Initiated - On Site Unannounced
09/11/2024	Contact - Document Sent I emailed the licensee designee requesting information about this complaint
09/11/2024	APS Referral I made an APS referral via email
09/17/2024	Contact - Document Received Documentation received regarding this complaint
09/17/2024	Contact - Telephone call made I interviewed staff Rodnesha McLaurin
09/17/2024	Exit Conference I conducted an exit conference with LD Beltran
09/17/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 08/22/24, Resident A was yelling for help all night and staff would not help her. Resident A was observed “covered head to toe in urine.”

INVESTIGATION: On 08/27/24, I conducted an unannounced onsite inspection of Beacon Home at Lennon Adult Foster Care facility. I interviewed Resident A, staff Shanareyha Johnson, and Resident B.

I asked Resident A general questions about her personal care habits, and she told me that she wears briefs. Resident A said that she can change her wet brief herself and

that staff helps Resident A if she asks for assistance. Resident A also said that she typically sleeps through the night and does not need help going to the bathroom.

According to Resident A, on/around 8/22/24, staff Rodnesha McLaurin was working the night shift. Resident A said that she wet her brief and it got on her clothes and her bedding. I asked Resident A if she asked anyone for help and Resident A said that she changed her own brief, clothes, and bedding. Later that night, Resident A wet herself again and when Resident A called out for help, Staff McLaurin told her to go back to sleep. Resident A said that the next morning, staff ShaNareyha Johnson came to work and helped Resident A get cleaned up. I asked Resident A how long she was sitting in her wet brief, and Resident A said she did not know. Resident A talked in a very low tone of voice, and she mumbled so it was difficult to hear her during this interview.

Staff Shanareyha Johnson said that she has worked at this facility for approximately two years, and she typically works from 7am-7:30pm. According to Staff Johnson, when she arrived to work on the morning of 08/22/24, Staff McLaurin said, “I need your help with (Resident A.)” Staff Johnson followed Staff McLaurin into Resident A’s room and found Resident A stuck in her bed, crying, and saying she was in pain. Resident A was “covered in urine and it was even in her hair.” According to Staff Johnson, Resident A’s knees were wedged up against the wooden slats in her bedframe and Resident A was stuck. Staff McLaurin told Staff Johnson that she needed help getting Resident A up so Staff Johnson helped her. By the time they got Resident A up, she could barely stand up and Resident A could not walk. Resident A had significant indentations and swelling in both knees. Staff Johnson said that she took pictures of Resident A’s legs and texted them to the nurse who advised her to call 911. Resident A was transported to Hurley hospital. When Resident A returned home, staff provided her with ice packs for her legs and they elevated her feet.

Staff Johnson told me that later that day, Resident B approached her and told her that Resident A had been crying for help since 2am but staff would not help her. Resident B told Staff Johnson that she asked Staff McLaurin to help Resident A, but Staff McLaurin said, “I can’t help her. I need a Hoyer lift and I don’t have one” so she left Resident A crying in bed. According to Staff Johnson, Resident A does not use a Hoyer lift and she only requires one staff’s assistance when Resident A asks for help. Staff Johnson told me that Resident A does have leg swelling and weakness at times and when she does, staff assists her by helping her up by one arm. Staff Johnson also said that one staff can reposition Resident A in bed and that Resident A does not use a wheelchair, walker, cane, or any other assistive devices for mobility.

Resident B told me that she has lived at this facility for approximately 1.5 years. Resident B said that she gets up frequently during the night and passes Resident A’s room when she does. According to Resident B, on 08/22/24 at 2am, Resident B got up to use the bathroom. Resident B heard Resident A calling out for help, so Resident B went in her room and offered to help Resident A. Resident A said she was fine so Resident B went back to bed. Resident B said that she got up again at 4am and Resident A was again yelling for help. Resident B again went to Resident A’s room and

asked Resident A if she could help, and Resident A said no. According to Resident B, she went back to bed and got up again at 6:40am. Resident A was again yelling for help so Resident B went and asked Staff McLaurin to help Resident A. According to Resident B, Staff McLaurin told her, “I can’t lift her by myself. I need a Hoyer lift.” Resident B said that Resident A continued crying and asking for help until 7am at which time Staff Johnson came on shift.

Resident B told me that she could clearly hear Resident A crying and yelling for help each time she got up to use the bathroom. Resident B said that she believes that Staff McLaurin heard her also but did not help her.

On 09/17/24, I reviewed AFC paperwork related to this complaint. Resident A was admitted to this facility on 01/19/23. According to her Health Care Appraisal dated 07/17/24, she is diagnosed with Bipolar I disorder, edema, anxiety, insomnia, asthma, and constipation. According to Resident A’s Assessment Plan, she does not require assistance with eating/feeding, toileting, dressing, personal hygiene or walking/mobility and she does not use any assistive devices.

I reviewed her Community Mental Health for Central Michigan Individualized Plan of Service (IPOS) dated 03/15/24. According to this document, Resident A wears briefs to avoid soiling her bedding and clothing. Resident A will limit liquids at nighttime and increase fluids during the day. Resident A has “high levels of pain and becomes tired easily when walking.” There is no documentation about how often staff is to check on Resident A at night and no documentation about checking her brief.

On 09/17/24, I interviewed staff Rodnesha McLaurin via telephone. Staff McLaurin confirmed that she worked from 7pm-7:30am on 08/22/24. Staff McLaurin said that during her shift, she conducted hourly checks on the residents as required by the facility. Staff McLaurin told me that she remembers seeing Resident A asleep in bed with her feet hanging over the side when conducting her checks. According to Staff McLaurin, Resident A often does not get all the way in bed when she goes to sleep so she was not concerned. Staff McLaurin told me that at approximately 6am, she checked on Resident A who was crying and saying her legs were hurting “really bad.” Staff McLaurin gave her some Ibuprofen and sat her up in bed. Staff McLaurin said that she was not able to get Resident A to her feet by herself because Resident A is very heavy. I asked Staff McLaurin if she said anything about using a Hoyer lift. Staff McLaurin said that she did suggest they have a Hoyer lift in the facility to use with Resident A in situations like this but was told that Resident A does not require a Hoyer lift and it is not in her Individualized Plan of Service (IPOS.)

Staff McLaurin told me that when staff ShaNareyha Johnson arrived to work the next morning at approximately 7am, she asked her to assist getting Resident A up to her feet. I asked Staff McLaurin what Resident A’s condition was when they got her up and she said that Resident A’s feet were swollen, her brief was wet, her nightgown was wet, and her bedding was wet. Staff McLaurin said that when she gave Resident A Ibuprofen at 6am, she did note that Resident A was wet but said that she could not change

Resident A by herself which is why she waited until Staff Johnson got to work. Staff McLaurin said that she and Staff Johnson changed Resident A's brief, cleaned Resident A up, changed Resident A's clothes and brushed Resident A's hair in preparation for Resident A going to the hospital.

According to Staff McLaurin, Resident A was not "soaked", Resident A had not called out for help during the night, and none of the other residents ever told her that Resident A needed assistance.

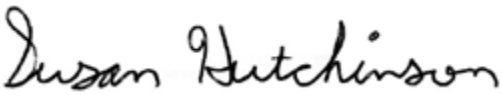
On 09/17/24, I conducted an exit conference with the licensee designee (LD), Ramon Beltran. I discussed the results of my investigation and explained which rule violation I am substantiating. LD Beltran agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

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:	Resident A said that on 08/22/24, she wet her brief and it got on Resident A's clothes and bedding. Resident A asked staff Rodnesha McLaurin for help and was told to go back to sleep. Resident B said that during the night of 08/22/24, Resident A called out for help on at least three separate occasions. Finally, at 6:40am, Resident B asked Staff McLaurin to help Resident A, but Staff McLaurin said she could not help her because she did not have a Hoyer lift. Staff Shanareyha Johnson said that when she arrived to work on the morning of 08/22/24, she found Resident A in bed and Resident A's body, clothes, and bedding were soaked in urine. Resident A also had swelling and indentations in her legs from being stuck in bed. Staff Johnson said that Staff McLaurin told her that she could not get Resident A up by herself which is why she waited for the next shift staff to arrive. Staff Rodnesha McLaurin said that during her shift on 08/22/24, Resident A did not call out for help and none of the residents told her that Resident A needed assistance. Staff McLaurin said that when she checked on Resident A at approximately 6am, Resident A had wet her brief, and her clothes and bedding were wet but "not soaked." Staff McLaurin said that she was unable to get Resident A into a standing position, so she gave Resident A

	Ibuprofen for pain and waited for the next shift staff to arrive at approximately 7am. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

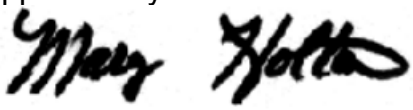
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



September 17, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:



September 17, 2024

Mary E. Holton Area Manager	Date