GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 24, 2024

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

RE: License #: AS630393369
Investigation #: 2024A0465036
Beacon Home at Clarkston

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 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 (248) 975-5053.

Sincerely,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630393369
Investigation #:	2024A0465036
Complaint Receipt Date:	08/21/2024
Investigation Initiation Date:	08/22/2024
Report Due Date:	10/20/2024
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 Clarkston
Facility Address:	10358 Horseshoe Circle Clarkston, MI 48348
Facility Telephone #:	(248) 922-7413
Original Issuance Date:	10/16/2018
License Status:	REGULAR
Effective Date:	11/24/2023
Expiration Date:	11/23/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff teased and beat up Resident A, and allowed other residents to beat up Resident A.	Yes
Direct care staff did not properly administer Resident A's Invega 6mg prescription medication.	No
Direct care staff are using a van with broken doors to transport residents.	No
The facility improperly discharged Resident A from the home.	Yes

III. METHODOLOGY

08/21/2024	Special Investigation Intake 2024A0465036
08/22/2024	Special Investigation Initiated – Letter Email exchange with Complainant
08/29/2024	Inspection Completed On-site I completed an onsite investigation; Conducted a walk-through of the facility, reviewed resident files, interviewed Resident A, Resident B and direct care staff, Christina Johnson and Janese Hall
08/29/2024	Contact - Document Received Facility documents reviewed
09/10/2024	Contact - Telephone call made I called Guardian A1; Requested a return call
09/27/2024	Contact - Document Received Documents received from Melissa Williams via email
09/27/2024	Contact - Telephone call made I spoke to Resident A via telephone

09/27/2024	Contact - Telephone call made I spoke to Trinity Oakland Inpatient Social Worker, Eva Melane, via telephone
09/27/2024	Contact – Telephone call made I spoke to licensee designee/administrator, Ramon Beltran, via telephone
09/27/2024	Contact - Document Received Email exchange with Melissa Williams from Beacon Corporation
09/30/2024	Contact - Document Received Documents received from Beacon Specialized Living Senior Case Manager, Cassidy Jewell-Chafin via email
09/30/2024	Contact - Face to Face I attended a Zoom Call with Melissa Williams, Nichole VanNiman and Ramon Beltran
09/30/2024	Contact - Document Received Email exchange with licensee designee, Ramon Beltran, Melissa Williams and Nichole VanNiman
10/04/2024	Contact - Telephone call made I spoke to direct care staff, Skylar Ward, via telephone
10/07/2024	Contact - Telephone call made I called Guardian A1; Requested a return call
10/08/2024	Contact - Document Received Facility documents received via email
10/11/2024	Contact – Telephone call made I spoke to Guardian A1 via telephone
10/15/2024	Contact - Telephone call made I spoke to Erin Schaaf via telephone
10/15/2024	Contact - Document Received Email received from Erin Schaaf
10/18/2024	Exit Conference I conducted an exit conference with licensee designee/ administrator, Ramon Beltran, via telephone

ALLEGATION:

Direct care staff teased and beat up Resident A and allowed other residents to beat up Resident A.

INVESTIGATION:

On 8/21/2024, a complaint was received, alleging that direct care staff teased, beat up, and allowed other residents to beat up Resident A. The complaint stated that direct care staff laugh at Resident A and tease her. The complaint stated that, on an unknown date, direct care staff beat up Resident A. The complaint stated that the other residents in the home also beat up Resident A on an unknown date.

On 8/22/2024, I spoke to Complainant via telephone. Complainant stated that the allegations in this complaint are accurate.

On 8/29/2024, I completed an onsite investigation. At the time of my onsite investigation, there were six residents residing in the home, including Resident A. I conducted a walk-through of the facility, reviewed resident files, interviewed Resident A, Resident B and direct care staff, Christina Johnson and Janese Hall. I observed the home to be in good condition and all residents to be properly dressed and with adequate hygiene. I did not observe any injuries or bruises on Resident A. I did not locate any facility incident/accident reports to confirm that Resident A was ever assaulted by staff or other residents.

On 8/27/2024, I spoke to Resident A, who stated, “I don’t like living here. I don’t want to be here. I don’t like the staff. I don’t like anything about here.” When I asked Resident A specifically about this complaint, she refused to provide any additional information or responses.

I interviewed Resident B, who stated, “I like living here. The staff treat me good. I like to sleep and don’t want to leave my room. Staff have never hurt me or mistreated me.” Resident B denied knowledge of this complaint being true.

I spoke to direct care staff, Christina Johnson, who stated that she has worked at the facility for five months. Ms. Johnson stated, “I am familiar with Resident A. Resident A is verbally and physically aggressive towards staff and residents in the home. She frequently makes threats to hurt other residents and has physically attacked staff and thrown things at us. I have never mistreated or caused any type of emotional harm to Resident A. I have never observed any other staff nor any resident emotionally harm or physically mistreat Resident A either.” Ms. Johnson denied knowledge of this complaint being true.

I spoke to direct care staff, Janese Hall, who stated, “Resident A has only been here for a few months and has been displaying significant behaviors. She is verbally and

physically aggressive. She will become extremely angry when she does not get her way. She often will make up lies as a form of retaliation. She makes threats on a daily basis to other residents in the home and staff. We do our best to redirect and de-escalate her behavior while a new placement is located. I have never caused emotional or physical harm to Resident A, and I have never observed any other staff, or any resident mistreat Resident A. It is the other way around." Ms. Hall denied knowledge of this complaint being true.

On 10/4/2024, I spoke to direct care staff, Skylar Ward, via telephone. Ms. Ward stated that she has worked at the facility for four months. Ms. Ward stated, "Resident A was verbally and physically aggressive towards staff and residents. She mistreated everyone that she came in contact with. She attacked staff and residents both. I never mistreated Resident A, and I never saw any other staff or resident mistreat Resident A either. Resident A was always the aggressor in every incident that occurred. I only ever saw Resident A mistreat and threaten others. I never saw anyone mistreat her." Ms. Ward denied knowledge of this complaint being true.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	On 8/29/2024, I observed Resident A to be appropriately dressed and with good hygiene. I did not observe any bruises or injuries on Resident A. According to Resident A, she does not like living at the facility, but she refused to provide any additional information related to this complaint. According to Resident B, staff have never caused harm or mistreated her. Resident B denied knowledge of this complaint being true. According to Ms. Johnson, Ms. Hall, and Ms. Ward, they have never mistreated any resident, including Resident A. Ms. Johnson, Ms. Hall and Ms. Ward denied knowledge of this complaint being true.

	Based on the information above, there is not sufficient information to confirm staff mistreated or caused emotional harm to Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Direct care staff did not properly administer Resident A's prescription medication.

INVESTIGATION:

On 8/21/2024, a complaint was received, alleging that direct care staff did not administer Resident A's prescription medication, Invega, from 8/16/2024-8/19/2024. The complaint stated that Resident A was prescribed Invega on the evening of 8/15/2024. The complaint stated that Guardian A1 brought the medication to the facility on 8/17/2024. The complaint stated that the facility had the medication onsite at the facility but refused to administer it due to needing time to enter it into the computer system.

During my onsite investigation on 8/29/2024, I reviewed Resident A's *Medication Administration* Record and compared it to the physical medications onsite at the facility. I did not observe any medication errors or discrepancies. I observed Invega 6mg on Resident A's MAR, to be administered once daily in the evening. According to the MAR, Resident A received Invega on 8/18/2024 and 8/19/2024.

I reviewed the *Staff Nursing Note*, dated 8/16/2024, which indicated that Resident A was discharged from the hospital on 8/16/2024 and returned to the facility with a prescription for Invega 6mg. Staff went to the pharmacy on 8/16/2024 to pick up Resident A's prescription for Invega and were informed that Guardian A1 had contacted the pharmacy and requested the medication be placed on hold due to concerns that the medication order was not correct. The pharmacy was able to obtain consent from Guardian A1 on 8/18/2024 for the prescription to be filled, and Resident A was administered Invega on this same date. Resident A received Invega on 8/18/2024 and 8/19/2024, however on 8/19/2024, Guardian A1 requested that this medication be discontinued, and the medication order was cancelled. Resident A did not receive any further doses of Invega.

On 8/27/2024, I spoke to Resident A, who stated, "I don't like taking medications that staff tell me to. I don't trust them." When I asked Resident A specifically about this complaint, she refused to provide any additional information or responses.

I interviewed Resident B, who stated, "I like living here. Staff give me my medication. I have not had any issues." Resident B denied knowledge of this complaint being true.

I spoke to Ms. Johnson while onsite at the facility. Ms. Johnson stated, “Resident A did receive her medication as ordered, but the delay was due to the guardian requesting a hold. I have never refused to administer medication to any resident, including Resident A. Resident A has refused to take medication and Guardian A1 has also refused to allow us to give medication or told Resident A not to take specific medications. That is an ongoing issue we are dealing with. But the medication issues are not because we do not want to administer them. That is not true.” Ms. Johnson denied knowledge of this complaint being true.

I spoke to Ms. Hall while onsite at the facility. Ms. Hall stated, “Resident A will refuse to take medication and Guardian A1 will try to manage the medications and change things on us. We do our best to administer all medication but if a guardian does not want something administered or filled by pharmacy, we have to work with them. We issued a discharge for Resident A because of ongoing issues like this. But I have never refused to administer a medication to Resident A. We fill all medications at the pharmacy once we get the doctor orders.” Ms. Hall denied knowledge of this complaint being true.

On 10/15/2024, I spoke to Ms. Schaaf, via telephone. Ms. Schaaf stated, “One of the main issues with maintaining a placement for Resident A has been interference from Guardian A1, which included medication involvement. The legal guardian would tell Resident A not to take medications that were prescribed and would try and withhold medications from Resident A. This is one of the main reasons the facility issued the discharge notice to Resident A. However, there has been court involvement and the court has appointed a new legal guardian to provide legal oversight for Resident A and I am hopeful this will help significantly.”

On 10/18/2024, I spoke to licensee designee/administrator, Ramon Beltran, via telephone. Mr. Beltran stated, “Resident A was in the hospital and was discharged back to the home on 8/16/2024 with a prescription order for Invega 6mg. I had staff go the pharmacy to pick up the prescription and we were told that Guardian A1 had contacted the pharmacy and requested the medication be placed on hold. Guardian A1 did not think the medication order was accurate even though it came directly from the hospital. Guardian A1 also called the facility and told my staff that she did not want Resident A taking the Invega medication. I was very concerned, but we had to follow the guardian’s request and wait for the medication to be filled. Once the medication was filled on 8/18/2024, we immediately picked the medication up and administered it to Resident A. But two days later, Guardian A1 requested the medication be discontinued and the primary care doctor agreed, and the medication was discontinued at that time. We did the best we could to manage the medications for Resident A and manage strong input from the guardian. We did not fail to administer medication to Resident A. We administered the Invega as soon as the guardian gave permission for the medication to be filled.” Mr. Beltran denied this complaint is true.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	According to the *MAR* and *Staff Nursing Note*, Resident A was prescribed Invega on 8/16/2024, but this medication was not filled until 8/18/2024 due to a delay request by Guardian A1. The facility did administer Invega 6mg to Resident A on 8/18/2024 and 8/19/2024. Invega 6mg was discontinued on 8/20/2024. According to Ms. Johnson, Ms. Hall, Ms. Ward and Mr. Beltran, the facility administered medication to Resident A as prescribed. Ms. Johnson, Ms. Hall, Ms. Ward and Mr. Beltran stated that the delay in the Invega 6mg medication was due to a medication hold placed with the pharmacy by Guardian A1. Ms. Johnson, Ms. Hall and Ms. Ward denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm the facility did not administer Resident A's Invega 6mg as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Direct care staff are using a van with broken doors to transport residents.

INVESTIGATION:

On 8/21/2024, a complaint was received, alleging that direct care staff are using a van with broken doors to transport residents.

During my onsite investigation on 8/29/2024, I completed an inspection of the van, and it was in good condition. The van doors opened and closed without issue. I did not observe any broken doors or handles. I did not observe any concerns with the condition of the van.

I spoke to Ms. Johnson, during my onsite investigation. Ms. Johnson stated, "The van we used to have here did have an issue with the door handle, but we immediately stopped using that van and a new van was delivered to the home while the other van is being repaired. We have not been driving residents around in a van with broken doors." Ms. Johnson denied knowledge of this complaint being true.

On 10/4/2024, I spoke to Ms. Ward, via telephone. Ms. Ward stated, “The van doors were broken and had to be fixed. The van was taken to the shop to be fixed and we have a new van here at the home that we are using. We did not use to old van to transport residents. As soon as we knew it needed repairs, a new van was sent to the home for use. Once the van is fixed, we will get that van back. We have not used the van that was broken because it is not here. It’s being fixed.” Ms. Ward denied knowledge of this complaint being true.

APPLICABLE RULE	
R 400.14319	**Resident transportation.**
	When a home provides transportation for a resident, the licensee shall assure all of the following: **(a) That a vehicle is in good operating condition.**
ANALYSIS:	On 8/29/2024, I observed the facility van to be in good operation condition, with no damage to the doors. According to Ms. Johnson, Ms. Hall, and Ms. Ward, the facility is not using a van with broken doors. Ms. Johnson, Ms. Hall and Ms. Ward all stated that the van was taken to the dealership for repairs and a new van, in good condition, is currently being used. Ms. Johnson, Ms. Hall and Ms. Ward denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm that staff transported residents in a vehicle that was not in good operating condition.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility improperly discharged Resident A from the home.

INVESTIGATION:

On 9/27/2024, an additional complaint was received, alleging that the facility improperly discharged Resident A from the home. The complaint indicated that Resident A has been in the hospital since 9/9/2024 and has nowhere to go. Resident A was issued a discharge notice from the facility and is no longer allowed to return to the home.

I previously conducted an onsite investigation at the facility on 8/29/2024, and did not complete a secondary onsite investigation, as Resident A was no longer residing at the facility.

On 9/27/2024, I spoke to Resident A via telephone. At the time of my telephone call with Resident A, she was inpatient at the hospital, awaiting a new placement. Resident A stated, “I am here at the hospital. The staff left me here and won’t let me go home. All my stuff is still there, my wallet, my insurance card. No staff has come to see me or tell me how to get all my stuff back. And no one from the facility has called Guardian A to tell her anything. I’m angry this happened.”

On 9/27/2024, I spoke to Mr. Beltran via email and requested additional facility documents for Resident A. I reviewed Resident A’s record. The *Face Sheet* and *Resident Registrar* stated that Resident A was admitted to the facility on 6/10/2024, discharged from the home on 9/9/2024 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A’s medical diagnosis as Morbid (Severe) Obesity, Autism Spectrum Disorder, Bipolar I Disorder Manic Severe, Borderline Personality Disorder and Unspecified Anxiety Disorder. The *Assessment Plan for AFC Residents* stated that Resident A moves independently in the community, has a history of verbal and physical aggression, has difficulty controlling sexual behavior, history of impulsive behavior, does not get along well with others, needs assistance with personal care tasks and does not use assistive devices for mobility.

I reviewed the facility files, which contained a *Warning of Discharge Letter*, *30-Day Discharge Notice*, and a *24-Hour Discharge Notice*, pertaining to concerns related to Resident A’s behaviors. The documents indicated the following:

> *Warning Letter, dated 6/14/2024, completed by Kim Knickerbocker, Senior Executive Director Behavioral Health; Sent to Guardian A1 and Easterseals/MORC: We regret to inform you that the current schedule and living environment for Resident A is greater than her current home can provide. Per our conversation(s), Beacon has asked for additional cooperation and assistance with transportation to and from Resident A’s scheduled appointments and willingness to adjust her appointment times to not disrupt her housemates’ standing appointments and daily activities. Additionally, Beacon has requested that over-the-counter medication not be brought into the home to be administered without a valid prescription. Due to this, we are sending you a warning letter to let you know if these concerns are not addressed, we will be sending out a 30-day discharge letter. In efforts to address these concerns, facility staff have worked with the CMH, home staff, and community agencies to meet the guardian’s expectations. Education has been provided to the guardian on licensing standards for all Beacon homes. Beacon has also provided additional interventions that include internal and external team meetings, contact with CMH and guardian, providing highly trained staff and access and support through our clinical and medical team. The guardian’s continued interference with Resident A’s treatment and refusal to comply with Beacon’s policies and procedures have impacted Resident A’s ability to adjust to the home and have caused disruption*

to the milieu. We would like to keep Resident A in a Beacon home and would like to collaborate with you to ensure that she is successful in her current placement.

30-Day Discharge Notice, dated 8/21/2024; completed by Kim Knickerbocker; Sent to Guardian A1 and Easterseals/MORC: We regret to inform you that due to the current level of care needed for Resident A, we are no longer able to maintain her placement at Beacon's Clarkston Home located in Clarkston, MI. Resident A was placed in the Clarkston Home on 06/10/2024. Since her admission, Resident A has demonstrated frequent verbal and physical aggression towards staff and her housemates, including throwing hot coffee on staff and making homicidal statements towards her housemates. In efforts to address these concerns, Beacon staff have been diligent at exploring a variety of interventions including gentle teaching, active listening, de-escalation techniques, encouraging positive behavior, and teaching coping skills. Beacon's Clinical Team has worked with the CMH, home staff, and community agencies to meet Resident A's behavioral needs. Beacon has also provided additional interventions that include internal and external team meetings, frequent contact with CMH and Guardian, providing highly trained staff and access and support through our clinical and medical team though these interventions have been unsuccessful in reducing the frequency and severity of aggressive behavior. Unfortunately, due to the increasing severity and frequency of these behaviors, Beacon staff and clinical team feel Resident A needs a higher level of care than we can provide. Resident A continues to struggle with aggressive behavior despite the interventions listed above. Her verbal and physical aggression have caused significant distress in the home and place Resident A, staff, and her housemates at risk of harm. We are therefore issuing a 30-day discharge and requesting that you find Resident A a new placement within the next 30 days.

24-Hour Discharge Notice, dated 8/28/2024; completed by Kim Knickerbocker; Sent to Guardian A1 and Easterseals/MORC: We regret to inform you that due to the current level of care needed for Resident A, we are no longer able to maintain her placement at Beacon's Clarkston Home located in Clarkston, MI. Resident A was placed in the Clarkston Home on 06/10/2024. Since her admission, Resident A's guardian has interfered with treatment resulting in missed medication and medication refusals. Beacon Specialized Living issued a warning letter on 6/14/2024 with similar concerns to no avail. Upon returning to the Clarkston home from inpatient hospitalization on 8/15/24, the guardian requested that Beacon staff withhold two medications which resulted in the medication being delayed for two days. Additionally, Resident A has displayed increasing verbal and physical aggression towards her housemates and Beacon staff, including throwing hot coffee at a staff member, making homicidal statements towards housemates, and displaying aggressive behavior resulting in her housemates being asked to leave public places. In efforts to address these concerns, Beacon staff have been diligent at exploring a variety of interventions including gentle teaching, active listening, de-escalation techniques, encouraging positive behavior, and teaching coping skills to assist with decreasing the frequency and severity of aggressive behavior. Beacon's medical, clinical, and operations team has worked with the CMH and the guardian to

provide education regarding Beacon's policies and procedures. Beacon has also provided additional interventions that include internal and external team meetings, frequent contact with CMH and guardian, providing highly trained staff and access and support through our clinical and medical team though these interventions have been unsuccessful. Unfortunately, due to the continued guardian interference and Resident A's aggressive behavior, Beacon staff feel Resident A needs a higher level of care than we can provide. Resident A continues to struggle with physical and verbal aggression despite the interventions listed above. Resident A's aggressive behavior along with the guardian's interference place Resident A, her housemates, and Beacon Staff at risk of harm. We are therefore issuing a 24-hour discharge and requesting that you find Resident A a new placement within the next 24 hours.

I reviewed the email communication from Cassidy Jewell to Erin Schaaf on 9/10/2024, which stated that following:

Good afternoon. I am reaching out to inform you that Beacon will not be accepting Resident A back into the Clarkston home if she has been admitted to the hospital due to her being on a 24-hour notice.

On 9/27/2024, I spoke to Trinity Oakland Inpatient Social Worker, Eva Melane, via telephone. Ms. Malone stated that she is the social worker assigned to Resident A. Ms. Melane stated, "Resident A is currently still a patient at the hospital as of today. She was originally admitted to the hospital on 9/9/2024 due to a skin infection. However, it only required minimal medical care, and she was ready for discharge within a day. Resident A has been ready for discharge since 9/10/2024. She has nowhere to go, and we have not received any calls or follow-up from the adult foster care facility she lived at. We were told by the Easter Seals/MORC care coordinator, Erin Schaaf, that the facility has refused to accept Resident A back into the home. She was left here. So, I have been trying to find a new placement but as of now, she has no place to go, and I do not know how long until we can find a place for her. She should not be here at the hospital."

On 9/27/2204, I spoke to licensee designee/administrator, Ramon Beltran, via telephone twice. During the first phone call, I informed Mr. Beltran of this complaint, and that Resident A is currently still inpatient at the hospital, in need of placement. Mr. Beltran stated, "I am familiar with Resident A but need to gather more information. I will call you back shortly." A short while later, Mr. Beltran did call me back and stated the following, "We did discharge Resident A from the facility. We did say that Resident A could not return, although I am unsure of who within our corporation conveyed this information." I informed Mr. Beltran that Resident A was at the hospital and in need of placement, and inquired if he would allow her to return to the facility. Mr. Beltran stated, "I will have to look into this."

On 9/30/2024, I spoke licensee designee/administrator, Ramon Beltran, Melissa Willams and Nichole VanNiman, via a Zoom call. Mr. Beltran, Ms. Willams and Ms. VanNiman stated they were familiar with Resident A. Mr. Beltran, Ms. Williams and Ms.

VanNiman stated that Resident A was displaying behavioral issues, verbal and physical aggression, refusal of medications and interference from Guardian A1. Mr. Beltran, Ms. Willams and Ms. VanNiman stated that they issued a warning, 30-day discharge notice and then an emergency 24-hour notice due to Resident A's escalating behaviors despite multiple attempts to address the issues. Mr. Beltran, Ms. Willams and Ms. VanNiman stated that when Resident A was admitted to the hospital on 9/9/2024, an email was sent to Easterseals/MORC, notifying them that the facility would not be accepting Resident A back to the home. Mr. Beltran, Ms. Willams and Ms. VanNiman stated, "We sent notice to Easterseals/MORC and thought we did everything we needed to. It's up to Easterseals/MORC to find placement since we do not provide case management. Once we confirmed with Easterseals/MORC that they received the email, we don't do anything further." Mr. Beltran, Ms. Williams and Ms. VanNiman acknowledged that they never called the hospital directly obtain a medical update regarding Resident A's care or placement needs. Ms. VanNiman stated, "We only issue a discharge notice and contact the hospital if the resident has nowhere to go." Ms. Williams stated, "Once we sent the email to Easterseals/MORC, saying Resident A could not return to the home, they never contact us to let us know she still needed placement. They should have called us. We also do not coordinate placements with legal guardians. Legal guardians do not make placement decision. The case manager does, so we never called Guardian A1." Mr. Beltran, Ms. Willams and Ms. VanNiman acknowledged that they did not follow-up with Easterseals/MORC, the hospital nor Guardian A1 after Resident A was admitted to the facility to inquire regarding placement.

On 10/11/2024, I spoke to Guardian A1 via telephone. Guardian A1 stated, "I was never contacted by anyone at the facility to let me know that she couldn't return to the home from the hospital. I found out this information from Ms. Schaaf. It wasn't right that they did this."

On 10/15/2024, I spoke to Easterseals/MORC Care Coordinator, Erin Schaaf, via telephone. Ms. Schaaf stated, "I am the case manager for Resident A. I meet with her monthly. Resident A has a long history of verbal and physical aggression. There was also a lot of interference by Guardian A1 that has made maintaining a placement for Resident A difficult. This was an issue at the facility and a 30-day discharge, and an emergency discharge notice were issued. However, I had not located a new placement yet and then Resident A was taken to the hospital on 9/9/2024 due to a skin infection. She received medical care and was ready for discharge the same day. I called the facility and spoke to a staff, Christian Johnson, via telephone. Ms. Johnson told me that Resident A could not return to the facility. I then requested to speak to the manager, and I was told to call another staff named Brooke. I spoke to Brooke over the phone, and she told me that Resident A was not allowed back at the facility. I told Brooke that I had nowhere for Resident A to go and she had no placement. I then received an email on 9/10/2024, from Cassidy Jewell from Beacon. She told me that Beacon would not allow Resident A to return to the facility. I never received any further communication

from the facility, and they were very aware that Resident A had no where else to go. As of now, Resident A is still in the hospital with no placement options. I also do not make placement decisions. I can assist with locating possible placements, but it is the legal guardian's final decision as to what placement a person will go to. In this case, the facility never contacted Guardian A1 to notify her that they were refusing to allow Resident A to return to the home. I called Guardian A1 to discuss new placement options and Guardian A1 had no idea what I was talking about. She had not been contacted by the facility nor told that they were refusing to allow her to return home from the hospital. The facility should be communicating all placement decisions, discharges and changes, to the legal guardian in addition to my agency. It is not my responsibility to be the middle-man of those communications."

On 10/18/2024, I conducted an exit conference with licensee designee/administrator, Ramon Beltran, via telephone. Mr. Beltran is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.**
ANALYSIS:	On 9/9/2024, Resident A was transported to the hospital for medical care. According to the *Resident Registrar,* Resident A was discharged from the facility on 9/9/2024. According to Ms. Schaaf and Ms. Melane, Resident A has been ready for discharge from the hospital since 9/9/2024. According to the email dated 9/10/2024, Ms. Jewell notified Ms. Schaaf that Resident A could not return to the facility effective 9/10/2024. On 9/27/2024, I notified Mr. Beltran that Resident A was still in the hospital and in need of placement.

	During the Zoom call on 9/30/2024 with Mr. Beltran acknowledged that he did not call the hospital to obtain an update on Resident A's care or discharge status on or after 9/9/2024. Mr. Beltran confirmed that Resident A was discharged from the facility without confirmation of an appropriate alternate placement being located and confirmed. Based on the information above, the facility discharged Resident A from the facility prior to confirming that an appropriate placement that met Resident A's immediate needs was located.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(6) A licensee shall not change the residency of a resident from one home to another without the written approval of the resident or the resident's designated representative and responsible agency.
ANALYSIS:	According to Ms. Schaaf and Guardian A1, the facility did not notify Guardian A1 that they were changing Resident A's placement by discharging her to the hospital. During the Zoom call on 9/30/2024, Mr. Beltran acknowledged that he, nor anyone from his staff to his knowledge called Guardian A1 to notify her of Resident A's placement change. Mr. Beltran acknowledged that he did not obtain written approval from Guardian A1 prior to changing Resident A's residency. Based on the information above, the facility changed Resident A's residency without written approval from Guardian A1.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend this special investigation be closed with no change to the status of the license.

10/22/2024

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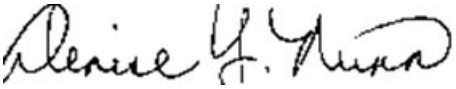
Stephanie Gonzalez — Date
Licensing Consultant

Approved By:



10/22/2024

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Denise Y. Nunn — Date
Area Manager