GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 16, 2024

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

RE: License #: AS630387842
Investigation #: 2025A0465001
Beacon Home at Dilley

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
gonzalezs3@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630387842
Investigation #:	2025A0465001
Complaint Receipt Date:	10/01/2024
Investigation Initiation Date:	10/01/2024
Report Due Date:	11/30/2024
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 Dilley
Facility Address:	7570 Dilley Road Davisburg, MI 48350
Facility Telephone #:	(248) 382-5648
Original Issuance Date:	08/13/2018
License Status:	REGULAR
Effective Date:	09/10/2023
Expiration Date:	09/09/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 9/29/2024, Resident A eloped from the home while direct care staff, Jasmine Dillard, was on duty. There is concern that may Ms. Dillard may have been sleeping while on duty. Direct care staff, Jakyra Cleaver and Kaniah Griffin, have been sleeping in their cars while on duty.	No
On 9/30/2024, Resident B physically assaulted Resident D, and staff were not present to provide protection.	No
Direct care staff curse at residents.	No
There is no food in the home.	No
Additional Findings	Yes

III. METHODOLOGY

10/01/2024	Special Investigation Intake 2025A0465001
10/01/2024	APS Referral Adult Protective Services (APS) referral denied
10/01/2024	Special Investigation Initiated - Letter Email exchange with Complainant
10/17/2024	Inspection Completed On-site I conducted an onsite investigation. I completed a walk-through of the home, observed residents, reviewed resident files and interviewed Resident A, Resident B, Resident C and direct care staff, Brenda Allen and Mariah Mayes
10/21/2024	Contact - Telephone call made I spoke to Guardian A1 via telephone
10/21/2024	Contact – Telephone call made I left a voice mail for Guardian B1; Requested a return call
10/29/2024	Contact - Document Received Facility documents received via email

10/30/2024	Contact – Telephone call made I spoke to direct care staff, Jasmine Dillard, via telephone
11/01/2024	Contact - Telephone call made I spoke to Guardian D1 via telephone
11/08/2024	Contact - Document Received Facility documents received via email
11/12/2024	Contact – Telephone call made I left a voicemail for direct care staff, Kaniah Griffin. Requested a return call
11/12/2024	Contact – Telephone call made I left a voice mail for Guardian B1; Requested a return call
11/18/2024	Contact - Telephone call made I spoke to Program Director/staff, Brooke Landis, via telephone
11/18/2024	Contact – Telephone call made I attempted to speak to direct care staff, Kaniah Griffin telephone. Ms. Griffin texted me back and stated she would call me later today
11/19/2024	Contact - Telephone call made I spoke to direct care staff, Jakyra Cleaver, via telephone
11/20/2024	Contact - Telephone call made I spoke to CMH Case Manager, Jennifer Martus, via telephone
11/20/2024	Contact – Telephone call made I sent a text message to Kaniah Griffin, to request a return call. Ms. Griffin stated she would call me back later today; No return call received
11/21/2024	Contact - Document Received Facility documents received via email
11/21/2024	Exit Conference I conducted an Exit Conference with licensee designee/administrator, Ramon Beltran, via telephone

ALLEGATION:

- **On 9/29/2024, Resident A eloped from the home while direct care staff, Jasmine Dillard, was on duty. There is concern that Ms. Dillard may have been sleeping while on duty.**
- **Direct care staff, Jakyra Cleaver and Kaniah Griffin, have been sleeping in their cars while on duty.**

INVESTIGATION:

On 10/1/2024, a complaint was received, alleging that on 9/29/2024, Resident A eloped from the facility while direct care staff, Jasmine Dillard, was on duty. The complaint stated that there is concern that Ms. Dillard may have been sleeping while on duty. The complaint stated that direct care staff, Jakyra Cleaver and Kaniah Griffin, have been sleeping in their cars while on duty.

On 10/1/2024, I spoke to Complainant via email exchange. Complainant confirmed that the information contained in the complaint is accurate.

On 10/17/2024, I conducted an onsite investigation at the facility. The home specializes in caring for the mentally ill, developmentally disabled and traumatically brain injured. At the time of my onsite investigation, there were five residents residing in the home with a staff to resident ratio of 1:5 at all times. I completed a walk-through of the home, observed residents, reviewed resident files and interviewed Resident A, Resident B, Resident C and direct care staff, Brenda Allen and Mariah Mayes. I reviewed all five residents' written assessment plans, which stated that there are not residents residing in the home that require 1:1 supervision. I did not observe any facility documentation to confirm that the home requires more than one staff on duty at all times. I observed the home to be in good condition and clean. I observed all residents to be properly dressed and with adequate hygiene. I reviewed the *Staff Schedule* for the months of August 2024, September 2024 and October 2024, which documented that the home always has one staff on duty at all times.

I reviewed Resident A's record. The *Face Sheet* stated that Resident A moved into the facility on 5/7/2024 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizophrenia, Bi-Polar and Depression. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, has a history of aggressive behavior, needs assistance and prompting for personal care tasks and does not require use of assistive devices. I was unable to locate an incident report dated 9/29/2024 related to Resident A's elopement on this date. According to Resident A's record, he does not require 1:1 supervision nor line of sight supervision. I was unable to locate any facility documents to confirm that there have been concerns or disciplinary action related to any staff sleeping while on duty, including Jasmine Dillard, Jakyra Cleaver, and Kaniah Griffin.

I spoke to Resident A, who stated, “I like living here but sometimes I get annoyed by Resident D, and I just want to be outside. But I usually go to the backyard or the front yard and the garage. I go outside to smoke cigarettes and then I go back inside. But last month, there was a night when I was wanting a break from the home, and I snuck out without staff knowing. The staff was in the living room doing work and I went outside to the garage. And I sat there for a while then I decided to go walking and I walked two houses down. I knocked on the neighbor’s door and asked them to use the phone to call 911. I wanted to go the hospital to get out of the home for a little while. I came home from the hospital the next day. I know I shouldn’t have left, and I haven’t done that since then. I only left that one time. I haven’t seen staff sleeping or in their cars while working. The night I left the home, the staff was awake.”

I spoke to Resident B, who stated, “Things here are good. I don’t have any concerns. The staff treat me good. If I need something in the middle of the night, staff help me. I have not seen any staff sitting in their cars or sleeping when they are working. I don’t have any problems here.”

I spoke to Resident C, who stated, “It’s okay here. The staff are good and treat us nice. Staff help when I asked for stuff. I have had to ask for help from staff at nighttime, and they always help. Staff don’t go to their cars or sleep while working. I haven’t seen that happen.”

I spoke to direct care staff, Brenda Allen, who stated that she has worked at the facility for five months. Ms. Allen stated, “We have staff here 24/7 and we provide supervision at all times. However, we do not have any residents that require 1:1 supervision. We do allow residents to go outside to smoke cigarettes and get air. I am not aware of any elopement issues for any resident except Resident A. There is one time that he did elope but that is not normal behavior for him. I am not aware of any other elopements. I have never slept while on duty, nor gone to my car to sit in it while I am working, and I am not aware of any other staff sleeping while on duty.”

I spoke to direct care staff, Mariah Mayes, who stated that she has worked at the facility for approximately a year. Ms. Mayes stated, “I wasn’t working when Resident A eloped from the facility and do not know the specifics. However, we do provide supervision to all of the residents 24/7. We do allow residents to go outside and smoke cigarettes. If there is an issue that residents need help with, we are always available to help. We follow every resident’s assessment plan. I have never slept while on duty nor gone to sit in my car while working.” Ms. Mayes denied knowledge of the facility failing to provide proper supervision, protection and care to residents.

On 10/21/2024, I spoke to Guardian A1 via telephone. Guardian A1 stated, “I have been Resident A’s legal guardian since 2021. I do not have any concerns related to staffing or proper care being provided to Resident A. I believe the facility is doing a good job. I am not aware of the elopement from the home on 9/29/2024, but Resident A is allowed to leave the home and go outside for cigarette breaks and to be outdoors. He does not require 1:1 supervision and staff do not have to have line of sight supervision. I am not

aware of any concerns with staff sleeping while on duty. I do not have any current concerns related to this complaint."

On 10/30/2024, I spoke to direct care staff, Jasmine Dillard, via telephone. Ms. Dillard stated that she has worked at the facility for seven months. Ms. Dillard stated, "I am familiar with Resident A. Prior to 9/29/2024, he had never eloped from the home and there was never a concern with not allowing him to go outside unsupervised. I was working on 9/29/2024. The night was a normal night. At around 11:00pm, the residents were all in the bedrooms relaxing or sleeping. It was not uncommon for residents to come out of their rooms to go outside to smoke cigarettes in the garage area. I was in the living room working on paperwork and documents, when I saw Resident A go outside to the garage area. I didn't think anything more than he was going to smoke. About 10 minutes later, I went outside to check on him because he hadn't come back in yet. When I went outside, I did not see him. I immediately looked around the premises of the home, and when I did not see him, I called 911. When I spoke to the dispatcher, they told me that they had Resident A on a call with another dispatcher. The dispatcher told me that Resident A was being transported to the hospital due to suicidal ideation. Resident A was taken to the hospital that night and returned home the next morning. As far as I know, Resident A has not eloped since then. I believe I did everything correctly and I had no idea Resident A was going to elope that night."

On 11/1/2024, I spoke to Guardian D1 via telephone. Guardian D1 stated, "Resident D has been residing at the facility since July 2023. My staff visit the home monthly and have not observed any concerns. The staff are providing supervision, protection and redirection to Resident D. Resident D has not vocalized any concerns related to staff sleeping while on duty. I do not have any concerns."

On 11/18/2024, I spoke to Program Director/staff, Brooke Landis, via telephone. Ms. Landis stated, "We provide 24/7 supervision, safety and protection to all of our residents, including Resident A. It is true that Resident A eloped from the home on 9/29/2024, however this was the first and only time that Resident A has eloped from the home. He has never done anything like this before or after that. Resident A does like to go outside and smoke cigarettes or sit outside in the backyard or garage sometimes, and his assessment plan allows him to be outside unsupervised. He does not have any safety plan requiring him to have constant supervision nor a requirement that he cannot go outside. Resident A has a history of going outside and sometimes becoming agitated, but he is always easily redirected and de-escalated. As for staff, they are not allowed to sleep while on duty. I am not aware of any staff sleeping while on duty."

On 11/19/2024, I spoke to direct care staff, Jakyra Cleaver, via telephone. Ms. Cleaver stated that she has worked at the facility for nine months. Ms. Cleaver stated, "I am familiar with Resident A. He normally does not elope from the home. He does like to go outside and sit in the garage or in the backyard, but he will come back into the home when asked by staff. He is usually very good at being redirected into the home without any issues. I have never had any issues with him eloping from the home. I was not working the day that Resident A eloped from the home, but I have not had any issues

on my end with Resident A. We have staff on duty at all times and ensure that supervision, protection and personal care are provided at all times. I have never sat or slept in my car while on duty. I have never observed staff outside in their car sleeping while on shift." Ms. Cleaver denied knowledge of this complaint being true.

On 11/20/2024, I spoke to CMH Case Manager, Jennifer Martus, via telephone. Ms. Martus stated, "I am the case manager for Resident A and have been for five years. Resident A does like to go outside and sit in the garage or backyard to smoke or to just be outside. He has freedom of movement and does not have any special supervision or safety requirements. Resident A does not have a history of eloping from the home, with the exception of the one time that I am aware of. Resident A has not vocalized any concerns related to staff sleeping while on duty. I am not aware of any staffing concerns."

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:	At the time of my onsite investigation, on 10/17/2024, there were five residents residing in the home with a staff to resident ratio of 1:5 at all times. According to the *Assessment Plan for AFC Residents,* for Resident A, Resident B, Resident C, Resident D and Resident E, there are no residents in the home that require 1:1 supervision. According to Resident A's *Assessment Plan for AFC Residents*, he does not have a history of elopement, does not require 1:1 supervision, and has freedom of movement to the exterior yard of the home. According to Resident A, he had not eloped from the home prior to 9/29/2024 and has not eloped since. Resident A stated that when he left the home, the staff were awake in the living room of the home. According to Resident B and Resident C, staff are available in the home at all times of the day, and they have never observed staff sleeping while on duty. According to Ms. Dillard, on the night of 9/29/2024, she allowed Resident A to go outside, as specified in his written assessment plan. Ms. Dillard stated that she did not know Resident A would

	elope from he home as he had no prior history of elopement. Ms. Dillard stated she has never slept while on duty. According to Ms. Allen, Ms. Mayes, Ms. Landis, and Ms. Cleaver, they always provide supervision, personal care and protection to residents. Ms. Allen, Ms. Mayes, Ms. Landis and Ms. Cleaver stated they have never slept while on duty and deny knowledge of this complaint being true. Based on the information above, staff are providing adequate supervision, protection and personal care as specified in Resident A's written assessment plan. There is not sufficient information to confirm that Ms. Dillard knew, or should have known, that Resident A was going to elope on 9/29/2024. There is also insufficient information to confirm that direct care staff are sleeping in their cars while on duty.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

On 9/30/2024, Resident B physically assaulted Resident D, and staff were not present to provide protection.

INVESTIGATION:

On 10/1/2024, a complaint was received, alleging that on 9/30/2024, Resident B physically assaulted Resident D, and staff were not present to provide protection.

On 10/17/2024, during my onsite investigation, I reviewed resident records and interviewed Resident B, Ms. Allen and Ms. Mayes. According to Resident B's *Face Sheet*, he was admitted to the facility on 10/24/2023 and has a legal guardian, Guardian B1. The *Health Care Appraisal* listed Resident B's medical diagnosis as Bi-Polar, Mild Seizures, and Poor Judgement. The *Assessment Plan for AFC Residents* stated that Resident B can move independently in the community, has a history of aggressive behavior towards others, independently completes self-care tasks and does not require use of assistive devices. Resident D's *Face Sheet* stated that he was admitted to the facility on 7/18/2023 and has a legal guardian, Guardian D1. The *Health Care Appraisal* listed Resident D's medical diagnosis as Schizophrenia and Asthma. The *Assessment Plan for AFC Residents* stated that Resident D requires supervision in the community, independently completes self-care tasks, and does not require use of assistive devices. I was unable to locate an *Incident/Accident Report* related to this incident. I did obtain a copy of an email dated 9/30/2024, which stated the following:

> *Email from Jordan Eldridge to Brooke Landis on 9/30/2024 at 10:54am: Hello all. Two sheriffs' deputies were in the driveway today due to Resident B and Resident D*

getting into a physical altercation. The two was able to be separated and the situation diffused. I was able to speak to both of the residents and Resident B admitted he started the fight as he believed Resident D had shot his family members. While speaking to Resident D, I noticed his speech was slurred. I advised he be sent out to the ER. Resident D is currently at the hospital. I will keep everyone posted.

I attempted to interview direct care staff, Jordan Eldridge, regarding this incident however she is currently on medical leave and was unavailable to be interviewed.

I spoke to Resident A, who stated, “Staff help when we need it. And sometimes when we get mad at each other or are in a bad mood, staff help us. I feel safe here and I know staff will help if I ask.”

I spoke to Resident B, who stated, “There was a time when I was mad at Resident D. But I don’t remember why. I did try to hit him, but staff were there, and they called the cops. The cops came and stopped everything. I have been okay since. No issues.” Resident B denied this allegation is true.

I spoke to Resident C, who stated, “I feel safe here. I haven’t had any problems with other residents hurting me. If something bad happened, I would tell the staff right away.”

I attempted to interview Resident D, but he presented as confused and not alert to his surroundings, therefore I was unable to interview him.

I spoke to Ms. Allen, who stated, “We have staff here 24/7 and we provide protection and safety at all times. But we do allow residents to go outside to smoke cigarettes or just to be outside. Residents are allowed to walk around the yard area and sit outside when they want to. We don’t restrict anyone to inside the home. I was not working at the time of this incident, and I don’t know anything about it. But I do know residents are supervised and we intervene when an issue arises that involve resident safety and protection” Ms. Allen denied knowledge of this complaint being true.

I spoke to Ms. Mayes, who stated, “I am familiar with Resident B and Resident D. I wasn’t working when this incident happened. We do provide protection and safety to all of the residents 24/7. We allow residents to go outside and smoke cigarettes. We do get involved if there is a concern of safety or protection for a resident. If we see arguing, we de-escalate and call 911 if needed.” Ms. Mayes denied knowledge of this complaint being true.

On 10/21/2024 and 11/20/2024, I attempted to speak to Guardian B1 via telephone. As of the date of this report, I have not received a return call.

On 11/1/2024, I spoke to Guardian D1 via telephone. Guardian D1 stated, “Resident D has a history of altered mental status and can become confused, agitated and verbally aggressive at times. I know this can trigger other residents and can cause tension in the

home. I am working on ways to address Resident D's behavior and working with the staff in the home as well with these issues. The staff are providing protection and safety monitoring to Resident D. Resident D has not vocalized any concerns related to feeling safe and protected while at the home."

On 11/18/2024, I spoke to Ms. Landis, via telephone. Ms. Landis stated, "We provide 24/7 staffing in the home to ensure the safety and protection to all of our residents. I am not aware of any incidents in which staff refused to intervene or assist a resident that was being harmed by another person in the home. I am aware of the incident on 9/30/2024. I was not working on that day and the only information I have pertaining to it is the information the email. The home manager at that time, Ms. Eldridge, is on leave and not currently available to be interviewed. But I know staff were present and that 911 was called as soon as the incident was observed outside. The incident happened in the front yard, and that is an area that residents are allowed to be in without supervision." Ms. Landis denied this allegation is true.

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:	According to the email dated 9/30/2024, Ms. Eldridge intervened when an altercation between Resident B and Resident D was observed. Ms. Eldridge called 911 and police responded, which led to Resident D being transported to the hospital for additional medical care. According to Resident A and Resident C, they feel safe in the home and comfortable asking staff for help when needed. According to Resident B, on 9/30/2024, Ms. Eldridge intervened and 911 was called to deescalate the situation. Resident B denied this allegation is true. According to Ms. Allen, Ms. Mayes, and Ms. Landis, the facility provides staffing 24/7 to ensure the protection and safety of all residents at all times. Ms. Allen, Ms. Mayes and Ms. Landis stated that they intervene when there is an issue related to resident safety and protection. Ms. Allen, Ms. Mayes and Ms. Landis denied knowledge of this complaint being true.

	Based on the information above, there is not sufficient information to confirm that, on 9/30/2024, Ms. Eldrige failed to provide protection and safety to Resident B and Resident D.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Direct care staff curse at residents.

INVESTIGATION:

On 10/1/2024, a complaint was received, alleging that direct care staff curse at residents.

During my onsite investigation on 10/17/2024, I interviewed Resident A, Resident B, Resident C, Ms. Allen and Ms. Mayes.

I spoke to Resident A, who stated, “I like living here. Staff are nice and help when needed. I haven’t had staff curse at me or be abusive to me. That hasn’t happened to me. I don’t see anything like that.” Resident A denied knowledge of this complaint being true.

I spoke to Resident B, who stated, “Things here are good. I don’t have any concerns. The staff treat me good. No staff have cursed at me, said bad things to me or yelled at me. I have not heard staff swear at anyone that lives here.”

I spoke to Resident C, who stated, “It’s okay here. The staff are good and treat us nice. Staff have not yelled at me or cursed at me. No one has been verbally abusive to me. I don’t have any problems with staff.” Resident C denied knowledge of this complaint being true.

I spoke to Ms. Allen, who stated, “I have never cursed at residents or treated them in a disrespectful manner. I have never observed other staff curse at residents either.” Ms. Allen denied knowledge of this complaint being true.

I spoke to Ms. Mayes, who stated, “We treat all residents with respect. I have never been verbally abusive or cursed at residents. I have never seen any other staff be verbally abusive to residents either.” Ms. Mayes denied knowledge of this complaint being true.

On 10/21/2024, I spoke to Guardian A1 via telephone. Guardian A1 stated, “I have not been made aware of any concerns related to staff being verbally abusive or inappropriate towards Resident A. Resident A has not vocalized any concerns related to this complaint.”

On 10/30/2024, I spoke to Ms. Dillard via telephone. Ms. Dillard stated, “We treat the residents with respect, and I have never cursed at a resident. I have never been verbally abusive towards any resident.” Ms. Dillard denied knowledge of this complaint being true.

On 11/1/2024, I spoke to Guardian D1 via telephone. Guardian D1 stated, “I am not aware of any concerns related to verbal or emotional abuse in the home. My staff have not reported any concerns when they complete monthly check-ins.”

On 11/18/2024, I spoke to Ms. Landis, via telephone. Ms. Landis stated, “I am not aware of any issues related to verbal or emotional abuse taking place in the home by staff. I have never done anything like this to residents and I have not observed any other staff do this either.” Ms. Landis denied knowledge of this complaint being true.

On 11/19/2024, I spoke to Ms. Cleaver, via telephone. Ms. Cleaver stated, “I have never cursed at a resident or been verbally abusive to a resident. I have not heard any other staff do this either.” Ms. Cleaver denied knowledge of this complaint being true.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.**
ANALYSIS:	According to Resident A, Resident B, and Resident C, they have not been cursed at or verbally abused by direct care staff. Resident A, Resident B, and Resident C denied knowledge of this complaint being true. According to Ms. Allen, Ms. Mayes, Ms. Dillard, Ms. Landis and Ms. Cleaver, they have never cursed at residents or verbally abused them. Ms. Allen, Ms. Mayes, Ms. Dillard, Ms. Landis and Cleaver denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm that direct care staff are cursing and/or being verbally abusive to residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

There is no food in the home.

INVESTIGATION:

On 10/1/2024, a complaint was received, alleging that there is no food in the home.

On 10/17/2024, I completed a walkthrough of the home. I observed there to an adequate amount of food in the refrigerator, freezer, and cabinets. I observed the Meal Menu posted on the refrigerator, which included three nutritious meals daily including a variety of snacks, beverage options, and dessert items. I did not observe any concerns related to the food items in the home.

I spoke to Resident A, who stated, “We get lots of food and staff let us go shopping to buy our own food items too. There is always food to eat, and we get meals every day.” Resident A denied knowledge of this complaint being true.

I spoke to Resident B, who stated, “We get food every day. Staff cook meals for us. Sometimes I don’t like the food but a lot of times I do. I eat snacks when I want to and go in the kitchen to get something to eat when I want.” Resident B denied knowledge of this complaint being true.

I spoke to Resident C, who stated, “The food here is okay. And sometimes we go shopping and pick out our own snacks for the house. We have food to eat here. And we get breakfast, lunch and dinner every day.” Resident C denied knowledge of this complaint being true.

I spoke to Ms. Allen, who stated, “There is always food in the home, and we cook three meals every day, unless it is a day we order food for dinner. Food is always available as well as snacks and we follow the meal menu. I am not aware of a time when we did not have food in the home.” Ms. Allen denied knowledge of this complaint being true.

I spoke to Ms. Mayes, who stated, “There is always food in the home. Food is always bought on an ongoing basis to ensure there is food in the home.” Ms. Mayes denied knowledge of this complaint being true.

On 10/21/2024, I spoke to Guardian A1 via telephone. Guardian A1 stated, “Resident A has not vocalized any concerns to me related to a lack of food in the home.” Guardian A1 denied knowledge of this complaint being true.”

On 10/30/2024, I spoke to Ms. Dillard via telephone. Ms. Dillard stated, “When I work, I have always observed there to be food in the home. I have not observed the home to be without food.” Ms. Dillard denied knowledge of this complaint being true.

On 11/1/2024, I spoke to Guardian D1 via telephone. Guardian D1 stated, “I am not aware of any concerns related to lack of food in the home. My staff have not reported any concerns related to food when they complete monthly check-ins at the facility.”

On 11/18/2024, I spoke to Ms. Landis, via telephone. Ms. Landis stated, “There is always food in the home. I am not aware of any food issues at the facility.” Ms. Landis denied knowledge of this complaint being true.

On 11/19/2024, I spoke to Ms. Cleaver, via telephone. Ms. Cleaver stated, “I have not seen any issues related to food. There is always food in the home.” Ms. Cleaver denied knowledge of this complaint being true.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	According to Resident A, Resident B, and Resident C, they are provided three meals daily plus snacks. Resident A, Resident B, and Resident C denied knowledge of time when they were not provided three meals and snacks to eat on a daily basis. According to Ms. Allen, Ms. Mayes, Ms. Dillard, Ms. Landis and Ms. Cleaver, residents are provided three meals daily plus snacks. Ms. Allen, Ms. Mayes, Ms. Dillard, Ms. Landis and Cleaver denied knowledge of a time when the home did not have food available to feed residents. Based on the information above, there is not sufficient information to confirm that the facility has been without food and failed to provide three meals daily to residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During my onsite investigation on 10/17/2024, I was unable to locate incident reports related to Resident A's elopement on 9/29/2024 and the verbal altercation on 9/30/2204 between Resident B and Resident D that led to Resident D's hospitalization.

On 11/18/2024, I spoke to Ms. Landis, via telephone. Ms. Landis stated, "The home manager for the facility went on leave and has been off work for two months. I am not sure where the two incident reports are at, but I cannot find them." Ms. Landis acknowledge that incident reports were completed but are unable to be located.

On 11/21/2024, I conducted an exit conference with licensee designee/administrator, Ramon Beltran, via telephone. Mr. Beltran stated that he is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(4) The department may review incident reports during a renewal inspection or special investigation. This does not prohibit the department from requesting an incident report if determined necessary by the department. If the department does request an incident report, the licensee shall provide the report in electronic form within 24 hours after the request. The department shall maintain and protect these documents in accordance with state and federal laws, including privacy laws.
ANALYSIS:	On 10/17/2024, I requested copies of the incident reports related to the 9/29/2024 and 9/30/2024 incidents involving Resident A, Resident B and Resident D. On 11/18/2024, Ms. Landis informed me that she completed a diligent search and is unable to locate the incident reports. Ms. Landis acknowledged that she cannot provide these reports for departmental review.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

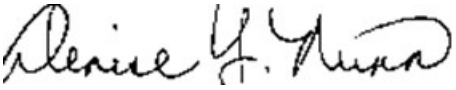
Upon receipt of an acceptable corrective action plan, I recommend this special investigation be closed with no change to the status of the license.

11/25/2024

_____

Stephanie Gonzalez Date
Licensing Consultant

Approved By:



12/16/2024

_____

Denise Y. Nunn Date
Area Manager