GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 7, 2026

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

RE: License #: AM590387866
Investigation #: 2026A1033007
Beacon Home At The Bunkhouse

Dear Mr. Beltran:

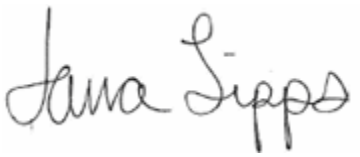
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 335-5985.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM590387866
Investigation #:	2026A1033007
Complaint Receipt Date:	11/18/2025
Investigation Initiation Date:	11/24/2025
Report Due Date:	01/17/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Ramon Beltran, Designee
Name of Facility:	Beacon Home At The Bunkhouse
Facility Address:	1550 E. Colby Road Stanton, MI 48888
Facility Telephone #:	(989) 831-0627
Original Issuance Date:	12/21/2018
License Status:	REGULAR
Effective Date:	06/21/2025
Expiration Date:	06/20/2027
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The facility is not kept at a comfortable temperature. It is too cold.	No
The direct care staff are not providing meals to Resident A.	No
Direct care staff are not providing proper supervision and protection for Resident A.	Yes
Resident A is not receiving adequate assistance with his personal care and hygiene needs.	No
The direct care staff are not assisting Resident A in following up with his medical appointments. He needs a hip replacement.	No
Additional Findings	Yes

III. METHODOLOGY

11/18/2025	Special Investigation Intake 2026A1033007
11/19/2025	APS Referral- Denied APS referral.
11/24/2025	Special Investigation Initiated - On Site Interviews conducted with direct care staff/Care Team Manager, Mandy Betancourt, direct care staff, Gennifer Flannigan, & Dorothy Beak, Resident A & Resident C. Review of Resident A's resident record initiated. Walkthrough of the facility was completed.
11/24/2025	Contact - Document Sent Email correspondence sent to licensee designee, Ramon Beltran, regarding investigation.
11/24/2025	Contact - Document Sent Email correspondence sent to Administrator, Roxanne Goldammer, regarding investigation based on Mr. Beltran's automatic email response noting he was not available.
11/25/2025	Contact - Document Sent Email correspondence sent to direct care staff, Mandy Betancourt, requesting a status report on requested documentation and an update regarding a status update on Resident A smoking in the facility.
11/26/2025	Contact - Document Received

	Email correspondence received and sent to Mandy Betancourt.
11/26/2025	Contact - Telephone call received Telephone correspondence received from Administrator, Roxanne Goldammer.
12/01/2025	Contact - Document Received Email correspondence received from Jonathan Mchenry, Assistant Director of Clinical Services, with Beacon Specialized Living Services, Inc.
12/05/2025	Contact - Document Received Email correspondence received from Administrator, Roxanne Goldammer.
12/12/2025	Inspection Completed On-site To view bedrooms and confirm smoking had stopped.
12/29/2025	Contact – Document Sent Email correspondence sent to Ms. Betancourt and Ms. Goldammer, requesting additional documentation for Resident A.
12/29/2025	Contact – Telephone call made Interview conducted with Ottawa County Community Mental Health, Case Manager, Matthew Vanderhyde.
01/05/2026	Contact – Document Received Email correspondence received from Beacon Specialized Living, Vice President of Clinical Operations, Cassidy Jewell, LMSW.
01/07/2026	Exit Conference Conducted via telephone with licensee designee, Ramon Beltran.

ALLEGATION: The facility is not kept at a comfortable temperature. It is too cold.

INVESTIGATION:

On 11/19/25 I received an online complaint regarding the Beacon Home at the Bunkhouse, adult foster care facility (the facility). The complaint alleged that the facility is not kept warm and the temperature is cold and not comfortable for residents. I could not interview a Complainant as this complaint stemmed from a denied Adult Protective Services (APS) complaint. On 11/24/25 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/Care Team Manager, Mandy

Betancourt. Ms. Betancourt reported that she is not aware of any issues with the furnace at the facility. She reported that the facility has been kept at 72 degrees Fahrenheit. Ms. Betancourt reported that no residents have made complaints about the temperature at the facility to her knowledge.

During the on-site investigation on 11/24/25 I interviewed Resident A regarding the allegation. Resident A had difficulty focusing on one topic of conversation at a time during this interview. He briefly discussed the temperature at the facility and noted that it has been cold in the facility but the other day (date not specified) the facility was "really hot".

During the on-site investigation on 11/24/25 I interviewed direct care staff, Gennifer Flanagan, regarding the allegation. Ms. Flanagan reported that there have not been any furnace repair issues reported at the facility. She reported that the furnace appears to be working well. She noted that the thermostats are kept in lock boxes to prevent people from tampering with the temperature. Ms. Flanagan reported that Resident A opens his window to smoke cigarettes and urinate. She reported that he dumps urine out of his bedroom window because he will not go to the bathroom. Ms. Flanagan reported that if Resident A is claiming the facility is cold it is most likely because of his behavior of opening his bedroom window.

During the on-site investigation on 11/24/25 I interviewed direct care staff, Dorothy Beak, regarding the allegation. Ms. Beak reported that she is not aware of any issues with the furnace. She reported that the facility is kept warm, and no residents have complained about the temperature.

During the on-site investigation on 11/24/25 I interviewed Resident B. Resident B had no complaints about the temperature of the facility.

During the on-site investigation on 11/24/25 I observed the thermostats at the facility. These devices were kept in a locked clear plastic case. The thermostats read 72 degrees Fahrenheit. The facility felt warm and I did not notice any cold air.

APPLICABLE RULE	
R 400.653	**Room temperature.**
	Resident-occupied rooms must be heated at no less than 68 degrees Fahrenheit. While air conditioning is not required, precautions must be taken to prevent prolonged resident exposure to noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations must be based on a resident's health care appraisal and addressed in the resident's assessment plan.

ANALYSIS:	Based upon the interviews conducted and the observations made during the unannounced, on-site investigation, there is not a preponderance of evidence to suggest that the facility is not being kept at a comfortable temperature for the residents. The thermostats recorded 72 degrees Fahrenheit, which is above the required 68 degrees Fahrenheit. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The direct care staff are not providing meals to Resident A.

INVESTIGATION:

On 11/19/25 I received an online complaint regarding the facility. The complaint alleged that direct care staff are not providing meals for Resident A. On 11/24/25 I conducted an unannounced, on-site investigation. I interviewed Ms. Betancourt regarding the allegation. Ms. Betancourt reported that Resident A has been experiencing a physical and mental decline over the past several months. She reported that he has resided at the facility for about seven years and recently he has become more combative and angrier with direct care staff members. Ms. Betancourt reported that Resident A has issues with his osteoarthritis, and would like hip replacement surgery, but this has not been scheduled yet by his physician. She reported that Resident A will tell the direct care staff that he cannot walk and spends most of his time in his bedroom. She reported that he has been refusing to come to the dining room for his meals. Ms. Betancourt reported that direct care staff provide encouragement and want him to keep walking to keep his strength up. She reported that direct care staff ask him to walk to the dining room for his meals. She reported that she is aware that Resident A can walk with the assistance of his walker because he was taken to a medical appointment recently and chose to leave this appointment and walk to the local Subway restaurant, which was two to three blocks from the doctor's office. Ms. Betancourt reported that Resident A is his own guardian and makes his own decisions. She reported that Resident A has been asking other residents to bring him his meal from the dining room to his bedroom because he does not want to leave his bedroom. Ms. Betancourt reported that direct care staff are not requesting the residents to deliver food to Resident A's bedroom, but residents do so because Resident A asks them to deliver his meals. Ms. Betancourt reported that meals are available to Resident A and he is eating.

During the on-site investigation on 11/24/25 I interviewed Resident A regarding the allegation. Resident A reported that for the past three days, direct care staff have delivered meals to his bedroom. Resident A reported that this began because Adult Protective Services (APS) became involved and requested that direct care staff start delivering food to Resident A. He reported that before this he was asking other residents to bring him meals to his bedroom. Resident A reported that as of the time of this interview (12:58pm) he had received breakfast but has not yet received his lunch. I

observed a plate on the floor of his bedroom. This plate had a banana peel that was empty and a second peeled banana that appeared to be partially eaten. There were other crumbs on the plate. Resident A confirmed that this had been his breakfast. Resident A reported direct care staff want him to walk to the dining room for his meals but he cannot walk due to osteoarthritis in his hip and knee, as well as neuropathy in his feet. He noted that walking is extremely painful for him and he is working with medical providers regarding these issues but does not feel they are making any progress in getting him the care he requires.

During the on-site investigation on 11/24/25 I interviewed Ms. Flanagan regarding the allegation. Ms. Flanagan reported that direct care staff encourage Resident A to eat in the dining room. She reported that Resident A will state that he does not have the capacity to walk, but then direct care staff will see him ambulating. She reported Resident A gets up and walks outside when his friend comes to visit him. She reported that he has been advised by his physician to keep moving or his osteoarthritis will further deteriorate. Ms. Flanagan reported that Resident A accepts his meals from residents and will ask residents to bring him his meals. She reported that when direct care staff interact with him, he swears at them and is extremely verbally aggressive. Ms. Flanagan reported that Resident A is offered meals, encouraged to eat them in the dining room, and brought his meals to his bedroom when he asks residents for assistance.

During the on-site investigation on 11/24/25, I interviewed Ms. Beak regarding this allegation. Ms. Beak reported that Resident A can ambulate with his walker but is choosing not to leave his bedroom. She reported that he refuses to go to the bathroom and the dining room. She reported that direct care staff have recently visualized him walking with his walker, but he claims he cannot ambulate. Ms. Beak reported that direct care staff encourage Resident A to walk to the dining room for meals. She reported that when he does not come to the dining room, a resident will take him his meals. Ms. Beak was cleaning up from lunch and reported that a plate would be offered to Resident A and noted that his breakfast was delivered to his bedroom this morning.

During the on-site investigation on 11/24/25 I interviewed Resident B regarding the allegation. Resident B reported that Resident A is rude to direct care staff. He reported that Resident A yells at the direct care staff and refuses assistance that is offered to him by direct care staff. Resident B reported that residents bring meals to Resident A's bedroom because he refuses to eat his meals in the dining room. He reported that Resident A asks other residents to bring him his meals. Resident B reported that he is offered adequate meals at the facility and does not feel the residents are not provided with adequate food.

During the unannounced, on-site visit, conducted on 11/24/25, I reviewed the following documents:

- *The Bunkhouse Menu*, for the month of November 2025. I observed the schedule to be complete and providing a variety of options for resident consumption.

- *Consumer Consumption Monitoring Chart*, for the dates 11/3/25 through 11/23/25. I observed the following information:
    - 11/3/25, Resident A ate 0% of breakfast, 100% of lunch, 100% of dinner.
    - 11/4/25, Resident A ate 100% of breakfast, 0% of lunch, and 50% of dinner.
    - 11/5/25, Resident A ate 100% of breakfast, 100% of lunch, 0% of dinner.
    - 11/6/25, Resident A ate 0% of breakfast and 100% of lunch and dinner.
    - 11/7/25, Resident A ate 0% of breakfast and 100% of lunch and dinner.
    - 11/8/25, Resident A ate 0% of breakfast and lunch and 100% of dinner.
    - 11/9/25, Resident A ate 0% of breakfast and lunch and 100% of dinner.
    - 11/10/25, Resident A ate 0% of breakfast and lunch and 100% of dinner.
    - 11/11/25, Resident A ate 100% of every meal.
    - 11/12/25, Resident A ate 0% of breakfast and 100% of lunch and dinner.
    - 11/13/25, Resident A ate 50% of breakfast, 0% of lunch, and 100% of dinner.
    - 11/14/25, Resident A ate 100% of every meal.
    - 11/15/25, Resident A ate 100% of every meal.
    - 11/16/25, Resident A ate 100% of breakfast, 0% of lunch, and 100% of dinner.
    - 11/17/25, Resident A ate 100% of every meal.
    - 11/18/25, Resident A ate 100% of breakfast and 0% of lunch and dinner.
    - 11/19/25, Resident A ate 0% of breakfast, 100% of lunch, and 0% of dinner.
    - 11/20/25, Resident A ate 100% of breakfast, 50% of lunch, and 0% of dinner.
    - 11/21/25, Resident A ate 100% of every meal.
    - 11/22/25, Resident A ate 100% of every meal.
    - 11/23/25, Resident A ate 100% of breakfast and lunch, and 0% of dinner.

On 11/26/25 I received email communication from Administrator, Roxanne Goldammer, regarding the allegation. Ms. Goldammer attached the following document to this correspondence:

- *Resident Weight Record*, for Resident A. This document records Resident A's weight each month from 8/4/24 through 11/25/25. His weight on 8/4/24 was recorded at 155.4lbs and his weight on 11/25/25 was recorded at 158lbs. The highest his weight was recorded was on 3/2/25 at 162.1lbs. The lowest weight recorded was on 12/8/24 at 144lbs. His weight appears to be very consistent per this document.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based upon the interviews conducted, documents reviewed, and observations made during the on-site investigation it can be determined that there is not adequate evidence to determine that Resident A is not being provided with at least three nutritious meals per day. It does appear that Resident A may be refusing the meals provided to him. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff are not providing proper supervision and protection for Resident A.

INVESTIGATION:

On 11/19/25 I received an online complaint regarding the facility. The complaint alleged that Resident A is not being provided with adequate supervision and protection as he attempted to hang himself with his bed sheet. The complaint reported that Resident A called 911 and the direct care staff assisted him in removing the bed sheet. The complaint also alleged that Ms. Betancourt knocked Resident A out of his rocker. There was no specific information about this allegation with a date of the incident available.

On 11/24/25 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Betancourt regarding the allegations. Ms. Betancourt reported that Resident A's mental and physical health have been deteriorating in recent weeks/months. She reported that he has demonstrated increased physical and verbal aggression toward direct care staff members. Ms. Betancourt reported that she is not aware of any incident where Resident A attempted to hang himself with his bed sheet. She reported that he has expressed suicidal ideation and has been placed on increased monitoring on different occasions related to these threats. She reported that when he is on increased monitoring direct care staff check on him every ten minutes to ensure his safety. She reported that direct care staff conducted a "room sweep" and removed all items that Resident A could harm himself with. Ms. Betancourt reported that Resident A gained access to a cell phone charging cable, she is not sure where he obtained this cable. She reported that he was found by direct care staff, Alicia Miller, in his bedroom with the cable tied loosely around his neck. She reported that the cable was removed and Resident A was not injured. She reported that Resident A has not been happy at the facility and wants to be placed in a nursing home. She reported that he has been evaluated for nursing home placement and was denied. Ms. Betancourt reported that direct care staff work with the Ottawa County Community Mental Health (CMH) case manager, Matthew Vanderhyde, regarding Resident A's mental health needs. Ms.

Betancourt reported that the allegation that she “knocked [Resident A] out of a rocker” is false and there is not even a “rocker” located at the facility. Ms. Betancourt denied any physical altercation with Resident A. Ms. Betancourt reported that Resident A has been smoking in his bedroom at the facility. She reported that this has been occurring for several months. Ms. Betancourt reported that the direct care staff advised Resident A that he should not smoke in the facility but due to regulations from CMH they are not allowed to take his cigarettes or lighters from him and restrict him from smoking in the facility. Ms. Betancourt reported that there was an occasion where Resident A became upset with Ms. Betancourt and lit his clothing on fire in his bedroom closet. When asked what steps have been taken to ensure the safety of Resident A and the other residents she reported, “We have done everything we can because he is his own guardian.” She reported that they will try to make him understand that smoking in his bedroom is unsafe, but Resident A does not care. When asked if a discharge notice had been issued for Resident A due to this unsafe behavior, Ms. Betancourt reported that this has not been discussed. She reported that there is currently a petition with the Probate Court to get Resident A a court appointed guardian, but the hearing is not until 12/11/25. Ms. Betancourt reported that the smoke in Resident A’s bedroom is “thick” at times and his roommate, Resident C has resorted to sleeping on the couch in the living room because of Resident A’s smoking. Ms. Betancourt reported that Resident B, who has a bedroom next to Resident A, has also complained about the smell of cigarette smoke in the facility.

During the on-site investigation on 11/24/25 I interviewed Resident A regarding the allegations. Resident A reported that he did not try to hang himself with his bed sheet but did try to hang himself with a cell phone charging cable. He reported that he tied the cable around his neck, placed the other end of the cable in the window. Closed the window on the cable and then rolled over in his bed, trying to tighten the cable around his neck. He reported that he was not injured because of these actions. Resident A reported that a direct care staff found him, removed the cable and he was then placed on “suicide watch”. He reported that the direct care staff checked on him every two hours throughout that evening and the next morning the supervision returned to normal. He reported that he asked to be sent out of the facility for mental health evaluation and this did not occur. Resident A reported that no direct care staff member has ever physically assaulted him at the facility. He confirmed that Ms. Betancourt has not ever physically assaulted him. While I was interviewing Resident A I observed that there were burnt cigarettes lying on the floor all around his bedroom. His bedroom smelled of cigarette smoke. I asked Resident A about smoking in his bedroom. He reported that he has been smoking in his bedroom because he has difficulty with mobility and getting outside. He reported that he has no plans to stop smoking in his bedroom. He further reported that Resident C has started sleeping in the living room on the couch due to his smoking in their bedroom.

During the on-site investigation on 11/24/25 I interviewed Ms. Flanagan regarding the allegations. Ms. Flanagan reported that within the past week Resident A had wrapped a cell phone charging cable around his neck to harm himself. She reported that direct care staff intervened and Resident A was not harmed. She reported that it has become

common for Resident A to threaten suicide. She reported that when these instances occur Resident A is placed on a “suicide watch” and direct care staff check on him between 5 minute and 15-minute intervals. Ms. Flanagan had no knowledge of Ms. Betancourt causing physical harm to Resident A. She reported that Resident A has been smoking in his resident bedroom because he states he is not strong enough to walk outside and smoke cigarettes in the designated smoking area outside the facility. Ms. Flangan reported that there is a designated smoking area near his room and he still chooses to smoke in his bedroom. She reported that when direct care staff ask him to smoke outside, he says to “fuck off”. Ms. Flanagan reported that Resident A also set a fire in his bedroom by lighting his clothing on fire. She reported she was not working on the date of the fire. She reported that it was reported to her that the direct care staff extinguished the fire with a fire extinguisher. Ms. Flanagan reported that the direct care staff cannot confiscate Resident A’s cigarettes and lighters due to CMH regulations.

During the on-site investigation on 11/24/25 I interviewed Ms. Beak regarding the allegations. Ms. Beak reported that Resident A does threaten suicide when he is upset about his medical condition. She reported that she is aware that Resident A wrapped a cell phone charging cable around his neck recently in effort to harm himself. Ms. Beak reported that direct care staff (unsure who was working) found Resident A and removed the cord. She reported that Resident A was unharmed. She reported that Resident A gets placed on “suicide watch” and will be placed on regular, frequent checks by direct care staff, usually, at least every ten minutes. Ms. Beak reported having no knowledge of any direct care staff member causing physical harm to Resident A. She reported that Resident A is a threat to the others in the building because he continues to choose to smoke inside his bedroom. Ms. Beak reported that Resident A will not listen to direct care staff members who tell him that he cannot smoke in the facility. Ms. Beak reported that Resident A states he cannot get outside to the designated smoking areas. She reported that direct care staff offer assistance with getting him outside and he refuses and becomes verbally combative with direct care staff members. Ms. Beak reported that the direct care staff have limited power to control this situation due to CMH regulations not allowing direct care staff members to restrict his actions or access to his cigarettes and lighter. She reported that Resident A did light his clothing on fire in his bedroom on a previous occasion.

During the on-site investigation on 11/24/25 I interviewed Resident B regarding the allegations. Resident B reported that he can smell cigarette smoke in his bedroom, which is next door to Resident A’s bedroom. He confirmed that Resident C has been sleeping on the couch in the living room due to Resident A’s smoking in their bedroom. Resident B reported that he is concerned about Resident A’s smoking in the facility and stated, “Secondhand smoke is no good.” He reported that Resident A also lit his clothing on fire in his bedroom on another occasion. He reported that this scares him, and he worries that Resident A will burn down the facility. He reported that he is worried about his safety with Resident A living in the facility.

During the on-site investigation on 11/24/25 I attempted to interview Resident C regarding the allegations. Resident C declined to be interviewed on this date.

On 11/24/25 I sent email correspondence to licensee designee, Ramon Beltran, and Administrator, Roxanne Goldammer, reporting the seriousness of the situation with Resident A smoking in the facility. I requested an immediate plan of correction to address this situation and noted if an immediate plan of correction was not received a six-month provisional license may be recommended for this facility due to the seriousness of the violation.

On 11/26/25 I received a telephone call from Ms. Goldammer regarding the email correspondence sent on 11/24/25. Ms. Goldammer reported that an emergency discharge notice is being drafted for Resident A due to his continued smoking in his bedroom at the facility. She reported that a copy of the emergency discharge notice would be emailed to this licensing consultant and a plan is underway. Ms. Goldammer acknowledged being aware of Resident C being displaced from his bedroom because of Resident A's smoking in the facility. She confirmed Resident C has been sleeping on the couch in the living room because of Resident A's smoking in their shared bedroom.

On 11/26/25 I received email correspondence from Administrator, Roxanne Goldammer. Ms. Goldammer provided the following documentation for my review:

- *Assessment Plan for AFC Residents*, for Resident A, dated 1/8/25. This document is signed by Mr. Vanderhyde, Resident A, and licensee designee, Ramon Beltran.
    - On page one, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, the document is marked, "yes", with the narrative, "Per [Resident A's] plan he has full community access. Staff will remind him to sign in and out with his leave and return times."
    - Under section, *I. Social/Behavioral Assessment*, subsection, *L. Exhibits Self Injurious Behavior*, the document is marked, "No".
    - Under section, *I. Social/Behavioral Assessment*, subsection, *N. Smokes*, it is marked "Yes" and reads, "Staff will encourage him to smoke in the designated smoking areas outside the ho" (the document cuts off and the rest of the narrative cannot be viewed).
- *Individual Plan of Service (IPOS),* for Resident A, dated 9/26/25. This document was completed by Matthew Vanderhyde with Ottawa County CMH.
    - On page one, under section, *Natural Supports*, subsection, *Barriers That May Impact Reaching My Goals*, the document reads, "Lack of mobility, inconsistent energy state (manic episodes), conflict with staff."
    - This document notes that Resident A previously requested to be evaluated for a more restrictive adult foster care setting and was being evaluated for a licensed adult foster care facility on the same campus as the facility. The document identifies reasoning for approving Resident A moving to a more restrictive setting being his dangerous behaviors of smoking in his bedroom, lighting his clothing on fire (June 2025), and having tendencies to get in cars with strangers and disappear, requiring police involvement to locate him and return him to the facility.

- The document further identifies a tiered plan for Resident A to have increased supervision in the community, including “line of sight” supervision from direct care staff members. The document also identifies that Resident A changed his mind about wanting to move to a restrictive setting.
- This document also noted on page five, under section, *Restriction*, subsection, *What is the restriction?,* it reads, “Staff will hold cigarettes and smoking supplies.” This section identifies that Resident A is creating a safety hazard by smoking in his bedroom and also impacting the health of the other residents in the facility. It is noted, “[Resident A] has refused redirection and smoking in the designated area and continues to smoke in his room. Holding his supplies is the least restrictive option since he continues to refuse redirection.”
- This document does not address any suicidal ideation by Resident A.

On 12/12/2025, Amanda Blasius, licensing consultant completed an unannounced onsite inspection at the facility. During the unannounced onsite investigation, she was informed that Resident A went to the hospital on 12/8/25 due to requesting to call 911. Resident A did not return from the hospital and was discharged from the facility. During the unannounced inspection, direct care staff Autumn Wright and Dorthy Beak reported that Resident A continued to smoke in his room up until he went to the hospital. Direct care staff, Dorthy Beak stated that they could not do anything about his smoking as it was within his rights. She explained that direct care staff requested that Resident A hand over the lighters and cigarettes, but he refused. Ms. Beak and Ms. Wright stated that 30 minute to 1 hour checks were completed for Resident A. Ms. Beak and Ms. Wright explained that Resident A received his cigarettes from other residents, and the other residents would also come into his room and light them for Resident A.

On 12/29/25 I interviewed Mr. Vanderhyde regarding the allegation. Mr. Vanderhyde reported that Resident A occasionally contacts him and to report complaints related to Ms. Betancourt. He reported that Resident A is often in a manic state and will “throw around accusations” regarding Ms. Betancourt, but he has never found anything “grounded in reality” in any of Resident A’s complaints. He reported he has no knowledge of any direct care staff member causing physical harm to Resident A. Mr. Vanderhyde reported that he had been made aware of Resident A’s suicidal ideation involving wrapping a cell phone charging cord around his neck, via IR’s that were sent to him electronically. Mr. Vanderhyde reported that before this incident he had not known Resident A to have suicidal ideation. He reported that he did not provide consultation to the direct care staff on whether to make any changes to Resident A’s plan of care at that point. Mr. Vanderhyde reported that he met with Resident A toward the end of September 2025 to complete his IPOS. He reported at the time of that meeting, Resident A was eloping frequently and making questionable decisions. These decisions would include getting into vehicles with strangers. He reported that at the time of the September IPOS meeting it was discussed with Resident A and the facility direct care staff to move Resident A to a restrictive setting. He reported that on the same campus as the facility there was another licensed adult foster care facility which was a

locked unit. He reported that Resident A agreed to move to the locked facility and the IPOS reflects that this was the plan. He reported that this move never occurred and he was not certain why Resident A was never moved to the more restrictive setting. He also identified that on the IPOS a goal was established to have the direct care staff hold Resident A's cigarettes and lighters to provide security/safety/protection for himself and others at the facility. He reported that he was made aware that the direct care staff were not following this plan of care and he was not certain why. He reported that he was told by the direct care staff that they could not restrict Resident A's rights due to "HCBS" rules. Mr. Vanderhyde reported that he works for CMH, which functions under the Home and Community Based Services (HCBS) guidelines and he identified that Resident A smoking in the facility was a health and safety risk to all those residing in the facility. Mr. Vanderhyde was asked about Resident A being his own guardian at the time of the allegations and how this could impact the direct care staff following through on restrictions placed in Resident A's IPOS document. Mr. Vanderhyde acknowledged that Resident A was his own guardian at the time the IPOS document was created but noted that the facility licensee designee can pursue eviction, regardless of guardianship status, if the resident chooses not to follow the IPOS documented goals. Mr. Vanderhyde reported that Resident A was eventually provided with an emergency discharge notice. He reported that Resident A was sent for medical evaluation and ultimately received his hip replacement surgery and is currently recovering in a subacute rehabilitation center. He reported that upon discharge he will be moved to another adult foster care setting if he is physically strong enough. Mr. Vanderhyde reported that Resident A's guardianship hearing was finalized and he has now been appointed a legal guardian. Mr. Vanderhyde also confirmed that he was aware that Resident A set fire to his clothing in July 2025.

On 12/29/25 I received email correspondence from Katrina Pierce, Program Director with Beacon Specialized Living. Ms. Pierce provided Resident A's incident reports (IRs) from October and November 2025 for my review. I reviewed the following IRs:

- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 7/1/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "Around 12:30pm today [Resident A] was lying on his bed, his eyes were fluttering, and he appeared to be choking and unresponsive to us. Once the EMTs arrived they asked if they could get a BP and he stuck his arm out and then when they told him the ambulance was coming, he sat up and became verbally aggressive. He refused service so they left. Within a few minutes the fire alarm went off. [Resident A] had lit his clothes on fire and refused to leave the room, and he began swinging his fist at the staff member, then tried to push the staff into the fire. He then fell on the staff." This IR was completed by Ms. Betancourt and notes that Resident A was sent to the hospital for further evaluation once the fire was extinguished.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 10/10/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "[Resident A] was observed by staff sitting on his bed smoking a cigarette. He extinguished it when prompted to by staff." The document notes that the direct

care staff provided education about smoking in designated smoking areas. This document was completed by Ms. Flanagan.

- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 10/24/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "[Resident A] was smoking a cigarette in his bedroom and had urinated all over his bed, floor, and clothes." Under the section, *Action Taken by Staff/Treatment Given*, it reads, "Staff reminded [Resident A] that smoking in the home is not permitted. His roommate stated he cannot sleep in the room as the smoke is causing him breathing difficulties as well as others. [Resident A's] urinating on the floor is causing the flooring to loosen." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Staff will continue to remind [Resident A] of the health and safety issues of smoking in the home and urinating on himself and the floor." This document was completed by Ms. Flanagan.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/7/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "Staff opened [Resident A's] bedroom door to find his room full of cigarette smoke. There were several butts on the floor and random containers full of urine. Several other residents have complained about the smell in the house. Other residents are in fear of a fire starting. [Resident A's] roommate is sleeping on the couch in the living room because he can't breathe in his bedroom." Under the section, *Action Taken by Staff/Treatment Given*, it reads, "Staff reminded [Resident A] that there is no smoking in the house. Staff also threw out the containers of urine. Staff found that he is damaging his bed frame by putting the cigarettes out on it." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Staff will continue redirect [Resident A] to smoke outside in the designated smoking areas for the health and safety of himself and others in the home." This document was completed by Ms. Flanagan.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/8/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "Staff entered [Resident A's] room to clean it – his room appeared to be filled with a light fog that smelled of cigarettes. There were several piles of cigarette butts, ashes, several empty food/beverage containers, and tissues on his floor. Staff returned to his room about an hour later a second mess of cigarette butts, ashes, and various garbage." This document was completed by direct care staff, Kameron Greenhoe, and noted the continued plan to inform Resident A that he cannot smoke in the facility, and document and report these instances.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/9/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "Residents were complaining of smoke in the home. Staff opened [Resident A's] door to find the room full of smoke. There were cigarette butts on the floor, along with cups full of urine." This document was completed by direct care staff, Brenda Jensen, and notes the continued plan to direct Resident A to smoke outside the facility due to health and safety risk.

- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/11/25. Under the section, *Explain What Happened/Describe Injury*, it reads, “Staff opened [Resident A’s] bedroom door and was met with a cloud of cigarette smoke.” Under the section, *Action Taken by Staff/Treatment Given*, it reads, “Staff reminded [Resident A] of the designated smoking areas outside of the home. Staff also noted burn holes on his bed frame and cigarette butts all over his floor. [Resident A’s] smoking in his room is affecting his housemates and staff that are non-smokers.” This document was completed by direct care staff, Alicia Miller, with the same plan of care noted to redirect Resident A to smoke outside.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/12/25. Under the section, *Explain What Happened/Describe Injury*, it reads, “Staff opened [Resident A’s] bedroom door and a cloud of smoke billowed out. There was cigarette butts scattered about his bedroom floor. His bed frame has cigarette burns on it from him extinguishing his cigarettes on it. His roommate will not sleep in the room as he cannot breathe due to heavy smoke. His housemates are terrified that he is going to burn the house down.” This document was completed by Ms. Flanagan and noted the continued plan to redirect Resident A to smoke outside for health and safety reasons and for direct care staff to document and report incidents.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/12/25. Under the section, *Explain What Happened/Describe Injury*, it reads, “Around 7:00pm on Wednesday evening [the facility] staff was notified that [Resident A] had called 911 and demanded that someone pick him up. He wanted an ambulance to take him to a hospital or a police officer to take him to jail, he “just wanted out of here”. He also said he was going to kill himself.” Under the section, *Action Taken by Staff/Treatment Given*, it reads, “Staff spoke with dispatch that informed them that he has blown up their emergency line, and something needed to be done. Staff explained [Resident A’s] right to have a phone and that we could not remove it and this appeared as behavioral. They then contacted Beacon’s on-call Clinical department who then spoke to [Resident A] on the phone. After much discussion clinical instructed a room sweep should be completed and remove anything he could use to hurt himself. Clinical also advised 15-minute welfare checks. Staff reminded [Resident A] that 911 is only to be used for emergency services.” Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, “All staff will continue to remind [Resident A] that calling 911 is for emergencies only. Staff will also remind him to come to them with any concerns he may have so they can appropriately assist him. Staff will continue to document and report.” This document was completed by Ms. Flanagan.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/13/25. Under the section, *Explain What Happened/Describe Injury*, it reads, “Upon entering [Resident A’s] room a cloud of smoke came out. [Resident A] was sitting on his bed smoking a cigarette. [Resident A] said he would open his window but he’s been smoking for 50 years and wasn’t going to stop now.”

This document was completed by Ms. Flanagan and noted the same plan of action to continue to redirect Resident A to designated smoking areas for the health and safety of other residents.

- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/14/25. Under the section, *Explain What Happened/Describe Injury*, it reads, “Staff went to give [Resident A] his mail and observed him smoking in his bedroom.” This document was completed by direct care staff, Autumn Wright, and noted the same plan of correction as previous IRs, to redirect Resident A to smoke in designated smoking areas.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/17/25. Under the section, *Explain What Happened/Describe Injury*, it reads, “[Resident A] was smoking in his room. A thick cloud of smoke billowed out of his room when staff entered. There were several cigarette butts on the floor as well. [Resident A] refused to stop smoking in his room.” This document was completed by Ms. Flanagan and noted that same plan of action to continue to redirect Resident A to designated smoking areas for the health and safety of other residents.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/18/25. Under the section, *Explain What Happened/Describe Injury*, it reads, “[Resident A] was smoking in his room with all the windows closed and refused to leave his room to smoke outside. He also refused both his 2:00pm Propranolol 10mg and 5:00pm Codeine 300-30mg medications.” This document was completed by Ms. Betancourt noting that direct care staff had prompted him multiple times to take his medications and redirected him to designated smoking areas.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/18/25. Under the section, *Explain What Happened/Describe Injury*, it reads, “[Resident A] called and spoke with a medical advisor nurse through his health insurance plan. He made statements to her that he wanted to kill himself. He then gave her the office phone number, and she called and reported it to the CTM. [Resident A] made the same statements to staff that he wanted to kill himself. He became verbally aggressive with staff calling them names and threatening them with physical harm and then became physically aggressive by using his walker as a weapon and swinging his walker attempting to hit them. He then lit a cigarette in his room and threw it on a pile of his clothing that was laying on the floor. Then [Resident A] obtained a cord from a housemate and wrapped it around his neck.” Under the section, *Action Taken by Staff/Treatment Given*, it reads, “After speaking with the nurse advisor, management spoke with Beacon clinical and was advised to do a room sweep and 15-minute checks. Management directed staff to do the room sweep and to contact clinical and on-call management if they needed further assistance. After further communication with on-call clinical, bed checks were shortened to 10 minutes after he threw the lit cigarette on his clothes, and finally down to 5 minute bed checks after he wrapped the cord around his neck. Clinical stated once he falls asleep, they can go return to 15 minute checks again. Staff continued bed checks and monitored [Resident A] until clinical called to

evaluate him. Staff removed all of his clothing, shoes and hoodies with strings, belt, lighter, and cord. Management and Beacon clinical spoke with [Resident A] and he stated he wants to be put in a nursing home to receive more hands-on care, and that his pain is getting worse. Management explained the importance of going to all of his scheduled appointments and they understand his pain and frustrations. But can't help him if he refuses to go. Clinical evaluated and cleared him." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Staff will continue to encourage and assist [Resident A] when needed. Along with working with him to maintain the health and safety of all individuals in the home." This document was completed by Ms. Wright.

- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/19/25. This document is completed by Ms. Betancourt and notes that Resident A contacted Adult Protective Services to complain about the direct care staff at the facility.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/19/25. Under the section, Explain What Happened/Describe Injury, it reads, "[Resident A] had been smoking in his bedroom on an off during this whole shift [Resident A] has been just throwing cigarette butts on his floor while still lit. [Resident A] stated, "I don't want to live here anymore, and I don't care about any of you"." This document is completed by Ms. Wright and notes the continued plan to redirect Resident A to smoke outside the facility in designated smoking areas.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/20/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "Upon entering [Resident A's] bedroom staff and management found it to be full of thick cigarette smoke. There were cigarette butts peppered across the floor. When management questioned him about it he responded by swearing at her and threatening her. [Resident A] told staff he was going to kill her (the manager) tomorrow." This document was completed by Ms. Flanagan and noted the continued plan to redirect Resident A to smoke in designated smoking areas.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/21/25. Document completed by Ms. Flanagan and again notes Resident A smoking in his bedroom with the continued plan to redirect him to designated smoking areas.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/22/25. This document was completed by Kameron Greenhoe and notes Resident A continuing to smoke in his bedroom. Citing the continued plan to redirect Resident A to smoke in designated areas and follow Beacon policies.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/24/25. This document was completed by Ms. Flanagan and noted the continued plan to redirect Resident A to smoke in designated areas and follow Beacon policies.

On 12/29/25 I had email correspondence with Ms. Pierce regarding statements made during this investigation, by Resident A, Ms. Betancourt, Ms. Flanagan, and Ms. Beak that Resident A had been placed on a “suicide watch” due to threats of self-harm and an incident involving him wrapping a cell phone charging cable around his neck. I requested further documentation surrounding this incident and another reported incident of Resident A lighting his clothing on fire. Ms. Pierce responded to this email and noted that direct care staff members cannot place a resident on “suicide watch” and noted that the Beacon clinician, Adrianna Pantano, could answer questions related to the incident of suicidal ideation. Ms. Pierce attached an IR regarding the incident when Resident A lit his clothing on fire at the facility.

On 1/5/26 I received email correspondence from Beacon Specialized Living, Vice President of Clinical Operations, Cassidy Jewell, LMSW-C, regarding my inquiries to Ms. Pierce on 12/29/25 regarding Resident A’s threats of self-harm. Ms. Jewell reported the following, “Our clinical team places individuals on enhanced checks (we do not use the term “suicide watch”) based on immediate health and safety needs related to SI or SIB. Typically, we use 15-minute checks as our general standard; however, if risk escalates, we may implement 5- or 10-minute checks as appropriate. This is often used in situations where an individual is experiencing distress or engaging in lower-level SIB but does not meet criteria for hospitalization. For example, if we receive an after-hours call indicating that someone has engaged in superficial SIB (such as scratching their arm), we may request a room sweep and initiate 10-minute checks. These remain in place until the assigned home clinician is able to meet with the individual the following day, assess their current presentation, and determine whether the checks can be discontinued.” I responded to Ms. Jewell’s email correspondence and requested additional information related to the following questions:

- “Who assessed [Resident A’s] suicidal ideation on [11/12/25 & 11/18/25]?
- How was it determined to keep him on-site instead of sending him out for mental health evaluation?
- Was his Community Mental Health case manager made aware of these incidents other than receiving an IR?”

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

ANALYSIS:	This investigation did not find any evidence to determine that Ms. Betancourt physically harmed Resident A in any manner. However based upon the interviews conducted with Resident A, Resident B, Ms. Betancourt, Ms. Flanagan, Ms. Goldammer, Ms. Beak, email correspondence with Ms. Pierce and Ms. Jewell, as well as documentation reviewed and observations made during the unannounced on-site investigation on 11/24/25, it can be determined that there is substantial evidence identifying that the direct care staff are not providing for the protection and safety of the current residents. There are verbal and written reports of Resident A smoking inside the facility and lighting fires in his bedroom. Resident A's IPOS document identifies this as a health and safety risk and noted the restriction to be put into place for the direct care staff to hold Resident A's cigarettes and lighters. When interviewed, Ms. Betancourt, Ms. Flanagan, & Ms. Beak, all reported that they could not restrict Resident A from smoking in the facility and could not take his cigarettes and lighters away from him due to HCBS regulations. The numerous incident reports reviewed for October and November 2025 identified that Resident A was smoking in the facility, causing a health and safety concern for all who reside and work in the facility and the common plan of action was to continue to redirect Resident A to smoke outside of the facility. It was not documented that direct care staff were following Resident A's IPOS document and holding his cigarettes and lighters in effort to prevent Resident A from continuing to smoke in the facility. I made observations while conducting an unannounced, on-site investigation, that Resident A was smoking in his bedroom based upon the numerous burned cigarettes found all around his bedroom and the strong smell of smoke in the facility. Based on these findings a violation has been established as the direct care staff did not follow Resident A's IPOS which clearly stated for direct care staff to hold Resident A's cigarettes and smoking supplies. In terms of the direct care staff not providing adequate supervision for Resident A regarding his suicidal ideation, this investigation found that Resident A's *Assessment Plan for AFC Residents* and *IPOS* documents did not highlight a previous history of suicidal ideation. Emergency services were called for Resident A and provided on-site and telephone assessments of Resident A. The direct care staff conducted "room sweeps" and added increased monitoring for Resident A after his suicidal ideation was assessed. It appears the direct care staff were being proactive in ensuring Resident A's safety from self-harm.

	The final step of contacting Resident A's mental health case manager to ensure Resident A's continued safety in the event of future suicidal ideations was not taken by direct care staff or administration, other than sending an IR. Consequently, there was no further evaluation to address this new behavior and mental health concern.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A is not receiving adequate assistance with his personal care and hygiene needs.

INVESTIGATION:

On 11/19/25 I received an online complaint regarding the facility. The complaint alleged that the direct care staff were not providing adequate assistance with personal care and hygiene needs to Resident A. On 11/24/25 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Betancourt regarding the allegations. Ms. Betancourt reported that Resident A has resided at the facility for multiple years. She reported that in the past two years he has experienced a decline in his physical health related to osteoarthritis affecting his hips and knees. She reported that he was scheduled to have hip replacement surgery, but this fell through due to insurance changes and a change in physicians. Ms. Betancourt reported that Resident A has started refusing to walk with his walker and just wants to remain in his bedroom. She reported that he refuses to use the bathroom and has started urinating in any container he can find in his bedroom. Ms. Betancourt reported that she obtained a urinal for Resident A and he "threw it away". She reported that he will urinate in cups or empty bottles and dump the urine out his bedroom window. She reported that it has been about two weeks since Resident A agreed to take a shower. She reported that showers are offered regularly by direct care staff and Resident A refuses to comply with the assistance. She reported that Resident A has always been a clean person and well-kempt. She reported that it is discouraging for the direct care staff members as they know this and can see Resident A physically declining. Ms. Betancourt reported that Resident A is his own guardian and cannot be forced to shower. She reported that there is a shower chair available for Resident A's use and he can utilize his seated walker to sit on while he dresses after his showers. She reported that Resident A will make excuses, stating he does not have any clean clothing to wear.

During the on-site investigation on 11/24/25, I interviewed Resident A regarding the allegation. Resident A reported that he has advancing osteoarthritis in his knee and hips and cannot ambulate without pain. He reported that he can ambulate with his walker and he is able to get to the bathroom, but it causes great pain. Resident A reported that he chooses to stay in his bedroom and urinate in cups and toss the urine out the bedroom window. He reported that his physician is working on obtaining him a power chair to assist with his mobility. Resident A reported that he washes himself up with a

washcloth. He reported that he is unable to shower at the facility because the shower is broken. He reported that he asks direct care staff members for assistance with his personal care and they tell him “No”.

During the on-site investigation on 11/24/25 I interviewed Ms. Flanagan, regarding the allegation. Ms. Flanagan reported that the showers at the facility are both in working order. I had Ms. Flanagan demonstrate the functionality of both showers and both showers were found to be in good working order. One of the showers was a walk-in shower equipped for individuals with mobility impairment. Ms. Flanagan reported that Resident A is experiencing advancing symptoms of osteoarthritis. She reported that he will state that he cannot do anything for himself, but direct care staff members have observed him walking. She reported that he has recently started to refuse personal care assistance at the facility. She reported that the direct care staff have daily tasks to verbally prompt Resident A to shower. She reported that three times per day Resident A is prompted to take a shower. She reported that Resident A continues to refuse showers or assistance with personal hygiene. Ms. Flanagan reported that Resident A states he cannot walk to get to the shower, but he has a seated walker, and the shower is handicap accessible. She further reported that Resident A chooses to remain in his bedroom and urinate in cups or other containers, instead of attempting to walk to the bathroom. She reported that Resident A will then dump this urine out the bedroom window next to his bed. Ms. Flanagan reported that she feels Resident A may need a placement at a facility that provides a higher level of care. She reported that he is not willing to receive assistance from the direct care staff and is unwilling to assist himself with his personal care/hygiene needs.

During the on-site investigation on 11/24/25 I interviewed Ms. Beak regarding the allegation. Ms. Beak reported that Resident A has started to isolate himself in his bedroom. She reported that he does not cooperate with direct care staff when they provide verbal prompts to take his shower. Ms. Beak reported that previously Resident A was able to shower himself and lately he refuses to perform most hygiene related tasks. Ms. Beak reported that Resident A has started urinating in containers in his bedroom and dumping the collected urine out his bedroom window.

During the on-site investigation on 11/24/25 I interviewed Resident B regarding the allegation. Resident B reported that he has observed the direct care staff make attempts to prompt Resident A to take his shower and offer assistance to Resident A. Resident B reported that Resident A is rude to the direct care staff and yells at them when they approach him about these issues. He reported he has observed Resident A refuse any personal care offered.

On 11/26/25 I received email correspondence from Ms. Goldammer. Ms. Goldammer provided the following documentation for my review:

- *Assessment Plan for AFC Residents*, for Resident A, dated 1/8/25.
    - Under section, *II. Self Care Skill Assessment*, subsections, *A. Eating/Feeding, B. Toileting, C. Bathing, D. Grooming (hair care, teeth, nails, etc.), E. Dressing, F. Personal Hygiene, G. Walking/Mobility*, each

area is Marked “No”, indicating Resident A does not require assistance with these tasks.
    - Under section, *III. Health Care Assessment*, subsection, *C. Physical Limitations*, the document is marked, “NO”. Under subsection, *D. Special Equipment Used (wheel chair, walker, cane, etc.)*, the document is marked, “No”.
    - Under section, *IV. Social and Program Activities*, subsection, *I. Physical Exercise*, the document is marked, “Yes”, and reads, “[Resident A] enjoys walking. Staff will encourage him to take arounds around the property to maintain his health.”

On 12/29/25 I received email correspondence from Katrina Pierce, Program Director with Beacon Specialized Living. Ms. Pierce provided Resident A’s incident reports (IRs) from October and November 2025 for my review. I reviewed the following IRs:

- *AFC Licensing Division – Incident/Accident Report*, dated 10/2/25, for Resident A. Completed by direct care staff, Kameron Greenhoe. This IR documented that Resident A soiled his bedding and direct care staff removed the soiled bedding, provided fresh bedding and encouraged Resident A to use the restroom or his urinal.
- *AFC Licensing Division – Incident/Accident Report,* dated 10/14/25, for Resident A. This document noted that Resident A had urinated in his clothes hamper and the urine was on the floor of his bedroom. The document noted that direct care staff educated Resident A about needing to use the restroom.
- *AFC Licensing Division – Incident/Accident Report,* dated 10/24/25, for Resident A. This document reported that Resident A was found urinating on the floor in his bedroom. He was encouraged to use the restroom.
- *AFC Licensing Division – Incident/Accident Report,* dated 11/7/25, for Resident A. This document identifies that direct care staff found Resident A in his bedroom with several containers of urine. Reported that direct care staff threw away the containers.
- *AFC Licensing Division – Incident/Accident Report,* dated 11/8/25, for Resident A. This document noted direct care staff attempting to clean Resident A’s bedroom. Noting empty food containers on the floor, tissues on the floor, cigarette butts and ashes on the floor, and other “various garbage.”
- *AFC Licensing Division – Incident/Accident Report,* dated 11/17/25, for Resident A. This document reported that Resident A refused a shower on 11/10/25 and 11/16/25.
- *AFC Licensing Division – Incident/Accident Report,* dated 11/24/25, for Resident A. The document reports that Resident A refused a shower the week of 11/17/25 through 11/23/25.

On 12/29/25 I interviewed Mr. Vanderhyde regarding the allegation. Mr. Vanderhyde confirmed that Resident A was having physical difficulties with mobility related to his osteoarthritis. He reported that he had received communication from the direct care staff at the facility, by way of IRs, that Resident A was refusing assistance with personal

care. He reported that he felt the direct care staff were attempting to assist Resident A with his personal hygiene needs and Resident A was refusing these services.

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(1) A licensee shall offer a resident appropriate opportunity, access to, and instructions for the following daily: **(a) Bathing or showering, or both.** **(b) Shaving.** **(c) Oral care.** **(d) Grooming.** **(e) Peri-care.** **2) A licensee shall ensure the resident receives or has access to all of the following:** **(a) Bathing at least weekly.** **(b) Toileting as needed.** **(c) Assistance with resident hygiene as needed.**
ANALYSIS:	Based upon interviews conducted and documentation reviewed it can be determined that there is not a preponderance of evidence that direct care staff were not attempting to provide for Resident A's personal care and hygiene needs. Resident A reported that the showers at the facility were broken. I tested the showers and found both showers in working order. The IRs reviewed indicated that Resident A had refused direct care staff attempts to assist with personal care needs. Based on this information a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The direct care staff are not assisting Resident A in following up with his medical appointments. He needs a hip replacement.

INVESTIGATION:

On 11/19/25 I received an online complaint regarding the facility. The complaint alleged that Resident A needs a hip replacement and the direct care staff are not providing proper follow up with his medical appointments to move this process along. On 11/24/25 I conducted an unannounced, on-site investigation and interviewed Ms. Betancourt. Ms. Betancourt reported that Resident A does have osteoarthritis in his hips and knees. She reported that he has been in the process of getting scheduled to have hip replacement surgery for about the past two years. Ms. Betancourt reported that Resident A was previously working with a physician with University of Michigan Health Sparrow Carson

City Hospital to get this surgery approved and then his health insurance plan changed and no longer covered this provider. Ms. Betancourt reported that Resident A is his own guardian and received a telephone call from an insurance agent asking him to switch his health insurance plan. She reported that he previously had a “straight” Medicaid insurance and this representative convinced Resident A to switch to a Medicaid HMO plan. Ms. Betancourt reported that Resident A approved of the health insurance change, not knowing this would impact the plans he made with his current provider. She reported that a week prior to the scheduled surgery Resident A’s health insurance changed, his provider discovered the change, noted they do not accept the new insurance, and Resident A was left to find a provider who would work with Resident A’s new health insurance plan. Ms. Betancourt reported that Resident A was then linked with a new provider, Cherry Health, out of Greenville, MI. She reported that this provider did not want to schedule him for the previously approved surgery right away and wanted him to complete physical therapy to see if this intervention helped. Ms. Betancourt reported that direct care staff tried to keep up with Resident A’s medical appointments, but he would make appointments without their knowledge and have his friend pick him up from the facility and drive him to the appointments. Ms. Betancourt reported that Resident A verbalized he was not going to follow through with the referral for physical therapy as he was in too much pain and did not feel this would help. She reported that she was aware that Resident A’s provider requested he meet with a gastroenterologist to receive a clearance for the surgery, related to some bowel issues he had been experiencing recently. Ms. Betancourt reported that the meeting with this provider was scheduled for 11/24/25 and Resident A refused to attend the appointment. Ms. Betancourt reported that Resident A’s mental status appears to be deteriorating. He is having more outbursts and combative behaviors. She reported that she feels Resident A needs to have a guardian appointed to assist with decision making. She reported as part of the guardianship request process, Resident A was required to go through a mental status exam. She reported she took him to this appointment on 11/10/25 and Resident A requested that she leave him at the appointment. She reported that Resident A refused to wait for a direct care staff member to come back to the appointment and pick him up and he decided to walk himself to Subway, which was about two to three blocks from the office where the assessment was conducted. Ms. Betancourt reported that a guardianship hearing has been scheduled for Resident A on 12/11/25 at the local Probate Court. Ms. Betancourt reported that Resident A’s next appointment with his primary care physician is scheduled for 12/17/25, where the plan is to review Resident A’s lab work and attempt to obtain a referral for an orthopedic surgeon.

During the on-site investigation on 11/24/25 I interviewed Resident A regarding the allegation. Resident A reported that he needs a hip replacement as there is no cartilage in his knee and he cannot walk without pain. Resident A reported that he also suffers from neuropathy in his feet which causes ambulation to be difficult. He reported that his current medical provider is Jennifer Hudson, Cherry Health in Greenville, MI. Resident A reported the same details that Ms. Betancourt reported about his hip replacement surgery being scheduled and then cancelled due to his change in medical insurance. He reported that he “was tricked” because the Molina Medicaid insurance company called

him and offered him a “food card” if he switched insurance. He reported frustration that his insurance change impacted his entire plan with his previous provider. When asked if direct care staff were working with him to get him to his medical appointments he reported, “They’re gonna say I’m refusing them because I refused today.” He reported that he had to switch providers to Jennifer Hudson about eight months ago. Resident A reported that Ms. Betancourt keeps telling him that all he needs is exercise and physical therapy to strengthen himself, but he does not believe this will work. Resident A reported that Jennifer Hudson will be placing a referral for an orthopedic surgeon in efforts to get a hip replacement scheduled.

During the on-site investigation on 11/24/25 I interviewed Ms. Flanagan regarding the allegation. Ms. Flanagan reported that Resident A’s previous medical provider was Dr. Ott, in Carson City, Michigan. She reported that Dr. Ott had requested Resident A stop smoking prior to the hip replacement surgery and reported that Resident A never stopped smoking. Ms. Flanagan reported that Resident A switched his Medicaid health insurance plan because he was offered a “food card” if he switched. Ms. Flanagan reported that this change occurred in the Fall of 2024 and Resident A had to start over with a new medical provider. She reported that the new provider was trying to get Resident A cleared for surgery, specifically anesthesia, and was requesting Resident A follow up with gastroenterology for a colonoscopy. Ms. Flanagan reported that Resident A refused to attend this appointment.

On 11/26/25 Ms. Goldammer sent email correspondence which included documentation for Resident A to be reviewed. I reviewed the following documents:

- *NextStep Note Printout*, for Resident A, dated 6/8/25. Under the section, “*Medical Issue”*, is noted, “Pain/headache”. Under the section, *Seen by*, it reads, “Carson City Hospital. [Resident A] was seen in the ER for having pain in his back, hips, and legs, A CT scan was run and showed arthritis in his hips and knees. He was given an oral medication of Gabapentin, an oral pain medication and an injection of muscle relaxer. He was discharged shortly after receiving medications.”
- *NextStep Note Printout,* for Resident A, dated 8/22/25. Under the section, *Medical Issue*, it reads, “New patient/HCA, DO, OTC PRN”. Under the section, *Seen By*, it reads, Cherry Health, [Resident A] had a new patient appointment that he refused. He had to change doctors because they would not take his new insurance. He was transferred to Cherry Health. His script for Pregablin is almost out and they can not write him a new script until he is seen in the office.”
- *NextStep Note Printout,* for Resident A, dated 8/26/25. Under the section, *Medical Issue*, it reads, “labs”. Under the section, *Seen by*, it reads, “Sheridan labs. Refused. [Resident A] has refused his labs that were requested by Dr. Petrovic from hos med review on 8.6. He has refused each day. Staff will continue to prompt until they are completed.”
- *NextStep Note Printout*, for Resident A, dated 9/10/25. Under the section, *Medical Issue*, it reads, “Annual Visit”. Under the section, *Seen by*, it reads, “Jennifer Hudson Cherry health centers. [Resident A] was transported to Cherry health for a new patient/Annual health review. [Resident A] requested a PRN for pain and stated he wanted a narcotic because nothing else worked. He also

requested a script for a wheelchair because he is unable to walk. Doctor did not prescribe either."

- *NextStep Note Printout,* for Resident A, dated 10/15/25. Under the section, *Medical Issue*, it reads, "Hip pain". Under the section, *Seen by*, it reads, "Jennifer Hudson, [Resident A] had an appointment with his primary care due to his hip pain. She went over his medications and ordered some lab work."
- *NextStep Note Printout,* for Resident A, dated 10/24/25. Under the section, *Medical Issue*, it reads, "ER follow up, wheel chair, pain management". Under the section, *Seen by*, it reads, "Jennifer Hudson, DO. Bilateral primary osteoarthritis of hip. Bilateral osteoarthritis of knee. Continue new Lidoderm patches. D/C ibuprofen from med list. Change Celebrex to daily routine instead of PRN. Add Tylenol with codeine Q6hrs PRN for pain. Establish new orthopedic Doctor. [Resident A] allowed staff to accompany him into the appointment. [Resident A] was honest in his answers to staffs knowledge."
- *NestStep Note Printout,* for Resident A, dated 11/7/25. Under the section, *Medical Issue*, it reads, "Physical Therapy". Under the section, *Seen by*, it reads, "Greenville Physical Therapy. [Resident A] was seen to begin physical therapy by order of his PCP. [Resident A] went to the appointment but refused to participate with the therapy. He stated that he was unable to move. No further appointments will be scheduled."
- *NextStep Note Printout,* for Resident A, dated 11/24/25. Under the section, *Medical Issue*, it reads, Gastroenterology. Under the section, *Seen by*, it reads, "Refused. [Resident A] had an appointment to see the gastroenterology. This is a apart of the steps he needed to take to get health clearance for the anesthesiologist. Part of clearance for hip surgery."

On 12/29/25 I interviewed Mr. Vanderhyde regarding the allegation. Mr. Vanderhyde reported that Resident A has been struggling with health issues for multiple months. Mr. Vanderhyde did confirm that Resident A had issues with insurance changes and changes in medical providers which has impeded his progress being made toward being approved for hip replacement surgery. Mr. Vanderhyde reported that the direct care staff were working with Resident A to get him to his medical appointments and there were times Resident A refused appointments. He reported that Resident A did have difficulty walking at the facility but also noted that direct care staff offered accommodations to meet his needs, such as a wheelchair, walker, and assist from direct care staff. He reported that Resident A was finally able to receive his hip replacement surgery and is currently placed at a subacute rehabilitation center recovering from this surgery. Mr. Vanderhyde had no concerns that direct care staff did not provide for Resident A's needs and ensured he received medical care when indicated.

On 12/29/25 I received email correspondence from Katrina Pierce, Program Director with Beacon Specialized Living. Ms. Pierce provided Resident A's incident reports (IRs) from October and November 2025 for my review. I reviewed the following IRs:

- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/24/25. This document was completed by Ms. Betancourt and noted that Resident A

refused to attend his gastroenterology appointment scheduled on this date. Under the section, *Action Taken by Staff/Treatment Given*, it reads, "Management notified [Resident A] two weeks in advance only with daily reminders and expressed the importance of this appointment. It was explained this was part of the steps he needed to take to get health clearance for the anesthesiologist for hip surgery. Management spoke with his nurse advocate that [Resident A] had contacted to assist with his health care. Management attempted to explain to [Resident A] that when he refuses his appointments it sets him back."

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Based upon interviews conducted and documentation reviewed it can be determined that there is not a preponderance of evidence that direct care staff were not following the instructions and recommendations of Resident A's physicians and health care team. It appears that the most significant barrier to Resident A obtaining the needed medical care (hip replacement) was related to his own personal decision to change his medical insurance, which became an obstacle to continuing to work with his established providers, resulting in starting the entire process of approval for surgery starting over again with new medical providers and a new insurance company. There is documented evidence that Resident A declined participating in physical therapy and attending mandatory appointments to pursue his goal of hip replacement surgery. There is documentation to support the direct care staff were trying to work with Resident A to assist him in his goal of being rescheduled for hip surgery. As a result, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 11/24/25 I interviewed Ms. Betancourt. Ms. Betancourt reported that Resident C has been displaced from his resident bedroom due to Resident A smoking in the facility. She reported that Resident A and Resident C are roommates and since Resident A chooses to smoke in their bedroom, Resident C has

decided to sleep on the couch in the living room due to the cigarette smoke in his bedroom.

During the on-site investigation on 11/24/25 I interviewed Resident A. Resident A reported that he does smoke in his and Resident C's bedroom. He reported that Resident C started sleeping on the couch in the living room because he does not like cigarette smoke.

During the on-site investigation on 11/24/25 I interviewed Ms. Flanagan. Ms. Flanagan reported that Resident C has been sleeping on the couch in the living room due to Resident A smoking in their shared bedroom.

During the on-site investigation on 11/24/25 I interviewed Ms. Beak. Ms. Beak reported that Resident C has been sleeping on the couch in the living room due to Resident A smoking in their shared bedroom.

During the on-site investigation on 11/24/25 I interviewed Resident B. Resident B reported that Resident C has been sleeping on the couch in the living room due to Resident A smoking in their bedroom.

During the on-site investigation on 11/24/25 I observed Resident C's bed to be stripped of bedding. I observed burned cigarettes all over the bedroom. I observed Resident C lying on the couch in the living room. Resident C declined to be interviewed on this date.

On 11/26/25 I received a telephone call from Ms. Goldammer. Ms. Goldammer acknowledged being aware of Resident C being displaced from his bedroom because of Resident A's smoking in the facility. She confirmed Resident C has been sleeping on the couch in the living room because of Resident A's smoking in their shared bedroom.

On 11/26/25 I received email correspondence from Administrator, Roxanne Goldammer. Ms. Goldammer provided the following documentation for my review:

- *Individual Plan of Service (IPOS),* for Resident A, dated 9/26/25. This document was completed by Matthew Vanderhyde with Ottawa County CMH.
    - This document noted on page five, under section, *Restriction*, subsection, *What is the restriction?,* it reads, "Staff will hold cigarettes and smoking supplies." This section identifies that Resident A is creating a safety hazard by smoking in his bedroom and also impacting the health of the other residents in the facility. It is noted, "[Resident A] has refused redirection and smoking in the designated area and continues to smoke in his room. Holding his supplies is the least restrictive option since he continues to refuse redirection."

On 12/29/25 I received email correspondence from Katrina Pierce, Program Director with Beacon Specialized Living. Ms. Pierce provided Resident A's incident reports (IRs) from October and November 2025 for my review. I reviewed the following IRs:

- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 10/24/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "[Resident A] was smoking a cigarette in his bedroom and had urinated all over his bed, floor, and clothes." Under the section, *Action Taken by Staff/Treatment Given*, it reads, "Staff reminded [Resident A] that smoking in the home is not permitted. His roommate stated he cannot sleep in the room as the smoke is causing him breathing difficulties as well as others. [Resident A's] urinating on the floor is causing the flooring to loosen." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Staff will continue to remind [Resident A] of the health and safety issues of smoking in the home and urinating on himself and the floor." This document was completed by Ms. Flanagan.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/7/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "Staff opened [Resident A's] bedroom door to find his room full of cigarette smoke. There were several butts on the floor and random containers full of urine. Several other residents have complained about the smell in the house. Other residents are in fear of a fire starting. [Resident A's] roommate is sleeping on the couch in the living room because he can't breathe in his bedroom." Under the section, *Action Taken by Staff/Treatment Given*, it reads, "Staff reminded [Resident A] that there is no smoking in the house. Staff also threw out the containers of urine. Staff found that he is damaging his bed frame by putting the cigarettes out on it." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Staff will continue redirect [Resident A] to smoke outside in the designated smoking areas for the health and safety of himself and others in the home." This document was completed by Ms. Flanagan.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/12/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "Staff opened [Resident A's] bedroom door and a cloud of smoke billowed out. There was cigarette butts scattered about his bedroom floor. His bed frame has cigarette burns on it from him extinguishing his cigarettes on it. His roommate will not sleep in the room as he cannot breathe due to heavy smoke. His housemates are terrified that he is going to burn the house down." This document was completed by Ms. Flanagan and noted the continued plan to redirect Resident A to smoke outside for health and safety reasons and for direct care staff to document and report incidents.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(q) Access their bedroom at their own discretion.**

ANALYSIS:	Based upon the interviews conducted, observations made during the on-site investigation, and documentation reviewed it can be determined that direct care staff were not following Resident A's *IPOS* document requiring them to hold Resident A's cigarettes and lighters, which resulted in Resident A continuing to smoke in his shared bedroom with Resident C. Resident C could not tolerate the smoking in the bedroom and was not able to have free access to his bedroom because of Resident A's smoking. Resident C began sleeping on the facility couch due to the smoke in his bedroom. As a result, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation on 11/24/25 I made observations of Resident A and Resident C's shared bedroom. I observed the following:

- Two large holes in the drywall on the wall above Resident A's bed. These holes were estimated to be around two to three feet in circumference.
- Multiple extinguished cigarettes covering areas of the flooring.
- Ashes from cigarettes found on the flooring and in Resident A and Resident C's bedframes.
- Dirty tissues littered around the room.
- A plate of food scrapes on the floor by the door.
- Numerous empty cups on the floor.

During the on-site investigation I interviewed Ms. Betancourt. Ms. Betancourt reported that Resident A smokes in his bedroom. She reported that he also refuses to leave his bedroom to urinate and urinates on the floor, in cups, and any other container he can find. She reported that Resident A caused the damage to his own bedroom wall by hitting the wall. Ms. Betancourt reported that this is the second or third time Resident A has put a hole in his bedroom wall, intentionally. She reported that there is currently a work order in and maintenance came to assess the damage last week. She reported that Resident A made this most recent hole in the drywall about two weeks prior. She reported that Resident A was made aware he would need to leave the bedroom for the repairs to take place because of the drywall dust. She reported that Resident A does not want to leave his bedroom.

During the on-site investigation I interviewed Resident A. Resident A reported that he did damage the drywall in his bedroom because he was mad. He reported that he smashed the wall with a hand weight. He noted it has been damaged for about four to five months. He reported that maintenance did come last Friday to assess the damage. He reported he was told he would need to vacate the room for the repairs to take place, and he does not want to vacate the bedroom. Resident A reported that he does urinate

in cups in the bedroom and dumps the urine out the bedroom window. He acknowledged that he is smoking cigarettes in his bedroom.

During the on-site investigation I interviewed Ms. Flanagan. Ms. Flanagan reported that Resident A smokes in his bedroom, leave the cigarettes on the floor. She reported that he also urinates in the bedroom into cups and other containers. Ms. Flanagan reported that Resident A did damage his own bedroom wall and this occurred about a month prior. She reported that initially Resident A damaged the wall, maintenance repaired the damage and then he damaged it again.

On 12/12/2025, Amanda Blasius, licensing consultant, completed an unannounced onsite inspection at the facility. Ms. Blasius reported that she observed the wall in Resident A's bedroom to have been repaired.

On 12/29/25 I received email correspondence from Katrina Pierce, Program Director with Beacon Specialized Living. Ms. Pierce provided Resident A's incident reports (IRs) from October and November 2025 for my review. I reviewed the following IRs:

- *AFC Licensing Division – Incident/Accident Report*, for Resident A, dated 10/4/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "[Resident A] was very verbally aggressive towards staff calling staff a b*tch and a whore. [Resident A] then bean to do property destruction on his bedroom wall and refused to talk with staff." Under the section, *Action Taken by Staff/Treatment Given*, it reads, "Staff tried to verbally redirect him to find out what he was upset about. Staff charted the incident." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Staff will continue to encourage [Resident A] to talk to staff when he is upset, along with maintaining the safety of the home. Staff will continue to document and report."
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 10/24/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "[Resident A] was smoking a cigarette in his bedroom and had urinated all over his bed, floor, and clothes." Under the section, *Action Taken by Staff/Treatment Given*, it reads, "Staff reminded [Resident A] that smoking in the home is not permitted. His roommate stated he cannot sleep in the room as the smoke is causing him breathing difficulties as well as others. [Resident A's] urinating on the floor is causing the flooring to loosen." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Staff will continue to remind [Resident A] of the health and safety issues of smoking in the home and urinating on himself and the floor." This document was completed by Ms. Flanagan.
- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/7/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "Staff opened [Resident A's] bedroom door to find his room full of cigarette smoke. There were several butts on the floor and random containers full of urine. Several other residents have complained about the smell in the house. Other residents are in fear of a fire starting. [Resident A's] roommate is sleeping on the couch in the living room because he can't breathe in his bedroom." Under the section,

Action Taken by Staff/Treatment Given, it reads, “Staff reminded [Resident A] that there is no smoking in the house. Staff also threw out the containers of urine. Staff found that he is damaging his bed frame by putting the cigarettes out on it.” Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, “Staff will continue redirect [Resident A] to smoke outside in the designated smoking areas for the health and safety of himself and others in the home.” This document was completed by Ms. Flanagan.

- *AFC Licensing Division Incident/Accident Report*, for Resident A, dated 11/12/25. Under the section, *Explain What Happened/Describe Injury*, it reads, “Staff opened [Resident A’s] bedroom door and a cloud of smoke billowed out. There was cigarette butts scattered about his bedroom floor. His bed frame has cigarette burns on it from him extinguishing his cigarettes on it. His roommate will not sleep in the room as he cannot breathe due to heavy smoke. His housemates are terrified that he is going to burn the house down.” This document was completed by Ms. Flanagan and noted the continued plan to redirect Resident A to smoke outside for health and safety reasons and for direct care staff to document and report incidents.

APPLICABLE RULE	
Rule 647.	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants. **(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.**
ANALYSIS:	Based upon interviews conducted, observations made during the unannounced on-site investigation, and documentation reviewed it can be determined that there is adequate evidence to identify that the direct care staff were not providing for the health, safety, and well-being of the occupants or providing a comfortable, clean, and orderly environment, due to Resident A’s continued smoking in the facility. The shared bedroom space between Resident A and Resident C was in a soiled and unsanitary condition upon my arrival at the facility on 11/24/25. Resident C made a choice to no longer utilize his bedroom due to the constant smoking of Resident A, causing an unsanitary and unhealthy living environment. The two large holes in the wall are documented as being made by Resident A on 10/4/25 (IR), yet the maintenance evaluation of the damage was noted as being conducted the week of 11/17/25. Based upon this information a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the current status of the license recommended at this time.

1/6/26

Jana Lipps Date
Licensing Consultant

Approved By:

01/07/2026

Dawn N. Timm Date
Area Manager