GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 3, 2023

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

RE: License #: AS390406165
Investigation #: 2023A0578054
Beacon Home at Richland

Dear Mr. Beltran:

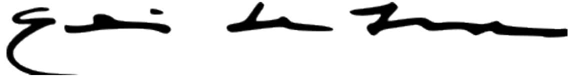
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9727.

Sincerely,



Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406165
Investigation #:	2023A0578054
Complaint Receipt Date:	08/10/2023
Investigation Initiation Date:	08/11/2023
Report Due Date:	10/09/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubrey Napier
Licensee Designee:	Ramon Beltran II
Name of Facility:	Beacon Home at Richland
Facility Address:	9445 N. 24th St. Richland, MI 49083
Facility Telephone #:	(269) 488-0024
Original Issuance Date:	01/11/2021
License Status:	REGULAR
Effective Date:	07/11/2023
Expiration Date:	07/10/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff did not maintain the supervision requirements in Resident A's behavior plan and as a result, Resident A was able to elope while in the community.	Yes

III. METHODOLOGY

08/10/2023	Special Investigation Intake 2023A0578054
08/11/2023	Special Investigation Initiated - On Site
08/11/2023	APS Referral
08/12/2023	Special Investigation Completed On-site- Interview with Resident A.
09/17/2023	Special Investigation Completed On-site- Interview with direct care staff Vanessa Berry.
09/17/2023	Contact-Document Reviewed- *Assessment Plan for AFC Residents* for Resident A, dated 01/19/2023.
09/17/2023	Contact-Telephone- With Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta.
09/17/2023	Contact-Document Reviewed- *Behavior Support Plan* for Resident A, dated 01/26/2023.
09/17/2023	Contact-Document Reviewed- *AFC Licensing Division Incident / Accident Report* dated 06/29/2023.
09/18/2023	Exit Conference- Message left for the licensee designee, Ramon Beltran II.

ALLEGATION:

Direct care staff did not maintain the supervision requirements in Resident A's behavior plan and as a result, Resident A was able to elope while in the community.

INVESTIGATION:

On 08/10/2023, I received this complaint through the BCHS On-line Complaint System. Complainant reported that direct care staff Vanessa Berry and direct care staff Samantha Slumkowski took all the residents on an outing and during this outing Resident A eloped. Complainant reported direct care staff at this facility are to always keep eyes on Resident A while in the community. Complainant alleged when Resident A went to use the bathroom, direct care staff Samantha Slumkowski continued to shop instead of waiting for Resident A at the restroom, and as a result, Resident A was able to elope.

On 08/12/2023, I completed an unannounced investigation on-site and interviewed Resident A regarding the allegations. Resident A acknowledged that when he goes in the community, direct care staff are to provide him with line-of-sight supervision. Resident A acknowledged eloping from this facility on two separate occasions but did not recall using a bathroom at a local grocery store or using this opportunity to elope while in the community. When asked what direct care staff were doing when Resident A eloped from this local grocery store, Resident A reported he did not know. Resident A reported he "just wanted to get away" and probably went downtown to hang out with his friends at the homeless shelter. Resident A reported that when he was done, he probably called this facility and had direct care staff return him to this facility. Resident A denied experiencing any injuries during this elopement.

On 09/17/2023, I interviewed direct care staff Vanessa Berry regarding the allegations. Vanessa Berry recalled the day of the incident and reported that all residents were taken to the local grocery store and that Vanessa Berry was monitoring several residents while direct care staff Samantha Slumkowski monitored the other residents including Resident A. Vanessa Berry acknowledged that Resident A's supervision requirements while in the community required line-of-sight by direct care staff. Vanessa Berry acknowledged that Resident A eloped after using a bathroom at a local grocery. Vanessa Berry reported that direct care staff could not follow Resident A into the bathroom. Vanessa Berry reported that she did not know why Samantha Slumkowski did not stay near this bathroom until Resident A had exited the bathroom, as she was monitoring other residents.

On 09/17/2023, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 01/19/2023. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A does not have community access and does not move

independently in the community and to refer to Resident A's *Behavior Support Plan* regarding community guidelines.

On 09/17/2023, I reviewed the *Behavior Support Plan* for Resident A, dated 01/26/2023. The *Behavior Support Plan* for Resident A documented that Resident A is diagnosed with bipolar I disorder, posttraumatic stress disorder, alcohol use disorder and cannabis use disorder. The *Behavior Support Plan* for Resident A identified Resident A's target behaviors as physical aggression, verbal aggression, elopement, substance seeking/use, and unsafe smoking. The *Behavior Plan* for Resident A documented that Resident A's restrictive interventions for supervision and community outings would involve direct care staff providing line-of-sight supervision while Resident A is in the community. The *Behavior Support Plan* for Resident A documented that direct care staff do not need to follow Resident A in the bathroom but clarified that if Resident A is agitated or purposely attempting to evade direct care staff during an outing, direct care staff will follow Resident A to provide supervision.

On 09/18/2023, I reviewed *AFC Licensing Division Incident / Accident Report* dated 06/29/2023 and completed by direct care staff Samantha Slumkowski. This *AFC Licensing Division Incident / Accident Report* included the following information:

> *"We were in Walmart with residents. [Resident A] was in the same aisle next to us. When we turned back around [Resident A] was out of sight by the time we turned around. We searched around aisles and [Resident A] was out of sight..."*

The *AFC Licensing Division Incident / Accident Report* documented that Resident A was found downtown and returned to the facility at 12:42AM.

On 09/18/2023, I interviewed Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta regarding the allegations. Suzie Suchyta reported that when she interviewed direct care staff Samantha Slumkowski, Samantha Slumkowski reported that Resident A had eloped after entering the bathroom at the local grocery store. Suzie Suchyta reported Samantha Slumkowski contradicted the *AFC Licensing Division Incident / Accident Report* that Samantha Slumkowski had completed on 06/29/2023 and was received by the Integrated Services of Kalamazoo recipient rights office. Suzie Suchyta reported that even if Resident A entered the bathroom at this local grocery store, she would have expected direct care staff to watch this bathroom door until Resident A exited this bathroom door to stay in compliance with Resident A's *Behavior Plan.* Suzie Suchyta reported for these reasons, she established a violation of neglect.

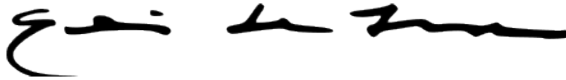
On 09/19/2023, I interviewed direct care staff Samantha Slumkowski regarding the allegations. Samantha Slumkowski recalled the day of the incident and reported that all residents at this facility were transported to a local grocery store on an outing. Samantha Slumkowski reported that Resident A and another direct care staff had to use the bathroom and Resident A, "ended up eloping." Samantha Slumkowski

acknowledged that Resident A's *Behavior Plan* required direct care staff to keep Resident A within line of sight but clarified that that none of the direct care staff could enter the bathroom with Resident A as they were all female. Samantha Slumkowski denied that any other direct care staff stayed outside of the bathroom Resident A was using and reported that she went with one group of residents while direct care staff Vanessa Berry went with another group of residents and continued through the local grocery store. I reviewed the details of *AFC Licensing Division Incident / Accident Report* dated 06/29/2023 and completed by Samantha Slumkowski. Samantha Slumkowski reported this *AFC Licensing Division Incident / Accident Report* was not accurate, and that she meant to say that Resident A entered a bathroom instead. When asked why Samantha Slumkowski documented on the *AFC Licensing Division Incident / Accident Report* that Resident A was in a shopping aisle instead of a bathroom, Samantha Slumkowski reported that at the time she completed this *AFC Licensing Division Incident / Accident Report*, she was doing her end of shift paperwork and making dinner for Residents and did not document the events of this incident accurately on the *AFC Licensing Division Incident / Accident Report* as a result.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care staff Samantha Slumkowski, direct care staff Vanessa Berry, and Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta, as well as a review of pertinent facility documentation relevant to this investigation, direct care staff did not provide Resident A with line-of-sight supervision while in the community as identified in Resident A's *Behavioral Support Plan*, resulting in Resident A eloping.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

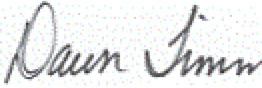
Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.



09/29/2023

Eli DeLeon — Date
Licensing Consultant

Approved By:



10/03/2023

Dawn N. Timm — Date
Area Manager