GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 18, 2024

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

RE: License #: AS130408635
Investigation #: 2024A0578013
Beacon Home at East Ave

Dear Ramon Beltran:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 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 #:	AS130408635
Investigation #:	2024A0578013
Complaint Receipt Date:	11/21/2023
Investigation Initiation Date:	11/27/2023
Report Due Date:	01/20/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Ramon Beltran
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at East Ave
Facility Address:	20271 East Ave N Battle Creek, MI 49017
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/04/2021
License Status:	REGULAR
Effective Date:	04/04/2022
Expiration Date:	04/03/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B eloped from this facility and were found 22 miles away.	Yes
Resident A fell from an 8-foot fence and was not brought to the hospital immediately. Resident A was later diagnosed with a spinal compression fracture.	No

III. METHODOLOGY

11/21/2023	Special Investigation Intake 2024A0578013
11/27/2023	APS Referral
11/27/2023	Special Investigation Initiated - On Site -Interview with direct care staff Heather Martinez. Interview with Resident B.
12/20/2023	Contact-Document Received -*AFC Licensing Division Incident / Accident Report* dated 11/18/2023.
12/20/2023	Contact-Document Received -*Health Care Appraisal* for Resident A, dated 10/25/2023.
12/20/2023	Contact-Document Received -*Health Care Appraisal* for Resident A, dated 05/30/2023.
12/20/2023	Contact-Document Received -*Interim Behavior Support Plan* for Resident A, dated 12/01/2022.
12/20/2023	Contact-Document Received -*Health west Skill and Behavior Support Plan* for Resident B, dated 06/02/2023.
12/20/2023	Contact-Telephone -*After Visit Summary* for Resident A from Bronson Hospital, dated 11/23/2023.
12/21/2023	Contact-Document Received -Interview with direct care staff Joanne Daily.
01/12/2024	Contact-Telephone -Interview with Guardian A1.

01/12/2024	Contact-Telephone -Integrated Services of Kalamazoo case manager Amanda Stone.
01/12/2024	Exit Conference -With the licensee designee Ramon Beltran.

ALLEGATION:

Resident A and Resident B eloped from this facility and were found 22 miles away.

INVESTIGATION:

On 11/21/2023, I received this complaint through the BCHS On-line Complaint System. Complainant reported Resident A is diagnosed with schizophrenia. Complainant alleged Resident A and another resident, later identified as Resident B, recently “escaped” from this facility and ended up 22 miles away. No additional details were provided.

On 11/27/2023, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Heather Martinez regarding the allegations. Heather Martinez identified serving as the home manager for this facility. Heather Martinez acknowledged that Resident A and Resident B had scaled an 8-ft perimeter fence at this facility with the use of a bedroom chair and dresser drawers. Heather Martinez reported it was suspected that Resident A had used her bedroom window to throw her bedroom chair and dresser drawers in the yard to avoid detection. Heather Martinez reported it was unknown if Resident A and Resident B were working together or if Resident B has seen an opportunity to make it over the fence using the chair and dresser and had done so. Heather Martinez reported direct care staff called her to report Resident A was missing at approximately 10AM or 11AM. Heather Martinez reported she received another call approximately 30 to 40 minutes later that Resident B was missing as well. Heather Martinez reported it was suspected that Resident A and Resident B had eloped from the facility approximately two hours before direct care staff noticed and notified her and law enforcement. Heather Martinez identified direct care staff Joanne Daily and direct care staff Katelyn Ashley as the two direct care staff working at the time of Resident A and Resident B’s elopement. Heather Martinez reported Resident A was found approximately 30 minutes later and Resident B was returned to this facility by 5PM. Heather Martinez denied that Resident A had traveled 22 miles and reported Resident A was found by law enforcement at a local restaurant approximately two miles away. Heather Martinez reported residents at this facility are to be observed by staff every hour but she asks direct care staff to do so every 15 minutes.

While at the facility, I attempted to interview Resident A and Resident A was unresponsive but alert and did not respond to questions. I observed Resident A with no visible signs of abuse or neglect and no obvious indicators of discomfort.

While at the facility, I interviewed Resident B regarding the allegations. Resident B reported living at this facility for almost four months. Resident B acknowledged eloping from this facility and reported Resident A had put a chair and drawers up next to the fence and used these items to climb over fence. Resident B reported once she had watched Resident A go over the fence this way, she had done the same. Resident B could not recall what time of day this event occurred. Resident B reported she was gone from this facility for “maybe ten hours.” Resident B denied having any injuries after this elopement and denied having any kind of behavior plan and reported direct care staff check on her every 20 minutes in this facility.

On 12/20/2023, I reviewed the *AFC Licensing Division Incident / Accident Report* related to the allegations. The *AFC Licensing Division Incident / Accident Report* documented that on 11/18/2023, Resident A and Resident B were not in this facility and a stack of chairs and dressers were observed in the yard of this facility next to the fence. The *AFC Licensing Division Incident / Accident* Report documented that law enforcement was notified and responded to the facility and took statements and descriptions from direct care staff. The *AFC Licensing Division Incident / Accident Report* documented that almost immediately, law enforcement reported Resident A was found at a local restaurant and returned to the facility. The *AFC Licensing Division Incident / Accident Report* documented that when being checked for further evaluation by paramedics, Resident A reported being dehydrated and held against her will at this facility. The *AFC Licensing Division Incident / Accident Report* documented the paramedics had contacted Resident A’s guardian, who had informed them Resident A did not need to be transported to the hospital and was living at this facility. The *AFC Licensing Division Incident / Accident Report* documented that paramedics found Resident A’s vitals to be withing normal limits and advised Resident A that no further treatment was needed but to call emergency services if Resident A’s condition changed.

On 12/20/2023, I reviewed the *AFC Licensing Division Incident / Accident Report* related to the allegations. The *AFC Licensing Division Incident / Accident Report* supplemented the previous *AFC Licensing Division Incident / Accident Report* and documented that law enforcement had received several calls regarding a person matching Resident B’s description approximately two hours prior to responding to this incident. The *AFC Licensing Division Incident / Accident Report* documented that Resident B was returned to the facility around 5PM.

On 12/20/2023, I reviewed the *Health Care Appraisal* for Resident A, dated 10/25/2023. The *Health Care Appraisal* for Resident A documented that Resident A is diagnosed with undifferentiated schizophrenia, anorexia, and hyperlipidemia.

On 12/20/2023, I reviewed the *Health Care Appraisal* for Resident B, dated 05/30/2023. The *Health Care Appraisal* for Resident B documented Resident B's diagnosis of schizophrenia.

On 12/20/2023, I reviewed the *Interim Behavior Support Plan* for Resident A, dated 12/01/2022. The *Interim Behavior Support Plan* Identified Resident A's diagnosis as schizophrenia with catatonic, chronic and acute exacerbation. The *Interim Behavior Support Plan* for Resident A documented that Resident A's target behaviors include elopement, which is described as Resident A leaving the property without staff or other authorized supervision. The *Interim Behavior Support Plan* for Resident A documents proactive strategies for direct care staff, which includes interacting positively with Resident A at least once every four hours. The *Interim Behavior Support Plan* for Resident A documents restrictive strategies for Resident A, which identified this facility's standard policy that direct care staff will have eyes on Resident A every thirty minutes during the day and every hour at night.

On 12/20/2023, I reviewed the *Health West Skill and Behavior Support Plan* for Resident B, dated 06/02/2023. The *Health West Skill and Behavior Support Plan* for Resident B identified Resident B's target behavior as elopement but only identified "verbal redirection" as a reactive strategy and did not identify any supervision requirements.

On 12/21/2023, I interviewed direct care staff Joanne Daily regarding the allegations. Joanne Daily acknowledged working the day of the allegations with direct care staff Katelyn Ashley. Joanne Daily reported direct care staff Katelyn Ashley had left the facility to obtain food while she completed paperwork and supervised residents. When asked to clarify if Katelyn Ashley went to get food from her personal vehicle or somewhere else, Joanne Daily reported Katelyn Ashley left the facility in her personal vehicle to obtain food from a local grocery and was gone approximately one hour. Joanne Daily reported that when Katelyn Ashely returned to the facility, another resident had informed them that Resident A had left the facility. Joanne Daily reported that when looking for Resident A, they had determined that Resident B was missing as well. When asked about supervision requirements, Joanne Daily denied that Resident A or Resident B required one on one staff supervision or line of sight but reported it was a policy to visually confirm residents every 15 minutes. When asked the last time Resident A or Resident B were observed prior to being reported missing from this facility, Joanne Daily could not confirm the last time Resident A or Resident B were observed in the facility, adding that she was "busy doing paperwork." Joanne Daily reported she suspected Resident A and Resident B eloped from this facility while direct care staff Katelyn Ashley was gone. Joanne Daily denied observing a chair or drawers in the yard next to the perimeter fence prior to Resident A and Resident B eloping.

On 01/12/2024, I interviewed Integrated Services of Kalamazoo case manager Amanda Stone regarding the allegations. Amanda Stone acknowledged being aware of the allegations and confirmed that Resident A was returned to the facility shortly

after law enforcement was notified. Amanda Stone reported Resident A does not want to live at this facility but has poor insight into her mental health or medical needs. Amanda Stone reported Resident A often denies that she has a guardian and tells others that she works for the “secret service.” Amanda Stone reported Resident A has a history of eloping and entering other people’s homes or going through their mailboxes. Amanda Stone reported for these reasons, Resident A requires a secured setting and added this facility was the best placement for Resident A at this time. Amanda Stone denied having any additional concerns.

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 Heather Martinez, direct care staff Joanne Daily and Integrated Services of Kalamazoo case manager Amanda Stone, as well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, staffing levels at this facility were not sufficient to carry out Resident A’s *Interim Behavior Support Plan*, which resulted in Resident A eloping from this facility. Direct care staff Joanne Daily reported she was working by herself for approximately one hour and could not recall the last time she had observed Resident A prior to Resident A and Resident B eloping from the facility. An *AFC Licensing Division Incident / Accident Report* documented that law enforcement had received several calls regarding an individual matching Resident B’s description two hours prior to being called regarding this incident, which was corroborated with direct care staff Heather Martinez during her interview.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon my investigation, which consisted of a review of pertinent documentation relevant to this investigation, Resident A’s personal need for protection and safety identified in her individual plan of service was not implemented by direct care staff, resulting in Resident A injuring herself upon her elopement

	from this facility and a diagnosis of compression fractures of the lumbar and thoracic vertebrae
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A fell from an 8-foot fence and was not brought to the hospital immediately. Resident A was later diagnosed with a spinal compression fracture.

INVESTIGATION:

On 11/21/2023, Complainant reported while eloping from this facility, Resident A fell from an 8-foot fence. Complainant alleged Resident A was not brought to the hospital immediately despite having hit her head and having a sore back. Complainant added that Resident A was later examined at the hospital with no significant findings and returned to the facility.

On 12/20/2023, I interviewed direct care staff Heather Martinez regarding the allegations. Heather Martinez reported paramedics treated and evaluated Resident A immediately when Resident A was returned to the facility by law enforcement. Heather Martinez reported Resident A's guardian was informed of Resident A's return and denied the need for any additional medical treatment at the hospital. Heather Martinez reported Resident A went to the hospital two days later regarding hip and back pain. Heather Martinez reported that when Resident A scaled the fence, she had fallen from the top off the fence to the other side. Heather Martinez reported Resident A was examined at Bronson hospital and diagnosed with a compression fracture of her spine but would not sit still for any x-rays and the hospital was unable to determine if Resident A's compression fractures were old or new. Heather Martinez reported Resident A's primary physician comes to the facility to follow Resident A's injury, but Resident A has been resistant to receiving care. Heather Martinez reported Resident A's guardian and case manager are aware of her condition. Heather Martinez reported Resident A is prescribed a PRN medication for pain but has only used this PRN medication once in the last year. Heather Martinez reported it is suspected that Resident A has a high pain tolerance.

On 12/20/2023, I reviewed the *After Visit Summary* for Resident A from Bronson Hospital, dated 11/23/2023. The *After Visit Summary* for Resident A documented the reason for Resident A's visit was back and hip pain. The *After Visit Summary* for Resident A documented that Resident A completed CT scans and x-rays before being diagnosed with compression fractures of the lumbar and thoracic vertebrae. The *After Visit Summary* for Resident A documented to follow-up appointments scheduled and instructions to return to the hospital if Resident A is unable to hold bowels or urine or experiences weakness in her arms or legs.

On 01/12/2024, I interviewed Guardian A1 regarding the allegations. Guardian A1 acknowledged that Resident A had eloped from this facility and was examined by paramedics before remaining at the facility instead of being transported to the hospital. Guardian A1 reported that Resident A makes frequent delusional comments. Guardian A1 reported that in less than 48 hours, direct care staff at this facility had Resident A examined and diagnosed with the compression fractures in her spine. Guardian A1 acknowledged that Resident A is prone to refusing treatment but stated this is the best facility for Resident A and believes direct care staff do an excellent job with Resident A. Guardian A1 reported Resident A is monitored at this facility for any additional complications and was recently observed doing exercise in this facility.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Direct care staff Heather Martinez, direct care staff Joanne Daily and Integrated Services of Kalamazoo case manager Amanda Stone, as well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, Resident A was provided with needed medical care immediately upon returning to this facility after an elopement and after reporting hip and back pain.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

01/12/2024

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Eli DeLeon Date
Licensing Consultant

Approved By:

01/18/2024

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Dawn N. Timm Date
Area Manager