STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

September 14, 2021

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

RE: License #: AS730407067
Investigation #: 2021A0871033
Beacon Home at Saginaw

Dear Mr. Beltran, II:

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730407067
Investigation #:	2021A0871033
Complaint Receipt Date:	07/26/2021
Investigation Initiation Date:	07/28/2021
Report Due Date:	09/24/2021
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, II
Licensee Designee:	Ramon Beltran, II
Name of Facility:	Beacon Home at Saginaw
Facility Address:	7705 Dutch Rd Saginaw, MI 48609
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	04/09/2021
License **Status:**	TEMPORARY
Effective Date:	04/09/2021
Expiration Date:	10/08/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A, who was in a wheelchair, was observed sitting at the end of the driveway for two hours. Every once in a while, a staff member would come out and stand by Resident A, but they did not bring her back inside. Resident A was observed in the road, yelling for help. She was outside for at least a half-hour yelling for help. There were multiple cars going by, trying to avoid her.	Yes
Additional Findings:	Yes

III. METHODOLOGY

07/26/2021	Special Investigation Intake 2021A0871033
07/26/2021	APS Referral From Saginaw County MDHHS
07/28/2021	Special Investigation Initiated - Letter Received information from Adult Protective Service Worker Alan Neilson
08/25/2021	Contact - Face to Face Meeting at Saginaw County CMH with Kim Knickerbocker and Kim Redmond from Beacon, Recipient Rights Officer Tony Navarre, Customer Service Supervisor Melynda Schaefer and Licensing Consultant Shamidah Wyden
08/24/2021	Contact - Document Received Received Resident A's Individual Plan of Service from Recipient Rights Officer Tony Navarre
09/01/2021	Contact - Telephone call made Telephone call to Guardian 1
09/10/2021	Contact - Telephone call made Telephone call to Manager Diasherra Jackson, Staff Jayla Finch, and Staff Roquneshia McCulloh
09/10/2021	Exit Conference Telephone exit conference with Licensee Ramon Beltran, II
09/10/2021	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A, who was in a wheelchair, was observed sitting at the end of the driveway for two hours. The intake date indicates on or about 07/25/2021. Every once in a while, a staff member would come out and stand by Resident A, but they did not bring her back inside. Resident A was observed in the road, yelling for help. She was outside for at least a half-hour yelling for help. There were multiple cars going by, trying to avoid her.

INVESTIGATION:

This complaint came in anonymously. It is unknown what date the incident occurred.

On July 30, 2021, I conducted an unannounced onsite investigation and interviewed Staff Nissaun Miller. Ms. Miller said that Resident A had “high behaviors” and likes to smoke. On Sunday, July 18, 2021, Ms. Miller told Resident A that it was too hot to go out to smoke and it was too hot to go outside. Ms. Miller said Resident A was in the driveway and she was offered cigarettes and drinks, but she would not come back in. Ms. Miller indicated that if you grab Resident A’s wheelchair, “she can be violent.” Ms. Miller said she would check on Resident A every 15 minutes. Ms. Miller advised that Resident A was just taken by ambulance to the hospital about ten minutes before I arrived.

On August 25, 2021, I attended a meeting along with Licensing Consultant Shamidah Wyden at Saginaw County Community Mental Health. Present were Senior Director of Clinical Services and Kim Redmond, Executive Director of East Region of Beacon Specialized Living Services, Inc., Recipient Rights Officer Tony Navarre, and Customer Service Supervisor Melynda Schaefer.

Mr. Navarre provided me with a copy of Resident A’s Plan of Service that was prepared on July 8, 2021, by Richard James, Ph.D. It indicates “Staff level needs to be considered for health and safety reasons she appears to require (at times) enhance staffing in the evenings, within the home, within a vehicle or in a community setting so as not to put herself, other residents or the community at undue risk

On September 14, 2021, I received a copy of Resident A’s *Assessment Plan for AFC Residents* that was signed and dated on 05/19/2021 by Resident A’s Guardian 1. The signature of licensee indicates ‘Kevin Kalinowski,’ who is not the Licensee Designee for this facility.

On August 30, 2021, I emailed Adult Protective Service Worker Alan Neilson. Mr. Neilson indicated the referral was made anonymously and he was unable to obtain any further information. It is unknown the exact date or dates that the incident occurred.

On September 1, 2021, I telephoned Guardian 1. Guardian 1 indicated staff should have been "at least in the line of site." Guardian 1 stated staff should have been more attentive, and they did not know if anything would have happened to Resident A while outside. Guardian 1 said staff should have been with Resident A when she was outside. Guardian 1 reported that "the placement was suspect from the beginning because they are short staffed." Guardian 1 said staff were poorly trained and "not focused on her care."

On September 10, 2021, I telephoned Staff Jayla Finch. Ms. Finch indicated Resident A would sit in the driveway but that she never witnessed her go to the road. Ms. Finch stated that when she was working, Resident A would sit outside about 30-40 minutes. Ms. Finch said sometimes she would sit outside with Resident A or she would sit in the living room on the couch and watch her out the window. Ms. Finch said Resident A was never outside for 15 minutes by herself when she was working.

On September 10, 2021, I telephoned Staff Roquneshia McCulloh. Ms. McCulloh stated anytime that she was working, Resident A would only go out on the porch. Ms. McCulloh also stated that she would walk with Resident A outside. Ms. McCulloh indicated when Resident A would be outside, she would open the window so she could hear her.

I also telephoned Home Manager Diasheera Jackson on September 10, 2021. Manager Jackson stated Resident A would walk to the end of the driveway and staff would try to get her to come back. Resident A would tell staff to "leave me alone." Manager Jackson indicated that a few different times, staff would offer her water or juice, and even took a cup out to her. Manager Jackson said "sometimes, [Resident A] would cross the road" and that the mailbox is across the road. Manager Jackson said she witnessed Resident A cross the road by herself and she would have to bring her back. Manager Jackson stated staff would do 10-15 minutes checks on Resident A. Sometimes, they would leave the door or window open so Resident A could be heard or seen. Manager Jackson said Resident A was aggressive with staff and she would tell you "get away." Manager Jackson said the longest time that Resident A was outside was two-three hours.

I did not observe Resident A as she was court ordered to Walter Reuther State Hospital on August 26, 2021.

On September 10, 2021, I conducted a telephone exit conference with Licensee Ramon Beltran, II. I advised Licensee Beltran that there would be a violation cited because of the lack of staff.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident A was the only resident in the facility and there was only one staff working with her. Resident A would go out by the road and staff would check on her every 10-15 minutes. Manager Jackson witnessed Resident A cross the road. Resident A's plan stated staffing levels appears to be enhanced at home or within the community so Resident A would not harm herself, other residents, or staff. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's *Assessment Plan for AFC Residents* was signed by Kevin Kalinowski, who is not the licensee designee for this facility.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's *Assessment Plan for AFC Residents* was not signed by Licensee Designee Ramon Beltran, II. Resident A's assessment plan was signed by Kevin Kalinowski, who is not the licensee designee for this facility. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult foster care small group home remain unchanged (capacity 1-6).

09/14/2021

Kathryn A. Huber   Date
Licensing Consultant

Approved By:

09/14/2021

Mary E Holton   Date
Area Manager