GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 19, 2022

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

RE: License #: AS390406169
Investigation #: 2022A1024010
Beacon Home at Al Sabo

Dear Mr. Ramon Beltran:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406169
Investigation #:	2022A1024010
Complaint Receipt Date:	11/22/2021
Investigation Initiation Date:	11/23/2021
Report Due Date:	01/21/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Ramone Beltran
Licensee Designee:	Ramone Beltran
Name of Facility:	Beacon Home at Al Sabo
Facility Address:	7519 S. 10th St. Kalamazoo, MI 49009
Facility Telephone #:	(269) 488-6943
Original Issuance Date:	05/10/2021
License Status:	REGULAR
Effective Date:	11/10/2021
Expiration Date:	11/09/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is ready for discharge from the hospital and there has been no contact made from the home.	No

III. METHODOLOGY

11/22/2021	Special Investigation Intake 2022A1024010
11/23/2021	Special Investigation Initiated – Telephone with district director Ramone Beltran
01/03/2022	Inspection Completed On-site with direct care staff member Kayla Brown
01/03/2022	Contact - Telephone call made with home manager Christina Graco
01/12/2022	Contact - Telephone call made with mental health clinician David Kalafut Beacon Specialized Services
01/12/2022	Contact - Document Received-email notes, *Borgess Clinical Discharge Summary*, *Hospital Discharge Assessment, AFC Licensing Division-Accident/Incident Report*, *Assessment Plan for AFC Residents, Health Care Appraisal*, *Order for Examination/Transport*
01/12/2022	Contact-Telephone call received from mental health case manager Daniel Stowe from Woodlands Behavioral Healthcare Network
01/12/2022	Exit Conference with licensee designee Ramone Beltran

ALLEGATION:

Resident A is ready for discharge from the hospital and there has been no contact made from the home.

INVESTIGATION:

On 11/22/2022, I received this complaint through the Bureau of Community and Health Systems. This complaint alleged Resident A is ready for discharge from the hospital but there has been no contact made from direct care staff at the AFC home.

This complaint also alleged Resident A has been cleared for discharge from the hospital since 11/8/2021 without contact from the home and the owner of the facility has not appeared at any meetings with the hospital. The complaint stated the home has abandoned Resident A at the hospital.

On 11/23/2022, I conducted an interview with district director and licensee designee Ramone Beltran. Mr. Beltran stated Resident A was picked up from the hospital on 11/22/2022. Mr. Beltran stated he and other direct care staff members stayed in constant contact with the hospital staff members as well as Resident A's mental health case worker to ensure Resident A would have adequate care upon her return home from the hospital. Mr. Beltran stated the AFC facility petitioned the courts in October 2021 for Resident A to receive psychiatric inpatient care due to self-harming behaviors that Resident A exhibited in the AFC facility such as refusing to eat any meals. Mr. Beltran stated an assessment was conducted by the AFC facility's medical clinical team a few days prior to Resident A's hospital discharge and it was found that Resident A's personal care needs, such as her mobility, was altered due to Resident A's mental health status therefore accommodations at the home had to be made to ensure Resident A's personal care needs and safety would be met. Mr. Beltran stated to accommodate Resident A's mobility needs, the staff relocated Resident A's bedroom to the main level of the home to avoid Resident A needing to use the stairs. Mr. Beltran stated the AFC facility, hospital and Resident A's mental health treatment team collectively worked together while Resident A was hospitalized, and Resident A has returned safely to the AFC without incident.

1/3/2022, I conducted an onsite investigation at the facility with direct care staff member Kayla Brown who stated she has worked regularly with Resident A and at no given time was Resident A abandoned at the hospital. Ms. Brown stated she observed home manager Kristina Graca speak to hospital staff members as well as Resident A's case manager regarding Resident A's mental and medical status. Ms. Brown also stated Ms. Graca regularly visited with Resident A while she was in the hospital. It should be noted Ms. Brown advised that Resident A was on a home visit and not in the AFC facility at the time of this onsite investigation therefore an interview was not conducted with Resident A.

On 1/3/2022, I conducted an interview with home manager Kristina Graca. Ms. Graca stated she spoke with the hospital staff and Resident A's mental health case manager Daniel Stowe regularly while Resident A was hospitalized for psychiatric and medical treatment. Ms. Graca statement the hospital communicated Resident A's vitals to Ms. Graca regularly and clinician David Kalafut conducted an assessment prior to Resident A's discharge to ensure the home was equipped to accommodate Resident A's personal care needs. Ms. Graca stated Resident A was immediately picked up from the hospital when the home and Resident A's treatment team cleared Resident A to return to the facility.

On 1/12/2022, I conducted an interview with medical clinician David Kalafut. Mr. Kalafut stated he spoke with hospital staff on multiple occasions at the hospital and

on via telephone regarding Resident A's mental and medical health status. Mr. Kalafut stated he also conducted a discharge assessment on 11/19/2021 at which time Mr. Kalafut believed Resident A was not ready to return to the home without modifications at the AFC facility. Mr. Kalafut stated he was hoping Resident A would qualify for long-term care placement at a rehabilitation facility however there were no available options at the time of discharge. Mr. Kalafut stated after modifications were made at the AFC facility, it was determined by her treatment team that Resident A could safely return to the AFC facility and Resident A was picked up from the hospital by home manager Mr. Graco on 11/22/2021. Mr. Kalafut stated Resident A was never abandoned from the hospital and there was continuous communication between staff members from the home, Resident A's mental health case manager Daniel Stowe and the hospital.

On 1/12/2022, I reviewed the facility's email notes. On 10/27/2021 Ms. Graca stated she met with Resident A's case manager, Borgess Hospital Psychiatrist, and Resident A's parent. This note stated most of the meeting was consisted of getting background information for the psychiatrist and answering questions. On 11/2/2021, district direct Aubrey Napier stated Ms. Graca was able to get an update on Resident A and Resident A is now taking Valium and is currently on a catheter. On 11/12/2021, Ms. Graca stated the hospital contacted her and stated Resident A is medically cleared for discharge however no changes have been made in her behaviors. Ms. Graca stated she was concerned since Resident A is demonstrating the same behaviors that warranted the facility to petition and refusing to take medications. On 11/15/2021, Mr. Kalafut stated he just spoke to the hospital staff and reported to hospital staff that AFC staff members do not believe Resident A is ready to return to the home based on her current behaviors. On 11/22/2021, Ms. Graca stated she will be picking up Resident A at 5:30pm.

I reviewed Resident A's *Health Care Appraisal* dated 7/22/2021. According to this appraisal Resident A is diagnosed with Unspecified Mood Disorder, Borderline Autism Spectrum, ADHD, Seizure Disorder, Incontinent, and Dyslipideemia.

I reviewed *Borgess Clinical Discharge Summary.* According to this summary Resident A was discharged on 11/22/2021. The diagnosis for this visit is: Acute Cystitis, Acute Hypokalemia, Autism Spectrum Disorder, Behavior disturbance, Catatonia, Intellectual disability, Vaginal candidiasis.

I reviewed *AFC Licensing Division-Accident/Incident Report* dated 10/22/2021 written by Kristina Graca. According to this report, the police and EMS arrived at the AFC facility at 7:20pm to pick up Resident A per the petition granted by Kalamazoo Probate Judge due to Resident A refusing meals, beverages, significant weight loss, and failure to thrive.

I reviewed *Order for Examination/Transport* dated 10/22/2021 signed by Kalamazoo County Probate Court. This order granted Resident A to be examined by psychiatrist and hospitalized with a peace officer escort.

I reviewed the facility's *Hospital Discharge Assessment* dated 11/16/2021. According to this assessment, Resident A was far from baseline as Resident A was originally able to independently complete her activities of daily living and her weight was 223 lbs. However, at the time of hospitalization, Resident A weighted 160 lbs. and needed assistance with all aspects of her personal care. The assessment stated Resident A appeared awake and alert but only stares when questioned and does not respond verbally. The assessment stated the AFC facility will not be able to meet Resident A's needs.

I also reviewed Resident A's *Assessment Plan for AFC Residents* dated 8/18/21. According to this plan, Resident A does not use any assistive devices and has no physical limitations.

On 1/12/2022, I conducted an interview with Resident A's mental health case manager Daniel Stowe. Mr. Stowe stated he worked extremely close with staff members from the home and hospital staff while Resident A was hospitalized in November 2021. Mr. Stowe stated Ms. Graco attended meetings at the hospital regularly and there were no issues with ever getting in contact with staff members from the home.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on my investigation which included interviews with direct care staff member Kayla Brown, home manager Kristiana Graca, district direct and licensee designee Ramone Beltran, clinician David Kalafut, mental health case manager Daniel Stowe, review of facility email notes, Resident A's health care appraisal, assessment plan, court order, discharge assessment, discharge summary, and Resident A's incident report, there is no evidence Resident A was abandoned at the hospital or the facility refused to pick Resident A up when she was ready for discharge. Mr. Beltran, Ms. Graca, Mr. Kalafut, and Mr. Stowe all reported staying in regular contact with the hospital staff and Resident A's mental health providers while Resident A was hospitalized. According to discharge summary Resident A was discharged from the hospital on 11/22/2021. According to email notes staff communicated with hospital staff on 10/27/21, 11/2/21, 11/12/21 and 11/15/21 at the very least. According to the facility's discharge assessment, an assessment was conducted at the hospital with Resident A on 11/16/21 by clinician Mr. Kalafut from Beacon Specialized Services at which time it was determined Resident A was not ready to return to the home. According to assessment plan, Resident A had no physical limitations however at time of the discharge assessment, Mr. Beltran stated Resident A could no longer use the stairs due to being immobile. Mr. Beltran stated after modifications were made to the home and working with Resident A's mental health provider, Resident A was able to safely return to the home on 11/22/2021 therefore the safety and protection for Resident A has been provided.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend the current license status remain unchanged.

01/12/2022

Ondrea Johnson
Licensing Consultant

Date

Approved By:

01/19/2022

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Dawn N. Timm
Area Manager

Date