GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 11, 2022

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

RE: License #: AS390406169
Investigation #: 2022A1024015
Beacon Home at Al Sabo

Dear Mr. Ramone 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 was required. On February 7, 2022, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 AFFAIRS12/20/2021
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS390406169
Investigation #:	2022A1024015
Complaint Receipt Date:	12/20/2021
Investigation Initiation Date:	12/20/2021
Report Due Date:	02/18/2022
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?
Residents were left home alone with no staff present.	Yes
Staff failed to make arrangements for resident to return to home when resident was ready for discharge from hospital.	Yes

III. METHODOLOGY

12/20/2021	Special Investigation Intake 2022A1024015
12/20/2021	Special Investigation Initiated – Telephone with Recipient Rights Officer Holly Hess
12/22/2021	Contact - Document Received additional allegations from Intake 184166 regarding Resident A.
12/22/2021	Contact - Telephone call made with home manager Christina Graca
12/27/2021	Contact - Telephone call made with case manager Laura Delong
01/03/2022	Contact - Document Received-facility's staff schedule
01/06/2022	Contact - Telephone call made with district director Ramone Beltran
01/07/2022	Inspection Completed On-site with direct care staff member Kayla Brown
01/07/2022	Contact - Telephone call made with direct care staff member Keon Casey
01/07/2022	Contact - Telephone call made with direct care staff members Tangela Stroud and John Gravatt, Residents B, C, and D
01/07/2022	Contact - Telephone call made with Resident A's foster care worker Michelle Dowsett
02/07/2022	Contact - Document Received-email notes and *Assessment Plan for AFC Residents*
02/07/2022	Exit Conference with licensee designee Ramone Beltran
02/07/2022	Inspection Completed-BCAL Sub. Compliance

02/07/2022	Corrective Action Plan Requested and Due on 02/24/2022
02/07/2022	Corrective Action Plan Received
02/07/2022	Corrective Action Plan Approved

ALLEGATION:

Residents were left home alone with no staff present.

INVESTIGATION:

On 12/20/2021, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged residents were left home alone with no staff present.

On 12/20/2021, I conducted an interview with Recipient Rights Officer Holly Hess regarding this allegation. Ms. Hess stated the Recipient Rights Office was informed by direct care staff that staff members Thomas Gravatt and Tangela Stroud arrived to work late and upon arrival found no staff present in the home with the residents. Ms. Hess stated direct staff members Keon Casey and Chakyra Morrow, who worked on the overnight shift, left their shift without waiting for any direct care staff members scheduled for the morning shift to arrive. Ms. Hess stated she believe the residents were left unsupervised with no staff present for at least 40 minutes.

On 12/22/2021, I conducted an interview with home manager Christina Graca. Ms. Graca stated she was contacted via text message on the morning of 12/17/2021 at 7:17am, by direct care staff member Chakyra Morrow who stated she needed to leave her shift and could not wait for the next scheduled staff members to arrive to provide supervision to the residents. Ms. Graca stated staff members Thomas Gravatt and Tangela Stroud were both scheduled to begin work at 7:00am and did not arrive to the home until 8am. Therefore, Ms. Graca stated the four residents living in the facility were left in the home without supervision after Ms. Morrow left her shift. Ms. Graca stated three of the residents were sleeping and Resident B was found pacing throughout the home when staff members finally arrived at 8am. Ms. Graca stated the residents have not been left unattended in the past and direct care staff member Chakyra Morrow was reprimanded.

On 1/3/2022, I reviewed the facility's staff schedule for the month of December 2021. According to this schedule Chakyra Morrow and Keon Casey were scheduled to work 7pm to 7:30am on 12/16/2021. The schedule further documented John Gravatt and Tangela Stroud were scheduled to work 7am to 7:30pm on 12/17/2021.

On 1/7/2022, I conducted an onsite investigation at the facility with direct care staff member Kayla Brown. Ms. Brown stated she was made aware by other staff members and the residents that the residents were left unsupervised for an unspecified timeframe. Ms. Brown stated she has no knowledge of any other incidents involving residents being left unsupervised.

On 1/7/2022, I conducted interviews with direct care staff member Keon Casey regarding this allegation. Mr. Casey stated he worked with another staff member by the name of Chakyra Morrow on 12/17/2021 with four residents in the home. Mr. Casey stated he left his shift early at 6:44am due to personal matters leaving Ms. Morrow with the four residents who were sleeping. Mr. Casey stated a couple of hours later he was informed by his manager that Ms. Morrow left her shift early prior to staff members Mr. Gravatt or Ms. Stroud arriving for their scheduled arrival time of 7:00am. Mr. Casey stated prior to leaving his shift, he was never informed by Ms. Morrow that she would be leaving early or had issues with staying with the residents until staff members from the next shift arrived. Mr. Casey further stated he could have returned to the home if Ms. Morrow would have communicated to him that she was unable to stay with the residents to ensure supervision was provided until the next shift arrived.

On 1/7/2022, I conducted interviews with direct care staff members Tangela Stroud and John Gravatt and Residents B, C, and D. Ms. Stroud stated on 12/17/2021 she called the facility's phone number at 7:30am to inform staff that she was running late for her morning shift which began at 7:00am and Resident B answered the phone. Ms. Stroud stated Resident B stated to her that no direct care staff member was present in the home with her and the other three residents were still sleeping. Ms. Stroud stated she immediately contacted her home manager and recipient rights to inform them that the residents were home with no staff supervision. Ms. Stroud stated she eventually arrived at the home at 8:10am and saw Mr. Gravatt in the home with the residents who were not harmed and seemed to be in good spirits.

Mr. Gravatt stated he arrived to work late on 12/17/2021 at 8:00am instead of his scheduled time of 7:00am. Mr. Gravatt stated when he arrived at the home, he observed Resident B pacing inside the home calling out staff's names but saw no staff person present. Mr. Gravatt stated the other three residents were still asleep. Mr. Gravatt stated he was informed by Resident B that Ms. Morrow left her and the other three residents in home alone. Mr. Gravatt stated Resident B also informed him that she called the manager to report the absence of staff.

Resident B stated on the morning of 12/17/2021 at 7:00am, she woke up and could not find any staff members in the home. Resident B stated she walked around the entire home and called out the staff's names but did not get any response. Resident B stated she was afraid therefore she called a staff member's phone number to see where they were. Resident B stated Ms. Stroud informed her that she was on her way to the home and that she overslept. Resident B stated Mr. Gravatt eventually arrived at

the home at 8:00am at which time the other residents had woken up. Resident B stated she has never been left home alone without supervision in the past which is why she was very concerned for the safety of staff. Resident B stated although she was afraid, she still feels safe in the home.

Residents C and D both stated they have no knowledge of being left home alone with no staff present and they are always supervised by direct care staff members.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.
ANALYSIS:	Based on this investigation which included interviews with home manager Christina Graca, direct care staff members Kayla Brown, Keon Casey, Tangela Stroud, Residents B, C, D, and review of the facility's staff schedule there is evidence to support the allegation residents were left home alone with no staff present. Ms. Graca, Mr. Casey, Mr. Thomas, and Ms. Stroud all stated that Ms. Morrow left prior to staff arriving to the home leaving the four residents unsupervised with no staff members present for at least 40 minutes. Mr. Gravatt stated he arrived to work late on 12/17/2021 at 8:00am instead of his scheduled time of 7:00am. Mr. Gravatt stated when he arrived at the home, he observed Resident B pacing inside the home calling out for a staff member but no direct care staff members were present in the AFC facility. On 12/17/2021 the ratio of direct care staff to residents was not adequate to carry out the responsibilities after the four residents were left unsupervised with no direct care staff members present.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff failed to make arrangements for resident to return to home when resident was ready for discharge from hospital.

INVESTIGATION:

On 12/22/2021, I received this complaint through the BCHS online complaint system. According to this complaint staff failed to pick up Resident A from the hospital when resident was ready for discharge.

On 12/22/2021, I conducted an interview with home manager Christina Graca. Ms. Graca stated Resident A was admitted to a psychiatric hospital in Indiana due to having aggressive behaviors in the home. Ms. Graca stated she spoke with Resident A's mental health case worker a week after Resident A was admitted to the hospital and was informed that Resident A needed to be transferred to a more secure facility with a fence due to his elopement risk. Ms. Graca stated she had not heard from the hospital regarding discharge plans and had not been made aware Resident A was ready for discharge back to the AFC facility.

On 12/27/2021, I conducted an interview with Resident A's mental health case manager Laura Delong from Riverwood Behavioral Health System. Ms. Delong stated she spoke with the home manger on 12/15/2021 and informed her Resident A was ready for discharge from the hospital. Ms. Delong stated she also spoke with district director Ramone Beltran on 12/3/2021 who stated to her that Resident A would possibly be transferred to another facility secured by a fence that would provide more protection due to Resident A's risk of elopement. Ms. Delong stated since 12/17/2022 she has left several messages for Mr. Beltran and other staff members from Beacon Specialized Living Services however no staff member has responded or communicated to her regarding Resident A to ensure Resident A is provided the personal care, safety, and protection he requires.

On 1/6/2022, I conducted an interview with district director Ramone Beltran. Mr. Beltran stated there was a breakdown in communication with his staff as he was not made aware until recently that Resident A has been ready for discharge since 12/17/2021. Mr. Beltran stated another staff member employed for Beacon Specialized Living Services was contacted by the hospital in December of 2021 regarding Resident A discharge date however Mr. Beltran was not in the office during this time due to illness therefore did not receive this communication until he returned to the office in January of 2022. Mr. Beltran stated he has not spoken to Resident A's foster care worker, nor has he spoken to Resident A's mental health provider from Riverwood as of yet. Mr. Beltran stated Resident A is able to return to the home and Mr. Beltran will contact the necessary parties to arrange for discharge.

On 1/7/2022, I conducted an onsite investigation at the facility with direct care staff member Kayla Brown regarding this allegation. Ms. Brown stated she does not believe Resident A will return to the home because he continues to demonstrate aggressive behaviors such as breaking all the windows in the home. Ms. Brown stated she has not had any contact with the hospital regarding Resident A's discharge however believes the home manager Ms. Graca has communicated with them. Ms. Brown further stated she does not believe Resident A has been given a discharge notice or has been officially discharged from the home.

On 1/7/2022, I conducted an interview with direct care staff member Keon Casey regarding this allegation. Mr. Casey stated Resident A is currently in a psychiatric hospital however is supposed to return to the home temporarily until permanent

placement is found. Mr. Casey stated he has not talked to any hospital staff or providers regarding Resident A's and has no direct knowledge of any discharge plans for Resident A.

On 1/7/2022, I conducted an interview with Resident A's foster care worker Michelle Dowsett. Ms. Dowsett stated Resident A was placed in a psychiatric hospital in Indiana on 12/3/2021 due to exhibiting aggressive behaviors in the home and has been ready to be discharged back to the home since 12/17/2021. Ms. Dowsett stated she has left numerous messages to the home regarding Resident A's need to be discharged back to the home however no one has returned any of her phone calls and members of Beacon Specialized Living Services has been completely unresponsive to her. Ms. Dowsett stated she has not received a discharge notice from the home therefore believe the home has abandoned Resident A at the hospital and has failed to provide the personal care, safety, and protection that he requires. Ms. Dowsett state she is currently working with Resident A's mental health case worker from Riverwood Behavioral Health System to find alternate placement at this time.

On 2/7/2022, I reviewed email notes from Ramone Beltran to Riverwood Center. On 1/6/2022, Mr. Beltran wrote that he apologized for the breakdown in communication as he did not see their original email regarding Resident A's discharge as he was out ill and there was no communication made directly to him. Mr. Beltran stated Resident A is able to return to the home temporarily until a permanent placement can be secured at another facility owned by Beacon Specialized Living Services.

On 1/24/2022, Andrew Mahler from Riverwood Center wrote to Mr. Beltran that Resident A is all set for enhanced 1:1 staffing 24 hours per day and will be moving to Anchor Pointe South in Bangor, MI, a facility owned by Beacon Specialized Living Services effective 1/26/2022.

I also reviewed Resident A's *Assessment Plan for AFC Residents* dated 11/9/2021. According to this plan, Resident A requires supervision in the community for safety and elopement risk. This plan also stated Resident A needs prompting with toileting, bathing, grooming and personal hygiene.

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 this investigation which included interviews with home manager Christina Graca, direct care staff members Kayla Brown, Keon Casey, Resident A's mental health provider Laura Delong, foster care worker Michelle Dowsett, district director Ramone Beltran, review of Resident A's *Assessment Plan for AFC Residents*, and email notes there is evidence AFC administrative and direct care staff did not make arrangements for Resident A to return to the AFC upon discharge from the hospital. Ms. Delong and Ms. Dowsett both stated the home was informed that Resident A was ready for discharge on 12/17/2021 and no staff members from the home or Beacon Specialized Living Services communicated with them to ensure Resident A was provided with the personal care, safety, and protection he required. Mr. Beltran stated there was a breakdown in communication with his staff as he was not made aware until January of 2022 that Resident A had been ready for discharge since 12/17/2021. Mr. Beltran stated another staff member employed for Beacon Specialized Living Services was contacted by the hospital in December of 2021 regarding Resident A discharge date however Mr. Beltran was not in the office during this time due to illness therefore did not receive this communication until he returned to the office. According to email notes, Mr. Beltran communicated to Resident A's mental health provider regarding the breakdown in communication with his staff and advised that Resident A could return to the home since Resident A was ready for discharge. Consequently, Resident A's personal protection, personal care, and safety were not provided while he waited for the facility direct care staff to pick him up from the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/7/2022, I conducted an exit conference with licensee designee Ramone Beltran. I informed Mr. Beltran of my findings and allowed him an opportunity to ask questions or make comments.

On 2/7/2022, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was approved; therefore, I recommend the current license status remain unchanged.

2/9/2022

Ondrea Johnson
Licensing Consultant

Date

Approved By:

02/11/2022

Dawn N. Timm
Area Manager

Date