GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 1, 2022

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

RE: License #: AS390406169
Investigation #: 2022A1024016
Beacon Home at Al Sabo

Dear Mr. Beltran, II:

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 #:	2022A1024016
Complaint Receipt Date:	01/07/2022
Investigation Initiation Date:	01/07/2022
Report Due Date:	03/08/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Patti Miller
Licensee Designee:	Ramon Beltran, II
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?
There is concern for protection because Resident A became unresponsive at the home and passed away.	No

III. METHODOLOGY

01/07/2022	Special Investigation Intake 2022A1024016
01/07/2022	Special Investigation Initiated – Telephone with home manager Jamara White
01/07/2022	Contact - Telephone call made with direct care staff members John Gravatt and Keon Casey
02/07/2022	Contact - Document Received-Resident A's *Health Care* Appraisal, *Assessment Plan for AFC Residents, and Licensing Division-Accident/Incident Reports*
02/07/2022	Contact - Telephone call made with Relative A1
02/07/2022	Contact - Document Received-Resident A's *Death Certificate*
02/07/2022	Contact - Telephone call made with mental health case manager Angie Vanover
02/14/2022	Inspection Completed On-site with home manager Kristina Graca
02/25/2022	Exit Conference with licensee designee Ramone Beltran

ALLEGATION:

There is concern for protection because Resident A became unresponsive at the home and passed away.

INVESTIGATION:

On 1/7/2022, I received this complaint through the Bureau of Community and Health Systems online complaint system. This complaint alleged there is concern for protection because Resident A became unresponsive at the home and passed away.

On 1/7/2022, I conducted an interview with home manager Jamara White regarding this allegation. Ms. White stated on the morning of 1/6/2022 she observed Resident

A in bed watching television. Ms. White stated Resident A was observed to be in good spirits and did not appear to have any unusual behavior. Ms. White stated Resident A mentioned to her that she was having pain in her knee while Resident A got up from bed to walk to the bathroom in order to take a shower however did not report needing any medical attention. Ms. White further stated Resident A often made complaints of having pain therefore this statement was not unusual to hear from Resident A. Ms. White stated she continued to talk to Resident A while walking with Resident A to the bathroom as Resident A requires prompting with her personal care such as toileting, bathing, and dressing. Ms. White stated she then placed a chair in the shower for Resident A to sit in during her shower and left the bathroom. Ms. White stated Resident A was talkative as usual and did not physically appear to have any adverse issues. Ms. White stated after she left the bathroom, she requested Mr. Gravatt finish assisting Resident A with her personal care needs and Ms. White left the facility. Ms. White stated she was later notified that Resident A had fallen over while in the bathroom with Mr. Gravatt and was in need of emergency medical services (EMS) who were called by home manager Kristina Graca. Ms. White stated she was informed Resident A became unresponsive while waiting for EMS at which time Ms. Graca performed Cardiopulmonary Resuscitation (CPR) until EMS arrived at the home. Ms. White stated she was informed Resident A was later pronounced dead at the hospital. Ms. White stated she believes Resident A died of an aneurysm however she is unsure of Resident A's exact cause of death.

On 1/7/2022, I conducted interviews with direct care staff members Keon Casey and John Gravatt. Mr. Casey stated he regularly worked with Resident A and noticed on 1/05/22 Resident A refused to get out of bed for most of the day which was very unusual behavior. Mr. Casey stated Resident A reported to him that she was tired and simply wanted to rest. Mr. Casey stated the following day he observed Resident A to wake up in good spirts. Mr. Casey stated she talked to him as usual, and Mr. Casey observed Resident A walk to the bathroom to take a shower with Mr. Gravatt following behind her about 10 minutes later to assist Resident A with dressing. Mr. Casey stated he then went to the kitchen to prepare food and while cooking Mr. Casey heard Mr. Gravatt yell that he needed help. Mr. Casey stated he and Ms. Graca went to the bathroom to assist Mr. Gravatt and found Resident A on the floor. Mr. Casey stated Mr. Gravatt informed them that while Resident A was getting up from the toilet, she “seized up and collapsed to the floor.” Mr. Casey stated he began to perform CPR on Resident A after noticing Resident A was not breathing and unresponsive until he was instructed by Ms. Graca to call 911. Mr. Casey stated Ms. Graca performed CPR for about 10 minutes until the police arrived. Mr. Casey stated it appeared EMS was able to revive Resident A while she was at the home however Mr. Casey learned later in the day that Resident A passed away while at the hospital. Mr. Casey stated he was not provided with Resident A’s cause of death.

Mr. Gravatt stated he regularly worked with Resident A and regularly assisted her in the bathroom particularly with dressing and toileting as Resident A requires

prompting with these two activities of daily living. Mr. Gravatt stated on 1/06/2022 he assisted Resident A in the bathroom after she was originally assisted by home manager Ms. White. Mr. Gravatt stated he observed Resident A dressing herself when he initially entered the bathroom. Mr. Gravatt stated Resident A complained about having pain in her leg however did not seem to need any additional hands-on assistance with performing her personal care needs of dressing nor did she request assistance. Mr. Gravatt stated Resident A walked over to sit on the toilet and interacted with him as usual while on the toilet however as Resident A stood up to grab her briefs, she started having seizure like movements and collapsed forward on to the floor. Mr. Gravatt stated he immediately yelled for assistance as he observed Resident A to be verbally unresponsive however still breathing. Mr. Gravatt stated Mr. Casey immediately came to the bathroom after he yelled for help and found Resident A not breathing therefore Mr. Casey began to perform CPR. Mr. Gravatt stated seconds later Ms. Graca came to the bathroom and instructed Ms. Casey to call 911 at which time Ms. Graca performed CPR until EMS arrived who transported Resident A to the hospital. Mr. Gravatt stated he was informed later in the day that Resident A passed away while at the hospital. Mr. Gravatt stated he did not observe Resident A to hit her head when she fell and did not observe any apparent physical injuries to Resident A. Mr. Gravatt stated he worked with Resident A days prior to this incident and Mr. Gravatt did not observe Resident A to have any unusual adverse behaviors.

On 2/7/2022, I reviewed Resident A's *Health Care Appraisal* dated 12/7/2021. According to this appraisal, Resident A was diagnosed with Psychotic Disorder NOS, Mild Mental Retardation, GERD, and Hypothyroidism.

I reviewed Resident A's *Assessment Plan for AFC Residents* dated 8/19/2021. According to this plan, Resident A has a history of constipation and requires prompting with toileting to ensure proper wiping. Resident A also requires prompting with bathing to ensure this task is completed thoroughly and prompting with dressing. Resident A does not require any adaptive equipment or assistance with mobility.

I also reviewed *Licensing Division-Accident/Incident Report* dated 1/6/2022. According to this report, on 1/6/2022 at 11:30am Mr. Gravatt was assisting Resident A after she had completed her shower. This report stated while engaging in conversation, Resident A began to have seizure like movements and appeared as if Resident A was gasping for air. This report stated Mr. Casey immediately began to perform CPR while making sure Resident A was flat on the surface. This report stated Ms. Graca then took over and instructed Mr. Casey to call 911. While waiting for EMS to arrive on-call medical was notified to the situation. The report stated paramedics arrived and performed compressions for roughly 30 minutes along with utilizing an AED to give 2 shock treatments however Resident A was still unresponsive. The report stated prior to leaving the home the paramedics were able to obtain a pulse and Resident A was placed on oxygen via nasal canal. This report stated Resident A was transported to the hospital and admitted to the ICU.

On 2/7/2022, I conducted an interview with Relative A1. Relative Al stated she is Resident A's guardian and has been involved in Resident A's care for many years. Relative A1 stated according to Resident A's death certificate Resident A cause of death was from a blood clot. Relative A1 stated Resident A complained about having pain in her legs and knees regularly over the years. Relative A1 stated Resident A also abused the emergency system over the years and would call 911 to make false complaints of being in pain in order to seek attention from the hospital staff and to eat the hospital food. Relative A1 stated although Resident A's death was unexpected, she does not have any concerns for the direct care staff at the home and believe Resident A was supervised and protected adequately.

On 2/7/2022. I reviewed Resident A's *Death Certificate*. According to this certificate, Resident A was pronounced dead on 1/6/2022 while at the hospital in inpatient status. This certificate stated the underlying cause of death was due to bilateral pulmonary thromboemboli and the immediate cause of death was due to probable lower extremity deep vein thrombosis. The certificate further stated the manner of Resident A's death was "natural."

On 2/7/2022, I conducted an interview with Resident A's mental health case manager Angie Vanover who stated that she has been Resident A mental health provider for many years and regularly visited Resident A at the home. Ms. Vanover stated Resident A often called 911 and made false complaints about being in pain in order to go to the hospital where she enjoyed interacting with hospital staff, watching television, and eating the hospital food. Ms. Vanover stated she was surprised to hear of Resident 's death however does not believe there was any "foul play" that contributed to Resident A's death and believe Resident A was properly cared for and protected while in the home.

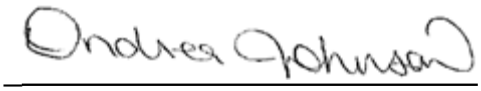
On 2/14/2022, I conducted an onsite investigation at the facility with home manager Kristina Graca. Ms. Graca stated while working on 1/6/2022 she was called to help Mr. Gravatt while he was in the bathroom assisting Resident A. Ms. Graca stated when she entered the bathroom, she found Resident A unresponsive on the floor. Ms. Graca stated Mr. Gravatt informed her that Resident A "seized up" and collapsed over while she was attempting to pull up her briefs. Ms. Graca stated she assisted another staff member in performing CPR and asked Mr. Casey to call 911. Ms. Graca stated she performed CPR until EMS arrived who then transported Resident A to the hospital. Ms. Graca stated she worked with Resident A regularly and Ms. Graca did not observe Resident A to have any unusual behaviors or seem to be in distress about anything days prior to this incident. Ms. Graca stated she was later informed by Resident A's guardian that Resident A passed away while at the hospital.

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 on this investigation which included interviews with home managers Jamara White and Kristina Graca, direct care staff members Keon Casey and John Gravatt, Relative A1, mental health case worker Angie Vanover, review of Resident A's *Health Care* Appraisal, *Assessment Plan for AFC Residents, Death Certificate, and Licensing Division-Accident/Incident Reports,* there is no evidence to support the allegation facility staff member did not protect Resident A after Resident A became unresponsive at the home and passed away. Mr. Gravatt stated while assisting Resident A in the bathroom Resident began to have "seizure like movements" and collapsed to the floor. Mr. Gravatt stated he immediately called for help at which time Mr. Casey and Ms. Graca performed CPR at different times while waiting for EMS to arrive. Ms. Graca, Ms. White, and Mr. Gravatt all stated they did not observe any adverse behaviors leading up to Resident A collapsing. In addition, Resident A was not observed to have any unusual physical limitations and did not request for medical attention when she complained of having pain. According to Resident A's *Assessment Plan for AFC Residents,* Resident A performed her own personal care needs however required prompting with bathing, dressing and toileting. According to Resident A's death certificate, the underlying cause of death was due to bilateral pulmonary thromboemboli and the immediate cause of death was due to probable lower extremity deep vein thrombosis. The certificate further stated the manner of Resident A's death was natural. Relative A1 and Ms. Vanover both stated they have no concerns for the direct care staff in the home and believe Resident A was protected and properly cared for by direct care staff members.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 2/25/2022, 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 and make comments.

IV. RECOMMENDATION

I recommend the current license status remain unchanged.



Ondrea Johnson — 02/25/2022
Licensing Consultant — Date

Approved By:

03/01/2022

Dawn N. Timm — Date
Area Manager