GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 12, 2022

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

RE: License #: AS390406169
Investigation #: 2022A1024021
Beacon Home at Al Sabo

Dear Mr. 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 21, 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 AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS390406169
Investigation #:	2022A1024021
Complaint Receipt Date:	02/11/2022
Investigation Initiation Date:	02/14/2022
Report Due Date:	04/12/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Howard
Licensee Designee:	Ramon 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?
The facility was observed to have multiple health and safety issues.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/11/2022	Special Investigation Intake 2022A1024021
02/14/2022	Special Investigation Initiated - Face to Face with home manager Christina Graca, direct care staff members Tangela Stroud, Kayla Brown
02/14/2022	Contact - Telephone call made with recipient rights Suzie Suchyta
02/14/2022	Contact - Telephone call made with licensee designee Ramon Beltran
02/14/2022	Contact - Document Received pictures of the facility
02/14/2022	Exit Conference with licensee designee Ramon Beltran
02/14/2022	Corrective Action Plan Requested and Due on 03/31/2022
02/21/2022	Corrective Action Plan Received
02/21/2022	Corrective Action Plan Approved
04/12/2022	APS Referral

ALLEGATION:

The facility was observed to have multiple health and safety issues.

INVESTIGATION:

On 2/11/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged the facility was observed to have multiple health and safety issues with the main concern being caustic or dangerous cleaning chemicals being accessible to residents.

On 2/14/2022, I conducted an onsite investigation at the facility with home manager Christina Graca, direct care staff members Tangela Stroud and Kayla Brown. Ms. Graca, Ms. Stroud, and Ms. Brown all stated the direct care staff members conducted deep cleaning of the facility for approximately two weeks due to a resident moving out of the facility which is why there were cleaning products accidentally left out accessible to the residents. Ms. Graca, Ms. Stroud, and Ms. Brown all stated that cleaning products are usually kept locked in a cabinet away from residents for safety. Ms. Graca believe the cleaning products were accidentally left out for a couple of days during their two weeks of deep cleaning the facility. Ms. Graca further stated she is unsure why a can of gasoline was left out in the garage and has not been able to determine what staff member left this can of gasoline out. Ms. Graca stated this can of gasoline was immediately removed from the facility when she was notified. Ms. Graca stated no resident was able to get a hold of any of the chemicals that were accidentally left out by staff members.

While at the facility, Ms. Graca gave a tour of the facility and identified the areas where the cleaning products were left out accessible to the residents. These areas included the bathroom, kitchen, and laundry area. At the time of my onsite investigation the caustic or dangerous chemicals were stored and safeguarded away from residents.

On 2/14/2022, I conducted an interview with Recipient Rights Officer Suzie Suchyta. Ms. Suchyta stated she is also investigating this allegation. Ms. Suchyta stated while visiting with a resident she also observed health and safety issues. Ms. Suchyta stated she observed a can of gasoline in the garage which is a designated smoking area for the residents and multiple cleaners including bleach were observed accessible to the residents in different areas of the home. Ms. Suchyta further stated the home is required to secure any toxic or potentially hazardous materials due to the nature of the residents in the home.

On 2/14/2022, I reviewed pictures of the facility taken on 2/11/2022. I observed pictures of cleaning products left out in the bathroom and laundry area both of which are areas accessible to residents.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.

ANALYSIS:	Based on my investigation which included interviews with home manager Christina Graca, direct care staff members Tangela Stroud, Kayla Brown, and recipient rights officer Suzie Suchyta there is evidence that direct care staff members left caustic and other dangerous chemicals in areas of the home that were easily accessible to residents. Ms. Graca, Ms. Stroud, and Ms. Brown all stated the direct care staff members conducted deep cleaning of the facility for approximately two weeks due to a resident moving out of the facility which is why there were cleaning products accidentally left out accessible to the residents. Ms. Graca, Ms. Stroud, and Ms. Brown also all stated that cleaning products are usually kept locked in a cabinet away from residents for safety. Ms. Graca stated she is unaware why a can of gasoline was left in the garage however the can was immediately removed from the home when she was notified. Ms. Suchyta stated she also observed hazardous cleaning products in various areas of the home accessible to residents and a can of gasoline in the garage which is a designated smoking area for the residents while visiting a resident. The staff members failed to maintain the home properly by not properly storing potentially hazardous, dangerous materials in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While at the facility on 02/14/2022, I observed debris in the garage along with two garbage cans that were not able to be closed with lids due to an overflow of garbage in the cans.

On 2/14/2022, I conducted an interview with Ms. Suchyta who stated on 2/11/2022 she observed garbage and debris in the garage which is designated smoking area for the residents while she was visiting with one of the residents.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(4) All garbage and rubbish that contains food wastes shall be kept in leakproof, nonabsorbent containers. The containers shall be kept covered with tight-fitting lids and shall be removed from the home daily and from the premises at least weekly.

ANALYSIS:	The garbage cans located in the facility garage were so full the lids were no longer tight-fitting as required. This left garbage and food waste spilling over and in the presence of residents who use the garage area for smoking.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

While at the facility I observed a missing cabinet door under the kitchen sink along with multiple boxes in the living room area.

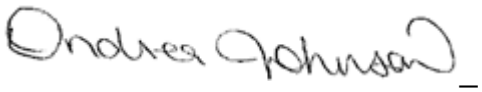
On 2/14/2021, Ms. Graca stated she made a maintenance request regarding the missing cabinet door about two months ago and has not heard a response back. Ms. Graca also stated a resident moved out a month ago and their designated representative have not returned to get the rest of the resident's belongings.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	While at the facility I observed a missing cabinet door under the kitchen sink and multiple boxes in the living room area. Ms. Graca stated she made a maintenance request regarding the missing cabinet door about two months ago and has not heard a response back. Ms. Graca also stated a resident moved out a month ago and their designated representative have not returned to get the rest of the resident's belongings. The housekeeping standards did not present to be of orderly appearance.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/14/2022, I conducted an exit conference with licensee designee Ramon Beltran and informed him of my findings. I allowed him an opportunity to ask questions and make comments.

IV. RECOMMENDATION

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



03/31/2022

Ondrea Johnson — Date
Licensing Consultant

Approved By:

04/12/2022

Dawn N. Timm — Date
Area Manager