GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 30, 2023

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

RE: License #: AS390406165
Investigation #: 2024A0578003
Beacon Home at Richland

Dear Ramon 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 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 (517) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406165
Investigation #:	2024A0578003
Complaint Receipt Date:	10/09/2023
Investigation Initiation Date:	10/09/2023
Report Due Date:	12/08/2023
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 Richland
Facility Address:	9445 N. 24th St. Richland, MI 49083
Facility Telephone #:	(269) 488-0024
Original Issuance Date:	01/11/2021
License Status:	REGULAR
Effective Date:	07/11/2023
Expiration Date:	07/10/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff Cynthia Longstreet was discovered sleeping during the overnight shift on 10/05/2023.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/09/2023	Special Investigation Intake 2024A0578003
10/09/2023	Special Investigation Initiated - Telephone
10/09/2023	APS Referral
10/09/2023	Contact-Telephone -With Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta.
10/19/2023	Contact-Documentation Reviewed -*AFC Licensing Division Incident / Accident Report* dated 10/05/2023.
11/27/2023	Special Investigation Completed On-site -Interview with administrator Aubrey Napier. Interview with Resident A.
11/27/2023	Contact-Telephone -Interview with direct care staff Cynthia Longstreet.
11/27/2023	Contact-Document Reviewed -Progressive Action Form, dated 10/05/2023.
11/29/2023	Exit Conference -With the licensee designee, Ramon Beltran II.

ALLEGATION: Direct care staff Cynthia Longstreet was discovered sleeping during the overnight shift on 10/05/2023.

INVESTIGATION:

On 10/09/2023, I received this complaint from Complainant. Complainant reported that direct care staff Cynthia Longstreet was the overnight direct care staff and the only staff working the early morning of 10/05/2023. Complainant alleged that Cynthia Longstreet was found by Resident A sleeping during the overnight shift, and this facility does not have sleeping shifts during the overnight. Complainant reported that Cynthia Longstreet admitted to sleeping during this shift.

On 10/09/2023, I reviewed the details of the allegations with Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta. Suzie Suchyta reported that during an interview, Resident A and Resident B confirmed that direct care staff Cynthia Longstreet was observed sleeping at the kitchen table with her head down. Suzie Suchyta added that Cynthia Longstreet had also acknowledged falling asleep but reported she had only done so for five or ten minutes. Suzi Suchyta reported that administrator Aubry Napier had arrived at the facility that morning and noted that it did not appear that any of the overnight responsibilities such as cleaning had occurred.

On 10/19/2023, I reviewed the *AFC Licensing Division Incident / Accident Report* related to the allegations and dated 10/05/2023. The *AFC Licensing Division Incident / Accident Report* documented that on 10/05/2023, administrator Aubrey Napier had arrived at this facility in the morning and was informed by residents that direct care staff Cynthia Longstreet was sleeping during the overnight shift. The *AFC Licensing Division Incident / Accident Report* documented that when asked, Cynthia Longstreet acknowledged “dozing off” but clarified that she typically does this after the residents “fall asleep.” The *AFC Licensing Division Incident / Accident Report* documented administrator Aubrey Napier reminded Cynthia Longstreet that sleeping during shift is prohibited and that being awake is critical to monitoring all residents for health and safety. The *AFC Licensing Division Incident / Accident Report* documented that a medication inventory was completed, and that Cynthia Longstreet would be receiving a *Progressive Action* which would include a suspension due to this incident. The *AFC Licensing Division Incident / Accident Report* documented that a verbal report was made to the office of recipient rights.

On 11/27/2023, I completed an unannounced investigation on-site at this facility and interviewed administrator Aubrey Napier regarding the allegations. Aubrey Napier acknowledged the allegations as reported and indicated when she had come into the facility that morning, she noticed the kitchen had several dishes in the sink and recalled leaving the night before with no dishes in the sink. Aubrey Napier reported that direct care staff Cynthia Longstreet had reported she was ill and had taken cold medicine, but Aubrey Napier reported that no illness had been reported prior to Cynthia Longstreet working the night of the incident. Aubrey Napier reported that

Cynthia Longstreet is no longer working at this facility and is not allowed to work the overnight shifts at other facilities on her own and primarily works during the day.

While at the facility, I interviewed Resident A regarding the allegations. Resident A reported living at this facility for almost a year. Resident A recalled the allegations and identified direct care staff Cynthia Longstreet by name. Resident A reported that he had entered the kitchen to obtain a drink of water when he observed Cynthia Longstreet at the dining room table with her head down. Resident A acknowledged that Cynthia Longstreet was the only direct care staff working in this facility at the time. Resident A denied that any similar allegations had occurred before or since. Resident A denied having any additional concerns.

On 11/27/2023, I interviewed direct care staff Cynthia Longstreet regarding the allegations. Cynthia Longstreet reported working at this facility for over eight years. Cynthia Longstreet acknowledged working alone and falling asleep at this facility and clarified that she had a cold and had taken some cold medicine which had made her tired. Cynthia Longstreet reported that she had only fallen asleep for 10 or 15 minutes.

On 11/27/2023, I reviewed the *Progressive Action Form* for direct care staff Cynthia Longstreet, dated 10/05/2023. The *Progressive Action Form* documented that between 7AM and 7:30AM a resident had reported that Cynthia Longstreet was sleeping on shift and Cynthia Longstreet admitted to “dozing off” and clarified that she usually only does so “after all residents are asleep.”

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based upon my investigation, which consisted of interviews with administrator Aubrey Napier, Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta, direct care staff Cynthia Longstreet, and Resident A, as well as a review of pertinent documentation relevant to this investigation, the staffing levels at this facility were not sufficient to implement the plans of services for residents at this facility while direct care staff Cynthia Longstreet was the only staff working at this facility and admittedly slept during her shift which is not adequate to meet the needs of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION

On 10/09/2023, Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta reported that during the occurrence of the allegations, the medication door was left open and the medication drawers unlocked. Suzie Suchyta reported the medication door has an automatic lock and was simply not shut all the way. Suzie Suchyta added that administrator Aubrey Napier found the door open and completed a medication count and determined that no medications were missing.

On 11/27/2023, administrator Aubrey Napier reported that when direct care staff Cynthia Longstreet was observed sleeping in this facility, the medication cabinet was observed left open, and the medication drawers were unlocked. Aubrey Napier confirmed completing a medication inventory and determined no medications were missing.

On 11/27/2023, Resident A reported that after observing direct care staff Cynthia Longstreet sleeping in the facility, Resident A noticed the medication cabinet was unlocked, and attempted to inform Cynthia Longstreet, but she was unresponsive.

On 11/27/2023, I reviewed the *Progressive Action Form* for direct care staff Cynthia Longstreet, dated 10/05/2023. The *Progressive Action Form* documented the medication room door was left open and the medication cabinet was not locked during the reported incident.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Based upon my investigation, which consisted of interviews with administrator Aubrey Napier, Integrated Services of Kalamazoo recipient rights officer Suzie Suchyta, direct care staff Cynthia Longstreet, and Resident A, as well as a review of pertinent documentation relevant to this investigation, the medications in this facility were not kept locked during the overnight shift on 10/05/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on a regular status.

11/29/2023

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Eli DeLeon Date
Licensing Consultant

Approved By:

11/30/2023

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Dawn N. Timm Date
Area Manager