GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 27, 2023

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

RE: License #: AS390403202
Investigation #: 2024A1034007
Beacon Home at Kal-Haven

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 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) 284-9730.

Sincerely,

Kevin L. Sellers

Kevin Sellers, Licensing Consultant
Department of Licensing and Regulatory Affairs
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-3704

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390403202
Investigation #:	2024A1034007
Complaint Receipt Date:	11/03/2023
Investigation Initiation Date:	11/03/2023
Report Due Date:	01/02/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubrey Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Kal-Haven
Facility Address:	5359 N. 8th Street Kalamazoo, MI 49009
Facility Telephone #:	(269) 214-4341
Original Issuance Date:	05/05/2020
License **Status:**	REGULAR
Effective Date:	11/05/2022
Expiration Date:	11/04/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Mykail Bigby left the facility leaving residents unsupervised.	Yes

III. METHODOLOGY

11/03/2023	Special Investigation Intake 2024A1034007
11/03/2023	APS Referral made relating to the allegations.
11/03/2023	Special Investigation Initiated – Telephone contact with Complainant, interviewed Complainant.
11/06/2023	Inspection Completed On-site interviewed direct care worker, Ladon Huntington, Residents A, C and C.
11/15/2023	Contact - Telephone call made interviewing direct care worker/program director, Denise Rogers.
12/15/2023	Contact - Telephone call made leaving a message for direct care worker Mykail Bigby requesting return contact.
12/18/2023	Contact - Telephone call made leaving a second message for Mykail Bigby to return contact.
12/20/2023	Contact - Telephone call made interviewing licensee, Ramon Beltran about investigation outcomes.
12/20/2023	Exit Conference with Ramon Beltran.
12/20/2023	Inspection Completed-BCAL Sub. Compliance.
12/21/2023	Contact - Telephone call made interviewing Intergraded Services of Kalamazoo case manager, Stephanie Short.

ALLEGATION: Direct care staff member Mykail Bigby left the facility leaving residents unsupervised.

INVESTIGATION:

On 11/03/2023, I received a complaint through the Bureau of Community Health Systems (BCHS) online complaint system alleging direct care staff member Mykail

Bigby was the only staff member assigned to work the nightshift at the home and he took the company vehicle leaving Residents A and B alone unsupervised in the home.

On 11/03/2023, I interviewed Complainant via telephone who verified the allegations identified in the complaint were accurate.

On 11/06/2023, I conducted an unannounced onsite investigation and interviewed direct care worker (DCW) Landon Huntington who denied any first-hand knowledge that Residents A and B were left unsupervised by DCW Mykail Bigby on 10/25/2023. DCW Huntington reported he was on vacation during the time of the incident.

On 11/06/2023, I interviewed Residents A, B and C all of whom reported DCW Bigby was not present in the home on the night of 10/25/2023. Residents A, B and C denied knowing an accurate amount of time DCW Bigby was gone from the home but each of then reported DCW Bigby left the home with the facility van. Residents A and B reported after DCW Bigby left, a gentleman from the pharmacy came but they told the gentleman DCW Bigby was not there. All three residents reported DCW Denise Rogers arrived later to address the situation. Residents A, B and C denied any prior issues of being left without any direct care staff member in the facility.

On 11/15/2023, I interviewed direct care worker (DCW)/program manager Denise Rogers via telephone who reported having firsthand knowledge of DCW Mykail Bigby leaving the facility during his scheduled nightshift on 10/25/2023 and thus leaving Residents A, B and C unsupervised for roughly 40 minutes. Ms. Rogers reported receiving a telephone call from their local pharmacy after the pharmacy driver delivered medication to the facility around 8:40 pm on the night of 10/25/2023. Ms. Rogers stated the pharmacy driver stated no direct care staff member was located on the facility premises and Residents A, B and C were left at the facility unsupervised. Ms. Rogers reported going to the facility immediately to address the situation, remaining at the facility for several hours, observing DCW Bigby return to the facility proximally at 9:05 pm with the company van. Ms. Rogers reported completing an internal investigation by interviewing Residents A, B and C, DCW Bigby, contacting licensee designee Ramon Beltran, reviewing facility video footage and company vehicle video footage logs. Ms. Rogers reported DCW Mykail Bigby was placed on suspension on the night of 10/25/2023 and then on 10/26/2023 DCW Bigby's employment was terminated.

On 12/15/2023 and 12/18/2023, I made several attempts to contact DCW Mykail Bigby via telephone but DCW Bigby never returned contact during the investigation.

On 12/16/2023, I reviewed Beacon Home at Kal- Haven Investigation Report dated 10/25/2023 which documented Residents A, B, and C, DCW Mykail Bigby were interviewed, review of facility and vehicle video footage/logs. According to the Beacon Home at Kal- Haven Investigation Report, the findings concluded DCW Mykail Bigby left the facility on the night of 10/25/2023 proximally at 8:33 pm and

returned at 9:05 pm with the company vehicle leaving Residents A, B and C unsupervised for a period of time and the investigation led to the termination of DCW Mykail Bigby.

On 12/21/2023, I interviewed Residents A and B's Intergraded Services of Kalamazoo (ISK) case manager, Stephanie Short, via telephone. Ms. Short reported she was aware of the incident on 10/25/2023 that DCW Mykail Bigby left Residents A, B and C unsupervised in the facility. Ms. Short reported completing her investigation learning administration conducted an internal investigation that concluded termination of DCW Bigby. Ms. Short stated she agrees with the outcome of the internal investigation and denied any concerns for Residents A and B's safety and supervision while living at the facility.

APPLICABLE RULE	
400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my interviews with DCW/program manager Rogers, DCW Huntington, Residents A, B and C, and ISK case manager Short, direct care worker Mykail Bigby left three residents unattended for at least 40 minutes. Even though facility administration responded immediately upon learning the residents were unattended, there was still a period of time during which residents' needs were not attended to as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remain unchanged.

Kevin L. Sellers 12/26/2023

Kevin Sellers Date
Licensing Consultant

Approved By:

Dawn Timm 12/27/2023

Dawn N. Timm Date
Area Manager