GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 26, 2024

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

RE: License #: AS250412389
Investigation #: 2024A0779049
Beacon Home at Clio

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) 643-7960

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250412389
Investigation #:	2024A0779049
Complaint Receipt Date:	08/12/2024
Investigation Initiation Date:	08/13/2024
Report Due Date:	10/11/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St., Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Ramon Beltran
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home at Clio
Facility Address:	1491 Bondy Dr., Clio, MI 48420
Facility Telephone #:	(810) 368-4621
Original Issuance Date:	09/07/2022
License **Status:**	REGULAR
Effective Date:	03/07/2023
Expiration Date:	03/06/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was sent to the hospital alone due to being aggressive and was left unattended at the ER (emergency room) with no staff with him.	Yes
Resident A is being denied his phone privileges.	No
On 8/8/24, staff Rashanda Bennett pulled on Resident B's arm and they got into a verbal On 8/8/24, staff Rashanda Bennett pulled on Resident B's arm and they got into a verbal altercation.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/12/2024	Special Investigation Intake 2024A0779049
08/13/2024	Special Investigation Initiated - Letter Email was sent to Complainant.
08/19/2024	APS referral Complaint received from APS centralized intake.
08/24/2024	Contact - Document Received Received email from complainant.
08/28/2024	Inspection Completed On-site
08/28/2024	Contact - Telephone call made Spoke to staff person, Shiree Robidabo.
08/28/2024	Contact - Telephone call made Voicemail message was left for staff person, Rashanda Bennett.
09/09/2024	Contact - Telephone call made Voicemail message was left for staff person, Rashanda Bennett.
09/09/2024	Contact – Telephone call made Spoke to home manager, Kenya Wright

09/23/2024	Exit Conference Held with licensee designee, Ramon Beltran

ALLEGATION:

Resident A was sent to the hospital alone due to being aggressive and was left unattended at the ER with no staff with him.

INVESTIGATION:

On 8/24/2024, an email was received from Complainant to confirm that no staff from this home was at the hospital with Resident A on 8/11/2024. Complainant stated that staff said that they did not have anyone available to go to the hospital with Resident A or to pick Resident A up from the hospital, when he was not admitted. Complainant reported that Resident A sat at the hospital for several hours alone before transportation could be arranged to take him back to the home.

On 8/28/2024, an on-site inspection was conducted and Resident A was interviewed. Resident A stated that he remembers getting mad and claims that he threw the fire extinguisher on the floor. Resident A stated that the police came and he was transported to the hospital by ambulance alone. Resident A confirmed that he was not admitted into the hospital and had to sit there for a long time alone, before he was transported back to the home by ambulance.

On 8/28/2024, home manager, Kenya Wright, confirmed that Resident A got upset, threw the fire extinguisher and threatened to kill her. Manager Wright stated that she called 911, the police came to the home and Resident A was transported to the hospital by ambulance. Manager Wright stated that the 2nd scheduled staff had not showed up for work that shift, so she did not have anyone available to go to the hospital with Resident A or pick Resident A up from the hospital. Manager Wright confirmed that Resident A was at the hospital with no staff present to supervise him. Manager Wright reported that she contacted her program director, Sonia McKeown, and they both tried, but could not find another staff available to work that shift. Manager Wright stated that Resident A is not allowed to be in the community unsupervised.

Resident A's *Assessment Plan for AFC Residents,* dated February 2023, was reviewed and stated that Resident A is not able to move independently in the community. A's CMH behavioral assessment was reviewed and found to state that staff will remain within eyesight Resident A while in the community.

On 9/23/24, an exit conference was held with licensee designee, Ramon Beltran. Licensee Beltran stated that he has spoken to the staff of this home regarding proper call-in procedures and how to better manage staffing coverage.

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:	It was confirmed that Resident A is not able to be in the community unsupervised and, per his CMH behavioral assessment, Resident A is to remain within eyesight of staff while in the community. Resident A stated that he was transported to the hospital by ambulance alone and had to sit at the hospital alone for a long time, before being transported back to the home by ambulance. Home manager, Kenya Wright, stated that she did not have enough staff on shift available to go with Resident A to the hospital or pick Resident A up from the hospital. Manager Wright confirmed that Resident A was sent to the hospital alone by ambulance and stayed there with no staff present. Licensee did not provide Resident A with the supervision required by his *Assessment Plan for AFC Residents* and his CMH behavioral assessment.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A is being denied his phone privileges.

INVESTIGATION:

On 8/28/24, Resident A stated that he remembers getting upset recently about not being able to use the phone, because of issues with the phone's battery, but that he could not remember how long he waited for the phone. Resident A stated that he has access to the home's phone when he needs it most of the time. Resident A was having difficulty staying focused, as he kept talking about several miscellaneous things off topic. Resident A stated that he had no concerns or problems to report.

On 8/28/24, Manager Wright stated that the home phone was not keeping a charge and she kept trying to charge it, but it wouldn't work and Resident A became very upset with the situation. Manager Wright stated that she was very busy passing medications and cooking lunch, so it took her while to find a battery for the phone that worked, but Resident A never got to use it before he had a behavioral episode and was sent out to the hospital. Manager Wright stated that Resident A has specific restrictions related to

phone use, per his IPOS and guardian, but that there is usually a house phone available for him and the other residents to use.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.**
ANALYSIS:	Due to an unusual problem with the battery of the home's phone, Resident A had to wait a while before having access to use it. Resident A stated that he has access to the phone when he needs it most of the time. Home manager, Kenya Wright, stated that there is a home phone that is available for all the residents to use. There was insufficient evidence found to prove that Resident A is being denied his right to reasonable access to a phone.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

On 8/8/24, staff Rashanda Bennett pulled on Resident B's arm and they got into a verbal altercation.

INVESTIGATION:

On 8/28/24, Resident B stated that staff person, Rashanda Bennett, was in the medication room and he has to put his arm through the window area for her to check his blood sugar. Resident B stated that Staff Bennet kept pulling his arm toward her. Resident B stated that it did not hurt his arm but he did not like it. Resident B admitted that he got frustrated and started cussing at Staff Bennett. Resident B reported that

Staff Bennett was yelling and cussing back at him but that he does not remember what Staff Bennett actually said.

On 8/28/24, Manager Wright stated that she was in the staff office when he she heard a loud argument and she went out to find Resident B and Staff Bennett yelling back and forth at each other. Manager Wright stated that she could not remember what was exactly said, but that she could get either Resident B or Staff Bennett to calm down and stop yelling.

On 8/28/24, a phone interview was conducted with staff person, Shiree Robidabo, who confirmed that she worked the day of Resident B and Staff Bennett's verbal altercation. Staff Robidabo stated that she did not see Staff Bennett pull on Resident B's arm but did witness Resident B yell at Staff Bennett first. Staff Robidabo confirmed that Staff Bennett was cussing at Resident B and appeared to be a little out of control. Staff Robidabo reported that Staff Bennett kept yelling at Resident B for about 20 minutes and that cussing was involved.

On 8/28/24 and 9/9/24, attempts were made to contact staff person, Rashanda Bennet by phone. Voicemail messages were left, but as of the date of this report, Staff Bennett has not returned those messages.

On 9/23/24, an exit conference was held with licensee designee, Ramon Beltran. Licensee Beltran stated that Staff Bennett was immediately suspended and has not been working. Licensee Beltran stated that Staff Bennett's employment with this company will be terminated following this licensing rule violation.

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:	Resident B stated that he does not remember the details of what staff person, Rashanda Bennett, said to him, but does remember her yelling and cussing at him. Home manager, Kenya Wright, confirmed that Staff Bennett was yelling at Resident B and that she could not get Staff Bennett to calm down or stop yelling. Staff person, Shiree Robidabo, stated that she witnessed Staff Bennett cussing and yelling at Resident B for about 20 minutes. There was preponderance of evidence

	found to prove that staff person, Rashandra Bennett, did not treat Resident B with dignity, but yelling and cussing at him.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 9/9/24, a phone conversation took place with home manager, Kenya Wright, regarding the status of Resident A's 2024 *Assessment Plan for AFC Residents.* Manager Wright stated that she was not able to find a copy of the updated assessment plan for 2024. The current assessment plan was completed in February 2023, making it in need of being updated by February 2024.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	As part of this investigation, the home was not able to provide an updated *Assessment Plan for AFC Residents for 2024* for Resident A. The current assessment plan was completed in February 2023 and should have been updated on or before February 2024. Not completing this assessment plan on an annual basis and not having it available in Resident A's file for review in September 2024, warrants citation of this licensing rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/23/24, an exit conference was held with licensee designee, Ramon Beltran. Licensee Beltran was informed of the outcome of this investigation and that a written corrective action plan is required.

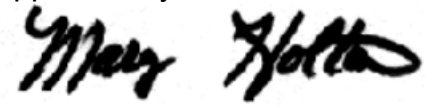
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

9/26/2024

Christopher Holvey Date
Licensing Consultant

Approved By:



9/26/2024

Mary E. Holton Date
Area Manager