GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 27, 2019

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

RE: License #: AS250387844
Investigation #: 2020A0501007
Beacon Home at Washburn

Dear Ms. Williams:

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 (810) 787-7031.

Sincerely,

Crecendra Brown

Crecendra Brown, Licensing Consultant
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(810) 931-0965

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250387844
Investigation #:	2020A0501007
Complaint Receipt Date:	11/08/2019
Investigation Initiation Date:	11/08/2019
Report Due Date:	01/07/2020
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Melissa Williams
Licensee Designee:	Melissa Williams
Name of Facility:	Beacon Home at Washburn
Facility Address:	8012 Washburn Rd. Goodrich, MI 48438
Facility Telephone #:	(810) 636-2281
Original Issuance Date:	09/07/2017
License Status:	REGULAR
Effective Date:	10/18/2019
Expiration Date:	10/17/2021
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A has a dark purple bruise the size of a baseball on the inside of his left leg near his knee from a staff member pushing him into something.	Yes

III. METHODOLOGY

11/08/2019	Special Investigation Intake 2020A0501007
11/08/2019	Special Investigation Initiated - Letter
11/08/2019	APS Referral Genesee County Adult Protective Services Tiffany Williams.
11/19/2019	Inspection Completed On-site Staff Melissa Hubble, Resident A and Staff Donovan Lee.
11/22/2019	Contact - Telephone call made Complainant 1.
11/22/2019	Contact - Telephone call made Guardian A.
11/22/2019	Contact - Telephone call made Staff Eric Love.
11/22/2019	Contact - Telephone call made Staff Erin Hudson.
12/20/2019	Exit Conference Licensee Designee Melissa Williams.

ALLEGATION:

Resident A has a dark purple bruise the size of a baseball on the inside of his left leg near his knee from a staff member pushing him into something.

INVESTIGATION:

On November 19, 2019, I conducted an onsite investigation at Beacon Home at Washburn. Staff Melissa Hubble, Resident A and Staff Donovan Lee were interviewed.

Staff Melissa Hubble stated that Resident A said Staff Erin Hudson caused the bruise on his leg and Staff Hudson no longer works here. Staff Hubble stated that Staff Hudson works at the Beacon Home in Linden, MI. Staff Hubble stated that Staff Hudson was removed from the home because of the bruise on Resident A's leg. Staff Hubble stated that she saw the bruise and it was big. Staff Hubble stated that Staff Hudson had Resident A on the ground when it happened, but she does not believe Staff Hudson meant to harm Resident A. Staff Hubble stated that Resident A showed her the bruise and Guardian A was contacted. Staff Hubble stated that Resident A was checked out by the Beacon Nurse and the nurse at his school. Staff Hubble stated that Resident A's story has not been consistent and people thought he was saying Eric did it, but when they pointed to Eric, Resident A said "no." Staff Hubble stated that Resident A identified Staff Eric Hudson as the one who caused the bruise on his leg from taking him down to the ground during a behavior. Staff Hubble stated that Staff Hudson is a tall and thin Black man, not Staff Eric Love.

I requested to see a copy of the incident report. Staff Melissa Hubble was unable to locate an incident report. No incident report was sent to Licensing in regard to this incident or allegation.

Resident A showed me his leg and the bruise is gone now. Resident A stated that the bruise was big. Resident A stated that staff had him on the ground in the kitchen and the staff's right knee was pressed into his left inner side of his knee. Resident A never said the staff member's name. Resident A stated that the staff was a tall Black man and his name was not Eric. Resident A stated that the staff member no longer works at the home. Resident A stated that the staff member is skinny and worked at night in the home.

Staff Donovan Lee stated that Resident A did have a large bruise on his leg. Staff Lee stated that Resident A told him that the bruise happened in the kitchen and a tall skinny Black man took him down to the ground. Staff Lee stated that the staff's right knee went into Resident A's left inner knee. Staff Lee stated that Resident A told him that Staff Eric Love didn't do it, but he identified Staff Erin Hudson as the one who did it. Staff Lee stated that Staff Hudson no longer works at the home. Staff Lee stated that Staff Hudson used to work third shift. Staff Lee stated that Resident A's story has not been consistent on who or how the bruise happened.

I requested to see Resident A's assessment plan. Staff could not find Resident A's assessment plan but provided me with a copy of his personal care plan (PCP). The PCP states that Resident A requires supervision, prompting and monitoring by the AFC home staff. The PCP doesn't say anything about staff doing "take downs" on Resident A or anything similar when his behaviors escalate or become uncontrollable.

On November 22, 2019, I conducted a phone interview with Complainant 1. Complainant 1 stated that Resident A kept saying "Eric did it" when it came to the large bruise on his leg. Complainant 1 stated that they do not know who "Eric" is, but the group home was notified. Complainant 1 stated that the bruise on Resident A's leg was the size of a baseball, dark purple and looked fairly new on November 6, 2019. Complainant 1 stated that Resident A said it didn't hurt when he touched it. Complainant 1 stated that Resident A described the staff member as a tall and thin Black man.

On November 22, 2019 and November 25, 2019, I attempted to contact Guardian A. I left voice messages each time I called. To date, I have not received a return phone call from Guardian A.

On November 22, 2019, I conducted a phone interview with Staff Eric Love. Staff Eric Love stated that he came into work the day Resident A showed staff the bruise on his leg. Staff Eric Love stated that Resident A kept changing his story about what happened to him and who did it. Staff Love stated that he didn't touch Resident A and he didn't witness anyone harming Resident A. Staff Love stated that Resident A was saying that a tall and skinny Black man pinned him to the ground. Staff Love stated that he does not fit that description.

On November 22, 2019, I conducted a phone interview with Staff Erin Hudson. Staff Erin Hudson stated that he never saw a bruise on Resident A. Staff Hudson stated that he would never harm Resident A or any of the other residents. Staff Hudson stated that he has been off from work because of this investigation. Staff Hudson stated that Resident A is very vocal and capable of telling someone if something happened to him. Staff Hudson stated that he never witnessed any staff being rough with Resident A. Staff Hudson stated that Resident A has behaviors sometimes but is rarely violent in the home. Staff Hudson stated that one day Resident A was chasing other clients and pushing them in the home. Staff Hudson stated that he had to do physical management on Resident A because he was trying to fight him. Staff Hudson stated that he did a "wrap" on Resident A. Staff Hudson stated that he took Resident A down to the ground slowly and he didn't try to harm him. Staff Hudson stated that he would never intentionally harm a resident. Staff Hudson stated that they do "wrap" their legs around the residents' legs when they take them down to the floor. Staff Hudson stated that stated that he worked 8pm to 8am at the home.

On December 20, 2019, I attempted to conduct an exit conference with Licensee Designee Melissa Williams. I left a voice message for Licensee Designee Melissa

Williams to call me back for the exit conference. To date, I have not received a return phone call from Licensee Designee Melissa Williams.

In Special Investigation 2018A0501045 dated October 19, 2018, Resident A was sexually assaulted by Resident B in the AFC home. Resident A's assessment plan stated the he was to received line-of-sight supervision and 24-hour safety monitoring in the home.

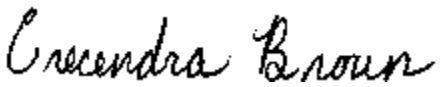
Corrective action plan dated November 1, 2018 for Special Investigation 2018A0501045 states that all staff will be trained on all resident behavior plans and on any updates.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	Resident protection. **(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.** **(2) All work that is performed by a resident shall be in accordance with the written assessment plan.** **(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 A, Complainant 1, Staff Melissa Hubble and Staff Donovan Lee stated that Resident A had a large bruise on his left leg. Resident A, Staff Melissa Hubble, Staff Donovan Lee and Staff Erin Hudson stated that Resident A was taken down to the ground by staff. Resident A stated that he received the bruise when he was taken down to the ground by staff. Staff Erin Hudson stated that he did take Resident A down to the ground when he was trying to fight.

	On November 19, 2019, I requested to see Resident A's assessment plan. Staff could not find Resident A's assessment plan but provided me with a copy of his personal care plan (PCP). The PCP states that Resident A requires supervision, prompting and monitoring by the AFC home staff. The PCP does not state anything about staff doing "take downs" on Resident A or anything similar when his behaviors escalate or become uncontrollable.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation Report dated October 19, 2018.**

IV. RECOMMENDATION

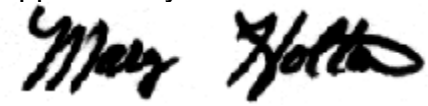
Upon the receipt of an approved and acceptable corrective action plan, no change to the license status is recommended.



December 27, 2019

Crecendra Brown — Date
Licensing Consultant

Approved By:



December 27, 2019

Mary E Holton — Date
Area Manager