GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 4, 2021

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

RE: License #: AS630387842
Investigation #: 2021A0993035
Beacon Home at Dilley

Dear Ms. Rawlings:

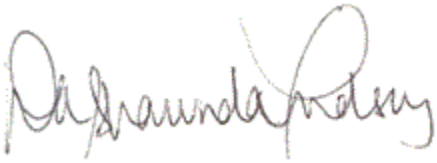
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630387842
Investigation #:	2021A0993035
Complaint Receipt Date:	09/24/2021
Investigation Initiation Date:	09/27/2021
Report Due Date:	11/23/2021
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 Rawlings
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Dilley
Facility Address:	7570 Dilley Road Davisburg, MI 48350
Facility Telephone #:	(248) 382-5648
Original Issuance Date:	08/13/2018
License Status:	REGULAR
Effective Date:	02/13/2021
Expiration Date:	02/12/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 9/11/2021, Resident A wandered from the facility and was detected on neighbor's ring camera at 1am. Resident A was going through neighbors' vehicles and was intoxicated. EMS and police report made. There is a concern for lack of proper care and supervision for the residents in the home.	Yes

III. METHODOLOGY

09/24/2021	Special Investigation Intake 2021A0993035
09/27/2021	Referral - Recipient Rights Forwarded allegations to recipient rights advocate Sondra Knisely
09/27/2021	Special Investigation Initiated - Letter Emailed recipient rights advocate Sondra Knisely
09/27/2021	Contact - Document Sent Requested police reports from Oakland County Sheriff's Department
10/04/2021	Contact - Document Received Received police reports from Oakland County Sherrif's Department
10/12/2021	Inspection Completed On-site Conducted an unannounced onsite investigation
10/12/2021	Contact - Document Received Received documentation
10/18/2021	Contact - Telephone call made Telephone call made to staff Skylar Rapphun. The number was not accepting incoming calls.
10/18/2021	Contact - Document Sent Sent a text message to staff Skylar Rapphun
10/18/2021	Contact - Telephone call made Telephone call made to staff Brittany Grass. Left a message.

10/18/2021	Contact - Telephone call made Telephone call made to staff Brittney Dixon. Left a message.
10/18/2021	Contact - Telephone call made Telephone call made to staff Nakeesha Woodward
10/18/2021	Contact - Telephone call made Telephone call made to neighbor David Couch
10/18/2021	Contact - Telephone call received Telephone call received from staff Brittney Dixon
10/18/2021	Contact - Telephone call made Telephone call made to neighbor Dean Lambouris. Left a message.
10/18/2021	Contact - Document Sent Requested documentation
10/18/2021	Contact - Document Received Received documentation
10/18/2021	Contact - Telephone call received Telephone call received from neighbor Dean Lambouris
10/18/2021	Contact - Telephone call received Telephone call received from neighbor Brittany Grass
10/21/2021	Contact - Telephone call made Telephone call made to staff Skylar Rapphun. The number was disconnected.
10/27/2021	Contact - Telephone call made Telephone call made to staff Skylar Rapphun. The number was disconnected.
10/27/2021	Exit Conference Held with licensee designee Kimberly Rawlings
11/03/2021	APS Referral Allegations forwarded to adult protective services (APS)

ALLEGATION:

On 9/11/2021, Resident A wandered from the facility and was detected on neighbor's ring camera at 1am. Resident A was going through neighbors' vehicles and was intoxicated. EMS and Police report made. There is a concern for lack of proper care and supervision for the residents in the home.

INVESTIGATION:

On 09/24/2021, I received the allegations from the Bureau of Child and Adult Licensing Online Complaints.

On 09/27/2021, I forwarded the allegations to recipient rights advocate Sondra Knisely.

On 10/04/2021, I received police reports from Oakland County Sheriff's Department. The reports dated 10/10/2020, 10/25/2020, 11/09/2020, 12/06/2020 and 01/01/2021 concerned Resident F. Resident F moved out of the facility prior to the commencement of this investigation. The following are summaries of reports received concerning the residents currently living in the facility:

- On 02/11/2021, there was a call concerning malicious destruction of property. Resident A took staff Brittany Grass' key remote out of her coat pocket, open the vehicle door and emptied trash in the front passenger seat and floor. The vehicle was not damage. Resident A returned the key remote without incident.
- On 05/28/2021, there was a mental health call. Resident B was transported for mental health care.
- On 06/17/2021, there was a call concerning damage to private property. Police observed Resident C to be hostile. He was upset when he was not allowed to sleep in the living room and was told to go back to his room. Resident D picked up a laptop and banged it on the table. He also chewed on the cordless remote jack for the mouse.
- On 07/09/2021, there was a mental health call. Resident B was transported for mental health care.

On 10/12/2021, I conducted an unannounced onsite investigation. I interviewed home manager Jordan Eldridge, Resident A's guardian (mother) as well as Resident A, Resident B, and Resident D. Resident C did not wish to talk to me. Resident E was at work at the time of the onsite investigation.

Ms. Eldridge stated she was not working when Resident A wandered from the facility and was found going through a neighbor's vehicle. Ms. Eldridge confirmed police transported him back to the facility, and he was intoxicated. Per Ms. Eldridge, staff Nakeesha Woodward called her to inform her about the incident. Ms. Eldridge stated Resident A is not known to elope from the facility. This is the first time something like this has occurred since he was admitted in October 2020. Regarding Resident A being

intoxicated, Ms. Eldridge stated Resident A informed her that he got the alcohol out of the vehicle he broke into. Ms. Eldridge stated Resident A has a history of alcohol use. As a result, staff watches him when he goes into the story and avoids stores that sell alcohol. Ms. Eldridge stated staff have never caught Resident A drinking alcohol, but when his roommate gets mad at him, his roommate brings Resident A's empty alcohol bottles to staff. Ms. Eldridge stated Resident A really does not go anywhere unless he is with staff. Ms. Eldridge stated she did not know where Resident A is getting the alcohol. In addition, she stated Resident A is not searched and/or his room is not randomly searched for alcohol.

Ms. Eldridge stated there are two staff on shift from 7am to 7pm, and there is one staff from 7pm to 7am. Ms. Eldridge stated all the residents have community access. None of the residents require staff to assistance with any of their personal care needs (i.e. eating/feeding, bathing, toileting, dressing, etc.).

Resident A's guardian (and mother) stated she was unaware of the incident involving Resident A wandering from the facility and being found going through a neighbor's vehicle. Per Resident A's guardian, Resident A cannot move independently in the community. Staff must be always with him. She acknowledged that Resident A has a history of alcohol use. She stated if given the opportunity, Resident A will drink. Resident D's guardian stated staff take good care of the residents.

Resident A confirmed he left the facility and was found going through a neighbor's vehicle. Per Resident A, he went outside, but he did not have anything to smoke. He left the premises to go get a vape or cigarette. Resident A stated he went into a neighbor's vehicle to look for a vape or cigarette. The police were called and transported him back to the facility. Regarding being intoxicated, Resident A stated he went to the store earlier that day to get some alcohol. Per Resident A, staff allow him to go to the story by himself. Resident A stated there are two to three staff on shift from 7am to 7pm. There is only one staff on shift from 7pm to 7am. Resident A stated he did not require staff to assist with any of his personal care needs (i.e. eating/feeding, bathing, toileting, dressing, etc.). Per Resident A, staff take good care of the residents.

Resident B stated she has lived in the facility for approximately four years. She lives with four other residents. She stated the number of staff per shift varies, but there is always at least one staff per shift. Resident A stated she can move independently in the community. She denied that she required staff to assist with any of his personal care needs (i.e. eating/feeding, bathing, toileting, dressing, etc.). Per Resident B, staff take good care of the residents.

Resident D stated he has lived in the facility for 1½ years. He lives with four other residents. There are two staff and Ms. Eldridge on shift during day shift and one staff on shift at night. Resident D stated he can move independently in the community. He denied that he required staff to assist with any of his personal care needs (i.e. eating/ feeding, bathing, toileting, dressing, etc.). Per Resident D, staff take good care of the residents.

On 10/12/2021, I reviewed Resident A's, Resident B's, Resident C's, Resident D's, and Resident E's assessment plans. Resident A cannot move independently in the community to prevent any stealing. He does not require assistance with personal care needs. In addition, Resident A's plan notes that he has a history of alcohol and drug use, but there is no measure in place to address it or prevent it (i.e. search him when he leaves or returns the facility, random bedroom searches, etc.). Resident B, Resident C, Resident D, and Resident E can move independently in the community. Resident B and Resident C do not require assistance with personal care needs (i.e. eating/feeding, bathing, toileting, dressing, etc.). Resident D requires staff to prompt him to take a shower/bathe and/or complete daily hygiene. Resident E requires staff to prompt him to bathe and groom occasionally. None of the residents' plans note that more than one staff is required per shift to meet the residents' needs.

On 10/18/2021, I conducted a telephone interview with staff Nakeesha Woodward. She verified she was working when Resident A wandered from the facility and was found going through a neighbor's vehicle. Ms. Woodward confirmed police transported him back to the facility, and he was intoxicated. Ms. Woodward stated Resident A left the facility between midnight and 1am, and police brought him back around 1:30am. Ms. Woodward stated the police initially came to the facility and asked if a resident was missing. At the time, Ms. Woodward stated she was unaware that Resident A had left. She told police that none of the residents were missing. About 15 to 20 minutes later, police brought Resident A back to the facility. Police informed her that they found Resident A and he was intoxicated. They also informed her that Resident A had broken into someone's car and found alcohol. Ms. Woodward stated she was the only staff working on shift that day. She stated two staff work from 7am to 7pm and one staff works from 7pm to 7am. Per Ms. Woodward, all the residents have community access, including Resident A. She stated this is the first time Resident A wandered away from the facility. Ms. Woodward stated none of the residents require assistance with personal care needs (i.e. eating/feeding, bathing, toileting, dressing, etc.). In addition, she stated staff properly care for the residents.

On 10/18/2021, I conducted a telephone interview with neighbor David Couch. He stated he observed Resident A in his wife's vehicle through his ring camera. He approached Resident A and observed that Resident A was intoxicated and had a fifth of alcohol in his pocket. Mr. Couch denied that Resident A took anything out of the vehicle. Per Mr. Couch, Resident A broke into multiple vehicles that night. The incident occurred on 09/11/2021. Resident A was alone, and staff did not know he was missing. Mr. Couch stated the residents are not properly supervised or cared for.

On 10/18/2021, I conducted a telephone interview with staff Brittney Dixon. Ms. Dixon stated she has worked in the facility since June 2021, but she was terminated today for a reason unrelated to this investigation. Ms. Dixon stated she worked both shifts. Two to three staff were scheduled to work from 7am to 7pm and one staff was scheduled to work from 7pm to 7am. Ms. Dixon stated she heard about the incident concerning

Resident A wandering away from the facility, but she was not working that day. Per Ms. Dixon, the residents are properly supervised and cared for.

On 10/18/2021, I reviewed the staff schedule from 06/28/2021 to 10/03/2021. Per the schedule, 0n 07/29/2021 and 07/31/2021, there was no staff scheduled from 7pm to 7am. For the remaining days during that period, there as adequate staff scheduled per shift.

On 10/18/2021, I conducted a telephone interview with neighbor Dean Lambouris. He stated a resident was found inside of another neighbor's vehicle on 09/11/2021 around 12:30am. The resident was intoxicated and had alcohol on person. Mr. Lambouris stated staff did not know the resident had wandered about two miles away from the facility. Mr. Lambouris stated the residents are not properly supervised or cared for.

On 10/18/2021, I conducted a telephone interview with staff Brittany Grass. Ms. Grass stated she has worked in the facility for about 2½ years. Ms. Grass stated two staff are scheduled to work from 7am to 7pm and one staff is scheduled to work from 7pm to 7am. None of the resident require assistance with personal care needs (i.e. eating/ feeding, bathing, toileting, dressing, etc.). Per Ms. Grass, the residents are properly supervised and cared for.

On 10/27/2021, I conducted an exit conference with licensee designee Kimberly Rawlings. I informed her of the findings. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 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:	I reviewed the residents' care plans. None of the residents' plans note that more than one staff is required per shift to meet the residents' needs. Staff and residents interviewed stated there are at least two staff working from 7am to 7pm and one staff working from 7pm to 7am.
CONCLUSION:	VIOLATION NOT ESTABLISHED

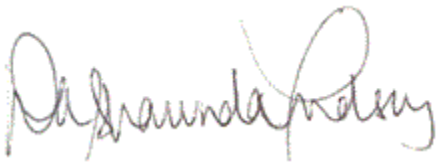
APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	I reviewed the staff schedule from 06/28/2021 to 10/03/2021. Per the schedule, 0n 07/29/2021 and 07/31/2021, there was no staff scheduled from 7pm to 7am. For the remaining days during that period, there were adequate staff scheduled per shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	According to staff interviewed as well as Resident A, Resident A can move independently in the community. However, per Resident A's assessment plan, he cannot move independently in the community to prevent any stealing. On 09/11/2021, Resident A wandered away from the facility and broke into a neighbor's vehicle. Resident A was observed to be intoxicated. Police were called, and he was returned to the facility. In addition, Resident A's plan indicates that he has a history of alcohol and drug use, but there is no measure in place to address it or prevent it (i.e. search him when he leaves or returns the facility, random bedroom searches, etc.)
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On 09/11/2021, Resident A wandered away from the facility and broke into a neighbor's vehicle. Resident A was intoxicated. Police were called and he was returned to the facility. Staff were unaware that Resident A was missing. In addition, Resident A has a history of alcohol and drug use, but there is no measure in place to address it or prevent it (i.e. search him when he leaves or returns the facility, random bedroom searches, etc.).
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

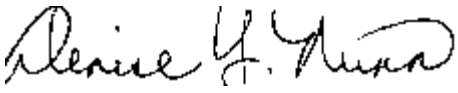
Contingent upon receipt of a corrective action plan, I recommend no change in the license status.



11/03/2021

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



11/04/2021

Denise Y. Nunn — Date
Area Manager