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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 25, 2022

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

RE: License #: AS130405804
Investigation #: 2022A0462016
Beacon Home At Battle Creek

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,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS130405804
Investigation #:	2022A0462016
Complaint Receipt Date:	01/21/2022
Investigation Initiation Date:	01/24/2022
Report Due Date:	02/20/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At Battle Creek
Facility Address:	5555 Bauman Rd. Battle Creek, MI 49017
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	01/08/2021
License Status:	REGULAR
Effective Date:	07/08/2021
Expiration Date:	07/07/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 01/14/2022 facility staff member Brittany Robinson engaged in an inappropriate verbal altercation with Resident A.	Yes

III. METHODOLOGY

01/21/2022	Special Investigation Intake 2022A0462016
01/24/2022	Special Investigation Initiated – Telephone interview with Resident A.
01/26/2022	Unannounced investigation onsite. Face-to-face interviews with home manager Diante Taylor, Residents A, B, C, and D, and direct care worker Michelle Robinson. Requested and received documentation.
02/03/2022	Contact - Telephone interview with facility staff member Brittany Robinson.
02/09/2022	APS Referral
02/25/2022	Exit conference with Ramon Beltran via telephone.

ALLEGATION: On 01/14/2022 facility staff member Brittany Robinson engaged in an inappropriate verbal altercation with Resident A.

INVESTIGATION: On 01/21/2022 the Bureau of Community and Health Systems (BCHS) received the above complaint via the BCHS' online complaint system. The written complaint indicated that on 01/14, direct care worker (DCW) Brittany Robinson attempted to get Resident A kicked out of the facility. According to the written complaint, Ms. Robinson told Resident A, "hit me so I can drop you on the floor." The written complaint indicated Resident A "got in (Ms. Robinson's) face" and told her to leave him alone. According to the written complaint, Resident A did not physically touch Ms. Robinson. The written complaint indicated similar incidents occurred in the past, Ms. Robinson treats Resident A differently, and Ms. Robinson yells at Resident A "constantly". Resident A requested Ms. Robinson be prohibited from providing care to him.

I reviewed an *AFC Licensing Division Incident/Accident Report* (IR) regarding an incident between Resident A and Ms. Robinson on 01/14, written by Ms. Robinson and submitted to the department on 01/15. Documentation on the IR read;

"[Resident A] was in another resident's room when staff was prompting that resident to come take their medications. When staff seen that [Resident A] was touching the resident multiple times on his shoulder, stomach, and arm.... staff then redirected [Resident A] that he could no longer be in the resident's room because of inappropriate touching. [Resident A] then got angry with staff and said, "I can do whatever the fuck I want, I don't have to leave his room." Staff responded back to [Resident A] that when it becomes a behavior and the resident is asking you to leave, you do need to leave the resident's room. [Resident A] then walked away screaming and raising his voice at staff. Staff still looking to prompt the other resident, [Resident A] came back down the hallway, getting into staff's face yelling "Fuck you Nigger!" Another staff then put their body in between staff and [Resident A]. [Resident A] was threatening to hit staff and kept calling staff the N word. [Resident A] then called the police and spoke with them about the altercation.

Staff will continue to remind [Resident A] that he is loved and cared for in his home environment. Staff will continue to encourage [Resident A] to utilize his coping skills when feeling frustrated."

On 01/24 I conducted a telephone interview with Resident A, who confirmed the allegation. Resident A stated his friend, Resident B, witnessed the allegation on 01/14. Subsequently, Resident A requested that I interview Resident B. Resident A stated, "she (Ms. Robinson) treats me like shit." According to Resident A, there had been no further issues with Ms. Robinson since the incident on 01/14. Resident A stated, "I just stay away from her." Resident A expressed his desire to move out of the facility. I informed Resident A I was unable to assist him with this request and I referred him to his responsible agency, Community Mental Health (CMH) case manager, and legally appointed guardian.

On 01/26 I conducted an unannounced investigation onsite and interviewed home manager Diante Taylor. According to Mr. Taylor, on 01/14 he was in his office when he heard a loud verbal exchange between Resident A and Ms. Robinson. Mr. Taylor stated that he later learned the exchange began after Ms. Robinson asked Resident A to leave Resident C's bedroom, causing Resident A to become upset. According to Mr. Taylor, he came out of his office to provide assistance. Mr. Taylor stated he overheard Resident A make several threats and inappropriate comments to Ms. Robinson. According to Mr. Taylor, he did not hear Ms. Robinson threaten Resident A. However, in response to Resident A's verbal threats, he did hear Ms. Robinson say, "I'm not scared of you" and "go ahead, hit me." Mr. Taylor admitted Ms. Robinson should have ignored Resident A's behavior and walked away. According to Mr. Taylor, he brought Resident A to his office and was able to calm him down. Mr. Taylor confirmed Resident A called the police and spoke to an officer about the incident, but no action was taken by law enforcement. Mr. Taylor also confirmed

Residents A and B were friends. Mr. Taylor stated he did not recall Resident B's presence during the incident. However, according to Mr. Taylor, the verbal exchange between Resident A and Ms. Robinson was loud enough for everyone in the facility to potentially hear it. Mr. Taylor stated that prior to this incident, Resident A and Ms. Robinson were "close." According to Mr. Taylor, he believed the issues between Resident A and Ms. Robinson had been resolved.

I conducted separate face-to-face interviews with Residents B, C, and D, and DCW Michelle Robinson. (DCW Michelle Robinson is not related to DCW Brittany Robinson). Resident B confirmed he witnessed the allegation on 01/14. According to Resident B, Resident A and Ms. Robinson engaged in a heated verbal altercation. Resident B stated he witnessed Resident A call Ms. Robinson a "nigger." Resident B stated, "but she (Ms. Robinson) kept egging him on." Resident B stated Ms. Robinson "got in (Resident A's) face" and said, "do it bitch" and "you ain't shit" [sic]. According to Resident B, although he and Resident A were good friends, he would not lie about witnessing the allegation.

Resident C confirmed that on 01/14, Resident A became upset when Ms. Robinson asked him to leave Resident C's bedroom. Resident C confirmed Resident A and Ms. Robinson engaged in a verbal argument. Resident C stated, "it was loud" and "I don't like to argue so I walked away." Subsequently, Resident C stated he did not hear what Resident A and Ms. Robinson specifically said to each other.

Resident D stated he had no knowledge of the allegation.

Both Residents C and D stated Ms. Robinson had never treated them inappropriately, nor had they previously witnessed Ms. Robinson be inappropriate or "mean" to other residents, including Resident A.

DCW Michelle Robinson stated she was aware of the allegation. However, she was not working at the facility at the time the alleged incident occurred. According to Michelle Robinson, when upset, Resident A often called Ms. Robinson a "nigger" and told her to "suck my dick." Michelle Robinson stated both Residents A and B reported Ms. Brittany Robinson antagonized them. However, Michelle Robinson stated she had never witnessed this behavior from Ms. Robinson. According to Michelle Robinson, she believed the issues between Resident A and Ms. Brittany Robinson had been resolved.

On 02/03 I conducted a telephone interview with Ms. Brittany Robinson who denied the allegation. Ms. Robinson confirmed that on 01/14, Resident A became angry when she requested he exit Resident C's bedroom. Ms. Robinson stated Resident A was "the aggressor." According to Ms. Robinson, Resident A "got in her face" and called her a "nigger." Ms. Robinson denied "egging" Resident A on and/or antagonizing him. Ms. Robinson stated, "I stepped back because he's a man and he is bigger than me." Ms. Robinson also stated, "I didn't run away from him" and "I told him to get back."

I reviewed a copy of Resident A's CMH Behavior Treatment Plan (BTP), which was recently updated on 12/13/2021. One of the "target behaviors" identified in Resident A's BTP was "verbal aggression". Documentation on Resident A's BTP read in part;

"Example(s) of target behavior: *Calling another person a derogatory name, using racial slurs, yelling and swearing at another person, threatening to harm another person.*

Verbal Aggression: *If [Resident A] makes threatening statements, staff should minimize attention to the statement to avoid escalation. [Resident A] may be looking for an argument, so staff should stay calm and say "We can talk when you use a quiet voice" in a neutral tone. If he begins to de-escalate, staff can redirect to a calming activity such as listening to music and praise him for using a quiet voice to speak with staff. If he continues verbal aggression, do not make eye contact or engage besides a calm "We can talk when you use a quiet voice". Giving space to [Resident A], asking residents to give him space and removing possibly dangerous items from the area may be beneficial at this time".*

On 02/09 I referred the allegation to Calhoun County Adult Protective Services via an email to the Centralized Intake Unit for Abuse and Neglect.

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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	On 01/14 Resident A became verbally threatening and aggressive and called DCW Brittany Robinson derogatory names. Based upon my investigation, there is no evidence to suggest Ms. Robinson ever threatened Resident A. However, it has been established that instead of ignoring Resident A's target behavior, walking away from Resident A, and/or seeking assistance from another facility staff member, Ms. Robinson further escalated the situation by engaging in an inappropriate verbal altercation with Resident A that could be heard throughout the facility.

CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On 01/14, Resident A displayed a target behavior of verbal aggression towards DCW Brittany Robinson. It has been established Ms. Robinson did not implement the reactive interventions to address Resident A's target behavior, as indicated in his CMH BTP.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/25 I conducted an exit conference with licensee designee Ramon Beltran via telephone and shared with him the findings of this investigation.

IV. RECOMMENDATION

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

Michele Streeter 02/25/2022

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 02/24/2022

Dawn N. Timm Date
Area Manager