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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 21, 2022

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

RE: License #: AS630387840
Investigation #: 2022A0465018
Beacon Home at Lake Orion

Dear Mr./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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-514-9391
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630387840
Investigation #:	2022A0465018
Complaint Receipt Date:	02/18/2022
Investigation Initiation Date:	02/18/2022
Report Due Date:	04/19/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 - 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Rawlings
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Lake Orion
Facility Address:	175 E. Silverbell Rd. Lake Orion, MI 48360
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/10/2017
License Status:	REGULAR
Effective Date:	08/08/2020
Expiration Date:	08/07/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged from the facility.	Yes

III. METHODOLOGY

02/18/2022	Special Investigation Intake 2022A0465018
02/18/2022	Special Investigation Initiated – Letter Spoke to Complainant via email
02/18/2022	APS Referral Adult Protective Services (APS) referral assigned for investigation; APS Worker is Marcie Fincher
02/23/2022	Contact - Document Received Email exchange with APS/Marcie Fincher
03/18/2022	Inspection Completed Onsite Reviewed Resident A's record; Resident A was not residing at the facility at the time of this onsite investigation.
03/18/2022	Contact – Telephone call I left a voice message for Guardian A1, requesting a return call.
04/06/2022	Contact - Telephone call made Interviewed Training Treatment Innovation Case Manager for Resident A, Sabrina Green.
04/06/2022	Contact - Telephone call made Interviewed Ascension Hospital Social Work Manager, Janine Jones
04/06/2022	Contact - Telephone call made Interviewed direct care staff, Shianne McGee
04/07/2022	Contact - Document Received Received facility documents via email from Steven Bailey and Kim Rawlings

04/07/2022	Contact - Telephone call made Interviewed Beacon District Director, Gerald Ross
04/08/2022	Contact - Telephone call made Interviewed Cathy DeMarco from Ascension Hospital
04/08/2022	Contact - Telephone call made Interviewed direct care staff/home manager Steven Bailey
04/11/2022	Contact - Telephone call made Conducted a Zoom conference call with Ms. Rawlings, Ms. Redmond, and Ms. Fincher/APS.
04/12/2022	Contact – Document received Email exchange with APS Worker, Marcie Fincher
04/18/2022	Contact – Telephone call made I interviewed Guardian A1 via telephone
04/18/2022	Exit Conference Conducted an Exit Conference with Ms. Rawlings

ALLEGATION:

Resident A was improperly discharged from the facility.

INVESTIGATION:

On 2/18/2022, a complaint was received, alleging that Resident A was improperly discharged from the facility. The complaint indicated that on 2/8/2022, the facility completed a psychiatric petition for Resident A due to his refusal to eat, take medications or allow his vitals to be taken. The complaint stated that Resident A was transported to the hospital by EMS. The complaint stated that Resident A has been ready for discharge for several days, but the facility has refused to pick Resident A up.

On 2/18/2022, I spoke to Complainant via email exchange. Complainant confirmed that the information contained in the complaint is accurate.

On 2/23/2022 and 4/12/2022, I spoke to Adult Protective Services Worker, Marcie Fincher. Ms. Fincher provided me with a copy of an email exchange between herself and direct care staff, Kimberly Redmond, dated 2/18/2022. In the email exchange, Ms. Fincher asked Ms. Redmond if the facility was willing to take Resident A back and Ms. Redmond's response was that she conveyed to the hospital and APS that the facility could not safely take Resident A back. Ms. Fincher stated that she has completed her

investigation and will be substantiating the facility for neglect based upon the refusal to allow Resident A to return to the facility.

On 3/18/2022, I conducted an onsite investigation at the facility. I reviewed Resident A's record. At the time of my onsite investigation, Resident A was not residing at the facility. The *Face Sheet* stated that Resident A was admitted to the facility on 8/24/2018 and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizoaffective Disorder – Bipolar Type. The *Assessment Plan for AFC Residents* stated that Resident A moves independently in the community, has a history of aggressive and sexual behavior, independently completes self-care tasks, and uses a walker for mobility assistance. *The Discharge Notice*, dated 2/2/2022, stated that a 24-hour discharge notice was issued due to Resident A's continued defiant and aggressive behavior. The *Discharge Summary* stated that Resident A was discharged from the facility on 2/8/2022 due to continued refusal to take medication, increased delusions, anger, and dismissive behavior.

On 4/6/2022, I interviewed social work supervisor, Janine Jones, from Ascension Hospital. Ms. Jones stated that she assisted with trying to locate placement for Resident A during the time that he was residing at the hospital. Ms. Jones stated, "On 2/8/2022, Resident A was admitted to the hospital for behavior issues and psychiatric evaluation. On 2/10/2022, medication adjustments had been made and Resident A would be ready for discharge from the emergency room on 2/11/2022. I was asked to assist in contacting the facility to request for them to pick Resident A up from the hospital. On this same date, I called Steven Bailey and left him a voice mail. In the voice mail, I told Mr. Bailey that Resident A's medications had been modified and he no longer met the criteria to remain in the emergency room or hospital and needed to be picked tomorrow. Also, our social worker, Cathy DeMarco also spoke to Mr. Bailey on this same day and told him that Resident A needed to be picked up tomorrow and Mr. Bailey told her that he needed to talk to his supervisor before any arrangements for transportation could be made. On 2/11/2022, Ms. DeMarco left another voice message for Mr. Bailey, informing him that Resident A was ready for pickup and could not remain in the emergency room, was not displaying any behaviors and was taking his medication as prescribed. We never received a return call from Mr. Bailey.

On 2/14/2022 at 8:34am, I spoke to direct care staff, Shianne McGee, via telephone. I told Ms. McGee that Resident A has been ready for discharge for several days and needed to be picked up. Ms. McGee told me that she could not make any decisions and that I needed to speak to Mr. Bailey. She told me she would pass my message on to Mr. Bailey. I did receive a return call from Mr. Bailey in the afternoon. I emphasized again to Mr. Bailey that Resident A could not remain in the hospital and needed to be picked up. Mr. Bailey told me that it was above his pay grade and that I needed to speak to his supervisor, Gerald Ross. Mr. Bailey gave me Mr. Ross's number and I called him. I told Mr. Ross that Resident A had been at the hospital for several days and needed to be picked up. Mr. Ross told me that it was above his pay grade, and he told me that I needed to speak to Kimberly Redmond. Mr. Ross gave me Ms. Redmond's number and I called and left her a voicemail on 2/14/2022. Ms. Redmond did not call me back until

2/18/2022. When I spoke to Ms. Redmond, I again told her that Resident A needed to be picked up. Ms. Redmond told me that the facility could not take him back due to his behaviors and because they had issued a 24-hour discharge notice to him. Ms. Redmond refused to pick Resident A up from the hospital. Resident A remained in the hospital until 2/19/2022, when we were able to locate a placement for him." Ms. Jones stated that Mr. Bailey, Mr. Ross and Ms. Redmond were all made aware of Resident A's discharge from the emergency room and need for pick up and refused to pick him up.

On 4/6/2022, I interviewed Training & Treatment Innovations Case Manager, Sabrina Green, via telephone. Ms. Green stated that she has been Resident A's case manager since February 2022. Ms. Green stated, "On 2/8/2022, Resident A was taken to the hospital by EMS based on a psychiatric petition that was submitted by the facility. Resident A was ready for discharge from the hospital a few days later but staff did not pick him up. On 2/14/2022, I spoke to Kimberly Redmond, to inquire as to why Resident A had not been picked up by staff. Ms. Redmond told me that the facility issued a 24-hour discharge notice to Resident A on 2/2/2022 and that Ascension Hospital was now responsible to find placement for him. Ms. Redmond told me that, because they had issued a discharge notice, they did not legally have to take Resident A back. Ms. Redmond nor anyone else from the facility came to pick Resident A up. The facility refused to take him back and he remained in the hospital for approximately nine days until a placement was found." Ms. Green stated that this allegation is true.

On 4/6/2022, I interviewed direct care staff, Shianne McGee, via telephone. Ms. McGee stated, "I do remember receiving a phone call from Ms. Jones at the hospital. Ms. Jones told me that Resident A was ready for discharge and someone needed to go and pick him up. I gave Mr. Bailey the message and he told me that there was a petition for Resident A to stay in the hospital and that the hospital would have to talk to Kim Rawlings. I gave him Ms. Jones's phone number, and no one ever told me to pick Resident A up from the hospital. I never heard anything else after that."

On 4/7/2022, I interviewed Beacon District Director, Gerald Ross, via telephone. Mr. Ross stated, "I am a district manager and do not work at the facility, but during the time that Resident A was in the hospital I did speak to Ms. Jones from the hospital. On 2/14/2022, I received a call from Ms. Jones at the hospital. She told me that Resident A was ready for discharge from the hospital and needed to be picked up. I told her that I would notify Ms. Rawlings of this information and I then sent an email to Ms. Rawlings with the information. The next day, 2/15/2022, Ms. Jones called me again and she was very upset. She stated that Resident A had still not been picked up yet. I told Ms. Jones that it was not my decision to make, and that Ms. Rawlings needed to address this issue. I then sent a second email to Ms. Rawlings, to again let her know that the hospital had called, and that Resident A needed to be picked up. In my email to Ms. Rawlings, I told her that I would pick Resident A up from the hospital if she needed me to. But I never received a response from Ms. Rawlings to either of my emails. So, I assumed she had handled the issue and addressed it. I have dealt with many of the same situations in which a resident has to be picked up from the hospital and I know

that we are supposed to pick them up. I don't know why Resident A was not picked up by the facility."

On 4/8/2022, I interviewed Ascension social worker, Cathy DeMarco, via telephone. Ms. DeMarco stated, "Resident A was brought to the emergency room on 2/8/2022 because Ms. Redmond has submitted a petition for psychiatric evaluation and treatment. On 2/9/2022 and 2/10/2022, the hospital psychiatry team was working on adjusting Resident A's medications. On 2/10/2022 at 9:00am, I called Mr. Bailey and asked him, if Resident A is taking his medications, would they take him back. I informed Mr. Bailey that Resident A would be ready for discharge tomorrow (2/11/2022). Mr. Bailey also told me that the facility had discharged Resident A and therefore they were not required to take him back. Mr. Bailey told me that he had to speak to his supervisor, and someone would call me back. Mr. Bailey never called me back. I called Mr. Bailey again at 1:42pm and left him a voice message, asking him to have his supervisor call me. On 2/11/2022 at 9:37am, I called and left another message for Mr. Bailey. In the voice message, I told Mr. Bailey that Resident A was ready for discharge, was taking medications without issue, not displaying behaviors, needed to be picked up because he could not remain in the ER, and I asked for him or his supervisor to call me back. I never received a return call from Mr. Bailey nor his supervisor. Resident A remained in the emergency room until 2/19/2022 because the facility refused to pick him up.

On 4/8/2022, I interviewed Steven Bailey via telephone. Mr. Bailey stated that he has been working for the facility for two years and is the home manager. Mr. Bailey stated, "On 2/8/2022, Resident A was taken to the hospital because he was refusing to take him medication and was displaying behaviors. I went to the hospital and stayed with Resident A until I was told I could leave. I did receive calls from the hospital staff a few days later, informing me that Resident A needed to be picked up, but it was in supervisor hands. I didn't have the authority to accept Resident A back. I am new and I would have needed supervisor help. Every time I received a call, I referred the hospital staff to my boss, Mr. Ross and that's all I could do. I could not make the decision to take Resident A back. Resident A was still a resident of our facility, but I could not take him back without supervisor approval."

On 4/11/2022, I conducted a zoom call with direct care staff, Kimberly Redmond and licensee designee and administrator, Kimberly Rawlings.

I interviewed Ms. Redmond during the zoom call. Ms. Redmond stated, "I wrote the petition for Resident A to be admitted to the hospital. A 24-hour discharge notice was issued for Resident A 1 week prior to his admission to the hospital. I spoke to the hospital while Resident A was there. I told the hospital that there was a discharge notice and that he could not return to the facility due to refusing to take medication and his behaviors. Guardian A1 did not want Resident A to return to the facility. He could not come back to our facility. I provided names of possible placements to the hospital." Ms. Redmond stated that Resident A was not discharged from the facility until after he left the hospital but acknowledged that the facility did not allow Resident A to return to the facility.

I interviewed Ms. Rawlings during the zoom call. Ms. Rawlings stated that she does not recall receiving any emails from Mr. Ross, informing her that Resident A was discharged from the hospital and in need of pickup by the facility. Ms. Rawlings acknowledged that residents cannot be discharged to a hospital setting.

On 4/18/2022, I spoke to Guardian A1 from the George Heitmanis Law Group. Guardian A1 stated, “I spoke to Mr. Ross and to Ms. Redmond on separate occasions via telephone during the time that Resident A was at the hospital. I was concerned and wanted to understand why the facility left Resident A at the hospital and refused to pick him up. I never received a clear answer from Mr. Ross nor Ms. Redmond. I never told Ms. Redmond or Mr. Ross that I did not want Resident A to return to the facility. That is a lie.” Guardian A1 denied that she told Ms. Redmond, nor anyone else, that Resident A could not return to the facility.

On 4/18/2022, I conducted an exit conference with Ms. Rawlings. Ms. Rawlings is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to**

	elect to return to the first available bed in the licensee's adult foster care home.
ANALYSIS:	The *Discharge Summary* stated that Resident A was discharged from the facility on 2/8/2022, the same date that Resident A was admitted to the emergency room for psychiatric evaluation. According to Ms. Jones, Ms. DeMarco, and Ms. Green, between the dates of 2/10/2022 and 2/18/2022, they had multiple phone call contacts with staff and management from the facility, all of whom refused to pick up Resident A from the hospital. According to Ms. McGee, Mr. Ross, Mr. Bailey, and Ms. Redmond, they were aware that Resident A was at the hospital and ready for discharge. However, all four employees failed to follow-through on ensuring Resident A was picked up and allowed to return to the facility. Guardian A1 denied that she told Ms. Redmond, nor anyone else, that Resident A could not return to the facility. Ms. Fincher, APS worker will be substantiating the facility for neglect based upon the refusal to allow Resident A to return to the facility. Based upon the information above, the facility improperly discharged Resident A from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Stephanie Gonzalez

4/20/2022

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Stephanie Gonzalez — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

04/21/2022

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Denise Y. Nunn — Date
Area Manager