GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 12, 2022

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

RE: License #: AS730407067
Investigation #: 2022A0871041
Beacon Home at Saginaw

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.

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730407067
Investigation #:	2022A0871041
Complaint Receipt Date:	06/22/2022
Investigation Initiation Date:	06/23/2022
Report Due Date:	08/21/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Gerald Ross
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Saginaw
Facility Address:	7705 Dutch Rd Saginaw, MI 48609
Facility Telephone #:	(989) 401-5456
Original Issuance Date:	04/09/2021
License **Status:**	REGULAR
Effective Date:	10/09/2021
Expiration Date:	10/08/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was able to access the keys to the med room and lock herself in it.	Yes
Resident A was arrested on Sunday, June 26, 2022, and was released on Tuesday, June 28, 2022, around 4 pm. Resident A called the facility for a ride, but no one went to get her. Resident A walked out of the jail and fell and walked to the hospital. Resident A arrived home via taxi around 10 pm.	No

III. METHODOLOGY

06/22/2022	Special Investigation Intake 2022A0871041
06/23/2022	Special Investigation Initiated - Letter Received information from Complainant 1
06/30/2022	APS Referral Denied to Saginaw County MDHHS
07/19/2022	Inspection Completed On-site Interviewed Home Manager Diasheera Jackson
07/27/2022	Inspection Completed On-site Interviewed Resident A
07/27/2022	Contact - Telephone call made Telephone call to Staff Catherine Jones
07/27/2022	Contact - Telephone call made Telephone call to Staff Catherine Jones
08/03/2022	Contact - Telephone call made Telephone call to Resident A's Guardian A1
08/09/2022	Inspection Completed On-site Interviewed Home Manager Diasheera Jackson
08/10/2022	Exit Conference Telephone exit conference to Licensee Kimberly Rawlings

08/12/2022	Exit Conference Updated exit conference with Ms. Rawlings.

ALLEGATION:

Resident A was able to access the keys to the med room and lock herself in it.

INVESTIGATION:

On June 23, 2022, Complainant 1 emailed me that she spoke with the home staff, and they agreed that the allegation of Resident A getting into the medication room did happen.

On June 20, 2022, I conducted an unannounced onsite investigation and interviewed Home Manager Diasheera Jackson. Manager Jackson stated she was not working at the time and that she was told that Resident A was angry with staff, "verbally aggressive." Manager Jackson said Staff Tiara Pollard was in the living room where Resident A was being aggressive with her. Manager Jackson indicated Staff Catherine Jones was the med passer and she came into the living room to assist Ms. Pollard. Manager Jackson said Resident A "was able to get the keys and locked herself in the med room." Resident A did come out and refused to give the keys back.

On July 27, 2022, I telephoned Staff Catherine Jones. Ms. Jones stated she worked third shift as the med passer. When I asked Ms. Jones about Resident A locking herself in the med room, Ms. Jones replied, "I don't recall that" and could not provide any information.

On July 27, 2022, Manager Jackson advised that Staff Tiara Pollard is no longer employed at the facility and did not have a phone number for her.

On July 27, 2022, I conducted an onsite investigation and interviewed Resident A. Resident A indicated that staff left the medication room door open and the keys in the med room. Resident A said she ran into the med room and while inside the med room, "I shut the door but didn't think about taking other people's meds." Resident A stated when she opened the door, she took the keys to her room and would not give them back to staff. Resident A stated the police were called and "when the cops came, I handed over the keys to them because they were nice." Resident A said the staff that were working were Tiara Pollard and Catherine Jones.

On August 3, 2022, I telephoned Resident A's Guardian A1. Guardian A1 stated she was aware of Resident A getting the keys but did not have any information to provide regarding the incident.

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:	Manager Jackson said Resident A "was able to get the keys and locked herself in the med room." Resident A did come out and refused to give the keys back. Resident A stated she did get the keys to the med room and locked herself in. Resident A said Staff Catherine Jones was working but Ms. Jones does not recall the incident. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was arrested on Sunday, June 26, 2022, and was released on Tuesday, June 28, 2022, around 4 pm. Resident A called the facility for a ride, but no one went to get her. Resident A walked out of the jail and fell and walked to the hospital. Resident A arrived home via taxi around 10 pm.

INVESTIGATION:

On June 28, 2022, I received a copy of an *AFC Licensing Division – Incident/Accident Report* that was signed and dated by Licensee Kimberly Rawlings on June 28, 2022. The date of the incident indicates 06/26/2022 @ 1:51 am. What happened indicates "[Resident A] had a good night tonight she didn't have any behaviors tonight this had to be a prior incident tonight. At 12:40 am, the police arrived knocking on the door. Staff opened the door and Officer Brennan Ward asked do [Resident A] still live here. Staff told him 'yes' and he said he had a warrant for her arrest for a felony larceny and that he was here to pick her up. Staff led him to her room where she was sleeping. Staff knocked on the door and informed her the police was here for her and she asked why. The officer told her for a felony larceny warrant. She was upset, started cursing and saying she didn't do anything. It wasn't her. The officer asked her to turn around so he can handcuff her. She did comply with what he asked. As they were walking out, he said that if staff has any more questions for him, to call the Thomas Township station and ask for him." Action taken by staff indicates "Staff informed home manager and clinical."

On July 20, 2022, I conducted an unannounced onsite investigation and interviewed Home Manager Diasheera Jackson. Manager Jackson indicated Resident A "destroyed the rearview mirror in the van" and they could not drive it. Manager Jackson stated

Resident A called about 3-3:30 pm and was released from the jail. Manager Jackson indicated she tried to contact the jail but was not able to get in touch with anyone. Manager Jackson contacted Guardian A1 and asked her if she heard anything and let her know about the situation. Manager Jackson said they needed a vehicle to pick her up but did not have one available. Manager Jackson indicated staff are not to transport Resident A in their personal vehicles. Manager Jackson said staff received a call from the hospital later from the hospital and the facility was able to get a taxi to bring her home. Manager Jackson indicated that she did not know that when Resident A was released from jail, she went outside and then walked to the hospital. Manager Jackson said she did know there were taxis available.

On July 27, 2022, I conducted an onsite investigation and interviewed Resident A. Resident A said she called the facility multiple times to receive a ride home. Resident A said she was released from jail about 3 pm and walked to the hospital. Resident A said she fell and hurt her knee but was okay. Resident A said a taxi picked her up from the hospital about 10 pm.

On August 3, 2022, I telephoned Guardian A1. Guardian A1 said Resident A did not have a way to contact her but the home was in contact with her. Guardian A1 said staff cannot take Resident A in their personal vehicles. Guardian A1 said Resident A was at the jail "for a while trying to find a ride." Guardian A1 indicated it "was concerning no one went to get her."

On July 1, 2022, I received an *AFC Licensing Division – Incident Accident Report* that was signed and dated by Licensee Kimberly Rawlings on July 1, 2022. It indicates what happened "[Resident A] was discharged from the hospital and arrived home around 11:30 pm. Staff asked permission from on call nurse to give [Resident A] her 8 pm mediation outside of timeframe." Action taken indicates "Per nurse on call, staff gave [Resident A] her 8 pm medication at 11:30."

On August 9, 2022, I received a copy of Resident A's 'Intake Assessment Plan for AFC and Apartments Residents' that was signed by Carol Welch, relationship not stated on the plan, on 05/17/2021. It indicates that Resident A 'moves independently in the community.' I also received a copy of Resident A's *Assessment Plan for AFC Residents* that was signed and dated on 03/14/22 by Licensee Kimberly Rawlings and Guardian A1. The agreement indicates 'No fee for local transportation.' It also indicates 'transportation fees are charged as follows- current mileage rate, plus staff time for transportation outside of the local area.' The care agreement does not specify that the facility will provide transportation from the jail.

Resident A was released from the jail and the facility did not have transportation for he due to the van being damaged. Staff did not realize that Resident A would walk away from the jail, and she can move independently in the community.

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:	Resident A's assessment plan indicates that she can move independently in the community. Resident A was released from jail and staff did not have means to transport her back to the facility. Resident A walked away from the jail and is able to move independently in the community. There is no evidence to confirm violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's 'Intake Assessment Plan for AFC and Apartments Residents' was signed and dated on 05/17/2021 by Resident A by Carol Welch, relationship unknown. The assessment plan includes all the information that is required by licensing but has not been updated in over a year.

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:	Resident A's assessment plan had not been updated annually. Resident A's most recent assessment plan was completed on 5/27/2021. I confirm violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On August 10 and August 12, 2022, I conducted a telephone exit conference with Licensee Kimberly Rawlings. I advised Licensee Rawlings there was a rule violation in regard to the protection of Resident A and the assessment plan had not been updated annually.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of this adult small group home remain unchanged (capacity 1-6).

08/12/2022

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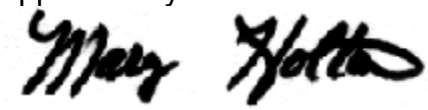
Kathryn A. Huber Date
Licensing Consultant

Approved By:



08/12/2022

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Mary E. Holton Date
Area Manager