GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 21, 2022

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

RE: License #: AS390403202
Investigation #: 2022A0578053
Beacon Home at Kal-Haven

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) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

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 #:	AS390403202
Investigation #:	2022A0578053
Complaint Receipt Date:	09/27/2022
Investigation Initiation Date:	09/27/2022
Report Due Date:	11/26/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Jamara White
Licensee Designee:	Ramon Beltran II
Name of Facility:	Beacon Home at Kal-Haven
Facility Address:	5359 N. 8th Street Kalamazoo, MI 49009
Facility Telephone #:	(269) 214-4341
Original Issuance Date:	05/05/2020
License Status:	REGULAR
Effective Date:	11/05/2020
Expiration Date:	11/04/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff member Helen Voltair yells at residents and will use vulgar language in front of residents.	Yes
Ms. Voltair restricted Resident A's movement by not allowing him to enter the main floor of the facility before 7AM.	No

III. METHODOLOGY

09/27/2022	Special Investigation Intake 2022A0578053
09/27/2022	Contact-Document Reviewed -*AFC Licensing Division Incident / Accident Report* dated 09/17/2022.
09/27/2022	Contact-Document Reviewed -*AFC Licensing Division Incident / Accident Report* dated 09/17/2022.
09/27/2022	ORR Referral -With Kalamazoo Office of Recipient Rights.
09/27/2022	Special Investigation Completed On-site -Interview with Resident A, interview with Resident B. Interview with direct care staff John Stokes.
09/29/2022	Contact-Telephone -Interview with staff member Heather Marchi.
09/29/2022	Special Investigation Completed On-site -Interview with Resident C.
10/07/2022	Contact-Telephone -Interview with direct care staff Helen Voltair.
10/10/2022	Contact-Telephone -Interview with MDHHS recipient rights officer Ms. Karen Currington.
10/27/2022	Exit Conference -With licensee designee Ramon Beltran.
11/15/2022	APS Referral Completed.

ALLEGATION:

Direct care staff Helen Voltair yells at residents and will use vulgar language in front of residents.

INVESTIGATION:

On 09/27/2022, *AFC Licensing Division Incident / Accident Report* dated 09/17/2022 and completed by direct care staff Amanda Morin documented that on 09/17/2022, Resident A came upstairs to go outside and smoke and direct care staff Helen Voltair asked Resident A what he was doing and when Resident A replied that he was going out to smoke. According to the *AFC Licensing Division Incident / Accident Report* Ms. Voltair yelled at Resident A, "I have told you to never come up those stairs until 7AM or after" and that from 6AM to 7AM was "her time." The *AFC Licensing Divisions Incident / Accident Report* documented that Resident A replied another direct care staff told him it was fine, and Ms. Voltair shouted back that she didn't care what other staff allowed him to do and that if this was how Resident A was going to act, Ms. Voltair wasn't going to do anything for Resident A again. The *AFC Licensing Division Incident / Accident Report* documented that when Ms. Voltair noticed she was missing her cigarettes, Ms. Voltair exclaimed, "where the fuck did my smokes go?" The *AFC Licensing Division Incident / Accident Report* documented that after Resident A realized he had mistakenly picked up Ms. Voltair's cigarettes, Ms. Voltair stated that she was "fed up" and couldn't stand a "thief" and that Resident A better not ask her for anything again. The *AFC Licensing Division Incident / Accident Report* documented that Resident A was very "visibly distraught" and did not understand Ms. Voltair's reaction. Ms. Morin documented on the *AFC Licensing Division Incident / Accident Report* that she informed the administrator and the office of recipient rights of this incident. The corrective measure on the *AFC Licensing Division Incident / Accident Report* documented that Ms. Voltair was placed on suspension.

On 09/27/2022, I reviewed another *AFC Licensing Division Incident / Accident Report* dated 09/17/2022 and completed by direct care staff Amanda Morin. The *AFC Licensing Division Incident / Accident Report* documented that on 09/17/2022, Resident B had asked Ms. Morin if she had tried to wake up Resident B as requested to use the bathroom. The *AFC Licensing Division Incident Accident Report* documented that direct care staff Helen Voltair yelled at Resident B, "No! we don't do that here, no one is going to baby her, and we don't do things like that." The *AFC Licensing Division Incident / Accident Report* documented that Ms. Morin directed Resident B into the bathroom where Resident B expressed fear of Ms. Voltair and wanted to file a report. The *AFC Licensing Division Incident / Accident Report* documented Ms. Morin informed the administrator and the office of recipient rights of this incident. The corrective measure on the *AFC Licensing Division Incident / Accident Report* documented Ms. Voltair was placed on suspension.

On 09/27/2022, I completed an unannounced investigation on-site and interviewed Resident A regarding the allegations. Resident A denied that Ms. Helen Voltair or any staff member ever called him a thief and denied ever hearing Ms. Voltair or any staff member yelling or using vulgar or degrading language in this facility.

While at the facility, I also interviewed Resident B regarding the allegations. Resident B reported living at this facility for only a short time. Resident B reported his only concern was staff member Helen Voltair. Resident B reported he feels like Ms. Voltair is degrading when she refers to his adult undergarments as “diapers” and suspects Ms. Voltair does this on purpose. Resident B also reported Ms. Voltair will often forget his preferred pronouns and Ms. Voltair attempted to convince Resident A he does not need to be addressed by his preferred name. Resident A confirmed that on at least one occasion, Ms. Voltair had yelled at him and threatened him with “consequences”, but Ms. Voltair did not explain what these “consequences” were. Resident B expressed being afraid of Ms. Voltair.

While at the facility, I interviewed direct care staff John Stokes regarding the allegations. Mr. Stokes reported working at this facility for 18 years. Mr. Stokes acknowledge that Ms. Voltair has been verbally threatening and uses vulgar language in the facility. Mr. Stokes reported that on one recent occasion, Ms. Voltair had returned to the facility with Resident A and that when Resident A was having a conversation with Mr. Stokes, Ms. Voltair yelled at Mr. Stokes, “keep my motherfuckin’ name out of your mouth.” Mr. Stokes confirmed that Resident A was present with this incident occurred and would have heard Ms. Voltair. Mr. Stoked reported completing an Incident Report. Mr. Stoked added that Resident C has expressed being afraid of Ms. Voltair.

On 09/29/2022, I interviewed staff member Heather Marchi regarding the allegations. Ms. Marchi reported serving as the home manager at this facility. Ms. Marchi acknowledged being aware of the allegations made against staff member Helen Voltair. Ms. Marchi reported that it had been an ongoing issue, but when attempting to address the occurrence with residents, residents would not confirm the allegations as the residents did want Ms. Voltair mad at them.

Ms. Marchi acknowledged being aware of the incident when Ms. Voltair had accused Resident A of being a thief and stealing her cigarettes and had followed Resident A and was yelling and stating that Resident A should never ask her for anything again.

Ms. Marchi denied ever observing Ms. Voltair being verbally aggressive or threatening with any resident but clarified that she had observed Ms. Voltair being verbally aggressive with staff, adding that on one occasion, Ms. Marchi instructed Ms. Voltair to observe a resident while at the hospital and Ms. Voltair reported, “you can get a fuckin’ babysitter and fuckin’ sit here yourself.”

Ms. Marchi confirmed hearing Ms. Voltair consistently yelling and swearing at other staff members, and suspects that residents in this facility can hear Ms. Voltair’s

language when this behavior occurs. Ms. Marchi confirmed being aware of the incident when Ms. Voltair was verbally threating to Mr. John Stokes. Ms. Marchi reported that human resources and the division director have been informed of Ms. Voltair's behavior.

On 09/29/2022, I interviewed Resident C regarding the allegations. Resident C could not recall how long she had lived at this facility. Resident C reported her only concern is staff member Helen Voltair. Resident C reported Ms. Voltair yells at her a lot and clarified the most recent occurrence happened when she inadvertently picked up Ms. Voltair's cigarettes. Resident C reported Ms. Voltair "blew her top" and began yelling at Resident C and Resident C yelled back. Resident C stated this occurrence ended when Resident C went to her room and slammed the door. Resident C reported that on one occasion, Ms. Voltair threatened to hit Resident C with a spatula by raising the spatula above her head and facing Resident C. Resident C reported that on another occasion, Ms. Voltair told her, "If you ever pick up my cigarettes again, I will choke you." Resident C reported that two weeks ago, while she was counting numbers, which an exercise that she sometimes does with Ms. Voltair, Ms. Voltair balled up her fist and looked like she was going to hit Resident C for doing the counting exercise incorrectly. Resident C denied having any concerns for any other staff in the facility and reported that staff treat her well. Resident C reported being afraid of Ms. Voltair due to Ms. Voltair's threatening behavior and yelling.

On 10/07/2022, I interviewed direct care staff Helen Voltair regarding the allegations. Ms. Voltair began the interview by stating that she was just interviewed by the office of recipient rights and felt like Resident A had been coached to say the things he said. Ms. Voltaire denied ever calling Resident A a "thief' and stated that when she went outside to smoke, she observed that she was missing a pack of cigarettes. Ms. Voltaire reported that she simply asked Resident A if he had picked up her cigarettes by mistake and Resident A had taken out two packs and stated, "oh I must have done it by mistake." Ms. Voltaire denied ever yelling at Resident A.

Ms. Voltair denied ever yelling or being threatening or abusing Residents in any way. Ms. Voltaire acknowledged on one or more occasion forgetting Resident B's preferred pronouns or inadvertently referring to his adult undergarments as diapers and reported that she had apologized to Resident B for this. Ms. Voltaire explained that on one occasion she called Resident B by the name that was listed on Resident B's medication administration sheet and explained that she had not done this on purpose and had apologized to Resident B for this as well. Ms. Voltair expressed that she was not homophobic and would have no reason to intentionally degrade Resident B.

Ms. Voltair denied ever verbally or physically threatening Resident C and denied ever stating to Resident C that she would choke her. Ms. Voltair reported that she doesn't even cook any more and would have no reason to be holding a spatula. Ms. Voltair reported that someone must be "talking in her (Resident C's) ear."

Ms. Voltair acknowledged yelling and being verbally aggressive with direct care staff John Stokes and direct care staff Olivia Kessely but denied every being verbally aggressive with any resident. Ms. Voltair acknowledged Resident A would have been present when she yelled at Mr. John Stokes and confirmed that she said, “keep my motherfuckin’ name out of your mouth.”

Ms. Voltair denied ever using degrading language but acknowledged referring to one resident in this facility as a “DT.” When asked to explain what a “DT” meant, Ms. Voltaire reported that “DT” stood for “Dick-tease” and explained that this resident acted out very sexually and made allegations against other residents, which resulted in this “nickname.” Miss Voltaire denied ever referring to this resident directly as “DT” or “Dick-tease” but explained that this resident was often referred to by her and other direct care staff as “DT” instead of “Dick-tease.” Ms. Voltaire explained this resident no longer lived at this facility. Ms. Voltair explained that she was currently suspended from working at this facility for arguing with other staff.

On 10/10/2022, I reviewed the allegations with Michigan Department of Health and Human Services recipient rights officer Karen Currington. Ms. Currington reported she interviewed two residents at this facility who confirmed staff member Helen Voltair was disrespectful and has yelled or threatened residents. Ms. Currington reported that during an interview, Ms. Voltair confirmed swearing at a resident. Ms. Currington confirmed that she would be substantiating allegations of abuse and neglect for Ms. Voltair’s yelling and disrespectful and degrading language.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means
ANALYSIS:	During this investigation, I reviewed two *AFC Licensing Division Incident / Accident Reports* where staff member Amanda Morin documented staff member Helen Voltair yelling or using vulgar or degrading language with Resident A and Resident B. In an interview, Resident B confirmed the allegations and added that Ms. Voltair had threatened him with consequences but did not explain what those consequences would be, while also not respecting Resident B’s preference in gender pronouns and suggesting that Resident B did not need to be called by his preferred name. In an interview, Resident C disclosed that Ms. Voltair has yelled and threatened to choke Resident C and has

	raised her hand or fist in a threatening manner towards Resident C on more than one occasion. Resident B and Resident C expressed being afraid of Ms. Voltair. During an interview, staff member John Stokes reported that Ms. Voltair used vulgar language and was yelling at him in front of Resident A. In an interview, direct care staff Helen Voltair denied ever making verbal threats or raising her hand in a threatening manner but did acknowledge using profane language in front of residents and using a derogatory moniker to identify a previous resident. As such, there is enough evidence that Ms. Helen Voltair has exposed residents to a serious risk of physical or emotional harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Ms. Voltair restricted Resident A's movement by not allowing him to enter the main floor of the facility before 7AM.

INVESTIGATION:

On 09/27/2022, I completed an unannounced investigation onsite at this facility and interviewed Resident A regarding the allegations. Resident A reported living at this facility for over a year. Resident A denied being aware of any house rule or restriction that would restrict him from entering the main floor of the facility by stairs from his bedroom on the basement level. Resident A denied being restricted or prevented from entering this main floor by Ms. Helen Voltair or any other staff. Resident A reported that if staff were to tell him something to this effect, he would just ignore them. Resident A clarified that a secondary egress was located adjacent to his bedroom leading to the outdoors if he could not use these stairs for any reason.

On 09/29/2022, I interviewed staff member Heather Marchi regarding the allegations. Ms. Marchi denied this facility had any restrictions in place or house rules that would prevent Resident A from entering the main floor of this facility from his bedroom located in the basement of the facility. Ms. Marchi reported Resident A did not have any type of plan that restricted his freedom of movement.

On 10/07/2022, I interviewed staff member Helen Voltair regarding the allegations. Ms. Voltaire denied ever restricting or limiting Resident A from entering the main floor of this facility. Ms. Voltaire explained that at one time they had a resident that would frequently get naked and walk around the facility and splash people with water early in the morning. Ms. Voltaire reported that she had asked Resident A not to come up before 6:30 AM as she did not want Resident A to be splashed with water or to see this other resident naked. Ms. Voltaire reported that when Resident A

attempted to enter the main floor before 6:30AM she only replied with “You are up kind of early” to which Resident A replied that he was going outside to smoke. Ms. Voltair acknowledged the resident who walked around naked and splashed others with water no longer resided at this facility. Ms. Voltaire reported Resident A was not prevented from entering the main floor and went outside to smoke.

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: **(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	During an unannounced investigation on-site, Resident A denied ever being restricted from entering the main floor of the facility for any reason. During an interview, staff member Heather Marchi denied that Resident A had any type of behavior plan that restricted his freedom of movement. In an interview, staff member Helen Voltair denied ever restricting Resident A’s movement in any way or restricting Resident A’s ability to enter the main floor of the facility before 7AM. As such, there is not enough evidence that Resident A’s right to freedom of movement was restricted in any way.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

11/15/2022

Eli DeLeon Date
Licensing Consultant

Approved By:

11/18/2022

Dawn N. Timm Date
Area Manager