GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 31, 2023

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

RE: License #: AS810393269
Investigation #: 2023A0122035
Beacon Home At Ypsilanti

Dear Kim 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 (517) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810393269
Investigation #:	2023A0122035
Complaint Receipt Date:	07/03/2023
Investigation Initiation Date:	07/03/2023
Report Due Date:	09/01/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kim Rawlings
Licensee Designee:	Kim Rawlings
Name of Facility:	Beacon Home At Ypsilanti
Facility Address:	7862 Tuttle Hill Road Ypsilanti, MI 48197
Facility Telephone #:	(734) 221-5424
Original Issuance Date:	05/24/2018
License Status:	REGULAR
Effective Date:	11/24/2022
Expiration Date:	11/23/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 07/01/2023, staff member, Moriah Harris, stayed in her vehicle all day. She also had her kids and boyfriend inside the facility.	Yes

III. METHODOLOGY

07/03/2023	Special Investigation Intake 2023A0122035 APS Referral Recipient Rights Referral
07/03/2023	Special Investigation Initiated - Telephone Completed interview with Complainant 1.
07/05/2023	On-site Inspection Completed Completed interview with Resident A.
07/05/2023	Contact – Telephone call made. Recipient Rights referral made.
07/12/2023	Contact – Telephone call received. Completed interview with Resident B.
07/14/2023	Contact – Documents received. Requested resident documents.
07/17/2023	Contact – telephone call made. Completed interview with Moriah Harris, staff member. Left voice message for Devontia Massey, staff member.
07/24/2023	Contact – telephone call made. Completed interview with Devontia Massey, staff member.
07/27/2023	Exit Conference Discussed findings with Kim Rawlings, Licensee Designee.

ALLEGATION: On 07/01/2023, staff member, Moriah Harris, stayed in her vehicle all day. She also had her kids and boyfriend inside the facility.

INVESTIGATION: On 07/03/2023, Complainant 1 received the report that on 07/01/2023, staff member Moriah Harris stayed in her vehicle all day instead of providing care to the residents within the facility. The report also stated that Moriah Harris had her kids and boyfriend inside of the facility along with the residents. Complainant 1 completed an Adult Protective Services referral on 07/03/2023.

On 07/06/2023, I completed an onsite inspection. I observed three residents in the facility. Resident A and Resident B were sitting in the living room. Resident C was pacing throughout the facility speaking quietly to himself. Resident D and E were being transported to community appointments. Resident D agreed to participate in an interview at a later time and gave his personal cell phone number as contact information.

On 07/06/2023, I completed an interview with Resident A. He confirmed that he was in the facility on 07/01/2023 and observed staff member, Moriah Harris, periodically go to her personal vehicle throughout her shift. Stating she would come into the facility, stay in the facility for an hour, and then return to her car. Resident A observed Ms. Harris repeat the cycle throughout her shift on 07/01/203. Resident A also reported that on 07/01/2023 and 07/04/2023, he observed a male friend of Ms. Harris and her child inside the facility and on outside the facility property.

On 07/12/2023, I completed an interview with Resident D. Resident D confirmed that on 07/01/2023 staff member, Moriah Harris, was sitting in the car with her boyfriend during most of her shift. Resident D stated that Ms. Harris kept going in and out of the facility, when she was out of the facility she was sitting in the car. Resident D also confirmed that Ms. Harris' boyfriend came into the facility once and her child came into the facility multiple times.

Resident D stated he felt like Ms. Harris' behavior was inappropriate as he felt that she should have stayed in the facility. Resident D further stated that he was concerned of Ms. Harris' behavior, he felt that there should have been two staff members in the facility in case there was a fight or something, "it's better to have two people step in."

Residents B, C, E, and F were unable to be interviewed due to limited understanding of questions during the interview process.

On 07/13/2023, I reviewed Resident A and Resident C's information. Per Resident A's Client Information Sheet, he is 5'8" and 200 pounds. He is diagnosed with Schizoaffective Disorder and Bipolar. His Assessment Plan dated 01/21/2023 he does not have a behavior plan, however, his Person-Centered Plan dated 06/15/2022 documents that he has periods when he is agitated. His goals address/suggest he uses music and journaling as coping skills to deal with periods

of agitation. Resident A also has a goal of interacting respectfully with residents and staff in the facility.

Resident C's Client Information Sheet documents that he is 5'11" and 230 pounds. Resident C is diagnosed with Schizoaffective Disorder and Bipolar. His Assessment Plan dated 11/11/2022 documents that he can become aggressive and sexually inappropriate. His Individual Plan of Service dated 07/19/2022 documents that he doesn't like to be told what to and can become aggressive. The plan also documents that "police have been to the home multiple times as he has locked himself in the bathroom, eloped and exhibited physically and verbally aggressive behaviors in the home."

On 07/14/2023, I reviewed Resident B's information. Resident B's Client Information Sheet documents that that he is diagnosed with Unspecified Disruptive, Impulsive Control Conduct Disorder, Attention Deficient/Hyperactivity Disorder, Neuromuscular Dysfunction of bladder, Schizoaffective Disorder and Bipolar Type. The document also states that "when wound up or angry 1:1 is necessary."

Resident B has a Behavior Plan which documents that he can be verbally aggressive and has a history of self-injurious behavior. His Person-Centered Plan dated 10/10/2022 states that Resident B "thinks of himself as someone who is kind, smart, and outgoing but can be at times someone that can threating while engaging in violent acts and on occasion act on threats causing property destruction."

On 07/11/2023, I reviewed Resident D's Person-Centered Plan dated 07/07/2022 and Behavior Plan dated 04/22/2022. His Person-Centered Plan documented that Resident D "requires a specialized residential placement that provides personal and community living support in face-to-face format 24 hours a day for 365 days in order to maintain health and safety. Staff will monitor for health and safety in the home and in the community." The Plan also documents that Resident D has a history of aggressive behaviors with targets being female partners.

Resident D's Behavior Plan documents that he is diagnosed with autism spectrum disorder and bipolar. It states that he has a history of domestic violence and physical aggression. The following information was presented in the plan: Resident D has engaged in one incident of physical aggression toward female staff, verbal aggression, and threats. The Plan addresses the following behaviors for Resident D, verbal and physical aggression, inappropriate touching and joking around, and elopement.

On 07/14/2023, I reviewed Resident E's information. Resident E's Client Information Sheet documents that he is 6'1". Resident E is diagnosed with Schizoaffective Disorder and Bipolar type. Resident E's Client Information Sheet was the only information received.

On 07/14/2023, I reviewed Resident F's information. Resident F's Client Information Sheet documents that he is diagnosed with unspecified schizophrenia spectrum, other psychotic disorder, and alcohol use disorder. His Assessment plan dated 10/13/2022 and Person-Centered Plan dated 02/07/2022 documents that he is need of adult foster care which means "the provision of supervision, personal care, and protection…for 24 hours a day, 5 or more days a week, and for 2 or more consecutive weeks for compensation."

On 07/17/2023, I completed an interview with Moriah Harris, staff member. Ms. Harris confirmed that she worked as a staff member on 07/01/2023 at Beacon Home at Ypsilanti. Ms. Harris denied staying in her vehicle during her shift on 07/01/2023. Ms. Harris denied that her male friend went inside the facility on 07/01/2023 but did state he was on the property as he dropped off antibiotic medication that she needed to take. Ms. Harris confirmed that her son went inside the facility to use the bathroom on 07/01/2023.

On 07/17/2023, I completed an interview with Katherine Lajiness, staff member. Ms. Lajiness denied working with Moriah Harris on 07/01/2023. Ms. Lajiness stated on 07/03/20223 she received reports from residents stating that Moriah Harris allowed a male and child to enter the facility. Ms. Lajiness stated residents reported that Ms. Harris stayed in her car during her shift on 07/01/2023.

On 07/24/2023, I completed an interview with staff member, Devontia Massey. Ms. Massey confirmed that she worked with Moriah Harris on 07/01/2023. Ms. Massey stated when she arrived to work on 07/01/2023, she observed a "male and baby in Ms. Harris' car." Ms. Massey stated both she and Ms. Harris were assigned to work an 8-hour shift however, Ms. Harris "stayed in her car the majority of the time" on 07/01/2023.

Ms. Massey stated she did not observe either the male or baby enter the facility but received reports from some of the residents that the male and the baby entered the property.

On 07/27/2023, I completed an exit conference with Kim Rawlings, Licensee Designee. Ms. Rawlings agreed with my findings and stated she would submit a corrective action plan to address rule violations.

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:	On 07/06/2023 and 07/12/2023, Residents A and D reported that staff member, Moriah Harris stayed in the car for most of her shift on 07/01/2023. On 07/17/2023, staff member Moriah Harris denied staying her car for her shift on 07/01/2023. On 07/24/2023, staff member Devonita Massey confirmed that staff member Moriah Harris "stayed in her car the majority of the time" during her shift on 07/01/2023. My resident file reviews disclosed: 5 residents (Residents A, B, C, E, and F) have mental health issues. 3 residents (Residents A, C, and D) have behavior issues including agitation, sexually inappropriateness, aggression, and elopement. Resident D has a behavior plan that address aggressive behavior. Resident B's Client Information Sheet states that "when wound up or angry 1:1 is necessary." Based upon my investigation I find there was insufficient direct care staff on duty on 07/01/2023 to provide supervision, personal care, and protection of the residents due to staff member, Moriah Harris, staying in the car for most of her shift.
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 07/06/2023 and 07/12/2023, Residents A and D reported that staff member, Moriah Harris stayed in the car for most of her shift on 07/01/2023. They also reported that she had a male friend and child come into the facility. On 07/17/2023, Moriah Harris confirmed that her son went into the facility on 07/01/2023. On 07/17/2023 and 07/24/2023, staff members Katherine Lajiness and Devontia Massey confirmed they had received reports from residents stating that Moriah Harris had a male friend and child enter the facility. Based upon my investigation I find that the residents were not treated with dignity nor were their protection and safety attended to on 07/01/2023 as staff member Moriah Harris had an unapproved male and child enter the property thereby placing the residents at risk physically as neither the male nor child has received a physical documenting physical fitness. The male did not complete a good moral character check to allow access to the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change in the status of the licensing.

Vanita Bouldin

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Vanita C. Bouldin Date: 07/27/2023
Licensing Consultant

Approved By:

A. Hunter

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Ardra Hunter Date: 07/31/2023
Area Manager