GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 24, 2023

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

RE: License #: AM800267887
Investigation #: 2023A1032011
Beacon Home At Breakwater East

Dear Ms. Howard:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616)-240-3850

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM800267887
Investigation #:	2023A1032011
Complaint Receipt Date:	11/10/2022
Investigation Initiation Date:	11/15/2022
Report Due Date:	01/09/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110,890 N. 10th St., Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Howard
Licensee Designee:	Kimberly Howard
Name of Facility:	Beacon Home At Breakwater East
Facility Address:	28730 63rd Street, Bangor, MI 49013
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/03/2005
License Status:	REGULAR
Effective Date:	05/13/2022
Expiration Date:	05/12/2024
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
An employee transmitted photos and videos of a deceased Resident A.	No
Additional Findings	No

III. METHODOLOGY

11/10/2022	Special Investigation Intake 2023A1032011
11/15/2022	Special Investigation Initiated - Telephone
11/17/2022	Contact - Telephone call made
11/17/2022	Contact - Telephone call made Interview with Home Manager #1 and Employee #1
01/16/2023	Exit Conference- With licensee Israel Baker

ALLEGATION:

An employee transmitted photos and videos of a deceased Resident A.

INVESTIGATION:

On 11/15/22, I confirmed the accuracy of the allegations with the complainant.

On 11/17/22, I interviewed direct care worker (DCW) Ashley Bowman, via telephone. Ms. Bowman stated that on the day in question, around 5:15 pm, Resident A was observed unresponsive, laying on the floor in the bathroom. She reported that DCW Tina Williams discovered Resident A on the bathroom floor, unresponsive. Ms. Bowman stated that employee Jason Marr started CPR while she called 911. Ms. Bowman stated that she secured the keys to the van and the home's PEX card. Ms. Bowman denied taking any photographs of Resident A, while the resident lay unresponsive on the bathroom floor, or after it was determined that Resident A had passed away.

I interviewed home manager Roberta Clemons via telephone. Ms. Clemons stated that at no time did she observe any of the home's employees take photographs of Resident A. Ms. Clemons reported that the residents were cleared out of the home. Ms. Clemons stated further that the employees stayed in the office once the ambulance and police arrived.

On 11/29/22, I interviewed Witness 1 via telephone. Witness 1 denied receiving any pictures of the deceased Resident A in the bathroom. Witness 1 denied transmitting any photographs of the decedent. Witness 1 explained that he does not communicate regularly with employees at the home.

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:	Ms. Bowman and Ms. Clemons both denied taking pictures of the deceased Resident A. Witness 1 denied receiving any pictures or videos from staff. To date, no one has produced a picture or video of the deceased resident. There is insufficient evidence to substantiate an administrative rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 1/16/23, I conducted an exit conference with licensee, Israel Baker. I shared the conclusions reached and Mr. Baker agreed with my findings.

IV. RECOMMENDATION

I recommend no change to the status of this license.

1/24/23

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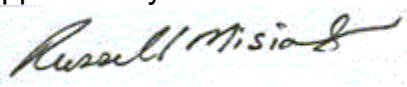
Dwight Forde — Date
Licensing Consultant

Approved By:



1/26/23

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Russell B. Misiak — Date
Area Manager