GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 31, 2025

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

RE: License #: AS330411152
Investigation #: 2025A0007014
Beacon Home At Cogswell

Dear Shelly Keinath:

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) 284-9730.

Sincerely,

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

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 #:	AS330411152
Investigation #:	2025A0007014
Complaint Receipt Date:	02/06/2025
Investigation Initiation Date:	02/07/2025
Report Due Date:	04/07/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Shelly Keinath
Licensee Designee:	Shelly Keinath
Name of Facility:	Beacon Home At Cogswell
Facility Address:	2117 Cogswell Drive Lansing, MI 48906
Facility Telephone #:	(517) 220-2157
Original Issuance Date:	03/28/2022
License Status:	REGULAR
Effective Date:	09/27/2024
Expiration Date:	09/26/2026
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff repeatedly saying curse words in front of residents.	Yes

III. METHODOLOGY

02/06/2025	Special Investigation Intake - 2025A0007014
02/07/2025	Special Investigation Initiated – Letter APS Referral
02/07/2025	APS Referral Made.
02/07/2025	Contact - Document Received APS Referral Denied.
02/10/2025	Inspection Completed On-site - Unannounced - Face to face contact with Shelly Keinath, Licensee Designee, Employee #1, Resident A, Resident B, Resident C, and Michele Hitsman, DCW.
03/28/2025	Contact - Document Sent - Email to Sarah Watson, ORR. Status update requested.
03/28/2025	Contact - Document Received - Email from Sarah Watson, ORR. Status update provided.
03/28/2025	Contact - Telephone call made - Interview with Guardian D1.
03/28/2025	Contact - Telephone call made to Alleigh Longstreet, for an interview. Phone subscriber was not in service.
03/28/2025	Contact - Document Sent - Email to Shelly Keinath, Licensee Designee. I requested that she give me a call when she returned to the office, to conduct the exit conference.
03/31/2025	Exit Conference conducted with Shelly Keinath, Licensee Designee.

ALLEGATION: Staff repeatedly saying curse words in front of residents.

INVESTIGATION:
As a part of this investigation, I reviewed the written complaint and the following additional information was noted: Alleigh Longstreet, Direct Support Professional (DSP) was repeatedly dropping the "F" bomb in front of Resident A and Resident B.

On February 10, 2025, I conducted an unannounced on-site investigation and made face to face contact with Shelly Keinath, Licensee Designee, Employee #1, Resident A, Resident B, and Resident C and Michele Hitsman, DCW.

I interviewed Resident A, who repeated what I asked back to me, and talked about the electronic devices that she wanted for her birthday. Resident A did not provide any information to confirm or refute the allegations.

During my interview with Resident B, she confirmed that she knew what curse words were. Resident B did not confirm that staff were cursing.

I spoke with Shelly Keinath, who informed me that due to other reasons, Kristin Starks, who had the role of home manager, Tanika Turner, DCW, and Jasmine Whitehead, DCW, would no longer be working for Beacon. In addition, that Alleigh Longstreet, DCW was transferred from another home, and she was currently suspended because of the allegations. Shelly Keinath informed me that it was reported that Alleigh Longstreet was the staff member who was cursing in front of Resident D's guardian, Guardian D. The other staff on duty were Employee #1 and Tanika Turner.

I interviewed Employee #1, who reported that Alleigh Longstreet was on the phone for about 45-minutes and during that conversation, she was cursing, using the "F-word," and talking about going out drinking. Tanika Turner told her twice that staff did not talk like that in the home and asked Alleigh Longstreet to get off the phone. Resident A, Resident B, and Resident C were in the living room and Resident D was in her bedroom. Employee #1 stated that Resident D's guardian, Guardian D1, was there and didn't say anything but just looked at the staff. Employee #1 stated "I couldn't believe she was talking like that because they repeat everything we say." Employee #1 stated that it was concerning for the residents to hear that information.

I interviewed Resident C. Resident C informed me that "snow" was a curse word. She did not provide any information to confirm or refute the allegations.

On March 28, 2025, Sarah Watson, Office of Recipient Rights, informed me that the allegations in her investigation were substantiated.

On March 28, 2025, I interviewed Guardian D1. She informed me that she was at the home for a visit and was sitting in the living room. There were three staff on duty, two experienced direct care staff that she was familiar with, and a new worker or a worker in training (Alleigh Longstreet). The newer worker was on her phone for quite a while and she spoke about a lot of things including partying, drinking, her finances, and she was swearing. Guardian D1 stated that one of the staff, who she confirmed was Tanika Turner, spoke up and said that was not appropriate. The new staff stopped talking in that manner and put her phone down. Guardian D1 informed that she didn't think the residents were in the living room, but some were in the hallway. She concurred that the hallway was in close proximity to the living room.

On March 28, 2025, I interviewed Tanika Turner who informed that she was in the living room, sitting on the couch, talking to Guardian D and the newer worker (Alleigh Longstreet) was sitting across from them on the phone. Tanika Turner could not recall everything she was saying but confirmed that she was swearing and saying the “F-Word.” Tanika Turner stated that she stopped her conversation with Guardian D1 and told Alleigh Longstreet not to talk like that, but she kept talking and swearing. Tanika Turner told Alleigh Longstreet that she was not supposed to be on her phone. Guardian D then got up and went into Resident D’s room, who was in the room with her bedroom door closed. Tanika Turner then told Alleigh Longstreet again that she was not supposed to be talking like that, and she was cursing in front of Resident D’s guardian. That is when she got off the phone. Tanika Turner stated that the residents were in their rooms with the doors open (except for Resident D), and Alleigh Longstreet was talking loud enough where she could be heard. Tanika Turner stated that she spoke with Kristen Starks, home manager about the incident.

On March 31, 2025, I conducted the exit conference with Shelly Keinath, Licensee Designee. We discussed the investigation and my recommendations. She stated that Alleigh Longstreet was on suspension pending the investigation and she would not be returning. Shelly Keinath agreed to submit a written corrective action plan to address the established violation.

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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	Based upon my investigation which consisted of an onsite investigation, interviews with facility staff members, and Guardian D1, it’s concluded that there is a preponderance of the evidence to support the allegations that Alleigh Longstreet was observed swearing and talking about personal matters that were within earshot of the residents; thus, she did not treat Resident A, Resident B, and Resident C with dignity and respect, in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.

03/28/2025

Mahtina Rubritius Date
Licensing Consultant

Approved By:

03/31/2025

Dawn N. Timm Date
Area Manager