GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 26, 2021

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

RE: License #:	AS410397920
Investigation #:	2021A0356032
	Beacon Home At Walker

Dear Mr. Kalinowski:

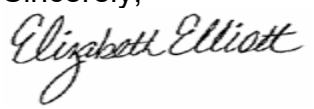
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410397920
Investigation #:	2021A0356032
Complaint Receipt Date:	06/21/2021
Investigation Initiation Date:	06/21/2021
Report Due Date:	08/20/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kevin Kalinowski
Licensee Designee:	Kevin Kalinowski
Name of Facility:	Beacon Home At Walker
Facility Address:	1706 Wilson Ave. Walker, MI 49534
Facility Telephone #:	(616) 591-3834
Original Issuance Date:	04/04/2019
License Status:	REGULAR
Effective Date:	10/04/2019
Expiration Date:	10/03/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A walked away from the facility without staff supervision.	Yes
Resident A reported that staff at the facility treat him poorly.	No

III. METHODOLOGY

06/21/2021	Special Investigation Intake 2021A0356032
06/21/2021	Special Investigation Initiated - Telephone Felisha Battice, home manager.
06/21/2021	APS Referral Denied.
06/29/2021	Contact - Face to Face Staff, Nakoia Ward, Felisha Battice, Mandy Bettencourt.
06/29/2021	Contact - Face to Face Resident A, DCW Keisha Coates.
06/29/2021	Contact - Face to Face Interviews conducted with Licensing Consultant, Anthony Mullins. Walker PD picked up (2) Police Reports.
06/29/2021	Contact - Document Received Pulled IR's for 06/06/2021 and 06/18/2021 for review.
07/13/2021	Contact - Telephone call made Former DCW Dina Wagner.
07/13/2021	Contact - Document Sent Facility documents requested.
07/19/2021	Contact-Document Received Facility documents.
07/19/2021	Contact - Telephone call made ARC of Midland, Cassidy Zucker.
07/26/2021	Exit Conference-Licensee Designee, Kevin Kalinowski.

ALLEGATION: Resident A walked away from the facility without staff supervision.

INVESTIGATION: On 06/21/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint forwarded to LARA (Licensing and Regulatory Affairs) from CI (Centralized Intake). The complainant reported on 06/18/2021, Resident A wandered away from the facility through the woods and ended up a couple of houses down from the facility, stated he was lost and did not know where he was or how to get back. The complainant reported the police were called, they picked Resident A up and were able to locate the facility. Kent County Department of Health and Human Services (DHHS) Adult Protective Services (APS) denied this complaint for investigation.

On 06/21/2021, I interviewed Home Manager, Felisha Battice via telephone. Ms. Battice stated Resident A walked away from the facility and was in the woods behind the houses, the neighbors were afraid and called the police. Ms. Battice stated the police brought Resident A back to the facility.

On 06/29/2021, Licensing Consultant, Anthony Mullins and I conducted an unannounced inspection at the facility. Ms. Mullins and I interviewed DCW (direct care worker) Nakoia Ward, Ms. Battice and another Home Manager, Mandy Bettencourt. Ms. Battice, Ms. Ward and Ms. Bettencourt stated that Resident A is able to be independent in the community during the daytime. Ms. Battice stated Resident A displays a lot of “attention seeking behaviors” and many of the behaviors have to do with cigarettes. Ms. Ward, Ms. Battice and Ms. Bettencourt stated Resident A has called the police in the past due to not having any cigarettes or nicotine. Ms. Battice, Ms. Ward and Ms. Bettencourt stated on 06/18/2021, Resident A became upset when another resident would not give him a cigarette, he punched the wall and left the facility on foot. Ms. Battice stated the neighbors saw Resident A behind their house in the woods and called the police. Resident A was picked up and the police noticed scratches on Resident A’s wrist and took him to the hospital for evaluation and treatment.

On 06/29/2021, Mr. Mullins and I interviewed Resident A at the facility. Resident A stated that he can go out and walk around without staff supervision and on 06/18/2021, he ended up in the woods and “a lady called the cops.” That is the extent of the information we were able to get from Resident A.

On 06/29/2021, Mr. Mullins and I interviewed DCW Markeisha Coates at the facility. Ms. Coates stated she was working on 06/18/2021and told Resident A that he would have to wait for a cigarette because he did not have any, so he went to another resident and attempted to get a cigarette from him. Ms. Coates stated she explained to Resident A that borrowing from each other is not allowed and that is what started all of Resident A’s behaviors. Ms. Coates stated Resident A became upset and punched a wall in the facility, ripped the phone off the wall and his “behaviors went on all day.” Ms. Coates stated Resident A has “community access” so he left the

facility and went to the neighbor's yard. Ms. Coates stated she had left the facility with some of the residents and went to the store. Staff at the facility called her (Ms. Coates) and told her the police were at the facility and because Resident A was in the woods and was attempting to harm himself, he was taken by the police to the hospital.

On 06/29/2021, Mr. Mullins and I received and reviewed the Walker Police Department report dated 06/18/2021 written by Officers Andrew Ringling and Tyler Kuipers. The report documents the following information, '*I was dispatched to the above location on a report of a male subject lost in the woods saying he lived at an AFC home, but didn't know which one. I made contact with the caller, Holly Davis. Holly said she was house watching her parents home while they were out of town. Holly said she looked outside and saw a subject standing in the woods looking lost. She spoke with him and he told her his name was* (Resident A). (Resident A) *said he lived at the AFC home, but didn't know which one. I spoke with* (Resident A) *who advised he lived at the AFC home at 1706 Wilson Ave. NW. I brought* (Resident A) *back and the employees advised that* (Resident A) *got upset at another resident and just left. While speaking with* (Resident A), *I could see a cut around the top and bottom of his left wrist as well as marks on the knuckles of his right hand. (Resident A) said he purposely hurt himself and cut his left wrist with broken glass he found in the woods.* (Resident A) *said he was mad at another resident for snitching on him for stealing someone's cigarettes. Because* (Resident A) *intentionally hurt himself, we requested LIFE EMS respond. LIFE responded and advised they would transport* (Resident A) *to Spectrum Butterworth Hospital. LIFE medics spoke with AFC home staff about notifying* (Resident A's) *guardian. I then cleared*.'

On 06/29/2021, while Mr. Mullins and I were at the Walker Police Department, we obtained another police report dated 06/06/2021 of a similar nature regarding Resident A. Officers Matt Welch and Chris Wietfeldt documented the following information, '*I was dispatched to the above location on a possible suicidal make that had left the AFC home with a shovel. I arrived and made contact with Beacon Specialized Living staff member Nickoia Ward. Ward advised that one of the AFC residents,* (Resident A), *had attempted to stab himself with a fork and then left the home. Ward said that* (Resident A) *was helping bring in groceries whe another resident started making fun of him.* (Resident A) *then grabbed a fork and went into his room and tried to stab his abdomen multiple times with the fork. Ward stated that (Resident A) was not able to harm himself at al with the fork and that she was able to take it away from him.* (Resident A) *then left the home through the garage, picked up a shovel in the neighbor's yard and walked south on Wilson Ave. NW. Ward then advised that she called police. Ofc. Glass and Cpl Wietfeldt checked the area for* (Resident A). *Dispatch then advised that a neighbor had called and stated that* (Resident A) *was in the woods just east of their address. Cpl Wietfeldt then went to the location and located* (Resident A). *he then brought him back to the AFC home. Cpl Wietfeldt asked* (Resident A) *if he wanted to hurt himself and (Resident A) advised that he did. Dispatch was advised to send LIFE EMS to our location for a*

mental health evaluation. LIFE EMS arrived and transported (Resident A) *to St. Mary's Hospital for a mental health evaluation. No further police action was needed.'*

On 06/29/2021, I pulled an Incident Report (IRs) dated 06/06/2021 for review. The IR was written by DCW Staci Tice and documented the following information, *'*(Resident A) *had suicidal ideation, the Police were called due to him eloping into the woods. He was transported to Saint Mary's Hospital. Clinical, medical, on call management and Police were contacted. Staff tried to deescalate the situation by talking with* (Resident A) *but he refused to be redirected. Staff will continue to work with* (Resident A) *on using his coping skills when he is feeling upset. Staff will reach out to clinical when needed also.'*

On 06/29/2021, I pulled and reviewed the 06/18/2021 IR which documented the following information written by Markeisha Coates, *'(Resident A) started having a behavior around 12p.m. however (Resident A) needed cigarettes and didn't have anything to smoke so he began yelling and say how everyone doesn't like him and he wanted to kill his self and began punching the walls and threw a dresser and broke the pay phone. The neighbors saw him and had a concern so they called 911. The police arrived and spoke to (Resident A) and you could visually see cuts and a bruise on him. The police called for an ambulance to come so they transport him to the hospital. (Resident A) went to the hospital and was evaluated and returned back to the home. Staff attempted to verbally redirect (Resident A) and speak with him about the situation. Staff called on call management and medical. Staff went to the hospital and remained with him until he returned back to the home. Home manager notified all appropriate parties along with following protocol and procedure. Staff will continue to work with (Resident A) on using his coping skills. Staff will reach out to clinical when needed.'*

On 07/13/2021, I interviewed (former) DCW Dina Wagner via telephone. Ms. Wagner stated there have been numerous times over the past year that Resident A has left the facility "out of the blue" and wandered away. Ms. Wagner stated Resident A has "access to the community" and after an hour, if staff do not hear from him, they call the police.

On 07/19/2021, I received and reviewed Resident A's Assessment Plan for AFC Residents dated 03/24/2021 and signed by Cassidy Zucker, The ARC Midland, legal guardian, Josh Willey, case manager, CMH (Community Mental Health) for Central Michigan and Licensee Designee, Kevin Kalinowski. The assessment plan documents that Resident A is capable of moving independently in the community with no indication that he requires any level of supervision while in the community.

On 07/19/2021, I received and reviewed Resident A's PCP (person centered plan) dated 03/03/2021 by Community Mental Health for Central Michigan supports coordination. In attendance at the PCP meeting were Lexi Traver, guardian representative from the ARC, Crystal Rose, assistant AFC home manager (previous AFC placement), Josh Willey and Resident A. On page 6 of the 14-page document it

states '**_All individuals in (_Resident A's_) life will read Health and Safety section of PCP. ****When_ (Resident A) _is upset he may make the choice to walk. STAFF should not become concerned but follow him at a distance. They SHOULD NOT get in their cars to follow. That is more upsetting to him when followed by car. They should follow him by foot._ (Resident A) _will often walk his frustrations out and then be ready to return home. (_Resident A_) has a history of self-harm, elopement and property destruction.'_

On 07/19/2021, I interviewed Cassidy Zucker, The ARC guardianship services via telephone. Ms. Zucker stated she is part of a legal guardian team for Resident A. Ms. Zucker stated the PCP reviewed was initiated while Resident A resided in a different AFC facility. Ms. Zucker stated the purpose of the information in the PCP is to provide some supervision to Resident A when he walks away from the facility. Ms. Zucker stated the events on 06/06/2021 and 06/18/2021 will be reviewed and an update to the assessment plan and PCP will be pursued so the two documents coincide with the goals set for Resident A.

On 07/26/2021, I conducted an Exit Conference with Licensee Designee, Kevin Kalinowski. Mr. Kalinowski and I discussed the need for all resident assessment plans to correspond with resident PCP's and that staff are properly trained and competent to provide the level of supervision each resident requires. Mr. Kalinowski stated an acceptable corrective action plan will be submitted.

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:	Ms. Wagner reported Resident A walks away from the facility often and if he does not return after an hour, the police are called. Walker Police Department reports dated 06/06/2021 and 06/18/2021 documented similar incidents of Resident A walking away from the facility unsupervised and engaging in self-harm. IR's dated 06/06/2021 and 06/18/2021 document police involvement and hospitalization due to Resident A walking away from the facility and engaging in self-harm. Resident A's assessment plan documents that Resident A is capable of moving independently in the community with no indication that he requires any level of supervision.

	Resident A's PCP plan documents that Resident A should be followed by staff on foot as a form of supervision when he walks away from the facility. Ms. Zucker stated the purpose of the information in the PCP is to provide some supervision to Resident A when he walks away from the facility. Based on investigative findings, there is a preponderance of evidence to show that Resident A requires some supervision when he walks away from the facility as documented in his PCP plan. Resident A's assessment plan does not indicate that he requires supervision when he walks away from the facility. Staff are not following Resident A or supervising him in any way when he walks away from the facility and therefore, a violation of this applicable rule is established. **Repeat Violation:** SI 2021A0356025 dated 04/05/2021 cited a violation of Rule R 400.14303(2) when Resident B's assessment plan and PCP plan documented that Resident B required staff supervision while out in the community yet Resident B was often independent in the community without staff supervision. A Corrective Action Plan for SI 2021A0356025 was submitted on 05/26/2021 by Licensee Designee, Kevin Kalinowski. The CAP documented Resident B's guardian and case manager would be contacted to obtain common knowledge regarding the new PCP plan no later than 06/16/2021, staff will be trained on Resident B's PCP plan no later than 06/16/2021 and District director, Emily Fairis will ensure the guardian and case manager are aware of the updates and all signatures are acquired when changes are made to Resident B's PCP plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A reported that staff at the facility treat him poorly.

INVESTIGATION: On 06/21/2021, I received a BCAL Online Complaint from CI. The complainant reported on 06/18/2021, Resident A reported Keisha is the day worker and Dina is the night worker, they treat him bad and treat him like a child. There were no further details. APS denied this complaint for investigation.

On 06/21/2021, I interviewed Home Manager, Felisha Battice via telephone. Ms. Battice stated she has never heard or seen any staff including Markeisha Coates or Dina Wagner being mean, treating Resident A poorly or like a child.

On 06/29/2021, Licensing Consultant, Anthony Mullins and I conducted an unannounced inspection at the facility. Ms. Mullins and I interviewed Ms. Ward, Ms. Battice and Ms. Bettencourt. Ms. Battice, Ms. Ward and Ms. Bettencourt stated they have never heard or seen staff including Ms. Coates or Ms. Wagner treat Resident A poorly or like a child. Ms. Ward stated when Resident A refuses to do things staff say “ok” and move on to the next thing and when Resident A wakes up in the night and wants breakfast, staff assure him breakfast will be made early in the morning and that he can have a snack. Ms. Ward stated she has never known staff to be harsh or negative to Resident A. Ms. Battice stated when Resident A speaks to certain family members, they reinforce negative behavior and tell Resident A that staff lie to him, and staff are stealing from him and possibly the reason for this complaint.

On 06/29/2021, Mr. Mullins and I interviewed Resident A at the facility. Resident A at first stated the Keisha that was mean to him was at the Stanton facility that he used to reside in. Resident A then stated that the Keisha at this facility says, “stop with that attitude” and Dina told him other residents in the facility tell her that he (Resident A) “claims” things. Resident A was not able to explain what was meant by “claims” things.

On 06/29/2021, Mr. Mullins and I interviewed Ms. Coates at the facility. Ms. Coates stated she has never told Resident A to “stop with that attitude.” Ms. Coates stated she follows the facility rules but is never mean to any of the residents including Resident A. Ms. Coates stated Resident A has a lot of behaviors they have to work through each day, but staff are not mean or derogatory towards Resident A. Ms. Coates stated DCW Dina Wagner is firm but nice to the residents including Resident A. Ms. Coates stated she knows Ms. Wagner gives the residents what they want and treats them well.

On 06/29/2021, Mr. Mullins and I received and reviewed the Walker Police Department report dated 06/18/2021 written by Officers Andrew Ringling and Tyler Kuipers. The report documents the caller, “*Holly said she was going to notify adult protective services because* (Resident A) *said the residents at the home were mean to him.”*

On 07/13/2021, I interviewed (former) DCW Dina Wagner via telephone. Ms. Wagner stated she had good communication with the residents in the facility and they were always “good for me.” Ms. Wagner stated Resident A is a smoker and if he spends all his money and does not have money to buy cigarettes, he has behaviors. Ms. Wagner stated throughout a day, Resident A will have several behaviors that staff have to deal with, but she is the night worker and would come on her shift and get Resident A to calm down. Ms. Wagner stated she was “lenient” with Resident A, gave him cigarettes and could always get him to “calm down with me.” Ms. Wagner stated Resident A would often think others were talking about him and talking mean about him, but Ms. Wagner stated she never saw or heard staff being mean to Resident A.

On 07/19/2021, I received and reviewed Resident A's PCP dated 03/03/2021 by Community Mental Health for Central Michigan supports coordination. The PCP documents that Resident A *'often thinks others are talking about him or looking at him. (Resident A) does not like a room to have more than a few people in it. He struggles with meeting new people and the thoughts that others will talk about him to that new person. (Resident A) needs to feel like he is on a team with his staff and that they are there to support him. In the past (Resident A) has felt as if staff felt they were better than him or more like a parent.'*

On 07/26/2021, I conducted an Exit Conference with Licensee Designee, Kevin Kalinowski. Mr. Kalinowski agreed with the information, analysis, and conclusion of this applicable rule.

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:	Based on investigative findings, there is not a preponderance of evidence to show that staff are treating Resident A poorly or speaking to him in a negative manner. A violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Elizabeth Elliott

07/26/2021

_____

Elizabeth Elliott, Licensing Consultant Date

Approved By:

Jerry Hendrick

07/26/2021

_____

Jerry Hendrick, Area Manager Date