GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 7, 2021

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

RE: License #:	AS730407067
Investigation #:	2021A0123042
	Beacon Home at Saginaw

Dear Ms. Kimberly 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (906) 226-4171.

Sincerely,

Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730407067
Investigation #:	2021A0123042
Complaint Receipt Date:	08/18/2021
Investigation Initiation Date:	08/19/2021
Report Due Date:	10/17/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Gerald Ross
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Saginaw
Facility Address:	7705 Dutch Rd Saginaw, MI 48609
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	04/09/2021
License Status:	TEMPORARY
Effective Date:	04/09/2021
Expiration Date:	10/08/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility is closing on 08/18/2021 due to recent behaviors Resident A has displayed. The facility will no longer have any staff, and placement needs to be found for Resident A, as soon as possible.	No
After being release from jail on 08/21/2021, Resident A returned back to the facility, and was left unsupervised for over one and a half hours.	No
Additional Findings	Yes

III. METHODOLOGY

08/18/2021	Special Investigation Intake 2021A0123042
08/19/2021	Special Investigation Initiated - On Site I conducted an unannounced on-site visit to the facility.
08/20/2021	Contact - Document Sent I sent an email to Tony Navarre of Recipient Rights, requesting a return call.
08/23/2021	Contact - Telephone call received I spoke with Mr. Navarre via phone.
08/23/2021	APS Referral Information received regarding APS referral.
08/25/2021	Contact - Face to Face A face-to-face meeting was held at Saginaw County Community Mental Health.
08/25/2021	Contact - Document Received I received documentation via email from Mr. Navarre.
08/31/2021	Contact - Document Sent I sent a follow-up email to Kim Knickerbocker, senior director of behavioral health at Beacon Specialized Living Services, Inc. requesting documentation.
09/02/2021	Contact - Document Received

	I received requested documentation via email from Gerald Ross, District Director- Eastern Michigan of Beacon Specialized Living Services, Inc.
09/23/2021	Contact - Document Sent I sent a follow up email requesting Resident A's assessment plan, health care appraisal, and resident care agreement.
09/27/2021	Contact - Document Received I received requested information via email.
09/29/2021	Contact - Telephone call made I left a message requesting a return call from Mr. Navarre.
09/29/2021	Contact - Telephone call made I left a voicemail requesting a return call from CMH case manager Nigela Disha-Cotten.
09/29/2021	Contact - Telephone call made I left a voicemail requesting a return call from Resident A's public guardian.
09/29/2021	Contact - Telephone call made I spoke with home manager Diasheera Jackson via phone.
09/29/2021	Contact - Telephone call received I spoke with Ms. Disha-Cotten via phone.
09/30/2021	Contact - Telephone call received I spoke with Mr. Navarre via phone.
09/30/2021	Contact - Telephone call received I spoke with Guardian 1 via phone.
10/04/2021	Contact- Document Sent A letter was faxed to the Saginaw Police Records Department requesting copies of police report(s).
10/04/2021	Contact- Telephone call made I left a voicemail requesting a return call from administrator Gerald Ross.
10/04/2021	Contact- Telephone call received I spoke with Mr. Ross via phone.
10/04/2021	Contact- Telephone call made

	I left a voicemail, requesting a return call from Kim Rawlings.
10/04/2021	Contact- Document sent I sent an email to Ms. Rawlings.
10/05/2021	Contact- Telephone call received I received a voicemail from licensee designee Kim Rawlings.
10/05/2021	Contact- Telephone call made I spoke with Ms. Rawlings via phone.
10/05/2021	Exit Conference I spoke with Ms. Rawlings via phone.
10/06/2021	Contact- Document Received I received a copy of an incident report via email from administrator Gerald Ross.
10/07/2021	Contact- Document Received I received a copy of a police report via fax, from the City of Saginaw Police Department.

ALLEGATION: The facility is closing on 08/18/2021 due to recent behaviors Resident A has displayed. The facility will no longer have any staff, and placement needs to be found for Resident A, as soon as possible.

INVESTIGATION: On 08/19/2021, I conducted an unannounced on-site at the facility. Staff Jayla Finch and Resident A were present. An attempt was made to interview Resident A, but she did not appear to be able to follow any line of questioning. Resident A denied receiving a discharge notice. She stated that there was a misunderstanding and that she went to the hospital due to health issues and was arrested because she would not leave the hospital premises. Resident A is the only resident currently residing in this facility.

Staff Finch stated that management is working on placement for Resident A, and the facility is waiting for Resident A to be placed somewhere else. She stated that Resident A is both physically and verbally aggressive.

On 08/23/2021, I spoke with recipient rights investigator Tony Navarre via phone. Mr. Navarre stated that Resident A is the only resident in the home. He stated that a harassment complaint was opened due to recipient rights having open investigations, and then a discharge noticed being issued for Resident A by the facility. He stated that it appears to be a lack of communication with staff and management in regard to following Resident A's plan of service, and this has been ongoing since 06/28/2021. He stated that attempts are being made to find Resident

A another placement. He stated that if the facility can prove that it is all on Resident A, he will not substantiate.

On 08/25/2021, I attended a meeting at Saginaw County Community Mental Health. Present was Kim Knickerbocker (Executive Director of Behavioral Health-Eastern Region), and Kim Redmon (Executive Director of Behavioral Health Services-Eastern Region) from Beacon Specialized Living Services Inc., as well as Melynda Schafer (supervisor of Recipient Rights), Mr. Navarre, and Kay Huber (AFC Licensing). Ms. Knickerbocker stated during the meeting that Resident A had about 20 incident reports within her first month of residing in the home. She stated that Resident A's case manager did not request more staffing, and new staff are typically not fully trained. Ms. Redmond stated that they have been cycling through staff and cannot get staff there long enough to be trained to address Resident A's behaviors. Ms. Redmond and Ms. Knickerbocker reported that they were not aware of a recipient rights complaint that came in just prior to the discharge notice being issued on 07/30/2021. They stated that their original intention was not to discharge Resident A, but they started losing staff and at this point cannot manage Resident A's behaviors.

On 08/31/2021, I received a copy of the discharge noticed dated for 07/29/2021. The discharge notice states that due to the current needs of Resident A, the facility is no longer able to maintain her placement. The discharge notice details that her aggressive behaviors started on 06/08/2021, as well as refusal to maintain ADL's even with staff assistance. The 24-hour discharge notice further states that Resident A would routinely call 911 and made statements that required police assistance. A Crisis Prevention Response Team meeting was scheduled on 07/19/2021 to discuss 1:1 staffing. After the meeting, Resident A resorted to defecating throughout the home and throwing it at staff. The discharge notice states that Beacon has provided multiple interventions including crisis response team meetings, contacting CMH case manager, hospitalizations, staff training, problem-solving, positive talk, active listening, and reviewed home rights and responsibilities with Resident A. The discharge notice is signed by Kimberly Knickerbocker.

On 09/29/2021, I interviewed home manager Diasheera Jackson via phone. Ms. Jackson stated that Resident A received a discharge notice due to the facility being short staffed due to Resident A's behaviors. She stated that staff were quitting, and they could not provide the care for Resident A due to her behaviors escalating. She stated that the discharge notice was due to staff doing all they could but being unable to manage Resident A's behaviors.

On 09/29/2021, I spoke with jail diversion specialist from CMH, Nigela Disha-Cotton. Mrs. Disha-Cotton stated that she received a call from Kim Rawlings of Beacon Specialized Services, Inc. saying they were going to close the home due to staffing issues (short staffing), but not that they were going to close the next day. She stated that they received a discharge notice for Resident A, and that she does not recall being told Resident A had to move out of the facility by the next day. She stated that

she does not believe there was any retaliation, and that Beacon Specialized Services, Inc. provided a discharge notice and checked in with CMH throughout the process. She stated that she feels Beacon Specialized Services, Inc. worked hard on this issue through weekly meetings with CMH, that they were receptive, and were trying to help.

On 09/29/2021, I spoke with Guardian 1, Resident A's public guardian, via phone. He stated that he did have concerns as staffing was sketchy. He stated that it was a messy situation. He stated that Resident A is very confrontational and obstinate, but it was staff's responsibility to make sure Resident A was safe. He stated that Resident A was admitted into psychiatric care about a month ago. He stated that Resident A has always been on the edge of being stable and not stable and would occasionally refuse medications. He stated that staff may not have been as attentive as they should have been.

On 09/29/2021, I received a return call from Mr. Navarre. He stated that they are not substantiating regarding retaliation, and Resident A receiving a discharge notice. He stated that it appears Beacon Specialized Services, Inc. did all they could in trying to assist Resident A.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**
ANALYSIS:	Mr. Navarre stated that they are not substantiating regarding retaliation, and Resident A receiving a discharge notice. He stated that it appears Beacon Specialized Services, Inc. did

	all they could in trying to assist Resident A. Mrs. Disha-Cotton stated that she received a call from Kim Rawlings of Beacon Specialized Services, Inc. saying they were going to close the home due to staffing issues (short staffing), but not that they were going to close the next day. She stated that they received a discharge notice for Resident A, and that she does not recall being told Resident A had to move out of the facility by the next day. She stated that she does not believe there was any retaliation, and that Beacon Specialized Services, Inc. provided a discharge notice and checked in with CMH throughout the process. There is no preponderance of evidence to substantiate a rule violation. A discharge notice was issues for Resident A on 07/29/2021. The reason for the proposed discharge and the alternatives attempted by the licensee were noted in the discharge. Resident A was discharged to another setting after a placement was found for her.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: After being release from jail on 08/21/2021, Resident A returned back to the facility, and was left unsupervised for over one and a half hours.

INVESTIGATION: An incident report dated of 08/20/2021 authored by home manager Diasheera Jackson details an incident where Resident A had refused personal care and was sitting in urine and feces. She had also refused medications. She was displaying behaviors (dumping mop bucket water, called 911 reporting staff was causing her harm, and then told MMR that staff had COVID-19 and she did not want to be in the home anymore.) Resident A was transported to Covenant Hospital, where she was cleaned up, was physically aggressive with Staff Jackson as well as hospital staff. She received a psych evaluation by crisis at the hospital. Staff was informed that Resident A's behaviors were baseline, and that there was nothing the hospital could do for Resident A. Staff details that they tried to advocate for Resident A and the safety of others stating that her behaviors had declined, and she needed care. Resident A was discharged from the hospital. She sat outside of the hospital, refusing transportation back to the facility. Her behaviors escalated, she threated staff multiple times, spit on staff, and was verbally aggressive. Hospital security intervened and called the police with a trespassing complaint. Police responded to the hospital. More attempts were made to prompt Resident A to go back to the facility. Resident A refused stating she wanted to go to jail. Office Megan Nelson of the Saginaw Police Department arrested Resident A for trespassing, cuffed Resident A and took her to jail.

A Saginaw Police Department report dated for 08/21/2021 states that Officer Megan Nelson responded to Covenant Hospital's emergency entrance due to Resident A refusing to leave again. It states that the hospital security gave Resident A a trespassing order, and Officer Nelson issued a trespass citation. Resident A continued to refuse to leave, and was then arrested for criminal trespass, transported, and lodged at the Saginaw County Jail. The police report states that Resident A refused MMR transportation back to the facility.

On 08/25/2021, I attended a meeting at Saginaw County Community Mental Health. Present was Kim Knickerbocker (Executive Director of Behavioral Health-Eastern Region), and Kim Redmon (Executive Director of Behavioral Health Services-Eastern Region) from Beacon Specialized Living Services Inc., as well as Melynda Schafer (supervisor of Recipient Rights), Mr. Navarre, and Kay Huber (AFC Licensing). Ms. Knickerbocker and Ms. Redmon reported that Resident A spit on a hospital security guard and was arrested on 08/20/2021 (a Friday). Resident A also assaulted home manager Diasheera Jackson at the hospital with a charging cord, and also assaulted a nurse. Ms. Schafer stated that Community Mental Health's crisis team had been called out to the home after Resident A called them stating she was at home with no staff (after being released from jail.) Mr. Navarre stated that Resident A called CMH staff after being release from jail, to bring her food and water until Beacon Specialized Living Services could get to the facility.

On 09/27/2021, I received a copy of Resident A's *Assessment Plan for AFC Residents.* The assessment plan is checked "no" for Moves Independently in Community. There is no description of her needs and how they will be met in regard to this area.

On 09/29/2021, I interviewed home manager Diasheera Jackson via phone. Ms. Jackson. She stated that one-night, Resident A was in the hospital, and then ended up going to jail. Ms. Jackson stated that she went home that night due to Resident A going to jail. She stated that she had spoken with her boss who gave her the okay to go home. She stated that Resident A was released from jail later that morning and was at the facility for about two to three hours with no staff. She stated that this happened at the end of August 2021. She stated that at the hospital, Resident A assaulted her (Staff Jackson), and the security guards intervened. The security guards called the police and made a trespassing complaint. Resident A opted to go to jail, so the police took her. Staff Jackson stated that she woke up about 12:00 pm later that day to missed calls from the CMH crisis team notifying her that Resident A was released and at the facility. She stated that she ended up having to go back into work. She stated that it took her about an hour to arrive to the home once she was notified because she does not reside in Saginaw. She stated that when she arrived, Resident A was inside the home, because Resident A knew the code to get in the door. She stated that Resident A was at the home for about three hours before she arrived at the home.

On 09/29/2021, I spoke with jail diversion specialist from CMH, Nigela Disha-Cotton. She stated that Resident A did go to jail, but she is not sure what happened. She stated that either Resident A attacked a nurse or maybe threatened to. She stated that she does not think Resident A was in jail overnight.

On 09/29/2021, I received a return call from Mr. Navarre. He stated that the police did not notify the home that they were going to drop her off at the facility, and that the police just dropped her off on the front porch. He stated that the facility did what they could to get a staff person there as soon as possible. He stated that the staff person had been told to go home the night before because Resident A was in jail.

On 09/30/2021, I spoke with Guardian 1 via phone. He stated that Resident A was arrested, and there was no staff at the home when she returned to the facility.

On 10/04/2021, I spoke with administrator Gerald Ross via phone. He stated that a call was made to the jail about two to three hours later (after Resident A was taken into custody), and Beacon staff were notified that Resident A was in processing. He stated that the jail did not provide any additional details. He stated that a second call was made, and Beacon staff was notified that Resident A would be at the jail overnight. He stated that when another follow-up call was made by Beacon staff, they were told that Resident A knew the code to get into the home, that she was an adult, and that jail did not need to call anyone. Mr. Ross was unsure which staff persons made the follow up calls.

On 10/05/2021, I spoke with licensee designee Kim Rawlings via phone. She stated that Resident A was taken from the hospital on a Friday night, early Saturday morning. The police reported that Resident A would most likely be in jail over the

weekend. She stated that the police had phone numbers for the home manager, staff, and a district director from Beacon. She stated that the police did not call anyone to inform them they were dropping Resident A off to the facility. She stated that Resident A called someone from her CMH crisis team, who called Beacon to inform them that Resident A was at the facility. She stated that the CMH crisis person went to Beacon Home at Saginaw and sat with Resident A until staff arrived. She stated that it was not okay for the police to leave Resident A, that Resident A has a guardian and should not be left alone.

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:	A City of Saginaw Police report dated for 08/21/2021 was reviewed. It stated that Resident A was displaying behavioral issues and refused to leave the hospital. She was issued two citations for trespassing, transported, and lodged at the Saginaw County Jail. Licensee Designee Kimberly Rawlings and administrator Gerald Ross reported that calls were made to the jail to get the status of Resident A, and that they were not notified when Resident A had been released and was transported back to the facility by police. Ms. Rawlings stated that the CMH crisis person went to Beacon Home at Saginaw and sat with Resident A until staff arrived. Recipient Rights officer Tony Navarre reported that the police did not notify the home that they were going to drop her off at the facility, and that the police just dropped her off on the front porch. He stated that the facility did what they could to get a staff person there as soon as possible. Staff Jackson stated that she responded back to work as soon as possible after she was informed Resident A had been released and was back at the facility. There is no preponderance of evidence to substantiate a rule violation. Attempts were made to communicate with the jail in regard to when Resident A would be released. The facility was not notified ahead of time that Resident A was going to be dropped off. Staff responded to the home as soon as they could.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 08/19/2021, I conducted an unannounced on-site at the facility. During this on-site, I observed garbage cans outside of the home that appeared to be overflowing with garbage, which was attracting flies. I observed what appeared to be feces smeared on the porch railing of the home prior to staff answering the door. I brought this to staff Jayla Finch's attention and informed her it needed to be cleaned. Inside of the home, there were many flies observed flying around in the dining room area. Ms. Finch stated that Resident A goes in and out of the home to sit on the porch and has been attracting flies due to her having bowel movements on herself and refusing personal care.

On 08/25/2021, I attended a meeting at Saginaw County Community Mental Health. Present was Kim Knickerbocker (Executive Director of Behavioral Health-Eastern

Region), and Kim Redmon (Executive Director of Behavioral Health Services-Eastern Region) from Beacon Specialized Living Services Inc., as well as Melynda Schafer (supervisor of Recipient Rights), Mr. Navarre, and Kay Huber (AFC Licensing). During this meeting, Ms. Schafer and Mr. Navarre stated that they conducted an on-site at the facility on 08/24/2021. Ms. Schafer stated that the facility was observed to be swarmed with flies, and there were flies and feces in Resident A's room, and that it was hot inside of the home. Mr. Navarre provided me with photos taken during their on-site on 08/24/2021. One photo is of the dried feces that was on the porch railing. Two other photos show flies in Resident A's room, and a fourth photo shows garbage cans full of trash, sitting outside of the garage door.

On 09/27/2021, I received a copy of Resident A's *Assessment Plan for AFC Residents.* The assessment plan states that Resident A is independent for transfers in regard to toileting but needs reminded to go and toilet due to incontinence. The assessment plan does not indicate Resident A needed staff assistance with bathing and personal hygiene.

On 09/29/2021, I interviewed home manager Diasheera Jackson via phone. Ms. Jackson. She stated that Resident A liked to sit in her urine and feces, and flies would attach to her. She stated that it was more than likely feces on the porch railing because this became a behavior of Resident A's over time. She stated that the trash was not normally be left like that, and that staff was probably at the hospital that week with Resident A and forgot to take the trash to the curb. She stated that this is not something that happens on a regular basis.

On 09/29/2021, I spoke with jail diversion specialist from CMH, Nigela Disha-Cotton. She stated that it is true that Resident A would refuse personal care and would throw feces.

On 09/29/2021, I received a return call from Mr. Navarre. He stated that they are substantiating for health and safety due to the feces on the railing, and the trash outside the home.

On 09/30/2021, I spoke with Guardian 1 via phone. Guardian 1 reported that he did not view the feces, but understood this behavior was going on. He stated that it was discussed in team meetings.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On 08/19/2021, I conducted an unannounced on-site at the facility. During this on-site, I observed garbage cans outside of the home that appeared to be overflowing with garbage,

	which was attracting flies. I observed what appeared to be feces smeared on the porch railing of the home prior to staff answering the door. Inside of the home, there were many flies observed flying around in the dining room area. Ms. Schafer and Mr. Navarre stated that they conducted an on-site at the facility on 08/24/2021. Ms. Schafer stated that the facility was observed to be swarmed with flies, and there were flies and feces in Resident A's room, and that it was hot inside of the home. Mr. Navarre provided me with photos taken during their on-site on 08/24/2021 confirming these issues. Ms. Jackson. She stated that Resident A liked to sit in her urine and feces, and flies would attach her. She stated that it was more than likely feces on the porch railing because this became a behavior of Resident A's over time. Mr. Navarre stated that recipient rights is substantiating for health and safety due to the feces on the railing, and the trash outside the home. There is a preponderance of evidence to substantiate a rule violation in regards to maintenance of premises.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/05/2021, I conducted an exit conference with licensee designee Kim Rawlings via phone. I informed her of the findings and conclusion.

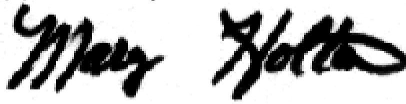
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend continuation of the AFC small group home license (capacity 6).

10/07/2021

Shamidah Wyden Date
Licensing Consultant

Approved By:



10/07/2021

Mary E Holton Date
Area Manager