GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 13, 2021

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

RE: License #: AS250395771
Investigation #: 2022A0569003
Beacon Home at Linden

Dear Ms. 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) 284-9730.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

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 #:	AS250395771
Investigation #:	2022A0569003
Complaint Receipt Date:	10/26/2021
Investigation Initiation Date:	10/27/2021
Report Due Date:	12/25/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Rawlings
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Linden
Facility Address:	14180 N. Hogan Road Linden, MI 48451
Facility Telephone #:	(269) 214-4341
Original Issuance Date:	10/09/2018
License Status:	REGULAR
Effective Date:	04/09/2021
Expiration Date:	04/08/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• **Resident A went into a store while on an outing, unsupervised by staff, on 10/12/21.**	Yes
• **The residents were served food with broken pieces of glass in the food on 10/19/21.**	Yes
• **Christina Reitz, staff person, swore at Resident A on 10/12/21.**	Yes

III. METHODOLOGY

10/26/2021	Special Investigation Intake 2022A0569003
10/26/2021	APS Referral Complaint received from APS.
10/27/2021	Special Investigation Initiated - Letter Email to RRO.
12/09/2021	Inspection Completed On-site
12/09/2021	Contact - Telephone call made Contact with Kim Nguyen-Forbes, RRO.
12/09/2021	Contact-telephone call made Attempted contact with Christina Reitz. The call was terminated without going to voicemail.
12/09/2021	Inspection Completed-BCAL Sub. Compliance
12/13/2021	Contact- Telephone call made Phone interview with Resident A.
12/13/2021	Exit Conference Left voicemail for Kim Rawlings, licensee designee. Ms. Rawlings was informed as to the findings in this report.

ALLEGATION:

Resident A went into a store while on an outing, unsupervised by staff, on 10/12/21.

INVESTIGATION:

This complaint was received from the office of recipient rights. Kim Nguyen- Forbes, recipient rights officer, was assigned to investigate this complaint. The complainant reported that on 10/12/21, Michelle Hitsman, facility manager, and Christina Reitz, staff person, took all of the residents residing in this facility on an outing to go shopping. The complainant reported that the two staff allowed the residents to go inside a dollar general store without any supervision. The complainant reported that Resident A requires direct supervision while in the community and was allowed to go into the store with no supervision. The complainant reported that when Resident A returned to the facility van, Ms. Reitz and Ms. Hitsman were in the van and when Resident A tried to get into the van, Ms. Reitz locked the door, refusing to allow Resident A into the van. The complainant reported that Ms. Reitz told Resident A, “you made us wait, and not you have to wait”.

An unannounced inspection of this facility was conducted on 12/9/21. Resident A was at an appointment and was not present during this inspection. Resident B was alert and oriented to person, place, and time. Resident B was appropriately dressed and groomed with no visible injuries. Resident B stated that he remembered the outing on 10/12/21. Resident B stated that Resident A was told that he could not go into the store, but he went anyway, and was in the store with the other residents without any supervision. Resident B stated that he is allowed to move in the community without staff supervision, but that Resident A requires supervision. Resident B stated that there were no staff in the store when Resident A was in the store. Resident B stated that when Resident A returned to the van, Ms. Reitz had locked Resident A out of the van to “get back” at Resident A. Resident B stated that Ms. Reitz no longer works at this facility.

Resident C was alert and oriented to person, place, and time. Resident C was appropriately dressed and groomed with no visible injuries. Resident C stated that he was present for the outing on 10/12/21. Resident C stated that staff were present in the store with the residents on 10/12/21. Resident C stated that he did not remember which staff was present with the residents. Resident C stated that Ms. Reitz no longer works at this facility and that he liked her “ok”. Resident C stated that he did not recall any other details regarding the outing.

Resident A was interviewed via telephone on 12/13/21. Resident A was alert and oriented to person, place, and time. Resident A stated that he “already talked to someone” about this allegation. Resident A stated that he did not have anything else to say and did not wish to be interviewed any further.

Ms. Hitsman stated on 12/9/21 that staff were present with the residents while they were in the store on 10/12/21. Ms. Hitsman stated that Resident A does not tell the truth, and that the residents were never left unsupervised. Ms. Hitsman stated that Resident A's care plan requires that staff be within "arms reach" of Resident A when he is in the community, and he was never allowed to be unsupervised.

The residents' plans of service were reviewed. Resident A's plan of service documents that he be within "arm's length" of a staff person when he is in the community. Resident B and Resident C are capable of moving independently in the community without staff supervision.

Ms. Nguyen-Forbes, recipient rights officer, stated on 12/9/21 that she has cited numerous recipient rights violations against Ms. Hitsman and Ms. Reitz. Ms. Nguyen-Forbes stated that she interviewed all of the residents on 10/14/21, 10/19/21, and 10/21/21. Ms. Nguyen-Forbes stated that all of the residents confirmed that Resident A went into the store on 10/12/21 with no staff supervision. Ms. Nguyen-Forbes stated that Resident C reported to her that Ms. Hitsman had instructed him to "change his story" about what had happened on 10/12/21. Ms. Nguyen-Forbes stated that Resident A and Resident B do not "get along", but Resident B has not changed his account that Resident A was left unsupervised in the store on 10/12/21. Ms. Nguyen-Forbes stated that all of the residents have also confirmed that Resident A was locked out of the van by Ms. Reitz when he returned to the van on 10/12/21.

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:	The complainant reported that Resident A entered a store on 10/12/21 without any staff supervision. Resident A's plan of service requires a staff person be within arm's length of Resident A when he is in the community. Resident B confirmed that Resident A was in the store on 10/12/21 without any staff supervision. Resident C denied this, but Ms. Nguyen-Forbes stated that Resident C reported to her that Ms. Hitsman instructed him to change his account regarding this incident. Ms. Nguyen-Forbes stated that all of the residents confirmed that

	Resident A was in the store with no staff supervision on three separate days. Ms. Nguyen-Forbes also stated that all of the residents confirmed that Resident A was locked out of the van by Ms. Reitz on 10/12/21 in retaliation for going into the store without any staff supervision. Ms. Hitsman denied that Resident A was allowed into the store without staff supervision. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The residents were served food with broken pieces of glass in the food on 10/19/21.

INVESTIGATION:

The complainant reported that Katrina Brantley, staff person, prepared the evening meal on 10/19/21. The complainant reported that Ms. Brantley served the residents goulash for dinner. The complainant reported that when the residents started eating the food, they found little pieces of glass in the food.

Resident B stated on 12/9/21 that he recalled the evening meal on 10/19/21. Resident B stated that Ms. Brantley prepared goulash for the meal. Resident B stated that when he took a bite of the food, he bit down on “something crunchy”. Resident B stated that he spit the food out onto his plate and found a little piece of glass in the food. Resident B stated that he threw the food away and made a sandwich instead. Resident B denied that he was injured in anyway.

Resident C stated on 12/9/21 that he recalled the evening meal on 10/19/21. Resident C stated that when he took a bite of the food, he felt “something gritty” as he chewed. Resident C stated that he spit the food out and also found little pieces of glass in the food. Resident C stated that he was not injured from the food.

Ms. Brantley stated on 12/9/21, that she did prepare goulash on 10/19/21 for the evening meal. Ms. Brantley stated that she was trying to open a jar of spaghetti sauce and tapped the lid on the counter to loosen it. Ms. Brantley stated that when she tapped the jar on the counter, the jar broke. Ms. Brantley stated that she thought she had gotten all of the glass out of the sauce, so she used the sauce to make the meal. Ms. Brantley stated that when the residents started eating the food, they were finding pieces of glass in the food, so she threw the food away.

Matt Potts, recipient rights officer, stated on 11/8/21 that he investigated this complaint. Mr. Potts stated that Ms. Brantley admitted to serving the food with glass in it to the residents. Mr. Potts stated that he substantiated a violation of the residents' rights.

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:	The complainant reported that Ms. Brantley served the residents food with pieces of glass in the food on 10/19/21. Resident B, Resident C, and Ms. Brantley all stated that Ms. Brantley made goulash on 10/19/21, and when the residents began eating the food, they found pieces of glass in it. Based on the statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Christina Reitz, staff person, swore at Resident A on 10/12/21.

INVESTIGATION:

The complainant reported that during the outing on 10/12/21, Ms. Reitz called Resident A derogatory names. The complainant reported that Ms. Reitz also swore at Resident A and verbally mistreated him.

Resident A stated on 12/13/21, that he had already talked about this allegation with someone (recipient rights officer Kim Nguyen-Forbes). Resident A stated that he "didn't want to talk about it anymore".

Resident B stated on 12/9/21 that he did observe Ms. Reitz "yell and swear" at Resident A while on the outing on 10/12/21. Resident B stated that he remembers Ms. Reitz calling Resident A a "mother fucker." Resident B stated that he did not remember everything that Ms. Reitz said to Resident A, but that Ms. Reitz was angry at Resident A for going into the store without a staff person when he was told that he could not go in.

Resident C stated that he recalls that Ms. Reitz was angry at Resident A because Resident A "kept running his mouth." Resident C stated that Resident A "doesn't know when to stop." Resident C stated that he "didn't remember" why Ms. Reitz was upset at Resident A. Resident C stated that he does not remember what Ms. Reitz said to Resident A.

An attempted phone interview with Ms. Reitz was made on 12/9/21. The phone call was terminated without going to voicemail.

Ms. Nguyen-Forbes stated on 12/9/21 that all of the resident stated to her that Ms. Reitz swore at Resident A when she interviewed them on three separate dates. Ms. Nguyen-Forbes stated that Resident A, Resident B, and Resident C all stated that Ms. Reitz told Resident A to "shut the fuck up" and called Resident A "mother fucker." Ms. Nguyen-Forbes stated that the residents also reported to her that when they arrived back at the facility on 10/12/21, Ms. Reitz threatened Resident A with calling the police to come to the facility and take him away. Ms. Nguyen-Forbes stated that she is substantiating several violations against Ms. Reitz for demeaning and threatening Resident A.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	The complainant reported that Ms. Reitz swore at Resident A during the outing on 10/12/21. Resident B confirmed that Ms. Reitz did swear at Resident A. Ms. Nguyen-Forbes stated that all of the residents confirmed that Ms. Reitz swore at Resident A and called him names on 10/12/21 when she interviewed them on three different occasions. Based on the statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An attempted exit conference was conducted with Kim Rawlings on 12/13/21. A voicemail was left noting the violations in this report. An email was also sent to Ms. Rawlings on 12/13/21 confirming the violations. Ms. Rawlings responded to the email on 12/13/21 acknowledging the rule violations. Ms. Rawlings stated that she would submit a corrective action plan after she receives this report.

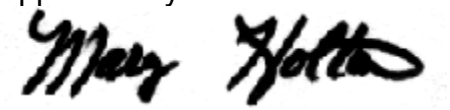
IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.

12/13/21

Kent W Gieselman Date
Licensing Consultant

Approved By:



12/13/21

Mary E Holton Date
Area Manager