STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

January 26, 2022

Mary Stewart-Thornton
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS130408635
Investigation #: 2022A1030016
Beacon Home at East Ave

Dear Ms. Stewart-Thornton:

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,

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130408635
Investigation #:	2022A1030016
Complaint Receipt Date:	12/15/2021
Investigation Initiation Date:	12/16/2021
Report Due Date:	02/13/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Mary Stewart-Thornton
Licensee Designee:	Mary Stewart-Thornton
Name of Facility:	Beacon Home at East Ave
Facility Address:	20271 East Ave N Battle Creek, MI 49017
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/04/2021
License Status:	TEMPORARY
Effective Date:	10/04/2021
Expiration Date:	04/03/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was unable to exercise her freedom of religion.	Yes
Direct care staff did not ensure the front door was locked in accordance with the variance.	Yes
Additional Findings	No

III. METHODOLOGY

12/15/2021	Special Investigation Intake 2022A1030016
12/16/2021	Special Investigation Initiated - On Site Interview with Resident A
12/16/2021	Contact - Face to Face Interview with D'nasia Wilson
12/16/2021	Contact - Face to Face Interview with Tiffany Ablin
12/28/2021	Contact - Telephone call made Interview with Shelia Evans-Moore
12/28/2021	Contact - Telephone call made Interview with Kamri Warren
12/28/2021	Documents Received – Reviewed Variance Request
12/29/2021	Exit Conference Exit Conference with licensee designee by phone

ALLEGATION:

Resident A was unable to exercise her freedom of religion.

INVESTIGATION:

On 12/16/2021, I interviewed Resident A at the facility. Resident A reported she has lived at this AFC since October 2021. Resident A reported she likes living here “ok” but has a problem with direct care staff member (DCSM) Sheila Evans-Moore. Resident A

reported Ms. Evans-Moore tried to “rub holy oil on her.” Resident A reported Ms. Evans-Moore rubbed her back like she was putting holy oil on her but later said she was “kidding.” Resident A reported Ms. Evans-Moore has stated “you need Jesus” in your life and wants her to go to church. Resident A reported she feels “targeted” by Ms. Evans-Moore as she does not identify with her religion.

On 12/16/2021, I interviewed DCSM D’nasia Wilson at the facility. Ms. Wilson reported Resident A “hates Shelia” because she goes “overboard with religion.” Ms. Wilson reported Ms. Evans-Moore may have thrown “holy water” on Resident A which made her very mad. Ms. Wilson reported she believes Ms. Evans-Moore should keep her opinions about religion to “herself” and not discuss religion at work.

On 12/16/2021, I interviewed house manager, Tiffany Ablin at the facility. Ms. Ablin reported Shelia Evans-Moore is a religious person and heard but did not witness that she threw holy water on Resident A. Ms. Ablin reported she has talked with Ms. Evans-Moore about the inappropriateness of her actions.

On 12/28/2021, I interviewed DCSM Shelia Evans-Moore at the facility. Ms. Evans-Moore reported she and Resident A have some difficulties getting along. Ms. Evans-Moore reported there was a situation a while ago where she “pretended” to put holy water on Resident A but never actually did. Ms. Evans-Moore reported she was “joking” with Resident A. Ms. Evans-Moore reported she does not believe she makes Resident A feel uncomfortable by talking about religion even though she knows Resident A is not a Christian. Ms. Evans-Moore reported she knows that the residents have rights.

On 12/28/2021, I interviewed DCSM Kamri Warren by telephone. Ms. Warren reported she aware of an incident involving direct care staff member Shelia Evans-Moore putting holy water on Resident A but did not witness it. Ms. Warren reported Ms. Evans-Moore says things about God and religion that are “unnecessary but not offensive.”

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: **(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association.**

ANALYSIS:	Interviews with staff and Resident A reveal Ms. Evans-Moore minimally was “joking” with Resident A and only pretended to put holy water on her. I can’t determine if a substance was actually applied onto Resident A. Regardless of Ms. Evans-Moore intentions or alleged action, it was inappropriate to make jokes with Resident A about religion when Resident A in fact had no desire to participate in such actions or discussion.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care staff did not ensure the front door was locked in accordance with the variance.

INVESTIGATION:

Resident A reported that on 12/5/2021 she became upset and ran out the front door and into the road in front of the home. Resident A reported the door is usually locked but it was not locked when she ran out of the door. Resident A reported she called 911 herself because she felt unsafe. Resident A reported two staff members followed her outside and made sure she did not get run over by any cars and in a short time the police and an ambulance showed up. Resident A reported she was taken to Bronson Battle Creek for a short time but returned to the AFC in just a few hours.

Ms. Wilson reported she was working on 12/5 and was a part of the incident with Resident A. Ms. Wilson reported Resident A was upset with her boyfriend because he did not pick up the phone when called. Ms. Wilson reported Resident A declared that she wanted to “kill herself.” Ms. Wilson reported Resident A grabbed an index card and held it to her neck. Ms. Wilson reported Resident A ran out of the front door and outside. Ms. Wilson reported the key was “in the door” because she was waiting for the staff on the next shift to enter the home. Ms. Wilson reported Resident A ran outside and into the street to try and get “run over by a car.” Ms. Wilson reported direct care staff members Shelia Evans-Moore and Kamari Warren both grabbed Resident A and pulled her out of the road. Ms. Wilson reported emergency responders took Resident A to the hospital.

Ms. Ablin reported she is aware that Resident A was able to run out of the door and onto the street in front of the home because the door had not been locked by direct care staff. Ms. Ablin reported she spoke with the whole staff about keeping the door locked unless someone is entering or exiting and not to unlock the door prematurely for shift change.

Ms. Evans-Moore reported working on 12/5 and that Resident A got angry at her boyfriend because she could not get ahold of him on the phone. Ms. Evans-Moore reported Resident A eventually ran out of the home and into the street in front of the house. Ms. Evans-Moore reported she and Ms. Warren went outside to ensure Resident A would not get hurt. The police responded to the home and took Resident A to the hospital. Ms. Evans-Moore reported Resident A was able to get out of the home because the front door was not locked "like it is supposed to be."

Ms. Warren reported she worked at the facility on 12/5. Her statements were consistent with those made by Ms. Wilson, Ms. Moore, Ms. Albin, and Ms. Evans Moore.

On 12/28/2021, I reviewed the approved 9/14/2021 variance request of R400.14304 (1)(b) Resident rights; licensee responsibilities. The justification for the variance indicated, The applicant requested to provide a "secure program" to serve six residents whose supervision and protection needs are best met in a more restrictive environment, due to their history of high behavioral concerns, which include elopement."

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:	Beacon Home at East Ave is home to six highly behavioral residents with poor safety awareness that have the capacity to elope from the facility. The facility is located closely to a busy street. Review of the licensing file reveals the facility was granted a variance from R 400.14304 so to allow locking of the door to prevent resident elopement. Interviews with staff reveals that on 12/5 a staff member left the door unlocked and the key accessible to all. While Resident A was without harm, the staff did not comply with the requirements of ensuring the adequate protection and safety required by this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/29/2021, I shared the findings of this report with licensee designee, Ramon Beltran by phone. Mr. Beltran acknowleded the violations cited in the investigation.

IV. RECOMMENDATION

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

Nile Khabeiry, LMSW

1/26/2022

Nile Khabeiry
Licensing Consultant

Date

Approved By:

Russell Misiak

1/26/2022

Russell Misiak
Area Manager

Date