GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 22, 2022

Ramon Beltran II
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS130408635
Investigation #: 2022A0578021
Beacon Home at East Ave

Dear Mr. Beltran:

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) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

- **THIS REPORT CONTAINS QUOTED PROFANITY**
- **THIS REPORT CONTAINS SEXUALLY EXPLICIT LANGUAGE**

I. IDENTIFYING INFORMATION

License #:	AS130408635
Investigation #:	2022A0578021
Complaint Receipt Date:	02/28/2022
Investigation Initiation Date:	03/03/2022
Report Due Date:	04/29/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubrey Napier
Licensee Designee:	Ramon Beltran II
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:	REGULAR
Effective Date:	04/04/2022
Expiration Date:	04/03/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Manager made inappropriate comments to Resident A.	Yes
Staff are not trained to deal with aggressive behavioral residents and contact police repeatedly.	No
Resident B was discharged without notice.	No
This facility has no working phone.	No

III. METHODOLOGY

02/28/2022	Special Investigation Intake 2022A0578021
02/28/2022	APS Referral Completed.
03/03/2022	Special Investigation Initiated - Telephone With Complainant.
03/03/2022	Special Investigation Completed On-site -Interview with direct care staff Haile Lea. Interview with Resident C and Resident D.
03/11/2022	Contact-Telephone -Interview with administrator Aubry Napier.
03/11/2022	Contact-Documents Reviewed -Direct care staff *Training Records*.
04/07/2022	Contact-Document Reviewed *-AFC Licensing Division Incident/Accident Report* dated 02/13/2022.
04/11/2022	Contact-Telephone -Interview with administrator Aubry Napier.
04/11/2022	Contact-Telephone -Interview with direct care staff Tiffany Ablin.
04/11/2022	Contact-Document Reviewed *-AFC Licensing Division Incident/Accident Report* dated 02/17/2022.
04/19/2022	Exit Conference -With licensee designee Ramon Beltran II.

ALLEGATION:

Manager made inappropriate comments to Resident A.

INVESTIGATION:

On 02/28/2022, I received this complaint through the BCHS on-line complaint system. Complainant alleged that staff member Tiffany Ablin made inappropriate comments to Resident A that started an altercation.

On 04/07/2022, I reviewed the *AFC Licensing Division Incident/Accident Report* dated 02/13/2022 and related to the allegations. The *AFC Licensing Division Incident/Accident Report* was completed by staff member Haile Lea and included the following information:

> "Tiffany asked [Resident A] while making the grocery list if she liked Brussel Sprouts and [Resident A] stated that she did not like them because of what her brother told her when she was younger. Other two staff on shift overheard [Resident A] and Tiffany arguing back and forth. [Resident A] then yelled at Tiffany to stop talking to her. Tiffany then stood up from the table and yelled back. [Resident A] started talking about other residents in the home. Tiffany told [Resident A] "you are 33 years old and still act like a child, no wonder your mom put you in one of these homes" [Resident A] shouted back at Tiffany "Fuck you bitch" Tiffany then told "That's queen bitch to you" Tiffany then told [Resident A] that the way she acted is probably why her dad has not called her. [Resident A] shouted back that she hopes her dad is dead…"

> "Tiffany walked towards [Resident A] and started yelling in her face. [Resident A] started spitting and told Tiffany she was going to spit on her. Tiffany then told [Resident A] "I would tell you I'm going to knock your teeth out but you already don't have them" [Resident A] grabbed her slipper off of her foot and acted like she was going to hit Tiffany. Tiffany grabbed [Resident A]'s slipper out of her hand and threw it across the common area of the home. Tiffany tried to grab [Resident A]'s foot to take her other slipper off of her foot. [Resident A] then started yelling at Tiffany again and called Tiffany a "slut." Tiffany started to laugh and said "You remember your past life when you were over there in that hotel getting fucked by multiple dudes? That makes you a mother fucking slut too…"

> "Tiffany kept instigating a fight with [Resident A]. [Resident A] stated she was not going to take a shower and Tiffany said "that's okay you can smell your own ass" [Resident A] started spitting on the floor again and Tiffany told her she sounded like a hissing cat. Tiffany then started making fun of her for being upset about not seeing her family. Tiffany told her "I'm the biggest bitch you will ever meet." Tiffany told [Resident A] "if you wanna do this we can do this, I have all day" [Resident A] then got upset and started crying and ran to her room. Tiffany

followed her and then came out to the common area of the home and told staff this is what needed to be done to get her to break and calm [Resident A] down."

Equipped with personal protective equipment, on 03/03/2022, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Halie Lea regarding the allegations. Ms. Lea reported that Ms. Tiffany Ablin was suspended after the allegations and clarified that she was present when Ms. Ablin had called Resident A, "child", "slut", and "bitch" which had made Resident A upset. Ms. Lea reported she was unaware of why this incident escalated but clarified that Resident A was upset and argumentative and Ms. Ablin continued to argue with Resident A. Ms. Lea reported that Resident A was currently unavailable for interview due to being hospitalized for a different medical reason.

While at the facility I interviewed Resident C regarding the allegations. Resident C reported living at this facility since January 2022. Resident C reported that staff member Tiffany Ablin had come into to the facility on her day off to shower and do her laundry. Resident C reported that Resident A was in the living room while Ms. Ablin was sitting at the table. Resident C reported that Resident A and Ms. Ablin began to "bicker" back and forth and this was when Ms. Ablin called Resident A "slut" and "bitch" and said Resident A had been "sex trafficked" and this was "why Resident A was living at this facility." Resident C reported that Resident A had attempted to hit Ms. Ablin with her slipper when Ms. Ablin took Resident A's slipper and threw it across the room. Resident C reported the incident ended when Resident A went to her room.

While at the facility, I interviewed Resident D regarding the allegations. Resident D reported living at this facility since October 2021. Resident D reported that on the day of the allegations, staff member Tiffany Ablin was at the facility when Resident A was upset. Resident D reported that staff and residents went to a local restaurant and upon their return to the facility, Resident A attempted to assault Resident D. Resident D reported shortly after this, Ms. Ablin began yelling derogatory things at Resident A. Resident D reported she could not recall the exact words used by Ms. Ablin, as she was trying not to be involved.

On 03/11/2022, I interviewed administrator Aubry Napier regarding the allegations. Ms. Napier acknowledged being aware of the allegations and reported that staff informed her immediately after the incident occurred. Ms. Napier reported that Ms. Ablin was immediately suspended pending the investigation and had not returned to work at this facility since.

On 04/11/2022, I interviewed staff member Tiffany Ablin regarding the allegations. Ms. Ablin denied the allegations and reported that she had only went to the facility after receiving a phone call from staff regarding a malfunctioning carbon monoxide detector. Ms. Albin denied going to the AFC facility to use their shower or laundering facilities. Ms. Ablin reported that when she arrived at the facility, Resident A was upset, and she spent time talking with Resident A and took all of the residents out to

breakfast at a local restaurant which she had paid for. Ms. Ablin reported that when they returned to the facility, Resident A was still upset and began to make comments about not being loved by her family. Ms. Ablin denied making any type of derogatory comments to Resident A. When asked why someone would make the allegations, Ms. Ablin reported that staff wanted her role as a home manager. When informed that multiple interviews corroborated that Ms. Ablin had made derogatory statements, Ms. Ablin became confrontational and reported that she no longer wanted to be “interviewed by anyone” and had received threats from multiple staff at this facility but did not provide any details before ending the interview.

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:	During an unannounced investigation on-site, direct care staff Haile Lea confirmed that direct care staff Tiffany Ablin had used derogatory language when addressing Resident A. During interviews, Resident C and Resident D confirmed that direct care staff Tiffany Ablin had used derogatory language when addressing Resident A. Resident A was unable to be interviewed at the time of the unannounced investigation on-site due to being hospitalized for a medical condition unrelated to this incident. An *AFC Licensing Division Incident/Accident Report* completed by staff member Haile Lea documented that direct care staff Tiffany Ablin had engaged in argumentative behavior and addressed Resident A with derogatory and explicit language. The *AFC Licensing Division Incident/Accident Report* completed by staff member Haile Lea documented that direct care staff Tiffany Ablin had taken Resident A’s slipper and thrown it across the room, which was corroborated in an interview with Resident C. Direct care staff Tiffany Ablin denied the allegations but became confrontational and ended her interview. As such, there is enough evidence that Resident A was not treated with dignity and her personal need for protection and safety was not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff are not trained to deal with aggressive behavioral residents and contact police repeatedly.

INVESTIGATION:

On 02/28/2022, Complainant alleged that staff are not trained to deal with aggressive behavioral residents. Complainant reported that law enforcement had to respond to this facility numerous times for aggressive residents.

On 03/11/2022, I interviewed Ms. Aubry Napier regarding the allegations. Ms. Napier reported that all direct care staff at this facility are trained in crisis management and intervention. Ms. Napier reported that when she first took over this facility, she noticed that staff were prone to calling law enforcement immediately when behavioral incidents occurred. Ms. Napier reported that when she reviewed this practice with direct care staff, she was informed that staff were instructed to do so by the previous home manager, Ms. Tiffany Ablin. Ms. Napier reported that she had since met with all staff and put an end to this practice. Ms. Napier agreed to provide documentation of direct care staff training in crisis management and intervention.

On 03/11/2022, I reviewed the training documentation for the direct care staff at this facility. I determined that all direct care staff received several types of training in crisis management and intervention from the Crisis Prevention Institute and the licensee.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas: **(h) Nonaversive techniques for the prevention and treatment of challenging behavior of clients.**

ANALYSIS:	During this investigation, I reviewed training documentation for all staff at this facility and confirmed that all staff have received training in nonaversive techniques for the prevention and treatment of challenging behavior.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B was discharged without notice.

INVESTIGATION:

On 02/28/2022, Complaint reported that Resident B was involved in an altercation with another resident. Complainant alleged this facility did not allow Resident B to return to the facility due to Resident B's aggressive behavior. Complainant acknowledged that Resident B was issued a *No Contact Order* with the resident she had assaulted who still resided at the facility.

On 02/28/2022, I contacted adult protective services worker Jennifer Stockford regarding the allegations. Ms. Stockford reported that an altercation occurred between Resident B and another resident, and the facility refused to allow Resident B to return to the facility. Ms. Stockford reported speaking to the District Manager for this facility who informed her that Resident B was never provided a discharge notice from this facility but was issued a *No Contact Order* by Calhoun County Probate County due to Resident B's physical aggression towards another resident.

On 04/11/2022, I reviewed the *AFC Licensing Division Incident/Accident Report* related to the allegations and dated 02/17/2022. The *AFC Licensing Division Incident/Accident Report* was completed by staff member Haile Lea and included the following information:

> "[Resident B] tried getting out the front door, when staff asked her if she was okay, she stated she wanted to go outside and scream. Staff went outside with [Resident B] and let her scream. [Resident B] screamed and said she wanted to leave Beacon; the home was becoming too much for her. Staff tried talking with her and offered for her to call her brother to help her calm down. [Resident B] then ran back into the home and began throwing apples at the wall and other house mates. Staff tried verbally redirecting her. [Resident B] grabbed a butter knife and tried self-harming. Staff was able to verbally redirect her, and she gave staff the butter knife. [Resident B] then went into the hallway where she started head banging on the wall. While trying to verbally redirect her behaviors, [Resident B] yelled for staff to leave her alone or she is going to punch staff. Since [Resident B] stopped head banging staff stepped back to give her some space to calm down. [Resident B] then went back outside and started screaming, staff continued to allow her to have her space in hopes she would deescalate.

> [Resident B] came back inside the house and sprinted to the living room where another resident was sitting on the couch. She pushed the other resident back into the couch and began repeatedly punching her in the right eye. Staff immediately went over to them while trying to verbally redirect [Resident B], [Resident B] then got off the other resident and went back to the kitchen and grabbed another butter knife and attempted to self-harm again. Staff grabbed all butter knives and forks to put them up and [Resident B] put the butter knife down and ran out the side door again to the yard. Staff attempted to call on-call clinical, no response, so they contacted the police because staff was unable to redirect [Resident B]. [Resident B] continued screaming outside and then ran back inside and locked herself in the bathroom. Staff heard banging so staff knocked and asked her to open the door, when she did not, staff unlocked the door to see her banging her head on the wall. At that time the police arrived and were let in by staff. The officers put [Resident B] in cuffs and took her to jail due to this being the third time coming out to the home in less than 24 hours because of physical aggression, property damage, and assault."

On 04/11/2022, I interviewed staff member Aubry Napier regarding the allegations. Ms. Napier was identified as the district director for this facility. Ms. Napier denied that Resident B was given any type of discharge notice and clarified that Resident B was transferred to new facility due to there being a *No Contact Order* placed between Resident B and the resident she assaulted.

On 04/19/2022, I interviewed Northeast Community Mental Health case manager Tamara Leeck regarding the allegations. Ms. Leeck acknowledged that Resident B did not receive a discharge notice but was moved to a different facility due to having a *No Contact Order* with the resident she assaulted. Ms. Leeck reported that when she was informed of the situation, Resident B was at the county jail. Ms. Leeck reported after consulting with Ms. Aubry Napier and the guardian for Resident B, and it was agreed that Resident B would be brought back to Alpena County. Ms. Leeck reported that on the way to transport Resident B from the jail, placement for Resident B was located in Bay City. Ms. Leeck denied having any concerns for the care provided to Resident B and acknowledged that Resident B has a history of physical aggression.

On 04/19/2022, I completed an exit conference with licensee designee Ramon Beltran II regarding the allegations. Mr. Beltran acknowledged the incident had occurred on 02/17/2022 and clarified that he was coordinating alternative placement for Resident B at another facility operated by the licensee when Northeast Community Mental Health reported they would be picking up Resident B and returning her to Alpena County. Mr. Beltran reported that for these reasons a discharge notice was never provided to Resident B.

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.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	During an interview, Northeast Community Mental Health case manager Tamara Leeck acknowledged that Resident B did not receive a discharge notice but was moved to a different facility due to having a *No Contact Order* with the resident she assaulted. In an interview, licensee designee Ramon Beltran II clarified that he was coordinating alternative placement for Resident B at another facility operated by the licensee when Northeast Community Mental Health reported they would be picking up Resident B and returning her to Alpena County. Mr. Beltran reported that for these reasons a discharge notice was never provided to Resident B.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

This facility has no working phone.

INVESTIGATION:

On 02/28/2022, Complainant alleged the facility does not have a working phone since 02/19/22 due to Resident A ripping out the phone from the wall and now residents don't have a way to contact family, friends, or physicians, etc. Complainant added the phone issue is supposedly being fixed by maintenance.

On 03/03/2022, I interviewed direct care staff Haile Lea regarding the allegations. Ms. Lea acknowledged the telephone was previously broken and repaired by maintenance but had since been broken on 03/02/2022 by another resident. Ms. Lea reported another maintenance request was completed but clarified that nearly all the residents have their own personal cell phone for private communications and staff

have made their own personal cell phones available for private communication until the telephone can be repaired again.

On 03/03/2022, I interviewed Resident C and Resident D regarding the allegations. Resident C and Resident D acknowledged that Resident A had broken the house telephone several days earlier by pulling out the telephone cords from the wall. Resident C and Resident D reported that all residents have their own personal cell phones with the exception of Resident E. Resident C and Resident D reported they have both made their cell phones available to Resident E and added that staff have made their cell phones available to Resident E as well. Resident D clarified that Resident E does not request to use the phone very often. Resident C and Resident D denied being unable to call their family members or friends or clinicians for any reason.

On 04/11/2022, I interviewed Ms. Aubrey Napier regarding the allegations. Ms. Napier acknowledged that most residents used personal cell phones and reported the telephone at this facility had since been repaired.

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: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	During an interview, Resident C and Resident D reported the cell phone in this facility was recently broken by Resident A but clarified that a maintenance request was completed to repair the phone and having their own personal cell phones available for private communication. Resident C and Resident D acknowledged that staff had provided a cell phone to Resident E for private communications. On 04/11/2022, Ms. Aubry Napier reported the telephone in the facility had been repaired.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

04/20/2022

Eli DeLeon Date
Licensing Consultant

Approved By:

04/22/2022

Dawn N. Timm Date
Area Manager