GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 10, 2022

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

RE: License #: AS380398558
Investigation #: 2022A0007025
Beacon Home at Sheffield

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 (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

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 #:	AS380398558
Investigation #:	2022A0007025
Complaint Receipt Date:	06/07/2022
Investigation Initiation Date:	06/08/2022
Report Due Date:	08/06/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Shelly Keinath
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Sheffield
Facility Address:	4162 Sheffield Drive Jackson, MI 49203
Facility Telephone #:	(517) 795-2004
Original Issuance Date:	02/05/2020
License Status:	REGULAR
Effective Date:	08/05/2020
Expiration Date:	08/04/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Ms. Kennedy, Direct Care Staff, could be heard yelling and swearing at the residents. Ms. Kennedy grabbed Resident A's wheelchair aggressively and spun her around, causing her colostomy bag to leak.	Yes

III. METHODOLOGY

06/07/2022	Special Investigation Intake - 2022A0007025
06/07/2022	APS Referral Received.
06/08/2022	Special Investigation Initiated – Letter to ORR
06/08/2022	Referral - Recipient Rights made.
06/09/2022	Inspection Completed On-site - Unannounced - Face to face contact with Home Manager #1, Resident A, Employee #4, other staff and residents.
08/02/2022	Contact - Telephone call made to Employee #1, message left. I requested a returned phone call.
08/02/2022	Contact - Telephone call made to Ms. Kennedy. Interview.
08/03/2022	Contact - Telephone call made to Employee #2. Interview.
08/03/2022	Contact - Telephone call made to Jackson County Guardian A - Message left regarding Resident A and other residents in the home.
08/03/2022	Contact - Telephone call made to Mr. Beltran, Vice President of Operations, to conduct the exit conference. No answer. Mr. Beltran is covering while Ms. Rawlings is out of the office.
08/03/2022	Contact - Document Sent - Email to Mr. Beltran regarding the exit conference.
08/03/2022	Exit Conference conducted with Mr. Beltran, Vice President of Operations.

08/04/2022	Contact – Telephone call received from Guardian A.

ALLEGATIONS:

Ms. Kennedy, Direct Care Staff, could be heard yelling and swearing at the residents. Ms. Kennedy grabbed Resident A's wheelchair aggressively and spun her around, causing her colostomy bag to leak.

INVESTIGATION:

As a part of this investigation, I reviewed the complaint, and the following additional information was noted:

> Resident A is a 33-year-old female, who residents at the Beacon Home at Sheffield AFC home. Resident A has been diagnosed with Autism and Intellectual Disability. Resident A is nonverbal, she requires a wheelchair, and has a colostomy bag.
>
> On the morning of June 7, 2022, Ms. Kennedy was observed slamming a computer, yelling, and swearing in front of the residents. Ms. Kennedy grabbed Resident A's wheelchair aggressively and spun her around very hard while Resident A's colostomy bag was leaking.
>
> Resident A was very disturbed and shaken up due to this but was not injured. Employee #1 intervened, told Ms. Kennedy to stop, and removed Resident A out of the situation. Ms. Kennedy was preparing to leave the home without properly ending her shift. Home Manager #1 came in and told Ms. Kennedy that if she left the home, it would be considered as abandonment. Ms. Kennedy then completed her documentation, per protocol, and left at the end of her shift. Resident A's colostomy bag was changed as needed. Management is working to have Ms. Kennedy terminated.

I also reviewed incident reports, which were completed by Home Manager #1 for Resident A, Resident B, Resident C, Resident D, and Resident E, and the following information was noted:

> When Home Manager #1 arrived at the facility on the morning of June 7, 2022, at 7:00 a.m., Ms. Kennedy and other staff were sitting at the dining room table working on the computer. Another resident [Resident B] came out of her room and Ms. Kennedy was instructed to move, as that was the residents' spot. The resident sat down at the table. Ms. Kennedy was angry as she began yelling that she had no help or training. In addition, that she was new to the home and needed help. When Home Manager #1 asked what she needed help with, Ms. Kennedy slammed the computer closed and began yelling at staff and swearing. Ms. Kennedy stated that she gets "no fucking help and no one showed her any

fucking thing." Employee #2 stated that she was more than willing to help; then Ms. Kennedy turned and yelled at Employee #2, stating no one helps. Ms. Kennedy attempted to push past a resident, pushing the chair with her in it, and once she realized she could not get past, she then pushed past Employee #1 and Employee #2, moving behind them.

Ms. Kennedy then grabbed Resident A's wheelchair and spun her around angrily, causing Resident A to jerk back and forth in her chair. Ms. Kennedy was yelling stating, "I can take care of her." Employee #1 jumped up and stated "no, you cannot." While Ms. Kennedy was holding on to Resident A's wheelchair, she yelled in Employee #1's face that she could care for the resident. Employee #1 pushed herself between Resident A and Ms. Kennedy, pushing Ms. Kennedy out of the way.

At this point, Ms. Kennedy started yelling that she was going to quit and walk out right now. Home Manager #1 then introduced herself, as she worked in another home, and explained that if Ms. Kennedy walked off shift, it would be six cases of rights violations. Ms. Kennedy started huffing and stating she was never trained, and no one helps her. Ms. Kennedy continued to yell at staff. Ms. Kennedy then went outside and used the phone. When she returned to the home, she was crying. Ms. Kennedy stated that she did not know how to change Resident A "and her bag." Employee #3 stated, "Yes, I did show you, I stepped back and was still in the room when you changed it." Ms. Kennedy started crying and walked away. Ms. Kennedy came back with no tears stating that, "I just think all of us should be trained." Home Manager #1 then explained to Ms. Kennedy that her behavior and cussing in front of the residents was not acceptable, and it was not okay to act like that. Home Manager #1 also noted that regarding the training, Ms. Kennedy just needed to ask, as all the girls showed they were willing to train or teach her. Ms. Kennedy just huffed away and completed her documentation.

On June 9, 2022, I conducted an unannounced on-site investigation and made face to face contact with Home Manager #1, Resident A, Employee #4, along with other staff and residents. I interviewed Home Manager #1 and what she reported was consistent with what she had documented in the incident reports. According to Home Manager #1, Resident A did not have any marks or bruises from the incident.

During the on-site investigation, I also interviewed Employee #4. Regarding the day in question, Employee #1 noticed that Resident A's colostomy bag was open, and Employee #4 told Ms. Kennedy that she needed to clean Resident A up. In addition, that the care of the residents was more important than paperwork. Ms. Kennedy had an attitude. While in the dining room, Ms. Kennedy got up, slamming the computer shut, went over, and grabbed Resident A's wheelchair. The way Ms. Kennedy grabbed the wheelchair, caused Resident A to rock back and forth. That is when Employee #1 said to Ms. Kennedy, "No, I got it." Employee #1 and Employee #4 ended up caring for Resident A. Employee #4 was concerned about how Ms.

Kennedy acted and questioned what she does behind their backs, or when no one was looking.

On August 2, 2022, I interviewed Ms. Kennedy. Regarding the day in question, Ms. Kennedy stated that she had just been moved to the home. No one had trained her on how to provide certain medical care procedures. She stated that she was transitioned from a behavioral home to a home with residents who were medically fragile. Ms. Kennedy stated, “I asked for help, and I was ignored.” Ms. Kennedy also stated that one of the staff made a “snarky” remark. Ms. Kennedy informed that she went over to Resident A to take her back and provide the care. Ms. Kennedy stated, “They said that I yanked the wheelchair, but I did not.” I inquired if Resident A’s head and body rocked from side to side, as she (Ms. Kennedy) was turning Resident A around to go back to the room; and Ms. Kennedy denied the allegations. She stated that the wheelchair was in the locked position and once she discovered that, she stopped and had to unlock the wheels; then she proceeded to assist Resident A. This is when an employee, name unknown, shoved her out of the way.

Ms. Kennedy stated that she told Ms. Keinath, Administrator, that they set her up to fail. Ms. Kennedy stated that if she was not going to be trained, that she might as well quit. When she asked for help, no one assisted her. Ms. Kennedy stated that after the incident, she was let go. I followed up and inquired if she was screaming or yelling in front of the residents at any time during this incident, and she stated that she was not. Ms. Kennedy stated that she had a disagreement with Employee #4, but they went outside, and it was not in front of the residents. Ms. Kennedy also expressed concerns regarding some of the operations of the corporation. She voiced concerns about clicks and if staff do not like you then complaints are filed against you. There is favoritism and bullying amongst staff, occurring in the homes. I encouraged Ms. Kennedy to promptly contact the appropriate officials should she have additional concerns regarding the residents in the future.

On August 3, 2022, I interviewed Employee #2. She acknowledged that there was an incident involving Ms. Kennedy, and Resident A. Employee #2 observed Ms. Kennedy inappropriately maneuver Resident A’s wheelchair, in an abrupt manner. Resident A appeared to be shocked with the way she was being handled. Employee #2 stated that Resident A’s eyes got large, as she had not been handled in that manner before. Employee #2 also witnessed Ms. Kennedy swear in front of the residents. Employee #2 witnessed Ms. Kennedy say that she was going to quit, she “didn’t give a fuck” and she “didn’t need the fucking job.”

On August 3, 2022, I conducted the exit conference with Mr. Beltran, Vice President of Operations, who is covering in the absence of Ms. Rawlings, Licensee Designee. I informed him of the investigation, findings, and recommendations. He agreed to submit a written corrective action plan to address the established violation.

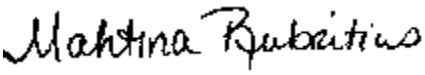
On August 4, 2022, Guardian A returned my phone call. She stated that she is the guardian for all the residents in the home. She was aware of these allegations and

stated that ORR investigated the case as well. It was her understanding that ORR also substantiated the allegations.

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:	On June 7, 2022, Ms. Kennedy handled Resident A in an inappropriate and abrupt manner, causing Resident A to appear shocked. Resident A was not physically injured during this incident. Ms. Kennedy was observed to be upset and cursed in the presence of the residents. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations the residents were not treated with dignity and their personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.



08/03/2022

Mahtina Rubritius — Date
Licensing Consultant

Approved By:

08/10/2022

Ardra Hunter — Date
Area Manager