GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 21, 2022

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

RE: License #: AS630387850
Investigation #: 2022A0991035
Beacon Home at County Line

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

A 1st provisional license was recommended in the Renewal Licensing Study report dated 05/06/22. This recommendation remains in effect. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (248) 975-5053.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

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 #:	AS630387850
Investigation #:	2022A0991035
Complaint Receipt Date:	07/25/2022
Investigation Initiation Date:	07/25/2022
Report Due Date:	09/23/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St. Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at County Line
Facility Address:	10750 County Line Road Ortonville, MI 48462
Facility Telephone #:	(248) 793-7232
Original Issuance Date:	10/10/2017
License Status:	REGULAR
Effective Date:	04/10/2020
Expiration Date:	04/09/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 07/23/22, direct care worker, Anne Dowell, cussed at Resident G and called him bad names.	Yes

III. METHODOLOGY

07/25/2022	Special Investigation Intake 2022A0991035
07/25/2022	Referral - Recipient Rights Call to Office of Recipient Rights (ORR)
07/25/2022	Special Investigation Initiated - Telephone Call to Office of Recipient Rights
07/25/2022	Contact - Telephone call made Left message for home manager, Candace Nickerson
07/26/2022	Contact - Telephone call made Left message for home manager
07/27/2022	APS Referral Call to Adult Protective Services (APS) Centralized Intake
07/28/2022	Contact - Document Received Email from APS- intake does not meet criteria for investigation
07/27/2022	Contact - Document Sent Email to home manager requesting return call
08/02/2022	Inspection Completed On-site Interviewed staff and residents
08/08/2022	Contact - Telephone call made Interviewed home manager, Candace Nickerson
08/08/2022	Contact - Telephone call made Left message for staff, De'Asia Bell

08/09/2022	Contact - Document Sent Email to home manager/compliance director requesting documents
08/12/2022	Contact - Document Received Medication records
08/16/2022	Contact - Telephone call made Interviewed staff, Anne Dowell
08/16/2022	Contact - Document Sent Requested copy of video recording
08/16/2022	Contact - Telephone call received From ORR worker, Sarah Rupkus
08/17/2022	Contact - Document Received Email with video recording of incident
08/22/2022	Contact - Telephone call made Interviewed direct care worker, De'Asia Bell
09/01/2022	Exit Conference Via telephone with licensee designee, Kimberly Rawlings

ALLEGATION:

On 07/23/22, direct care worker, Anne Dowell, cussed at Resident G and called him bad names.

INVESTIGATION:

On 07/25/22, I received an incident report from Beacon Home at County Line. The incident report noted that on 07/23/22 direct care worker, Anne Dowell, arrived for her shift and began asking Resident G about money of his that was reported missing. Resident G stated, “I never told anyone that my money was missing.” Ms. Dowell then proceeded to call Resident G bad names. Staff called the home manager who sent Ms. Dowell home. I created a special investigation intake, which was assigned to me for investigation. I initiated my investigation on 07/25/22 by referring the complaint to the Office of Recipient Rights (ORR). I also made a referral to Adult Protective Services (APS), which was denied for investigation. On 08/02/22, I conducted an unannounced onsite inspection with the assigned ORR worker, Sarah Rupkus.

On 08/02/22, I interviewed direct care worker, Chaelcie Mosley. Ms. Mosley stated that she has worked in the home since July 2022. Approximately two weeks ago on

Saturday, Ms. Mosley was working from 7:00am-7:30pm. Direct care worker, Anne Dowell, arrived early for her shift. She was supposed to come in at 7:00pm, but Ms. Dowell arrived at 5:00pm. Ms. Mosley stated that Ms. Dowell appeared to be under the influence and smelled like liquor. Ms. Mosley did not see Ms. Dowell drinking alcohol and did not see her with any liquor. Ms. Mosley stated that the home manager recently sent a group text message to the staff at Beacon Home at County Line stating that Resident G was missing money. Shortly after Ms. Dowell arrived at the home, she began questioning Resident G about his missing money and became verbally aggressive towards him. Resident G was not aware that any money was missing. Ms. Dowell was yelling at Resident G and telling him that staff did not take his money. She called him a “bitch” and took the remote for the tv. She also called Resident G a criminal and an addict. She told Resident G, “Get out of the office, you stupid bitch.” Ms. Mosley stated that Ms. Dowell also called Resident C a “bitch”. Ms. Mosley stated that she called the home manager, Candace Nickerson, and told her what was happening. Ms. Nickerson came to the facility and sent Ms. Dowell home. Ms. Mosley stated that she felt Ms. Dowell “stepped out of her character” and went too far. Ms. Mosley stated that Ms. Dowell has “gotten into it” with other employees in the past and the residents do not like when she is working in the home.

On 08/02/22, I interviewed direct care work, Remy Walker. Mr. Walker stated that he has worked at Beacon Home at County Line for six or seven months. He stated that he never works shifts with Anne Dowell, because “she has an attitude problem.” He stated that he refuses to work with her. He has “had words with her” a few times during shift change and has heard her arguing with Resident G, Resident C, and Resident R in the past. Mr. Walker stated that he brought Ms. Dowell’s attitude to the attention of management a few weeks ago and the manager stated that she would address it.

On 08/02/22, I interviewed Resident G. Resident G stated that there was an incident with staff, Anne Dowell, recently. He stated that Chaelcie and the other staff who was working have it taped. Ms. Dowell was making “smart ass comments” towards him and was running her mouth. He stated that she acts unprofessional and behaves like a child. Her verbal aggression was mostly directed towards Resident G. He stated that the other staff called the home manager, Candace, and she came to the home. He stated that “she’s on something.” Ms. Dowell’s attitude is different every time she comes on shift. Sometimes she is cool and sometimes she is mean. He did not recall Ms. Dowell calling him a drunk, an addict, or a “bitch”. He stated that she told him he needed to get help and accused him of telling the home manager that someone took his money. He stated that he was not aware of any money being missing. Ms. Dowell came back later and apologized.

On 08/02/22, I interviewed Resident R. Resident R stated that he recalled a time when Ms. Dowell told everyone to come into the living room. She was yelling and cussing at the residents. Resident R stated that Ms. Dowell “always does that crap.” She yells at Resident C and calls him names. She states that she is tired of chasing Resident C. Resident C does not like to take his medications for Ms. Dowell, but he does for other staff. Resident R stated that Ms. Dowell has yelled at Resident G, but he did not recall

what she said. He stated that she “gets lippy” with him sometimes. He is sick of her mouth and does not like to deal with her. He did not recall Ms. Dowell arguing about missing money. He stated that he did hear Ms. Dowell call Resident G a “stupid bitch” or something like that. He heard her call him an addict, but he could not remember when this happened. He stated that she curses at everyone, but he could not recall specifically what she says. Resident R stated that he could smell liquor on Ms. Dowell’s breath. He stated that Ms. Dowell appeared to be high or drunk while on shift “a few times.”

During the onsite inspection, I observed Resident C walking around the home. I was unable to interview Resident C due to his limited cognitive abilities.

On 08/08/22, I interviewed the home manager, Candace Nickerson, via telephone. Ms. Nickerson stated that she has worked with Beacon for two and a half years, and she has been the home manager at Beacon Home at County Line for one month. Ms. Nickerson stated that she has not worked any shifts with Anne Dowell, as Ms. Dowell typically works third shift from 7:00pm-7:30am. Ms. Nickerson stated that on 07/23/22, she received phone calls from the staff on shift, Chaelcie and De’Asia, stating that Ms. Dowell appeared to be intoxicated. Ms. Nickerson contacted the vice president of Beacon, Ramon Beltran, who instructed her to go to the home and see if Ms. Dowell appeared to be intoxicated. When Ms. Nickerson arrived at the home, Ms. Dowell was passing medications. She did not appear to be intoxicated to Ms. Nickerson. Ms. Dowell was not stumbling or slurring her words, and she did not smell like alcohol. The staff on shift reported to Ms. Nickerson that Ms. Dowell was cussing at Resident G and “going off on him.” They told Ms. Nickerson that Ms. Dowell called Resident G an addict and told him that he was using his mental illness as an excuse. Ms. Dowell called Resident G “a son of a bitch.” Ms. Nickerson was not aware of staff taking a video of this incident. Ms. Nickerson asked Ms. Dowell to leave for the night after completing shift change duties with her, which includes doing a medication count of the narcotics. Ms. Dowell refused to do the shift change duties and snuck out of the house through the garage.

Ms. Nickerson stated that she spoke to Resident G about the incident, and he told her not to contact recipient rights. He stated that Ms. Dowell does this often. It was not the first time. Ms. Nickerson stated that this type of behavior was never reported to her prior to that night. She stated that Ms. Dowell began arguing with Resident G because she thought he reported his money missing and she kept telling Resident G that he was trying to get staff in trouble. Ms. Nickerson stated that Resident G did not report his money missing. Ms. Nickerson sent a text message to the staff after she could not locate Resident G’s incentive money that he earns. Ms. Nickerson thought the money was in the middle drawer, but she later located it in the top drawer of the filing cabinet. Resident G was never aware of an issue with his money and Ms. Dowell questioned him about the money without having the authority to do so. Ms. Nickerson stated that Ms. Dowell was only sent home for that night. She is back on the schedule and did not receive a formal write up. Ms. Dowell works third shift, so she typically works alone. Ms. Nickerson stated that she did not feel comfortable with Ms. Dowell working alone in the

home and that they were trying to schedule someone else to work with her. Since 07/23/22, Ms. Dowell worked at least two shifts by herself.

On 08/08/22, I interviewed Resident J. Resident J stated that he has lived in the home for three months. He stated that he recalled a time when Ms. Dowell was working in the home, and she was cursing at Resident G. He stated that Ms. Dowell and Resident G went into the office, and he heard a noise, which sounded like a stumble. They came out of the office and Ms. Dowell was yelling at Resident G. This went on for five to ten minutes. He stated that they were in the living room, and he was trying to get away from it. He stated that he has a bad memory and could not recall exactly what she was saying. Resident J stated that Ms. Dowell does not yell at him, and she treats him fair. He only heard her argue with Resident G. He stated that he never smelled alcohol on Ms. Dowell and she never appeared to be drunk or high.

On 08/12/22, I received an email from Michelle Brausch, Beacon's Director of Compliance for the East Region. Ms. Brausch stated that Anne Dowell was suspended pending the outcome of the investigation.

On 08/16/22, I interviewed direct care worker, Anne Dowell, via telephone. Ms. Dowell stated that she has worked at Beacon Home at County Line for six months. She stated that there was an incident recently when the home manager, Candace Nickerson, sent her home. Ms. Dowell initially stated that she was not told why she was being sent home. She later stated that another staff person was taping her and told the home manager that she was speaking inappropriately to the residents. Ms. Dowell stated that she "had a conversation" with Resident G. Resident G has substance abuse issues and frequently elopes from the home. Ms. Dowell was irritated that day because staff received a text message from the home manager about Resident G's missing money. Ms. Dowell assumed that Resident G took his money since he is always leaving the home and purchasing alcohol. She questioned Resident G about the missing money. He stated that he did not report any missing money. Resident G got irritated and told Ms. Dowell to "fuck off". Ms. Dowell became irritated with Resident G. She stated that she told him he was "playing the mental health card" and she did call him an addict. She could not remember exactly what else she said to him.

Ms. Dowell admitted that her tone was not pleasant. She stated that she was not screaming, but voices were raised. She did not handle the situation well and it was not her best moment. Ms. Dowell stated that she did not recall calling Resident G a "stupid bitch". She stated that she did not recall swearing at anyone or calling anyone names. She did not take the remote or touch the tv. Ms. Dowell denied ever being drunk or high while on shift. Ms. Dowell stated that there were two other staff people present during this incident, but she did not recall their names. She stated that she usually works third shift and does not know the day shift staff. Ms. Dowell stated that she has been frustrated with other staff in the home recently, because they do not complete their shift duties. She stated that it is a hostile work environment, and she is viewed as the "snitch" because she follows the rules and will not sign off on medication counts if they are not correct.

On 08/22/22, I interviewed direct care worker, De'Asia Bell, via telephone. Ms. Bell stated that she does not typically work at Beacon Home at County Line, but she was covering a shift in the home on 07/23/22. She stated that she was the one who reported the incident to the home manager, Candace Nickerson. Resident G had just returned to the home after eloping, and the home manager sent out a text message about Resident G's missing money. When Ms. Dowell arrived at the home, she "jumped down Resident G's throat." She was asking Resident G why he was telling the home manager that his money was missing, and she began yelling and screaming at him. Ms. Dowell called Resident G a "crackhead" and a "bitch". Ms. Dowell was taking the remote for the TV and was vacuuming so that Resident G could not hear the tv. She refused to take a break and was snapping at everyone. Ms. Bell stated that this went on for an hour. Ms. Bell began recording the altercation. She later sent the video to an area manager. Ms. Bell stated that Resident G got upset and asked Ms. Dowell to leave him alone. He threw the remote and flipped the couches over. Ms. Bell called the home manager and took Resident G outside to the porch. Ms. Bell stated that she smelled alcohol on Ms. Dowell. Ms. Dowell also pulled her car into the garage and kept going back and forth to her car. Ms. Bell stated that the home manager came to the facility and sent Ms. Dowell home. Ms. Dowell refused to complete shift change duties and just left the home.

On 08/17/22, I received and reviewed copies of the cell phone video recordings taken by Ms. Bell. In the videos, Ms. Dowell can be heard telling Resident G, "You're an asshole." She states, "I have a job, do you? You got a job? You do anything? No. You're playing the mental health card. 'I'm crazy.' No, you're not. You're a drunk. You're an addict." Ms. Dowell also states, "You're a sociopath." Resident G states to Ms. Dowell, "Did you take your medication? I don't think you did. You're acting kind of strange." Ms. Dowell responds by stating, "Fuck off. You're a fucking stupid bitch." Resident G calls Ms. Dowell a "bitch." Ms. Dowell stood up from the table where she was sitting and approached Resident G. Her voice was raised as she accused Resident G of telling the home manager that staff were stealing his money. Ms. Dowell then states, "You're nothing but a street thug."

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that direct care worker, Anne Dowell, is not suitable to meet the emotional and social needs of each resident. On 07/23/22, Ms. Dowell was recorded by the other staff on shift being verbally aggressive and making inappropriate comments towards Resident G. While

	Ms. Dowell denied being drunk or under the influence of drugs while on shift, both direct care workers on shift, Chaelcie Mosley and De'Asia Bell, stated that they smelled alcohol on Ms. Dowell. Resident R also stated that he smelled liquor on Ms. Dowell's breath and Resident G stated that she was "on something."
CONCLUSION:	**VIOLATION ESTABLISHED**

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: (ii) Verbal abuse. (iii) Derogatory remarks about the resident or members of his or her family.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that direct care worker, Anne Dowell, was verbally abusive and made degrading comments towards Resident G on 07/23/22. The staff and residents who were interviewed all reported that they witnessed Ms. Dowell being verbally aggressive towards Resident G. Ms. Dowell admitted that she called Resident G an addict and told him that he was playing the mental health card. Video taken by another staff on shift shows Ms. Dowell calling Resident G a drunk, an addict, a sociopath, a street thug, and a "stupid fucking bitch."
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my interview with the home manager, Candace Nickerson, on 08/08/22, Ms. Nickerson stated that she arrived at the home around 7:30-8:00pm on 07/23/22. Anne Dowell was in the process of passing medications. Ms. Nickerson asked Ms. Dowell to complete shift change duties and count medications with her before sending her home for the night due to her verbal altercation with Resident G. Ms. Dowell refused to complete shift change duties and left the home. Ms. Nickerson stated that Resident C's

8:00pm medications were not initialed in the electronic medication administration record (eMAR). The other residents stated that Resident C received his medications. Ms. Nickerson stated that she could not tell if Resident C received his medications or not, as it was not clicked on the computer, and she could not determine if medications were passed from the bubble packs. She tried to contact Ms. Dowell, but Ms. Dowell did not respond. Ms. Nickerson did not want to give Resident C his medications twice, so she called the on-call nurse. The nurse instructed her not to pass the medications. Ms. Nickerson wrote a missed medication note in the eMAR and did not pass the medications.

Beacon Home at County Line utilizes an electronic medication administration record (eMAR) system. Staff click and initial within the computer system to indicate that medications were administered. They also print a "paper MAR" as a backup, which staff initial by hand if the computer system is not functioning properly.

I reviewed Resident C's eMAR and paper MAR for July 2022 and noted the following:

- The 8:00pm medications on 07/23/22 were initialed by Candace Nickerson "CN*9" indicating that there was an exception, and the medication was not passed.
- The eMAR and paper MAR were not initialed for the following medicaitons:
    - 8:00am dose of Amlactin 12% on 07/29/22
    - 8:00pm dose of Amlactin 12% on 07/01/22 or 07/25/22
    - 8:00pm dose of Atorvastatin 10mg on 07/01/22 or 07/25/22
    - 8:00pm dose of Clonazepam 0.5mg on 07/01/22 or 07/25/22
    - 8:00pm dose of Clonazepam 1mg on 07/01/22 or 07/25/22
    - 8:00pm dose of Divalproex 500 mg on 07/01/22 or 07/25/22
    - 8:00am dose of Docusate Sodium 100mg on 07/29/22
    - 6:00am dose of Humalog Insulin (sliding scale dosage) on 07/14/22 or 07/26/22
    - 12:00pm dose of Humalog Insulin (sliding scale dosage) on 07/03/22, 07/25/22, 07/26/22, or 07/28/22
    - 5:00pm dose of Humalog Insulin (sliding scale dosage) on 07/08/22, 07/13/22, 07/23/22, or 07/25/22
    - 8:00pm dose of Humalog Insulin (sliding scale dosage) on 07/01/22, 07/03/22, or 07/25/22
    - 8:00am dose of Lactulose 10G/15ML on 07/25/22
    - 6:30am dose of Levothyroxine 75mcg on 07/26/22
    - 8:00pm dose of Lithium ER 300mg on 07/01/22 or 07/25/22
    - 8:00am dose of Lorazepam 1mg on 07/29/22
    - 8:00pm dose of Lorazepam 1mg on 07/01/22 or 07/25/22
    - 8:00pm dose of Paliperidone ER 3mg on 07/01/22 or 07/25/22
    - 8:00pm dose of Trazodone HCL 50mg on 07/01/22 or 07/25/22

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not initial Resident C's medication administration record (MAR) at the time medications were passed. Resident C's electronic medication administration record (eMAR) was not initialed for 8:00pm medications on 07/23/22 when the home manager arrived at the facility and sent the medication passer, Anne Dowell, home for the evening. It could not be determined if the medications were passed or not. Resident C's eMAR was also missing several initials throughout the month of July 2022 and staff did not initial the backup paper MAR. The medication logs were not initialed for 8:00pm medications on 07/01/22 or 07/25/22 and 8:00am medications on 07/29/22. Resident C's Humalog Insulin (sliding scale dosage) was not initialed for the 6:00am dose on 07/14/22 or 07/26/22; the 12:00pm dose on 07/03/22, 07/25/22, 07/26/22, or 07/28/22; the 5:00pm dose 07/08/22, 07/13/22, 07/23/22, or 07/25/22; or the 8:00pm dose on 07/01/22, 07/03/22, or 07/25/22.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Renewal Licensing Study Report dated 07/28/20; CAP dated 08/07/20; Special Investigation Report #2022A0993005 dated 01/27/22; CAP dated 01/31/22; Renewal Licensing Study Report dated: 05/06/22**

INVESTIGATION:

During the onsite inspection on 08/02/22, I observed two portable space heaters in the manager's office/laundry room. One of the heaters was plugged in and the other was unplugged and sitting under the desk.

On 09/01/22, I conducted an exit conference via telephone with the licensee designee, Kimberly Rawlings. Ms. Rawlings stated that Anne Dowell quit and is no longer

employed with Beacon. She stated that Beacon Home at County Line is in the process of implementing a new medication system, which should address the ongoing medication issues. Ms. Rawlings also stated that the space heaters have been removed from the home. Beacon contested the provisional license recommendation that was made in the renewal licensing study report dated 05/06/22. A compliance conference was held on 08/10/22. Ms. Rawlings stated that Beacon administration is in the process of deciding if they will move forward with requesting an administrative hearing or accept the provisional license.

APPLICABLE RULE	
R 400.14510	**Heating equipment generally.**
	(5) Portable heating units shall not be permitted.
ANALYSIS:	Based on my observation during the onsite inspection on 08/02/22, there is sufficient information to conclude that portable heaters were being used in the facility. I observed two portable heaters in the office area of the home. One of the heaters was plugged in and the other was under the desk.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

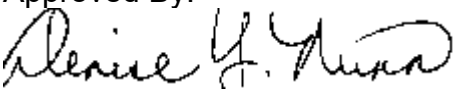
A 1st provisional license was recommended in the Renewal Licensing Study report dated 05/06/22. Contingent upon the receipt of an acceptable corrective action plan, the recommendation for a 1st provisional license remains in effect.

09/01/2022

_____

Kristen Donnay Date
Licensing Consultant

Approved By:



09/21/2022

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Denise Y. Nunn Date
Area Manager