GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 29, 2022

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

RE: License #: AS390403155
Investigation #: 2022A0581048
Beacon Home At Ravine

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

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 #:	AS390403155
Investigation #:	2022A0581048
Complaint Receipt Date:	09/01/2022
Investigation Initiation Date:	09/02/2022
Report Due Date:	10/31/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At Ravine
Facility Address:	6595 Ravine Road Kalamazoo, MI 49009
Facility Telephone #:	(269) 488-3967
Original Issuance Date:	04/21/2020
License Status:	REGULAR
Effective Date:	10/21/2020
Expiration Date:	10/20/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff and identified home manager, Monique Johnson, verbally and physically assaulted Resident A.	Yes

III. METHODOLOGY

09/01/2022	Special Investigation Intake 2022A0581048
09/01/2022	APS Referral Referral was made by the facility.
09/02/2022	Referral - Recipient Rights Confirmed ISK received allegations and are investigating.
09/02/2022	Special Investigation Initiated - Telephone Contact with ISK RRO, Lisa Smith.
09/02/2022	Contact - Document Received Received videos of alleged incident and photos of Resident A's injuries.
09/07/2022	Inspection Completed On-site Interview with staff and residents.
09/12/2022	Contact - Telephone call received MiTeam interviews with staff.
09/12/2022	Contact - Document Received Received Kalamazoo Sheriff's Office police report #: # 22-29189
09/15/2022	Contact - Telephone call made Attempted to contact direct care staff, Monique Johnson, but unable to leave a voicemail.
09/20/2022	Inspection Completed-BCAL Sub. Compliance
09/28/2022	Exit conference with Licensee Designee, Ramon Beltran, via telephone.

ALLEGATION:

Direct care staff and identified home manager, Monique Johnson, verbally and physically assaulted Resident A.

INVESTIGATION:

On 09/01/2022, the facility's District Director, Jamara White, contacted Adult Foster Care Consultant, Eli Deleon, to report the facility's home manager had been verbally and physically aggressive with Resident A on 08/31/2022. She reported the incident had been video recorded by other direct care staff within the facility. Ms. White indicated to Mr. Deleon that law enforcement, Adult Protective Services (APS), and Integrated Services of Kalamazoo (ISK) Recipient Rights Office (RRO) had been notified as well. Ms. White indicated the home manager would be terminated.

On 09/02/2022, I confirmed with ISK RRO, Lisa Smith, she received the allegations and was investigating. Ms. Smith sent via email copies of four pictures of Resident A's injuries and two video recordings of the alleged incident.

The four pictures consisted of one picture of Resident A's bruised eye and the remaining three pictures were of Resident A's bruised arms. The pictures showed Resident A's entire right eye was covered in a dark purple bruise. The bruise covered her eye lid and extended to her cheek area. I also observed parts of her eyeball to be red potentially from a broken blood vessel. I reviewed the arm pictures, which showed an approximate two inch by one-inch purple bruise in the middle of Resident A's left forearm. The second arm picture showed Resident A's bruised left elbow and another approximate two inch by one-and-a-half-inch sized bruise in the middle of her left tricep. Both bruises had green and purple hues. The third arm picture showed two additional bruises on Resident A's left bicep. Both bruises were approximately a half inch by two inches and were also shades of green and purple.

The first video I reviewed showed the facility's home manager, Monique Johnson, in what appeared to be a corner of the facility's dining room. Ms. Johnson was observed with her left hand on the facility wall above Resident A, just a couple inches from her face, angrily shouting and yelling at her, "It's taking God and all his angels to keep me from beating your ass! Do you understand me?

The second video I reviewed did not show anything other than a black screen, but I could hear sound. The beginning of the video had rustling sounds, and then someone yelled, "Stop!". I also heard someone yell, "Guys, let go!". There were sounds of what appeared to be slapping or punching and then I heard someone yell, "Monique!" several times in a row. I then heard someone crying and wailing loudly. I then heard someone yell, "Get up!". I heard the crying and wailing continue. I also heard someone say, "Liz, you got to chill."

On 09/07/2022, I conducted an unannounced onsite inspection, in conjunction with Ms. Smith. I interviewed Resident A in her bedroom. Resident A recalled a recent incident with Ms. Johnson. She stated prior to Ms. Johnson hitting her in the eye and left knee with a closed fist, Resident A had been throwing things in the facility. She indicated she had thrown a chair at Resident B, picture frames, plants, and various arts and craft materials. I observed Resident A's right eye faintly bruised but did not observe any arm bruises.

Ms. Smith and I interviewed Resident B who stated on the night of the alleged incident, Resident A had grabbed Ms. Johnson around the neck and then Ms. Johnson "lost it". She stated Ms. Johnson hit Resident A in the eye with a closed fist. She indicated direct care staff, Camilla Perry, tried telling Ms. Johnson to stop.

Ms. Smith and I interviewed direct care staff, Camilla Perry and Indiah Darden, at the facility. Ms. Perry stated she has been working at the facility since approximately November 2020. She stated on the day of the incident, Resident A was not displaying any behaviors until around 5 pm when she stated she had "mono" and wanted to go the hospital. Ms. Perry indicated she contacted Ms. Johnson to ask about transporting Resident A to the hospital, but Ms. Johnson told her not to due Resident A not being sick. Ms. Perry stated Resident A began to display behaviors, which included throwing a chair at Resident B. Ms. Perry stated she contacted on-call medical who advised her to contact the on-call clinical staff as Resident A was having behavioral issues. Ms. Perry stated Resident A requested a PRN, or as needed, medication to help calm herself down, which Ms. Perry administered to her. Ms. Perry stated approximately five minutes after administering Resident A's PRN, Ms. Johnson showed up to the facility. Ms. Perry stated Resident A was in her bedroom "being quiet", but Ms. Johnson came into her bedroom and told her to clean up the messes she made throughout the facility. Ms. Perry stated Ms. Johnson had a "heavy" tone and was intermittently swearing at Resident A. Ms. Perry stated when Ms. Johnson was yelling at Resident A in her bedroom, it upset Resident C who then started screaming, pulling her hair, and yelling she wanted to go home.

Ms. Perry stated she took Resident C outside to help calm her down. She stated she had only gone back into the facility to get Resident C a PRN medication at which time she observed Ms. Johnson and Resident A at the facility dining table. She stated Ms. Johnson was yelling at Resident A. She stated for example, she was yelling at Resident A to apologize to Resident C, but Ms. Perry stated Resident A wasn't receptive to apologizing. Ms. Perry stated, at some point, Ms. Johnson and Resident A were standing up and Ms. Johnson was standing over Resident A but was not touching her. She stated Ms. Johnson "just got louder" and "madder." She stated Resident A appeared "calm" and was not saying anything to Ms. Johnson. Ms. Perry stated she walked back out of the facility to address Resident C, but then went back into the facility when she heard direct care staff, Amaya Boehm, screaming, "No, Monique, no!". She stated when she came into the facility, she saw Ms. Johnson leaning over Resident A and telling her to get up. She stated Resident A was on the floor, on her side and in a cradled position.

Ms. Perry stated she had never seen Ms. Johnson physically assault any of the residents before the incident; however, she indicated Ms. Johnson had a “stern tone” with residents.

Ms. Darden stated she had only been working at the facility for approximately two weeks when the incident occurred. She indicated she and Ms. Boehm were shadowing Ms. Perry and direct care staff, Jayla Lockhart. Ms. Darden’s statement to me was consistent with Ms. Perry’s statement to me. Ms. Darden provided additional information as to more specific statements made by Ms. Johnson to Resident A. She stated when Ms. Johnson arrived at the facility and Resident A was in her bedroom, Ms. Johnson asked Ms. Darden, “where the hell she at?” in reference to Resident A’s location. Ms. Darden stated when she told Ms. Johnson Resident A was in her bedroom, Ms. Johnson replied, “No, fuck that!” and yelled at Resident A, “Get your ass out that room!”. After the assault took place, Ms. Darden stated Ms. Johnson stated to her, “I just whooped her ass”.

On 09/12/2022, Ms. Smith and I interviewed direct care staff, Jayla Lockhart, via MiTeams. Ms. Lockhart’s statement to me was consistent with previous staff’s statements to me. She stated when Ms. Johnson arrived at the facility she appeared “erratic” and was “on a level 10.” She stated she was following Resident A around the facility yelling at her to “pick this shit up” in reference to the things Resident A threw around the facility.

We also interviewed direct care staff, Amaya Boehm, via MiTeams. Ms. Boehm’s statement to me was consistent with previous staff’s statements to me. Ms. Boehm stated she observed Ms. Johnson assault Resident A in the dining room. She stated Resident A had gone around the facility picking things up that she had thrown, but Ms. Johnson grabbed her by the back of the shirt towards her neck area leading her around the facility indicating the items she needed to pick up. She stated when Ms. Johnson was in the corner with Resident A, she was telling Resident A to kick her and that she “didn’t give a fuck about losing [her] job.” Ms. Boehm stated she also heard Ms. Johnson tell Resident A she hoped her breath stunk. Ms. Boehm stated Resident A then kicked Ms. Johnson and grabbed at her necklace. She stated that was when Ms. Johnson grabbed Resident A’s hair, pushed her head against the facility wall, took her to the ground and punched her. Ms. Boehm stated she yelled at Ms. Johnson to get off Resident A.

On 09/12/2022, I received and reviewed Kalamazoo Sheriff’s Office police report # 22-29189. According to my review of the police report, Deputy Nick Sawicki interviewed Ms. Johnson who denied the allegations of assaulting Resident A. Ms. Johnson reported to Deputy Sawicki when she arrived back to the facility on 08/31/2022, Resident A already had a bruise under her eye. Ms. Johnson reported to Deputy Sawicki she had no idea how Resident A obtained the bruise on her eye, but indicated Resident A got the bruising from throwing tantrums and slamming

doors. Additionally, Deputy Sawicki's review of the two videos were consistent with my review of the two videos documenting the assault.

On 09/12/2022, Ms. White stated Ms. Johnson's employment had been terminated.

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 08/31/2022, Resident A was verbally and physically assaulted by direct care staff and home manager, Monique Johnson. Ms. Johnson was observed by direct care staff, Amaya Boehm, and Resident B, engaging in the assault, which included swearing at Resident A and punching her in the face. Though videos did not show the actual assault, it provided evidence of Ms. Johnson verbally assaulting Resident A and direct care staff could be head yelling at Ms. Johnson to "stop" indicating Ms. Johnson was assaulting Resident A. Subsequently, Resident A was not provided with protection and safety on 08/31/2022, as required.
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: **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(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:	Based on my investigation, which included a review of two videos, pictures of Resident A's injuries, a review of Kalamazoo Sheriff's Department police report # 22-29189, and interviews with multiple direct care staff, and interviews with Resident A and Resident B, there is substantial evidence establishing home manager, Monique Johnson, was verbally threatening and assaultive to Resident A on 08/31/2022. Multiple direct care staff stated Ms. Johnson swore at Resident A and in conjunction with Ms. Boehm's interview and my review of the videos, there is evidence Ms. Johnson used physical force on Resident A, which caused Resident A to have a black eye and bruising on her arms.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Ms. Perry stated that once her shift was over at 7:30 pm, she left the facility. She stated she did not check on Resident A or assess her for injuries. She also stated she did not contact RRO, APS or the police to report the incident.

Ms. Darden stated she did not contact 911 while the incident was occurring or after it occurred. She stated she contacted a Human Resource (HR) personnel to report it because the HR person was who she had been communicating the most with since she'd been hired.

Ms. Boehm stated she observed Ms. Johnson grab Resident A's hair, push her head against the facility wall and punch her in her the face. Ms. Boehm also stated she did not contact 911 or help Resident A obtain medical attention after the incident.

Ms. Smith and I interviewed the facility's District Director, Jamara White, via MiTeams. Ms. White stated she had gotten a call around 9 or 10 pm on 08/31/2022 from a Human Resource personnel who stated a resident had been assaulted. She stated the HR person didn't provide much information about the incident. Ms. White indicated the police came out to interview Resident A and direct care staff but confirmed Resident A did not go to the Emergency Room (ER).

Ms. White stated the following morning Resident A requested to go to the ER because she thought she had a concussion; however, Ms. White stated she contacted Resident A's guardian, Guardian A1 (who needed to give approval), but Guardian A1 told Ms. White Resident A didn't need to be seen at the ER. Ms. White later learned Ms. Johnson had contacted Guardian A1 after the incident and reported to Guardian A1 Resident A had been having behaviors and got injured by

running into a facility door. Ms. White stated that based on that information, Guardian A1 believed Resident A did not need to be seen at the ER and did not require medical attention.

Based on my review of the police report, the incident occurred at approximately 5:30 pm and lasted until 6 pm. The police report indicated police were notified of the incident at approximately 8 pm.

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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Four direct care staff were working on 08/31/2022 and either witnessed or were aware of Resident A getting assaulted by the facility's home manager, Ms. Johnson, and they neither called 911 to assist her nor called on her behalf. Subsequently, Resident A's rights of being treated with dignity and respect as a vulnerable adult were not safeguarded, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Based on my investigation, the facility's home manager, Ms. Johnson, physically assaulted Resident A on 08/31/2022 sometime between 5 pm and 6 pm, by slamming her head against the facility wall and punching her causing injuries. Despite multiple direct care staff being aware of the assault and/or observing it, none of the direct care staff working sought immediate medical attention for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/28/2022, I conducted my exit conference with the Licensee Designee, Ramon Beltran, via telephone. Mr. Beltran acknowledged and agreed with my findings. He indicated he had already spoken to staff about contacting the appropriate parties when they witness any staff or management engaging in inappropriate and/or aggressive behavior. Mr. Beltran stated at the time he terminated Ms. Johnson she neither admitted nor denied the assault took place.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

09/29/2022

Cathy Cushman Date
Licensing Consultant

Approved By:

09/29/2022

Dawn N. Timm Date
Area Manager