GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 7, 2022

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

RE: License #: AS250395771
Investigation #: 2022A0569059
Beacon Home at Linden

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.

A six-month provisional license is recommended. 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.

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) 643-7960.

Sincerely,

Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250395771
Investigation #:	2022A0569059
Complaint Receipt Date:	09/27/2022
Investigation Initiation Date:	09/28/2022
Report Due Date:	11/26/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Rawlings
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Linden
Facility Address:	14180 N. Hogan Road Linden, MI 48451
Facility Telephone #:	(269) 214-4341
Original Issuance Date:	10/09/2018
License Status:	REGULAR
Effective Date:	04/09/2021
Expiration Date:	04/08/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
• **Leandria Berry, staff person, was in an accident with the facility van while transporting Resident A and Resident B, then left the scene of the accident.**	Yes
• **Resident A and Resident B smoked marijuana at the facility.**	Yes

III. METHODOLOGY

09/27/2022	Special Investigation Intake 2022A0569059
09/27/2022	APS referral Complaint received from APS
09/28/2022	Special Investigation Initiated - Letter Email to Matt Potts, RRO.
11/01/2022	Inspection Completed On-site
11/01/2022	Contact - Telephone call made Attempted contact with Leandria Berry. Left voicemail requesting a return phone call.
11/02/2022	Contact - Telephone call made Contact with Matt Potts, RRO.
11/02/2022	Contact - Telephone call made Contact with Pat Shepard, RRO.
11/02/2022	Contact - Telephone call made Contact with Levan Whiteside.
11/02/2022	Contact - Telephone call made Attempted contact with Leandria Berry. Left voicemail.
11/02/2022	Inspection Completed-BCAL Sub. Non-Compliance
11/03/2022	Exit Conference Exit conference with Kim Rawlings, licensee designee.
11/07/2022	Contact- Document Sent.

	Email sent to Sgt. Reid, Flint City P.D. requesting a copy of the police report.
11/07/2022	Recommend Modify to Provisional

ALLEGATION:

Leandria Berry, staff person, was in an accident with the facility van while transporting Resident A and Resident B, then left the scene of the accident.

INVESTIGATION:

This complaint was received via the on-line complaint portal and the adult protective services central intake department. The complainant reported that the facility van was observed to have damage, but when Katherine Blackburn, facility manager, asked staff and residents how the damage occurred no one would admit to what had happened. The complainant reported that Resident A then stated that Leandria Berry, staff person, was driving the van while transporting Resident A and Resident B when she hit another vehicle. The complainant reported that Ms. Berry did not stop and did not report the accident to anyone.

An unannounced inspection of this facility was conducted on 11/1/22. Resident A was alert and oriented to person, place, and time. Resident A was appropriately dressed and groomed with no visible injuries. Resident A stated that he did not remember the exact date of the accident, but that he was sitting in the back seat of the van when Ms. Berry was driving the van. Resident A stated that Ms. Berry was in “the middle lane” that was supposed to “go straight” through the intersection. Resident A stated that Ms. Berry then tried to turn left and hit another car in the left turning lane. Resident A stated that a man in a yellow vest started waiving his arms and yelling for Ms. Berry to pull the van over, but Ms. Berry stated, “I’m not stopping” and “sped off” without stopping. Resident A stated that Resident B was also in the van. Resident A stated that there were no other staff or residents in the van when this incident occurred. Resident A stated that his neck hurt following the accident, but he was not seriously injured. Resident A stated that he finally reported the accident to Ms. Blackburn on 9/26/22 when he had learned that Ms. Berry had been fired from her employment.

Resident B was alert and oriented to person, place, and time on 11/1/22. Resident B was appropriately dressed and groomed with no visible injuries. Resident B stated that he was riding in the van when Ms. Berry hit another vehicle. Resident B stated that Ms. Berry then drove away without stopping. Resident B stated that he was not injured. Resident B did not give any additional information.

Matt Potts, recipient rights officer, stated on 11/2/22 that he investigated this allegation and was citing Ms. Berry for a recipient rights violation. Mr. Potts stated that he

determined that Ms. Berry was in an accident in the van while transporting Resident A and Resident B and did not report the accident. Mr. Potts stated that if Ms. Berry would have reported the accident, the residents would have been examined by a physician to determine if they needed medical treatment for any injuries. Mr. Potts stated that Ms. Berry's failure to report the accident was neglectful of the residents' rights.

Katherine Blackburn, facility manager, stated on 11/1/22 that she noticed that the facility van had damage on 9/15/22. Ms. Blackburn stated that she asked the staff and residents what had happened to the van, but no one would give any information. Ms. Blackburn stated that Leandria Berry, staff person, was terminated from employment on 9/26/22 for mistreating the residents and poor job performance. Ms. Blackburn stated that when she informed the residents that Ms. Berry had been fired, Resident A then stated that the van was damaged in an accident when Ms. Berry was driving it. Ms. Blackburn stated that she then informed the Flint City Police of the date, time, and approximate area where the accident happened, and gave Ms. Berry's information to a detective. Ms. Blackburn stated that she believes that Ms. Berry is currently in jail.

Ms. Blackburn completed an incident report on 10/11/22. The incident report (IR) documents that Resident A disclosed that Ms. Berry was driving the facility van on 9/14/22 while transporting Resident A and Resident B. The IR documents that Resident A disclosed that Ms. Berry hit another vehicle, then drove away from the scene without stopping. The corrective measures documented in the IR were that Ms. Berry has been terminated from employment. Ms. Berry's file contains a copy of her valid Michigan driver's license active at the time of the accident.

Multiple attempts have been made to contact Ms. Berry via telephone. Ms. Berry has not responded to the attempted phone contacts to give a statement regarding this incident.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	Resident A and Resident B stated that they were in the facility van when Ms. Berry was transporting them. Both Resident A and Resident B stated that Ms. Berry hit another vehicle while driving the van, and then refused to stop. Ms. Blackburn and Mr. Potts stated that Ms. Berry also did not report this accident on 9/14/22 so Resident A and Resident B were not taken to the doctor until after Resident A disclosed the accident on 10/11/22. Mr. Potts stated that he is citing Ms. Berry for neglecting Resident A and Resident B's need to be medically assessed. Based on the statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A and Resident B smoked marijuana at the facility.

INVESTIGATION:

The complainant reported that Resident B went on an unsupervised family visit on 9/23/22. The complainant reported that Resident B returned to the facility, but staff failed to search Resident B's person as is required in Resident B's plan of service. The complainant reported that Resident B brought marijuana into the facility when he returned from his family visit, and that Resident B and Resident A then smoked the marijuana outside of the facility.

During the inspection on 11/1/22 Resident A was interviewed regarding this allegation. Resident A stated that Resident B did return to the facility from a family visit on 9/23/22 with marijuana. Resident A stated that Resident B offered to let Resident A smoke some of the marijuana, so they went outside of the facility and smoked the marijuana. Resident A stated that he did not know where Resident B got the marijuana, but that staff did not search Resident B when he returned to the facility.

Resident B refused to give a statement regarding this incident when interviewed on 11/1/22 during the inspection. Resident B walked away from the interview when asked about this allegation.

Ms. Blackburn stated on 11/1/22 that a worker from another Beacon facility was working when Resident B returned to the facility and did not know that Resident B was supposed to be searched when he returned to the facility from an unsupervised family visit. Ms. Blackburn stated that Lavan Whiteside, staff person, was also scheduled to work that shift, but had called to say he would be late for his shift. Ms. Blackburn stated

that the next day, she checked the “time clock” and Mr. Whiteside had reported at his normal time, so he also would have been working. Ms. Blackburn stated that Mr. Whiteside stated that he did report for his shift on time and was present when Resident B returned to the facility. Ms. Blackburn stated that she questioned Mr. Whiteside about searching Resident B when he retuned to the facility, and Mr. Whiteside reported that he did not know that he was supposed to search Resident B. Ms. Blackburn stated that Resident B takes psychotropic medications and is not supposed to use marijuana. Ms. Blackburn stated that Mr. Whiteside and other staff have signed a document that they reviewed all of the resident care plans and are aware of the requirements in the plans.

Pat Shepard, recipient rights officer, stated on 11/2/22 that she has investigated this allegation and is substantiating a recipient rights violation. Ms. Shepard stated that Resident B’s plan of service states that Resident B is to be searched upon return to the facility from any unsupervised visits with his family and is to be searched specifically for alcohol and marijuana. Ms. Shepard stated that Mr. Whiteside reported to her that he was present when Resident B returned to the facility, but that he was not aware that he was supposed to search Resident B when Resident B returned. Ms. Shepard stated that Resident B did return to the facility on 9/23/22 with marijuana and that Resident A and Resident B then smoked the marijuana on the facility premises.

Levan Whiteside, staff person, stated on 11/2/22 that he arrived at the facility after Resident B had returned to the facility on 9/23/22, contradicting what he has stated to Ms. Blackburn and Ms. Shepard. Mr. Whiteside stated that he was not aware that staff are required to search Resident B when he returns from an unsupervised family visit. Mr. Whiteside stated that Resident B was able to get marijuana into the facility, and that Resident A and Resident B then smoked the marijuana outside of the facility.

Resident B’s plan of care was reviewed during the inspection on 11/1/22. Resident B’s plan of care documents that Resident B is to be subject to “search and seizure” for any contraband, including alcohol and marijuana, when he returns to the facility from any unsupervised family visits.

A violation of this rule was cited in SIR#2022A0569003 dated 12/13/21. The investigation found that staff had allowed Residents requiring staff supervision while in the community, to go into a store without staff supervision. One of the residents documented in this report was Resident B. The corrective action plan was submitted on 12/14/22 and signed by Kimberly Rawlings, licensee designee. The CAP documented that all of the staff were retrained and signed documentation of acknowledgement that they had reviewed all of the resident treatment plans.

A second violation of this rule was cited in SIR#2022A0569036 dated 7/21/22. The investigation found that staff at this facility allowed Residents to travel in the community without staff supervision who require staff supervision. Two of the residents allowed to move in the community without staff were Resident A and Resident B. One of the staff found to have not followed the residents’ plans of service was Mr. Whiteside. The corrective action was dated 8/15/22 and signed by Kim Rawlings, licensee designee.

The corrective action plan documents that the staff received disciplinary action, and that all of the staff were, again, required to review all of the resident service plans and sign documentation to confirm that they had reviewed the service plans.

An exit conference was conducted via phone call on 11/3/22 for Kimberly Rawlings, licensee designee. The findings in this report were reviewed, and Ms. Rawlings was informed of the recommendation to modify this license to a provisional status.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	The complainant reported that Resident B returned to the facility after visiting his family on 9/23/22 and was not searched by staff which is required in Resident B's service plan. Resident A confirmed that Resident B did have marijuana when he returned from his family visit, and that staff did not search Resident B. Resident A also admitted that he and Resident B then smoked the marijuana outside of the facility. Mr. Whiteside has stated to Ms. Blackburn and Ms. Shepard that he was at the facility when Resident B returned on 9/23/22, but that he was not aware of the requirement to search Resident B when he returned from a family visit. Mr. Whiteside the stated on 11/2/22 that he did not get to the facility until after Resident B returned which was inconsistent with the information he gave to Ms. Blackburn and Ms. Shepard. Ms. Blackburn also confirmed that Mr. Whiteside has reported for his shift on 9/23/22 when he was scheduled to. Mr. Whiteside also stated on 11/2/22 that he was not aware of the requirement to search Resident B when he returned to the facility from a family visit. Resident B's plan of service documents that he is to be searched by staff for alcohol and marijuana when he returns to the facility from a family visit. Resident A's file contains documentation that Mr. Whiteside

	signed acknowledging that he reviewed and understood Resident B's plan of service. Based on the statements given and documentation reviewed, it is determined that there has been a violation of this rule. This is the third violation of this rule in the past 11 months. One of the previous violations was cited because Mr. Whiteside allowed Resident A to move unsupervised in the community when Resident A did require staff supervision.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR#2022A0569003 dated 12/13/21.** **SIR#2022A0569036 dated 7/21/22.**

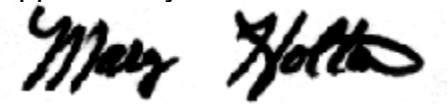
IV. RECOMMENDATION

Due to the repeated violations documented in this report, I recommend that the status of this license be changed to a provisional status with the receipt of an acceptable corrective action plan.

11/7/22

Kent W Gieselman Date
Licensing Consultant

Approved By:



11/7/22

Mary E. Holton Date
Area Manager