GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 19, 2022

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

RE: License #: AS390403155
Investigation #: 2023A0578005
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) 284-9727.

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**

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS390403155 |
| | |
| **Investigation #:** | 2023A0578005 |
| | |
| **Complaint Receipt Date:** | 10/27/2022 |
| | |
| **Investigation Initiation Date:** | 10/28/2022 |
| | |
| **Report Due Date:** | 12/26/2022 |
| | |
| **Licensee Name:** | Beacon Specialized Living Services, Inc. |
| | |
| **Licensee Address:** | Suite 110<br>890 N. 10th St.<br>Kalamazoo, MI 49009 |
| | |
| **Licensee Telephone #:** | (269) 427-8400 |
| | |
| **Administrator:** | Aubry Napier |
| | |
| **Licensee Designee:** | Ramon Beltran II |
| | |
| **Name of Facility:** | Beacon Home At Ravine |
| | |
| **Facility Address:** | 6595 Ravine Road<br>Kalamazoo, MI 49009 |
| | |
| **Facility Telephone #:** | (269) 488-3967 |
| | |
| **Original Issuance Date:** | 04/21/2020 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/21/2022 |
| | |
| **Expiration Date:** | 10/20/2024 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was dragged and pushed and shoved by staff. Resident A now has bruises on her arms and knees. | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 10/27/2022 | Special Investigation Intake<br>2023A0578005 |
| 10/28/2022 | Special Investigation Initiated - Face to Face |
| 10/28/2022 | APS Referral |
| 10/28/2022 | Special Investigation Completed On-site<br>-Interview with Resident A, direct care staff Felicia Mitchell. |
| 12/06/2022 | Contact-Telephone<br>-Interview with adult protective services worker Lindsay Bickmeyer. |
| 12/12/2022 | Contact-Telephone<br>-Interview with direct care staff Jahleiah Woods. |
| 12/12/2022 | Contact-Telephone<br>-Interview with direct care staff Jayla Lockhart. |
| 12/12/2022 | Contact-Telephone<br>-Message left for Ms. Jamara White, division director. |
| 12/12/2022 | Referral to Integrated Services of Kalamazoo RRO. |
| 12/14/2022 | Exit Conference<br>-Message left for licensee designee, Mr. Ramon Beltran. |

**ALLEGATION:**

**Resident A was dragged and pushed and shoved by staff. Resident A now has bruises on her arms and knees.**

**INVESTIGATION:**

On 10/27/2022, I received this complaint through the BCHS On-line Complaint System. Complainant reported Resident A is diagnosed with Depression, Bipolar

Disorder, and has seizures. Complainant alleged that on 10/26/2022, Resident A and direct care staff members got into a verbal altercation that turned physical. Complainant alleged Resident A was dragged up the steps by direct care staff Jayla Lockhart and direct care staff Jahleiah Woods. Complainant alleged Resident A was also pushed and shoved by Ms. Lockhart and Ms. Woods. Complainant reported Resident A sustained marks on her right and left arm, and on both knees.

On 10/28/2022, I completed an unannounced special investigation on-site and interviewed Resident A regarding the allegations. Resident A reported living at this facility for over a year. Resident A recalled the incident related to the allegations and reported she was not following staff directions and had entered the basement which is restricted from resident use. Resident A disclosed that she is diagnosed with bipolar disorder and was physically restrained by staff for less than five minutes with one staff on each arm. Resident A disclosed she was pushing and shoving direct care staff members as they went upstairs and was actively trying to obtain release from being restrained, which is how she received the bruising on her arms. Resident A reported direct care staff member Jahleiah Woods restrained her left arm while direct care staff member Jayla Lockhart restrained her right arm. Resident A denied being assaulted or pushed by either direct care staff member in anyway. Resident A added that she was previously assaulted by another direct care staff member at this facility which was investigated by this department and that staff member no longer works at this facility. Resident A disclosed she was being argumentative and was not following directions before and/or after this incident occurred. I photographed, with Resident A's permission, the inside upper arms of Resident A and observed three to four circular bruises on each arm, in close proximity to each other, less than ½ inch wide and approximately three inches in total length. I examined Resident A's knee's and photographed no evidence of bruising. Resident A denied having any additional concerns.

While at the facility, I interviewed direct care staff Felicia Mitchell regarding the allegations. Ms. Mitchel denied the allegations and reported the two direct care staff members directly involved with Resident A were new and were punched in the face and scratched by Resident A while they attempted to restrain Resident A using CPI (Restraint Training). Ms. Mitchel reported that before the staff had left for shift change, she had inquired if staff involved had completed an Incident Report related to their use of restraint and utilizing CPI and the staff simply responded by saying "no" before leaving the facility. Ms. Mitchell clarified that if an Incident Report was ever completed, she would not have access to the electronic record system to retrieve it.

On 12/12/2022, I interviewed direct care staff member Jayla Lockhart regarding the allegations. Ms. Lockhart recalled the incident and working with direct care staff Jahleiah Woods at the time. Ms. Lockhart reported Resident A was eager to use the phone, but it was late at night and was not at the time of Resident A's routine phone calls. Ms. Lockhart reported Resident A became upset and went into the basement and attempted to assault direct care staff when she and Ms. Woods placed Resident

A in a CPI hold and were able to bring Resident A upstairs. Ms. Lockhart reported Resident A was released and began throwing things at staff and threw a set of keys or something at her face, which broke Ms. Lockhart's glasses. Ms. Lockhart reported that shortly thereafter she was told the facility was not liable for her glasses and Ms. Lockhart ended her employment. Ms. Lockhart denied completing an Incident Report and clarified this facility did not have a home manager at the time, but stated the incident was reported to Ms. Jamara White, division director for the facility. Ms. Lockhart denied that Resident A was injured in any way and clarified the only damages were to her glasses. Ms. Lockhart stated that due to being trained in CPI, direct care staff can only utilize restraint for so long before having to release the resident. Ms. Lockhart reported utilizing restraint with Resident A for less than five minutes. Ms. Lockhart denied pushing, shoving, dragging, or assaulting Resident A in anyway. Ms. Lockhart stated Resident A was attacking and attempting to punch direct care staff.

On 12/12/2022, I interviewed direct care staff Jahleiah Woods regarding the allegations. Ms. Woods recalled the incident and working with direct care staff Jayla Lockhart. Ms. Woods reported Resident A wanted to use the staff computer and was upset she was not allowed to do so. Ms. Woods reported Resident A then wanted to call a relative but was unsuccessful due to the request occurring late in the evening. Ms. Wood reported this made Resident A even more upset and Resident A entered the basement which is restricted from resident use. Ms. Woods reported she and Ms. Lockhart attempted to verbally redirect Resident A when Resident A became combative but were unsuccessful and Resident A had to be restrained utilizing CPI. Ms. Woods reported she attempted to restrain one of Resident A's arms while Ms. Lockhart attempted to restrain the other. Ms. Woods denied pushing or shoving or assaulting Resident A in anyway. Ms. Woods reported Resident A was released after calming down but shortly thereafter, threw a set of keys at Ms. Lockhart's face and broke her glasses. Ms. Woods reported direct care staff continued to provide Resident A with verbal redirection and offered Resident A PRN medication which she refused. Ms. Woods reported direct care staff member Jamara White was called and Ms. White also attempted to deescalate Resident A. Ms. Woods reported Resident A eventually agreed to take a PRN medication. Ms. Woods denied Resident A was injured in any way but reported that she (Ms. Woods) had scratches on her stomach from Resident A. Ms. Woods reported Resident A was restrained on two occasions during this incident for less than two minutes each time. Ms. Woods denied completing an Incident Report related to the incident.

On 12/06/2022, I reviewed the details of the allegations with adult protective services worker Lindsay Bickmeyer. Ms. Bickmeyer confirmed Resident A was restrained by direct care staff due to aggressive behavior on 10/26/2022. Ms. Bickmeyer reported she spoke to the guardian for Resident A, who denied having concerns for the care provided for Resident A at this facility, despite Resident A being assaulted by a staff member as established in SIR# 2022A0581048. Ms. Bickmeyer reported also speaking with the case manager for Resident A, who denied having any concerns regarding the care provided to Resident A.

| 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, Resident A clarified that she was pushing and shoving direct care staff members as they went upstairs and was actively trying to obtain release from being restrained, which is how she received the bruising on her arms. I confirmed Resident A had three to four circular bruises on the inside of her upper arm, in close proximity to each other, less than ½ inch wide and approximately three inches in total length and consistent with the use of physical restraint. During an interview, direct care staff members Jayla Lockhart and Jahleiah Woods denied dragging, pushing, or shoving Resident A, and identified Resident A as the aggressor, which resulted in Ms. Woods being scratched and Ms. Lockhart having her glasses broken. In an interview, adult protective services worker Lindsay Bickmeyer reported Resident A's guardian and case manager had no concerns for the level of care provided for Resident A at this facility. As such, there is not enough evidence that Resident A's personal need for protection and safety was not attended to at all times. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ADDITIONAL FINDINGS:**

On 12/06/2022, I reviewed *AFC Licensing Division Incident / Accident Report* received by this department for this facility. I did not find an *AFC Licensing Division Incident / Accident Report* related to the date of the allegations and including the identified staff.

On 12/12/2022, I reviewed the details of the allegations with Integrated Services of Kalamazoo recipient rights officer Lisa Smith. Smith denied that an incident report related to the allegations was received by her department.

On 12/12/2022, Ms. Jamara White reported that no incident report was completed on 10/26/2022 related to the allegations.

| APPLICABLE RULE | |
|---|---|
| **R 400.14311** | **Investigation and reporting of incidents, accidents, illnesses, absences, and death.** |
| | **(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:**<br><br>**(c) Incidents that involve any of the following: (i) Displays of serious hostility. (ii) Hospitalization. (iii) Attempts at self-inflicted harm or harm to others. (iv) Instances of destruction to property.** |
| **ANALYSIS:** | On 12/12/2022, Jamara White, division director for this facility, confirmed that a written incident report regarding Resident A display of hostility toward direct care staff members was not provided to this department. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

12/14/2022

_____

Eli DeLeon Date
Licensing Consultant

Approved By:

12/19/2022

_____

Dawn N. Timm Date
Area Manager