GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 26, 2023

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

RE: License #: AS810393269
Investigation #: 2023A0122011
Beacon Home At Ypsilanti

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 (517) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810393269
Investigation #:	2023A0122011
Complaint Receipt Date:	01/03/2023
Investigation Initiation Date:	01/03/2023
Report Due Date:	03/04/2023
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 Ypsilanti

Facility Address:	7862 Tuttle Hill Road Ypsilanti, MI 48197
Facility Telephone #:	(734) 221-5424
Original Issuance Date:	05/24/2018
License **Status:**	REGULAR
Effective Date:	11/24/2020
Expiration Date:	11/23/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 12/25/2022, Resident A observed staff members having an argument with each other.	Yes
On 12/26/2022, staff member yelled at Resident B.	Yes

III. METHODOLOGY

01/03/2023	Special Investigation Intake 2023A0122011
01/03/2023	Special Investigation Initiated - Telephone Incident report discussed.
01/04/2023	Inspection Completed On-site Completed interview with Resident A. Reviewed Resident A and B's files.

01/05/2023	Contact – Telephone call made Completed interview with Jazsmin Blue, staff member. Left voice message, Christine Laurain, staff member.
01/09/2023	Contact – Telephone call received Completed interview with Christine Laurain.
01/24/2023	Contact – Face to face Completed interview with Resident B.
01/25/2023	Exit Conference Discussed findings with Kimberly Rawlings, Licensee Designee.

ALLEGATION:

- **On 12/25/2022, Resident A observed staff members having an argument with each other.**
- **On 12/26/2022, staff member yelled at Resident B.**

INVESTIGATION: On 01/03/2023, I reviewed incident reports dated 12/28/2022 documenting the following: On 12/25/2022, staff members, Jazsmin Blue, and Christina Laurain, had an argument with each other which included yelling, shaking table and chair, and using profanity towards each other. Resident A witnessed this interaction between Ms. Blue and Ms. Laurain. On 12/26/2022, a separate incident was documented that Ms. Blue yelled at Resident B and made him take medications that had fallen on the floor.

On 01/04/2022, I completed an interview with Resident A. Resident A confirmed that he witnessed the argument between staff members, Ms. Blue, and Ms. Laurain. Resident A stated Ms. Laurain attempted to obtain Ms. Blue's attention, when Ms. Blue didn't respond, Ms. Laurain shook the table. Ms. Blue responded by calling Ms. Laurain names. Resident A stated he heard profanity but was uncertain who used that language.

On 01/04/2022, I received an email from Emily Ferguson, District Director, stating that an internal investigation had been completed. The company has responded by meeting with Human Resources and our Compliance team. Progressive Action forms were put together for both employees as this behavior is not permissible in any of their homes. Neither employee is on the schedule as they are awaiting a time to meet with them and a representative from Human Resources to go over Progressive Action.

On 01/05/2023, I completed an interview with Jazsmin Blue. Ms. Blue confirmed that she and Christina Laurain, had an argument with each other which included

yelling, shaking table and chair, and using profanity towards each other. Ms. Blue confirmed that Resident A witnessed the interaction between herself and Ms. Laurain.

On 01/05/2023, Ms. Blue denied yelling at Resident B during the incident that involved him on 12/26/2023. Ms. Blue reported that Resident B's medication fell on the floor, and she responded by saying, "are you going to pick those up." Ms. Blue stated she observed Resident B pick up the pills from the floor and take them. Ms. Blue stated she did not redirect Resident B from taking the medication that fell to the floor.

On 01/09/2023, Christina Laurain confirmed that she and Jazsmin Blue had an argument in front of Resident A on 12/25/2022. However, Ms. Laurain denied yelling or shaking the table to get Ms. Blue's attention.

On 01/24/2023, I completed an interview with Resident B. Resident B stated his medications were dropped on the floor by Ms. Blue and that he took them in her presence. Resident B stated Ms. Blue dropped the pills by accident.

On 01//2023, I completed an exit conference with Kimberly Rawlings, Licensee Designee. Ms. Rawlings agreed with my findings and stated a corrective action plan will be submitted to address the rule violation found.

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.

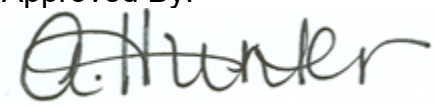
ANALYSIS:	On 01/04/2023, Resident A reported he witnessed an argument between staff members, Jazsmin Bule, and Christina Laurain, which included yelling, shaking table and chair, and use of profanity. On 01/05/2023 and 01/09/2023, respectively both Jazsmin Blue and Christina Laurain confirmed they had an argument with each other witnessed by Resident A. On 01/09/2023 and 01/24/2023, respectively both Jazsmin Blue and Resident B confirmed that Resident B's medication fell on the floor and Resident B took the medication without intervention from Ms. Blue. Based upon my investigation, I find that both Resident A and Resident B were not treated with dignity by staff members, Jazsmin Blue, and Christina Laurain. The staff members engaged in an argument with each other including yelling, shaking table and chair, and use of profanity. Resident B was allowed to take dirty medication that had fallen on the floor without intervention from staff member, Jazsmin Blue.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change in the status of the license.

Vanita C. Bouldin
Licensing Consultant
Date: 01/25/2023

Approved By:



Ardra Hunter
Area Manager
Date: 01/26/2023