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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 8, 2023

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

RE: License #: AS630387842
Investigation #: 2023A0612011
Beacon Home at Dilley

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.

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 (248) 975-5053.

Sincerely,

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630387842
Investigation #:	2023A0612011
Complaint Receipt Date:	01/05/2023
Investigation Initiation Date:	01/06/2023
Report Due Date:	03/06/2023
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 Dilley
Facility Address:	7570 Dilley Road Davisburg, MI 48350
Facility Telephone #:	(248) 382-5648
Original Issuance Date:	08/13/2018
License Status:	REGULAR
Effective Date:	02/13/2021
Expiration Date:	02/12/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 12/30/22, Resident D was attacked by Resident C with a piece of lumber from the front porch after they had been in a verbal altercation earlier that evening.	No
An Incident Report was not sent to the adult foster care licensing division within 48 hours.	Yes

III. METHODOLOGY

01/05/2023	Special Investigation Intake 2023A0612011
01/06/2023	Special Investigation Initiated - Telephone I initiated my investigation by making a complaint to Adult Protective Services (APS) via centralized intake
01/06/2023	APS Referral I made a referral to Adult Protective Services (APS) via centralized intake on 01/06/23
01/06/2023	Referral - Recipient Rights I made a referral to Oakland Community Health Network (OCHN) - Office of Recipient Rights (ORR)
01/24/2023	Contact - Document Received I received an email from APS worker, Ra'Shawnda Robertson that contained a collateral APS contact made with Resident C
01/26/2023	Inspection Completed On-site I completed an onsite investigation. I interviewed home manager, Jordan Eldridge, Resident D, Resident G and Resident S
01/26/2023	Contact - Document Received I received a copy of Resident D's hospital discharge paperwork
02/07/2023	Contact - Telephone call made I interviewed direct care staff, Nakeesha Woodward via telephone
02/08/2023	Contact - Document Received I received a copy of Resident C and Resident D's crisis plans

02/08/2023	Exit Conference I called licensee designee, Kimberly Rawling to conduct an exit conference

ALLEGATION:

On 12/30/22, Resident D was attacked by Resident C with a piece of lumber from the front porch after they had been in a verbal altercation earlier that evening.

INVESTIGATION:

On 01/06/23, I received a complaint that indicated on 12/30/22, Resident D was attacked by Resident C with a piece of lumber from the front porch after they had been in a verbal altercation earlier that evening. The direct care staff on shift failed to provide appropriate supervision and did not ensure Resident D's safety. Also, an Incident Report was not sent to the adult foster care licensing division within 48 hours.

On 01/06/23, I initiated my investigation by making a referral to Adult Protective Services (APS) via centralized intake and the Office of Recipient Rights (ORR) via email to Recipient Rights Specialist, Katie Garcia. I coordinated with APS worker, Ra'Shawnda Robertson who indicated on 01/06/23, Resident D was admitted to St. Joseph hospital in Pontiac, MI. Resident C was arrested and charged with felonious assault. Resident C was moved from the Beacon home at Dilley to Beacon home at Clio in Genesee county. A courtesy collateral contact and interview attempt was made on 01/20/23 by APS in Genesee county. Resident C declined to be interviewed. On 01/24/23, Ms. Robertson emailed me the interview:

"APS worker made courtesy F2F contact and interview effort with (Resident C) at the Beacon Home in Clio on 1/20/23 @ 1:53pm. (Resident C) was informed by his staff in his room there was a worker with APS come to visit and interview with him and he was cooperative to come and interview with the worker after he put some personals away. Worker sat at the living room table for the interview and (Resident C) did come and sit with the worker to interview. He was found to be orient, aware. And verbal and the worker informed him to his identity with showing of identification and the reason for contact on behalf of Oakland County complaint on (Resident C) and an incident that occurred with this person on 12/30/22. He did not deny to knowledge of who the client was and asked the worker to this contact being in regard to his case and if the worker was sent to interview with him by his lawyer and when worker informed again to courtesy interview regarding the incident occurring with the client on behalf of Oakland County APS he stated that he did not want to do the interview and he got up and left the table. Worker told him okay and checked out with the staff and left Beacon Home."

On 01/26/23, in collaboration with Recipient Rights Specialist, Katie Garcia, I completed an onsite investigation. I interviewed home manager, Jordan Eldridge, Resident D, Resident G and Resident S. During the onsite investigation, I observed the front porch. The wooden piece of lumber that was broken off by Resident C has been repaired.

On 01/26/23, I interviewed home manager, Jordan Eldridge, Ms. Eldridge stated she was not on shift at the time of the incident she was off work. Ms. Eldridge was informed by staff that Resident D accused Resident C of stealing his pendent. Resident C did not steal his pendent he traded it for a cigarette and three dollars. Resident D called the police, they came to the home and spoke to both residents. Resident D was upset. Resident C was paranoid as he has a history of 20 years in prison. Ms. Eldridge spoke to Resident C via phone to deescalate him. He assured her that he was fine and said that he was going to go to bed. Later that evening, Resident C used a slat of wood from the front porch to hit Resident D. Resident D was taken to the hospital and Resident C was arrested. Ms. Eldridge stated the front porch has been repaired. Resident C has moved to a different home within the Beacon network. Ms. Eldridge provided a copy of Resident D's hospital discharge paperwork.

On 01/26/23, I reviewed Resident D's hospital discharge paperwork dated 12/31/22. Resident D was seen at Trinity Health Emergency Center. The discharge paperwork stated that he was diagnosed with assault, contusion of left upper extremity- initial encounter, closed nondisplaced fracture of styloid of left ulna - initial encounter, and laceration of left hand without foreign body- initial encounter. Resident D was referred to an orthopedic doctor upon discharge.

On 01/26/23, I interviewed Resident D. I observed that his left hand was bandaged. Resident D was a poor source of information and a poor historian. He was unable to answer open ended interview questions. His speech was tangential. When asked what happened to his left arm Resident D stated, "my cousin beat me up because I was selfish. I was buying expensive cars."

On 01/26/23, I interviewed Resident S. Resident S stated he was aware that there was an altercation between Resident C and Resident D however, he was asleep when the incident occurred. Resident S had no information to provide regarding this allegation.

On 01/26/23, I interviewed Resident G. Resident G stated Resident D was visiting him in his bedroom when the incident occurred. Resident C came into his bedroom and "cracked (Resident D) on the arm." Resident G stated Resident C just missed hitting his TV. Resident G has never seen Resident C become aggressive before.

On 02/07/23, I interviewed direct care staff, Nakeesha Woodward via telephone. Ms. Woodward has been employed with the company for four years. She is a lead staff. Ms. Woodward works third shift, 7:00 pm – 7:00 am. There is only one staff on third shift. Ms. Woodward stated on 12/30/22, she was informed at shift change that Resident D and Resident C had got into an argument on the previous shift. Resident D was not at the home when her shift started, he was gone to the hospital. Resident D returned home around 9:00 pm. When Resident D arrived home he was being verbally aggressive. She provided verbal redirection. Ms. Woodward assisted Resident D into his bedroom and talked to him one on one. Resident D calmed down, she gave him his evening medications and he got into bed.

Then, Resident C became paranoid, pacing the halls. Ms. Woodward spoke to Resident C to provide de-escalation. However, Resident C would not deescalate. Ms. Woodward got a chair and sat in the hallway between the two bedrooms. Resident C began making threats, pacing the hallway, and expressed that he felt unsafe. Ms. Woodward explained that she did not understand why Resident C felt unsafe as Resident D was in his bedroom. Resident C made attempts to open Resident D's bedroom door. Ms. Woodward asked Resident D for permission to lock the door, which he allowed. Ms. Woodward called 911. Law enforcement came out and spoke with both residents. Resident C appeared to deescalate after talking to the sheriff. Law enforcement told the residents that if they had to come back out to the home someone would be arrested. Ms. Woodward stated while law-enforcement was in the home she did a count on all sharps to make sure no one had gotten a hold of anything. Additionally, she did a visual sweep of the house looking for anything unsafe. When law enforcement left Resident C "revved up" again. Ms. Woodward called Beacon clinical staff and they spoke with Resident C. After speaking to clinical staff Resident C appeared to be calm. However, after the call ended, he "revved up" again. Ms. Woodward called Beacon clinical staff back. They deescalated Resident C. Ms. Woodward stated it remained calm in the home for approximately 20 minutes. It was so calm that Resident D came out of his bedroom and went into Resident G's bedroom to visit him. It is common for Resident D to hang out in Resident G's bedroom.

Ms. Woodward went to the kitchen table to complete her required documentation and write an Incident Report. While she was doing her documentation, she heard screams. She got up and saw Resident C was in Resident G's bedroom swinging a big pole and Resident D was yelling. Ms. Woodward stated she never saw or heard Resident C exit his bedroom. Ms. Woodward verbally prompted Resident C more than three times to stop. While doing so she grabbed her phone and called 911. She stayed on the phone with 911 as directed. While on the phone with 911 she remained in the hallway visible of all bedrooms. 911 asked several questions regarding the weapon, what each resident was wearing, and where they were in the home. Resident C was walking around aggressively with the weapon. While on the phone with 911, Resident C attacked Resident D a second time. Law enforcement arrived, Resident C was arrested, and Resident D was taken to the hospital. Ms. Woodward stated she provided all the necessary information to EMS and law enforcement.

Ms. Woodward stated she has no idea when or how Resident C obtained the piece of lumber from the porch. She assumes he had it hidden in his bedroom as she never seen or heard him go outside. Ms. Woodward stated after the second attack and before law enforcement arrived Resident C went to his bedroom and hide the piece of lumber. Ms. Woodward stated following the incident she completed Incident Reports using Beacon's electronic Incident Report system.

On 02/08/23, I reviewed Resident C's crisis plan dated 08/05/22. The crisis plan indicated that Resident C has a history of paranoia, disorganized thinking, inappropriate phone calls, being sexually inappropriate, starting fires, verbal aggression, medication

refusal, and delusions. The crisis plan does not indicate that Resident C has a history of physical aggression.

On 02/08/23, I reviewed Resident D's crisis plan dated 04/06/22. The crisis plan does not indicate that Resident D has any behavioral concerns including, physical or verbal aggression.

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:	Based on the information gathered through my investigation there is insufficient information to conclude that direct care staff, Nakeesha Woodward failed to provide Resident D with supervision and protection as specified in the residents written assessment plan. On 12/30/22, when Ms. Woodward arrived on shift, she was informed that Resident D and Resident C had gotten into an argument on the previous shift. When her shift started, Resident D was not in the home. Resident C's crisis plan does not indicate that Resident C has a history of physical aggression. The crisis plan does not provide any proactive or reactive strategies to guide staff's behavior if Resident C should become physically aggressive. In the absence of such guidance, Ms. Woodward chose the least restrictive approach in an attempt to keep Resident D safe when Resident C became aggressive towards him. Ms. Woodward separated the residents and provided de-escalation. She then sat in the hallway which allowed her to monitor both resident's bedrooms. Ms. Woodward encouraged Resident D to lock his bedroom door for safety, which he did. She contacted Beacon's clinical staff for assistance with deescalating Resident C, twice. Ms. Woodward did a count of the sharps to assure they were not accessed by any residents, and she further completed a sweep of the home for any visible safety concerns. When Resident C became physically aggressive, Ms. Woodward provided multiple verbal prompts to stop while calling 911. She remained in the hallway visible of the residents and appropriately interacted with EMS and law enforcement.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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:	Based on the information gathered through my investigation there is insufficient information to conclude that direct care staff, Nakeesha Woodward failed to make reasonable attempts to provide Resident D with protection and safety. When Resident C became verbally aggressive towards Resident D, Ms. Woodward separated the residents and provided de-escalation. She sat in the hallway between their bedrooms which allowed her to monitor both residents. Ms. Woodward encouraged Resident D to lock his bedroom door for safety, which he did. She contacted Beacon's clinical staff for assistance with deescalating Resident C, twice. When Resident C's verbal aggression escalated to threats Ms. Woodward called 911. She did a count of the sharps to assure they were not accessed by any residents, and she further completed a sweep of the home for any visible safety concerns. Then, when both residents appeared calm for at least 20 minutes. Resident D exited his bedroom and went into Resident G's bedroom. Ms. Woodward went to the table to complete her required documentation. She never heard or saw Resident C exit his bedroom. Ms. Woodward suspects that Resident C had the piece of lumber hidden in his bedroom as he did not exit the home to obtain it. When Resident C became physically aggressive towards Resident D, Ms. Woodward provided verbal prompts to stop while also calling 911 for help.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

An Incident report was not sent to the adult foster care licensing division within 48 hours.

INVESTIGATION:

On 01/06/23, I reviewed four Incident Reports (IR's) that were emailed to the department on 01/04/23, by home manager, Jordan Eldridge. The IR's were written and signed by direct care staff, Nakeesha Woodward on the following dates/ times. The IR's

are consistent with what Ms. Woodward reported when interviewed. The IR's were signed by Ramon Beltran, Beacon's VP of Operations on 01/04/23.

The IR's detail incidents of serious hostility, hospitalization, harm to others, destruction to property and the arrest of a resident as follows:

- IR written on 12/30/22 at 11:02 pm regarding Resident C
- IR written on 12/30/22 at 12:41 am regarding Resident D
- IR written on 12/31/22 at 12:10 am regarding Resident C

On 01/26/23, I interviewed home manager, Jordan Eldridge, Ms. Eldridge stated she was not on shift at the time of the incidents, she was off work for a few days during that time. Ms. Eldridge stated direct care staff, Ms. Woodward completed the IR's at the time of the incident and submitted the reports using the Beacon computer system for IR submission. When an IR is submitted the home manager is to sign off on it then, the district director signs it. When both signatures are completed the home manager sends the IR to adult foster care licensing. Ms. Eldridge stated she was off work when the incident occurred on 12/30/22. When she is off work, she cannot sign off on IR's or send them to adult foster care licensing. The IR's do not get sent to licensing until she returns to work and sends them. Ms. Eldridge confirmed that there are other Beacon managers who can access the IR's in the computer system, sign off on them, and send them to licensing if she is off work or unavailable.

On 02/07/23, I interviewed direct care staff, Nakeesha Woodward via telephone. Ms. Woodward stated following the incidents that occurred on 12/30/22, she completed IR's for each resident that was involved and submitted them on Beacon's electronic Incident Report system.

On 02/08/23, I called licensee designee, Kimberly Rawling to conduct an exit conference. There was no answer. I left a detailed voice message detailing my findings and informing Ms. Rawlings that a corrective action plan will be needed.

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: (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. (d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.
ANALYSIS:	Based on information gathered through my investigation, there is sufficient information to conclude that an Incident Report was not sent to the adult foster care licensing division within 48 hours of the incident. Direct care staff, Nakeesha Woodward completed the incident reports at the time the incident occurred. The Incident Reports were not signed off on by Ramon Beltran, Beacon's VP of Operations until, 01/04/23, at which time they were emailed by home manager, Jordan Eldridge to the department. The incidents involved, displays of serious hostility, hospitalization, harm to others, destruction to property and the arrest of a resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

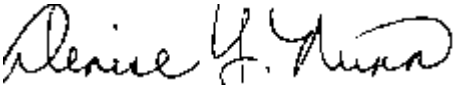
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remains unchanged.

02/08/2023

Johnna Cade Date
Licensing Consultant

Approved By:



02/08/2023

Denise Y. Nunn Date
Area Manager