GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 9, 2023

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

RE: License #: AS130405804
Investigation #: 2023A0578011
Beacon Home At Battle Creek

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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS130405804
Investigation #:	2023A0578011
Complaint Receipt Date:	12/20/2022
Investigation Initiation Date:	12/20/2022
Report Due Date:	02/18/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At Battle Creek
Facility Address:	5555 Bauman Rd. Battle Creek, MI 49017
Facility Telephone #:	(269) 223-7662
Original Issuance Date:	01/08/2021
License Status:	REGULAR
Effective Date:	07/08/2021
Expiration Date:	07/07/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff Michelle Robinson used vulgar language with Resident A.	Yes
Direct care staff Michelle Robinson pushed Resident B.	Yes
Direct care staff Michelle Robinson left the facility, leaving only one other staff with six residents.	No

III. METHODOLOGY

12/20/2022	Special Investigation Intake 2023A0578011
12/20/2022	Special Investigation Initiated - Telephone -With Complainant.
12/20/2022	APS Referral
01/17/2023	Special Investigation Completed On-site -Interview with direct care staff Michelle Robins, direct care staff Diante Taylor, Resident A and Resident B.
01/17/2023	Contact-Document Reviewed -*AFC Licensing Division Incident / Accident Report*, dated 12/17/2022.
02/07/2023	Contact-Telephone -Interview with former direct care staff Brittany Labadie.
02/08/2023	Exit Conference -With licensee designee Ramon Beltran.

ALLEGATION:

- **Direct care staff Michelle Robinson used vulgar language with Resident A.**
- **Direct care staff Michelle Robinson pushed Resident B.**

INVESTIGATION:

On 12/20/2022, I received this complaint through the BCHS On-line Complaint System. Complainant reported that residents at this facility have chores they can do to earn money. Complainant clarified that if a resident misses a day during the week, they are allowed to make up this day on the weekend. Complainant reported that on

12/17/2022, after taking out the garbage, Resident A had asked direct care staff Michelle Robinson if he had made up all his chore days for the previous week. Complainant alleged Ms. Robinson was “mean” to Resident A and Resident A responded by calling Ms. Robinson a “bitch.” Complainant reported the other staff working at this facility heard this comment. Complainant alleged after Resident A began to walk away, Ms. Robinson began to follow Resident A when Resident B intervened, and Ms. Robinson told Resident B to "get the fuck out of my way."

On 01/17/2023, I reviewed the *AFC Licensing Division Incident / Accident Report*, dated 12/17/2022 and documented by direct care staff Brittany Labadie. The *AFC Licensing Division Incident / Accident Report* documented that when Resident A asked Ms. Robinson to check to see if he completed his previous work training days earlier in the week, Ms. Robinson responded by saying that residents get “babied” by other staff too much. The *AFC Licensing Division Incident / Accident Report* documented that Resident A responded by stating to Ms. Robinson “why are you acting like a bitch” and then proceeded to return to his room. The *AFC Licensing Division Incident / Accident Report* documented Ms. Robinson responded with, “You’re a bitch, I don’t know what you have an attitude for but I’m not the one” and followed Resident A, shoving Resident B into a wall in the process. The *AFC Licensing Division Incident / Accident* Report documented Ms. Robinson left the facility but returned approximately 30-45 minutes later. *The AFC Licensing Division Incident / Accident Report* documented corrective actions included notifying responsible agencies and adult protective services and suspending direct care staff Michelle Robinson.

On 01/17/2023, I reviewed the *AFC Licensing Division Incident / Accident Report*, dated 12/17/2022 and written by direct care staff Brittany Labadie. The *AFC Licensing Division Incident / Accident Report* documented that while arguing with Resident A, Ms. Robinson shoved Resident B into a wall to get Resident A out of the way while continuing to argue with Resident A.

On 12/20/2022, I reviewed the details of the allegations with adult protective services worker Heather Townsend. Ms. Townsend reported direct care staff Michelle Robinson denied ever pushing Resident B but acknowledged that she “got into it” with Resident A because Resident A had called her several derogatory names and she responded by calling Resident A several derogatory names. Ms. Townsend reported being unable to interview direct care staff Brittany Labadie who was present during the incident.

On 01/17/2023, I completed an unannounced investigation on-site and interviewed direct care staff Michelle Robinson regarding the allegations. Ms. Robinson reported working at this facility for over one year. Ms. Robinson acknowledged being involved in a verbal altercation with Resident A and that Resident A had called her several derogatory names before Ms. Robinson responded with telling Resident A that he was “acting like a bitch.” Ms. Robinson denied ever pushing Resident B, and reported that she was honest with Ms. Aubry Napier, deputy director for this facility,

and recipient rights regarding her derogatory comment to Resident A. Ms. Robinson reported this behavior resulted in her temporary suspension from working at this facility.

Ms. Robinson stated direct care staff Brittany Labadie would not be a reliable direct care staff person to interview as they are related and had a poor relationship after a previous investigation involving false allegations. Ms. Labadie reported these allegations had been investigated and unfounded.

Ms. Robinson added “everyone knows” that Resident A and Resident B tend to lie.

While at the facility, I interviewed Resident A regarding the allegations. Resident A reported living at this facility for over two years. Resident A acknowledged using derogatory language with direct care staff Michelle Robinson and confirmed Ms. Robinson has used derogatory language with him as well and called him a “bitch.” Resident A denied observing Ms. Robinson pushing Resident B and reported he was walking away from Ms. Robinson and had his back towards her.

While at the facility, I interviewed Resident B regarding the allegations. Before the interview, I noted that direct care staff Ms. Robinson introduced Resident B and commented to Resident B that I was here to discuss the “false allegations” and Resident B agreed. Once Ms. Robinson left, Resident B reported Ms. Robinson is a great person and that he loves her but acknowledged Ms. Robinson did indeed push him during the incident involving Resident A. Resident B reported Ms. Brittany Labadie observed Ms. Robinson push Resident B and Ms. Labadie documented her observation on an incident report.

Resident B reported the incident was preceded by Resident A asking Ms. Robinson if he had any “incentive days” to make up. Resident B reported that all residents are provided with work training days involving chores in this facility, and if they miss a day, they are allowed to make up these missed chores at the end of the week. Resident B reported there is a list of household chores that residents can choose from. Resident B reported that when Resident A asked Ms. Robinson a question related to work training, Ms. Robinson responded with “I told your motherfuckin’ ass, not right now.” Resident B reported Resident A responded with, “you don’t have to act like a bitch” when Ms. Robinson and Resident A began exchanging derogatory language. Resident B reported Resident had called Ms. Robinson a “fucking bitch” and Ms. Robinson had called Resident A “bitch.” Resident B reported Resident A began to walk away when Ms. Robinson commented that she was “not done” with Resident A and began walking after Resident A. Resident B reported he attempted to intervene and got between Ms. Robinson and Resident A and told Ms. Robinson, “No Michelle, please don’t” when Ms. Robinson pushed him out of the way with her right hand on Resident B’s right shoulder. Resident B reported direct care staff Brittany Labadie observed this pushing motion occur. Resident B reported Ms. Robinson instead slammed the front door and went outside.

While at the facility, I interviewed direct care staff Diante Taylor regarding the allegations. Mr. Taylor reported serving as the home manager for this facility. Mr. Taylor reported Ms. Robinson had called him on the night of the incident and explained Resident A had called her a “bitch” and she reacted and called Resident A “bitch” back. Mr. Taylor reported Ms. Robinson was “hysterical” and crying in her car. Mr. Taylor reported he helped Ms. Robinson calm down and informed Ms. Robinson she could not be “doing stuff” like that and Ms. Robinson apologized. Mr. Taylor reported he instructed Ms. Robinson to finish the rest of her shift.

Mr. Taylor denied being informed by Ms. Robinson that she had pushed Resident B. Mr. Taylor added Ms. Robinson was provided with a written counseling and suspended from working at this facility for four weeks.

On 02/07/2023, I interviewed former direct care staff Brittany Labadie regarding the allegations. Ms. Labadie reported working at this facility for approximately six months before ending her employment. Ms. Labadie recalled the allegations and stated the incident occurred when Resident A asked direct care staff Ms. Michelle Robinson how many work training days he had missed during the week so that he could make them up that day. Ms. Labadie reported Ms. Robinson did not want to get up initially but when she did, Resident A commented how Ms. Robinson should do her “job.” Ms. Labadie reported Resident A and Ms. Robinson began arguing back and forth when Resident A called Ms. Robinson a “bitch” and Ms. Robinson commented, “don’t call me a bitch, I’m not the fuckin’ one.” Ms. Labadie reported Resident A and Ms. Robinson exchanged derogatory language while Resident B was monitoring the incident at the end of a hallway. Ms. Labadie reported Resident A began to walk down the hallway when Ms. Robinson followed Resident A. Ms. Labadie reported Resident B attempted to intervene and attempted to block Ms. Robinson when Ms. Robinson shoved Resident B out of the way. Ms. Labadie denied that Resident B fell or incurred any type of injury.

Ms. Labadie acknowledged being personally related to Ms. Robinson but reported she was unwilling to lose her job for not reporting the incident. Ms. Labadie acknowledged completing an incident report and reporting the incident to Mr. Diante Taylor. Ms. Labadie reported Mr. Taylor contacted responsible agencies and the division director for this facility, Ms. Aubry Napier.

According to SIR # 2023A0581006, dated 01/04/2023, the facility was in violation of rule 400.14305 when it was established that on 11/06/2022, direct care staff, Takisha Alexander, arrived to work intoxicated and subsequently became incapacitated, leaving residents unattended without direct care staff and leaving the facility and medication keys out in the open and accessible to residents. The facility’s approved Corrective Action Plan (CAP) dated 01/24/2023 stated that Ms. Takisha Alexander was no longer employed as of 11/07/2022 due to this incident and the assigned home manager and district director may do unannounced “drop ins” to make sure all staff are following the expectations of their roles.

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 interviews, former direct care staff Brittany Labadie and Resident B confirmed direct care staff Michelle Robinson used derogatory language when arguing with Resident A and pushed Resident A against a wall while following Resident A. Ms. Labadie documented her observations on two separate *AFC Licensing Division Incident / Accident Report* dated 12/17/2022. Resident A confirmed Ms. Robinson had referred to him as "bitch" but denied observing Ms. Robinson pushing Resident B as he clarified that his back was turned to Ms. Robinson at the time. In an interview, Ms. Robinson confirmed using vulgar language with Resident A and reported referring to Resident A as a "bitch" but denied pushing Resident B. As such, there is enough evidence direct care staff Michelle Robinson did not treat Resident A with dignity when she used vulgar language and Ms. Robinson did not attend to Resident B's personal need for protection or safety when she pushed Resident B.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[Reference SIR #2023A0581006 dated 01/04/2023 and CAP dated 01/24/2023].**

ALLEGATION:

Direct care staff Michelle Robinson left the facility, leaving only one other staff with six residents.

INVESTIGATION:

On 12/20/2022, Complainant alleged that after being involved in the verbal altercation with Resident A, Ms. Robinson then left the facility and came back about 20 minutes later to finish her shift. Complainant alleged that Ms. Robinson was not supposed to leave the facility because there are supposed to be two staff always present.

On 01/17/2023, I reviewed the *AFC Licensing Division Incident / Accident Report*, dated 12/17/2022 and documented by direct care staff Brittany Labadie. The *AFC Licensing Division Incident / Accident* Report documented that Ms. Robinson left the facility but returned approximately 30-45 minutes later.

On 01/17/2023, I interviewed direct care staff Michelle Robinson regarding the allegations. Ms. Robinson denied ever leaving the facility after the verbal altercation with Resident A and reported that she had gone outside to report the incident to direct care staff Diante Taylor, home manager for this facility. Ms. Robinson reported she went outside to the facility to “take a breather.” Ms. Robinson denied that any residents required line of sight or one on one supervision.

On 01/17/2023, I interviewed Resident A regarding the allegations. Resident A reported being unaware of Ms. Robinson leaving the facility shortly after their verbal altercation.

On 01/17/2023, I interviewed Resident B regarding the allegations. Resident B reported that after the verbal altercation between Ms. Robinson and Resident A, Ms. Robinson left the facility and indicated he knew Ms. Robinson had left as he was able to observe Ms. Robinson’s vehicle leave the facility and drive down the road through the window at the front of the facility. Resident B denied having any injuries after the incident and clarified that he was a little surprised Ms. Robinson was allowed to return to work.

On 01/17/2023, I interviewed direct care staff Diante Taylor regarding the allegations. Mr. Taylor denied there was ever inadequate staffing at this facility and denied Ms. Robinson had left the facility after her verbal altercation with Resident A. Mr. Taylor reported Ms. Robinson informed him that she was outside the facility in her car. Mr. Taylor acknowledged if Ms. Robinson had left the facility, staffing would not be within the required staffing ratio for this facility.

On 02/07/2023, I interviewed former direct care staff Brittany Labadie regarding the allegations Ms. Labadie reported that after the verbal altercation with Resident A, she thought Ms. Robinson had walked off the job and watched Ms. Robinson’s vehicle drive down the road. Ms. Labadie reported that approximately 30 minutes later, Ms. Robinson returned to the facility. Ms. Robinson acknowledged being continuously present in this facility with six residents while Ms. Robinson was unaccounted for.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and

	children who are under the age of 12 years.
ANALYSIS:	Although Resident B and former direct care staff Brittany Labadie corroborated that direct care staff Michelle Robinson had left this facility in her personal car, in an interview, Ms. Labadie confirmed that she was continuously present with the residents of this facility until Ms. Robinson returned. As such there is not enough evidence the staffing at this facility was not adequate as there was at least one direct care staff to 12 residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

02/08/2023

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Eli DeLeon Date
Licensing Consultant

Approved By:

02/09/2023

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Dawn N. Timm Date
Area Manager