GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 10, 2023

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

RE: License #: AS250412239
Investigation #: 2023A0779047
Beacon Home at Swartz Creek

Dear Kimberly 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) 643-7960.

Sincerely,

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250412239
Investigation #:	2023A0779047
Complaint Receipt Date:	06/01/2023
Investigation Initiation Date:	06/01/2023
Report Due Date:	07/31/2023
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 Swartz Creek
Facility Address:	5263 W. Maple Ave., Swartz Creek, MI 48473
Facility Telephone #:	(810) 339-6812
Original Issuance Date:	05/02/2022
License **Status:**	REGULAR
Effective Date:	11/02/2022
Expiration Date:	11/01/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff took residents out for ice cream and paid for all residents except Resident A. Resident A was made to pay for her own food.	Yes
On 5/29/23, staff Kamira Briggs threw ice water on Resident B.	Yes

III. METHODOLOGY

06/01/2023	Special Investigation Intake 2023A0779047
06/01/2023	APS Referral Complaint referred to APS centralized intake.
06/01/2023	Special Investigation Initiated - Telephone Interview conducted with staff person, April Carlson.
06/01/2023	Contact - Telephone call made Interview conducted with staff person, Kamira Briggs.
06/02/2023	Inspection Completed On-site
06/12/2023	Exit Conference Held with licensee designee, Kim Rawlings.

ALLEGATION:

Staff took residents out for ice cream and paid for all residents except Resident A. Resident A was made to pay for her own food.

INVESTIGATION:

On 6/1/23, a phone interview was conducted with staff person, Kamira Briggs, who confirmed that she took a few residents to Dairy Queen to get ice cream for one of the resident's birthday. Staff Briggs stated that Resident A got ice cream and mushrooms that she paid for using the facility credit card.

On 6/1/23, a phone interview was conducted with staff person, April Carlson, who stated that she was the other staff who took residents to Dairy Queen, but that it was staff Kamira Briggs that was in control of the facility credit card that day. Staff Carlson confirmed that staff Briggs only paid for the staff and Resident C's ice cream, but made Resident A pay for her own mushrooms and milkshake. Staff Carlson stated that Staff

Briggs told the Dairy Queen worker that Resident A would be paying for her own items. Staff Carlson stated that she was not sure why Staff Briggs did not pay for Resident A. Staff Carlson reported that Resident D was asked if she wanted ice cream, but she only wanted food, so she did not get anything. Staff Carlson stated that both her and Staff Kamira got ice cream as well.

On 6/2/23, an on-site inspection was conducted, and Resident A, Resident C and Resident D were interviewed. Resident A stated that the only thing she got at Dairy Queen was some mushrooms and that she paid for them herself. Resident A reported that she asked for a malt, but that staff Kamira Briggs told her that she had to pay for the malt to and that when she said she would only pay for the mushrooms, Staff Briggs had the malt sent back for a refund. Resident A stated that Staff Briggs never said why she could not have the malt.

Resident C stated that they went to Dairy Queen to get ice cream for her birthday and that staff Kamira Briggs told them they could only get ice cream, but Resident A and Resident D kept asking to get food. Resident C stated that Staff Briggs got upset and told Resident A and Resident D that they had to pay for their own ice cream. Resident C reported that Resident A paid for her own mushrooms but did not get the malt that she asked for and that Resident D did not get anything. Resident C stated that both staff got ice cream and that she was the only resident to get ice cream (banana split).

Resident D confirmed that she went to Dairy Queen, but that it was very unorganized and that she did not get anything. Resident D stated that she wanted ice cream and food but that she could not remember why she did not get anything.

The home provided a copy of the receipt documenting what items were purchased using the facility credit card. The receipt showed that one banana split, and two ice cream blizzard items were the only things purchased.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**

ANALYSIS:	It was confirmed that staff persons, Kamira Briggs, and April Carlson, took Resident A, Resident C, and Resident D to Dairy Queen to get ice cream for Resident C's birthday. Resident A stated that she purchased herself mushrooms but was told by staff Kamira Briggs that she had to also pay for her own ice cream and that Staff Kamira had the malt that she ordered sent back. Resident C and staff April Carlson both confirmed that Staff Briggs only paid for Resident C and both staff to get ice cream and that Resident A did not get the malt that she asked for. The receipt for the facility credit card confirmed that only three ice cream items were purchased. There was sufficient evidence found to prove that staff Kamira Briggs did not treat Resident A with consideration or respect by paying for the staff and Resident C's ice cream but refusing to pay for Resident A's ice cream.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

On 5/29/23, staff Kamira Briggs threw ice water on Resident B.

INVESTIGATION:

On 6/1/23, staff person, Kamira Briggs, stated that she was one of two staff who took Resident A and Resident B to the beach on 5/29/23. Staff Briggs stated that Resident B was having a behavior and was screaming and cussing, so she took Resident B back to the van to calm her down. Staff Briggs claimed that there was a jug of water sitting between the front seats of the van that flew backwards onto Resident B when she hit the brakes. Staff Briggs denied that she intentionally dumped ice water on Resident B.

On 6/1/23, staff person, April Carlson, confirmed that she was the other staff who took Resident A and Resident B to the beach on 5/29/23. Staff Carlson stated that while at the beach, Resident B was having a behavior and that Staff Briggs was threatening to dump ice water on Resident B if Resident B did not stop screaming and cussing, but that she told Staff Briggs that she could not do something like that. Staff Carlson reported that once they started leaving the beach, Resident B continued to have behaviors in the van and Staff Briggs slammed on the brakes of the van and then poured a pitcher of ice water onto Resident B in the back seat.

On 6/2/23, Resident A confirmed that Resident B was acting out and screaming while at the beach and in the van. Resident A stated that Staff Briggs kept trying to get staff Carlson to pour water on Resident B, but Staff Carlson would not do it. Resident A

reported that Staff Briggs then reached back into the backseat and poured/splashed ice water on Resident B three times in a row until the pitcher was empty.

On 6/2/23, home manager, Jacqueline Wilson, stated that Resident A came to her and said that staff Briggs pored ice water on Resident B. Manager Wilson stated that when she asked Staff Carlson about the alleged incident, staff Carlson told her Staff Briggs started by sprinkling water on Resident B to get Resident B to stop screaming and then Staff Briggs dumped the pitcher of water on Resident B.

On 6/2/23, Resident B was viewed to be clean, well-groomed, and doing well. Due to Resident B's cognitive deficiencies, Resident B was not able to be interviewed.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(4) Intervention techniques shall not be used for the purpose of punishment, discipline, or for the convenience of staff.
ANALYSIS:	It was confirmed that while at the beach and in the van on 5/29/23, Resident B was having behaviors, screaming, and cussing. Resident A and staff person, April Carlson, both stated that they witnessed staff person, Kamira Briggs, dump a pitcher of ice water onto Resident B to try and get Resident B to stop screaming. There was sufficient evidence found to prove that staff person, Kamira Briggs, used an inappropriate intervention technique as a form of punishment when she dumped a pitcher of ice water on Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/12/23, an exit conference was held with licensee designee, Kimberly Rawlings. Licensee designee Rawlings was informed of the outcome of this investigation and that a written corrective action plan is required.

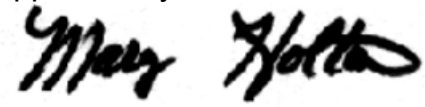
IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remain unchanged.

7/7/2023

Christopher Holvey Date
Licensing Consultant

Approved By:



7/10/2023

Mary E. Holton Date
Area Manager