GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 21, 2023

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

RE: License #: AM590387872
Investigation #: 2023A1038003
Beacon Home At The Cottage

Dear Ms. Hunter:

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 (517) 284-9727.

Sincerely,

Johnnie Daniels, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

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 #:	AM590387872
Investigation #:	2023A1038003
Complaint Receipt Date:	08/25/2023
Investigation Initiation Date:	08/28/2023
Report Due Date:	09/24/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Katrina Pierce
Licensee Designee:	Susan Hunter
Name of Facility:	Beacon Home At The Cottage
Facility Address:	1550 E. Colby Road Stanton, MI 48888
Facility Telephone #:	(989) 831-0625
Original Issuance Date:	01/30/2018
License **Status:**	REGULAR
Effective Date:	07/30/2022
Expiration Date:	07/29/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was without proper supervision, personal care, and protection from Direct care staff members.	No
Direct care staff member Cassandra Lewis used derogatory language in front of Resident A.	Yes

III. METHODOLOGY

08/25/2023	Special Investigation Intake 2023A1038003
08/28/2023	Special Investigation Initiated - Telephone call was made to complainant
08/31/2023	Inspection Completed On-site
08/31/2023	Inspection Completed-BCAL Sub. Compliance
08/31/2023	Contact - Face to Face- Interviews were conducted with direct care staff members Jeffrey Wright, Lisa Bowers and Cassandra Lewis.
08/31/2023	Contact - Face to Face- Interview was conducted with home manager Cheryl Shook
08/31/2023	Contact - Face to Face- Interviews were conducted with Resident A and Resident B.
09/13/2023	Corrective Action Plan Requested and due on 9/28/23
9/18/2023	Exit conference- with Licensee designee Suzanne Hunter

ALLEGATION: Resident A was without proper supervision, personal care, and protection from direct care staff members.

INVESTIGATION:

On 8/25/2023 I received a complaint through the BCHS on-line Complaint System. According to Complainant, DCSM Cassandra Lewis became upset with DCSM Lisa Bowers after Ms. Bowers questioned Ms. Lewis about dinner. According to Complainant, Ms. Lewis tossed the (house) key at DCSM Jeff Wright and said, "Fuck it,

I quit." According to Complainant Resident A was in the same room with Ms. Bowers, Ms. Lewis and Mr. Wright when Ms. Lewis made this statement. According to Complainant, this incident occurred on 8/21/2023 around 5:30pm.

On 8/28/2023, I interviewed Complainant who stated direct care staff member Cheryl Shook, whose role is home manager, provided this information. Complainant stated it is unknown if any other residents were present when the incident happened. Complainant stated DCSM Cassandra Lewis left Beacon Home at the Cottages (facility) after the incident and Complainant did not know if she returned. Complainant stated this incident happened in the kitchen and verified DCSM Lisa Bowers, Cassandra Lewis and Jeffery Wright were all working during the incident.

On 8/31/2023, I interviewed DCSM Cheryl Shook who stated Resident A does not require 1:1 supervision or any other type of enhance supervision. Ms. Shook stated DCSM Cassandra Lewis did not leave the premises rather she only stepped outside the facility then returned to work. Ms. Shook stated DCSM Lisa Bowers and Jefferey Wright were present and remained in the facility to monitor residents. Ms. Shook provide me with Resident A's *Assessment Plan for AFC Residents* and *Resident Care Agreement* which upon my review confirmed he did not require any type of enhanced or specialized supervision.

On 8/31/2023, I interviewed DCSM Jefferey Wright who stated himself, Ms. Bowers and Ms. Lewis were all working at the facility. Mr. Wright stated Resident A was not left alone or unsupervised during any point during his shift. Mr. Wright stated Ms. Lewis only stepped outside the facility momentarily but returned and finished her shift.

On 8/31/2023 I interviewed DCSM Lisa Bowers who stated Resident A was not left alone during her work shift. Ms. Bowers stated herself and DCSM Jefferey Wright were present. Ms. Bowers stated DCSM Ms. Lewis only went outside the facility but was still on the premises and worked the entirety of her shift. Ms. Bowers stated none of the residents were ever left unsupervised.

On 8/31/2023 I interviewed DCSM Cassandra Lewis who stated she did not leave the property only stepped outside of the building. DCSM Cassandra Lewis denied ever leaving any resident unsupervised at any time. Ms. Lewis stated she only went outside to calm down from talking with Ms. Bowers and then went back inside the facility. Ms. Lewis stated DCSM Ms. Bowers and Mr. Wright were also present at the home.

On 8/31/2023 I interviewed Resident A who verified Ms. Lewis only stepped outside the facility but returned and finished her shift. Resident A stated Mr. Wright and Ms. Bowers was also present at the facility so no residents were ever left unsupervised.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my interviews with direct care staff members Lisa Bowers, Cassandra Lewis, Jeff Wright , and Cheryl Shook, and Resident A and Resident B, there was no evidence Resident A or any other resident were left without proper supervision, and personal care. There were three direct care staff members on duty providing care and supervision.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff member Cassandra Lewis used derogatory language in front of Resident A.

INVESTIGATION:

On 8/31/23 I interviewed DCSM, whose role is home manager, Cheryl Shook who stated DCSM Ms. Lewis threw her facility keys at DCSM Mr. Wright while stating “Fuck it, I quit” during her shift. Ms. Shook stated this was said in front of Resident A. Ms. Shook stated Ms. Bowers and Mr. Wright were present during this incident. Ms. Shook stated the statement was made during an argument with DCSM Ms. Bowers regarding cooking food for the residents for dinner.

On 8/31/2023 I interviewed DCSM Mr. Wright who stated Ms. Lewis gave him the facility keys and stated, “fuck it, I quit.” Mr. Wright stated this was due to an argument Ms. Lewis was having with DCSM Ms. Bowers. Mr. Wright stated himself, Ms. Lewis, Ms. Bowers, Resident A and possibly Resident B heard the argument. Mr. Wright stated Resident B was in his room so he was not sure how much of the argument Resident B heard.

On 8/31/2023 I interviewed DCSM Ms. Bowers who stated Ms. Lewis was upset at her with her questioning her cooking. Ms. Bowers stated Ms. Lewis stated while Resident A was present “fuck it I quit” and “fuck it you guys cook it yourself [sic].” Ms. Bowers stated Mr. Wright, Ms. Lewis, herself, and Resident A was present during this argument. Ms. Bowers stated Resident A was standing in the kitchen with the three direct care staff members. Ms. Bowers stated this was the first time something like this has ever happened.

On 8/31/2023, I interviewed DCSM Ms. Lewis who stated she was upset at Ms. Bowers who was questioning her cooking. Ms. Lewis stated she did say “fuck it I quit” while Resident A was in the kitchen. Ms. Lewis stated she knows she is not supposed to swear in front of residents. Ms. Lewis stated herself, Mr. Wright, Ms. Bowers, and Resident A were the only one present during the argument.

On 8/31/2023 I interviewed Resident A who stated he was present when Ms. Lewis said, “fuck it I quit”. Resident A stated she said it to Ms. Bowers due to them having an argument. Resident A stated he could hear Ms. Lewis raising her voice at Ms. Bowers. Resident A stated he was unsure of any another time hearing direct care staff members arguing or swearing in front of Residents.

On 8/31/2023 I interviewed Resident B who stated he did not hear or observe any arguing or swearing from any direct care staff members. Resident B stated he has not ever heard or observed any arguing or swearing from direct care staff members.

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 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.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on my interviews with direct care staff members Lisa Bowers, Cassandra Lewis, Jeff Wright, and Cheryl Shook, Resident A and Resident B, there was evidence DCSM Cassandra Lewis did not treat Resident a with respect while she used derogatory language and argued with a coworker in his presence.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

9/19/2023

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Johnnie Daniels Date
Licensing Consultant

Approved By:

09/21/2023

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Dawn N. Timm Date
Area Manager