GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 3, 2024

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

RE: License #: AM590387878
Investigation #: 2024A0622049
Beacon Home At The Lodge

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.
- 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,

Amanda Blasius, 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 #:	AM590387878
Investigation #:	2024A0622049
Complaint Receipt Date:	08/29/2024
Investigation Initiation Date:	08/29/2024
Report Due Date:	10/28/2024
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:	Suzanne Hunter
Name of Facility:	Beacon Home At The Lodge
Facility Address:	1550 E. Colby Road Stanton, MI 48888
Facility Telephone #:	(989) 831-0626
Original Issuance Date:	04/17/2018
License **Status:**	REGULAR
Effective Date:	10/17/2022
Expiration Date:	10/16/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct Care Worker, Janet Hollister slammed a door in Resident A's face.	Yes

III. METHODOLOGY

08/29/2024	Special Investigation Intake 2024A0622049
08/29/2024	Special Investigation Initiated – Telephone call with office of recipient rights officer, Sarah Watson.
09/10/2024	Email contact with office of recipient rights officer, Sarah Watson.
09/10/2024	Inspection Completed-BCAL Sub. Compliance
09/19/2024	Telephone call made to direct care workers, Janet Hollister and Shelby VanHorn.
09/24/2024	Telephone call to direct care worker, Cherly Woodard.
10/03/2024	Exit Conference with Suzanne Hunter

ALLEGATION: Direct Care Worker, Janet Hollister slammed a door in Resident A's face.

INVESTIGATION:
On 06/12/2024, I received this complaint through the Bureau of Community and Health Systems online complaint system. According to the complaint, Resident A knocked on the door where the staff were meeting during shift change to request a snack and direct care worker, Janet Hollister slammed the door in Resident A's face and then stated the following: "that is how you handle it."

On 08/29/2024, I interviewed Sarah Watson, recipient rights officer and she reported that she has not completed her interviews with staff, so had not additional information to add. On 09/10/2024, I contacted recipient rights officer, Sarah Watson and she provided the names of direct care workers who were involved in the shift change meeting.

On 09/10/2024, I completed an unannounced, onsite investigation to Beacon Home at the Lodge. During the investigation, I interviewed direct care worker (DCW), April McCreery in person. She is the home manager for the Beacon Home at the Lodge and stated that she was informed of the alleged incident the following day but was

not directly involved. DCW McCreery, explained that they have another resident in the home that will eat all the food that is left in the refrigerator, therefore they keep leftovers and food for upcoming meals in the refrigerator within the locked staff room. She explained that snacks are kept in the cupboard and in the refrigerator, therefore residents can access them at any time. DCW McCreery reported that Resident A was wanting to have dinner, as he did not eat dinner on 08/26/24. She explained that shift change between second and third shift occurs between 9pm-9:30pm.

On 09/10/2024, I interviewed direct care worker, Mindy Allen in person. She was working at Beacon Home at the Lodge on 08/26/2024. She reported that she was not in the staff room when the incident occurred and reported that she does not remember any details from the incident.

On 09/10/2024, I interviewed direct care worker, Cassondra Finney in person. She reported that she was in the staff room and was charting before her shift ended. DCW Finney reported that Resident A had knocked on the door and was getting ready to ask for food. DCW Finney reported that she observed DCW Janet Hollister slammed the door with a full hand and then started yelling at DCW Cherly Woodard and stated the following: “you are the lead staff, and you should not be allowing him to come to the door asking for food.” DCW Finney explained that she checked on Resident A before she left for her shift, and she told DCW Hollister that he was hungry and wanted food.

On 09/10/2024, I interviewed Resident A in person. He reported that he wanted some food, and the staff lounge room door was somewhat open, so he knocked on the door. Resident A explained that before he could ask for food, DCW Hollister shut the door in my face. He reported that the incident made him upset, and he pulled the fire alarm and ran down the road.

On 09/19/2024, I interviewed direct care worker, Janet Hollister via phone. DCW Hollister reported that during shift change, Resident A knocked on the door and she heard another resident tell him that staff are in there doing shift change. DCW Hollister reported that she got up, said “this is how we have to do it”, said hi to Resident A and shut the door. DCW Hollister stated that she shut the door hard but denied slamming the door. DCW Hollister reported she was unaware that Resident A wanted food and did not have dinner. DCW Hollister, explained that she was having a rough day and should not have handled the situation that way. DCW Hollister explained that she did apologize to Resident A later. DCW Hollister confirmed that Resident A did pull the fire alarm and ran away from Beacon Home at the Lodge after this incident. She stated that Resident A ran into the woods and staff were unable to find him for a short period of time. Once they found him, it took some time to convince him to come back to the AFC home. DCW Hollister reported that Resident A was away from the AFC home for about two hours.

On 09/19/2024, I interviewed direct care worker, Shelby VanHorn via phone. She reported that during shift change, Resident A was knocking on the door and DCW Woodard went to the door and asked Resident A to wait, but he wanted to eat right then. DCW Hollister then came to the door, moved DCW Woodard out of the way and slammed the door and said, “this is how you handle it.” DCW VanHorn stated that DCW Hollister then said that Resident A was only knocking for her attention. DCW VanHorn, confirmed that the door being slammed in Resident A’s face caused him to have a behavior, pull the fire alarm and run the down the driveway. DCW VanHorn reported that this occurred after she clocked out. She was driving home, when she saw Resident A on the side of the road. She pulled over to try and get Resident A back to the AFC home. DCW VanHorn stated that Resident A reported the following: “Fuck that bitch. If I have to see her, I'm going to kill her.” DCW VanHorn explained that she had him calmed down and he was going to walk back to the AFC home with her but when DCW Hollister pulled up in the company van, Resident A ran back into the woods.

On 09/24/2024, I interviewed direct care worker, Cherly Woodard via phone. She reported that during shift change, Resident A came to the door, and she told him to hold on and asked what was going on. DCW Woodward stated that DCW Hollister than said, “this is not how you do things” and then opened the door, said hi and slammed the door on Resident A. DCW Woodard reported DCW Hollister slammed the door as hard as she could. DCW Woodard reported DCW Hollister then said the following to her: “you are the lead staff, and you should set an example for the new girls.” DCW Woodard stated that she said the following to her: “no, technically our job is to jump and help them.” DCW Hollister stated that another staff member came in and asked what was going on because all Resident A wanted was dinner. DCW Woodard got up and helped get Resident A a plate of food. DCW Woodard reported that she clocked out for her shift before Resident A ran away from the AFC home.

On 9/10/2024, I viewed an incident report documenting, Resident A pulling the fire alarm and running away from Beacon home at the Lodge.

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.** **(2) A licensee shall respect and safeguard the resident’s rights specified in subrule (1) of this rule.**

ANALYSIS:	Based on interviews with direct care workers and Resident A it was confirmed that DCW Janet Hollister slammed the door in the face of Resident A, which caused him to become upset and run away from Beacon Home at the Lodge. Resident A was attempting to ask for food for dinner, since he did not attend dinner, when this incident occurred. DCW Hollister did not treat Resident A with consideration or respect and was unwilling to give him time to explain his needs before slamming the door in his face.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/24/2024

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Amanda Blasius Date
Licensing Consultant

Approved By:

10/03/2024

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Dawn N. Timm Date
Area Manager