GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 3, 2025

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

RE: License #:	AS410397920
Investigation #:	2025A0356012
	Beacon Home At Walker

Dear Ms. Hunter:

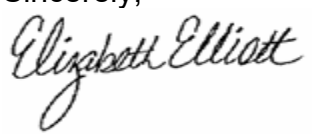
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410397920
Investigation #:	2025A0356012
Complaint Receipt Date:	11/13/2024
Investigation Initiation Date:	11/13/2024
Report Due Date:	01/12/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110, 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Suzy Hunter
Licensee Designee:	Suzy Hunter
Name of Facility:	Beacon Home At Walker
Facility Address:	1706 Wilson Ave. Walker, MI 49534
Facility Telephone #:	(616) 591-3834
Original Issuance Date:	04/04/2019
License Status:	REGULAR
Effective Date:	10/04/2023
Expiration Date:	10/03/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct Care Workers Jaekwon Shaw and Yukia Robinson engaged in a verbal altercation with Resident A.	Yes

III. METHODOLOGY

11/13/2024	Special Investigation Intake 2025A0356012
11/13/2024	APS Referral Denied for investigation.
11/13/2024	Special Investigation Initiated - Telephone Suzy Hunter, LD and Jessica Griswold, home manager.
12/10/2024	Contact - Document Sent Email, Suzy Hunter and Jessica Griswold.
12/19/2024	Contact - Document Received Facility documents received for review.
12/20/2024	Inspection Completed On-site
12/20/2024	Contact - Face to Face Yukia Robinson, staff. Resident A.
12/20/2024	Contact - Face to Face Walker PD office, the office was not open.
01/02/2025	Contact-Telephone call made Jessica Griswold, home manager.
01/02/2025	Contact-Document received IR (incident report)
01/03/2025	Exit conference-Suzy Hunter, Licensee Designee.

ALLEGATION: Direct Care Workers Jaekwon Shaw and Yukia Robinson engaged in a verbal altercation with Resident A.

INVESTIGATION: On 11/13/2024, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant, Jessica Griswold, home manager, reported that on 11/10/2024, staff

instructed Resident A to leave the room he was in and go to his bedroom. Resident A called home manager, Ms. Griswold and reported frustration with staff. Ms. Griswold reported that during Resident A's conversation with her, Resident A began to yell and staff, Jaekwon Shaw and Yukia Robinson intervened and began to argue with Resident A. Ms. Griswold reported that Resident A became verbally aggressive with Mr. Shaw and Ms. Robinson. He dropped the phone, picked up a chair and a butter knife and Ms. Griswold reported that she heard Mr. Shaw tell Resident A, "I will beat your ass." Ms. Griswold reported Resident A did not harm staff with the chair or the butter knife and staff did not harm Resident A. The Walker Police Department responded and deescalated the situation until Ms. Griswold arrived and take over.

On 11/13/2024, I interviewed Jessica Griswold. Ms. Griswold stated Resident A called her and reported that staff told him to go to his room, and Ms. Griswold stated she was on the telephone with Resident A and heard entire incident. Ms. Griswold stated Ms. Robinson sounded as though she was trying to de-escalate the situation, but Mr. Shaw continued "pushing (Resident A's) buttons and kept the situation escalated." Ms. Griswold stated Resident A was yelling racial slurs and profanity at Mr. Shaw and Ms. Robinson and while Ms. Robinson was trying to de-escalate the situation by saying, "let's go to your room and listen to music," Ms. Griswold stated she heard Mr. Shaw say, "I'm not dealing with this, I'll beat your ass." Ms. Griswold stated Resident A then picked up a chair and grabbed a butter knife and was threatening staff. Ms. Griswold stated she immediately called 9-1-1 to get to the facility as soon as possible and then she went to the facility. Ms. Griswold stated when she arrived, the Walker Police were there, and one officer had Mr. Shaw outside of the facility while the other officer was inside the facility with Ms. Robinson and Resident A. Ms. Griswold stated there were relatives of Mr. Shaw or Ms. Robinson's outside the facility also. Ms. Griswold stated she requested that Mr. Shaw leave the facility, and it was the end of Ms. Robinson's shift, so she relieved her of her duties and worked in the facility until the third shift staff came in. Ms. Griswold stated the other residents were in their rooms and the incident only involved Resident A, Mr. Shaw and Ms. Robinson. Ms. Griswold stated Ms. Robinson continues to work at the facility, but Mr. Shaw no longer does.

On 12/19/2024, I reviewed Resident A's assessment plan for AFC residents. Resident A's assessment plan was dated 04/03/2024 and documented that Resident A does not control aggressive behavior and explained, *'(Resident A) does have high anxiety that will cause him to act out both physically and verbally. (Resident A) is currently working with a behaviorist to create new coping skills, Beacon staff will encourage (Resident A's) positive behaviors.'*

On 12/19/2024, I reviewed Resident A's behavior treatment plan, dated 02/08/2024 and written by Savannah Wirth, MA, QBHP and Cora Santman, MA, BCBA, LBA with Sparks Behavioral Services, LLC. The behavior plan documented; *'Target behavior #1: Physical aggression-any instance in which (Resident A) attempts, successful or unsuccessful, to hurt or cause harm to another person.' Target*

behavior #2: Property destruction,' and 'Target behavior #3: Verbal aggression: Any instance in which (Resident A) uses derogatory language, profanity, slurs, and/or threats of harm directed at others.' The behavior treatment plan documented prevention strategies for all 3 target behaviors as rapport building with high-quality conversations and explains that (Resident A) is most successful when he develops a trusting relationship with caregivers, intervening on precursor behavior, refrain from coercion and avoid triggers or antecedents to problem behavior when possible.' The behavior plan also documented, 'Strategy #1: Reacting to physical aggression, property destruction, and verbal aggression. If (Resident A) is observed becoming "triggered," maintain a neutral tone and demeanor, instead of telling (Resident A) what to do, listen to (Resident A). Staff should refrain from raising their voices or allowing (Resident A) to see frustration, anger or disappointment. Staff should calmly deliver short and clear expectations when problem behavior is being displayed.'

On 12/20/2024, I conducted an inspection at the facility and attempted to interview Resident A. Resident A refused to be interviewed and stated he has already talked about this incident and does not want to talk about it with me.

On 12/20/2024, Ms. Griswold informed me that Mr. Shaw is no longer employed at this facility, and he is unavailable to participate in an interview.

On 12/20/2024, I interviewed Ms. Robinson at the facility. Ms. Robinson stated the incident occurred on a Sunday and staff had been informed by management that they are not allowed to perform "shift change" duties in front of the residents. Those duties include briefing the incoming shift on any events, relevant information, incidents, or medication anomalies that took place during the previous shift so incoming shift is informed. Ms. Robinson stated she went into the kitchen to discuss her shift with Mr. Shaw and Resident A came into the kitchen and she asked Resident A to go into the living room so she could perform shift change duties. Ms. Robinson stated she and Mr. Shaw completed the shift change information, but Mr. Shaw had some questions as they were having computer issues for medication passes so Mr. Shaw called Ms. Griswold to ask questions about what to do. Ms. Robinson stated Resident A was "worried and fidgety" because he was concerned about getting his medications. Ms. Robinson stated she was in the living room waiting for her ride to arrive, the other residents were in their rooms, and she (Ms. Robinson) thinks that Resident A thought she was gone when she heard Resident A talking to Ms. Griswold stating the "kid was being rude, telling me to go to my room" and then Resident A realized she (Ms. Robinson) was still in the facility and he threw the phone and his tablet at her. Ms. Robinson stated she "dodged the tablet," and she was never being rude to Resident A. She said Resident A "ran up behind me" and said, "I'm gonna beat your ass" and was calling her racial slurs. Ms. Robinson stated Resident A threw a chair and went into the kitchen and came out with a butter knife and that is when Mr. Shaw stepped in between her and Resident A. Ms. Robinson stated she was able to get Resident A to give her the knife and she went into the kitchen and gathered all the knives and put them in the dishwasher to keep them away from Resident A. Ms. Robinson stated Mr. Shaw was telling Resident A

to calm down and she never heard Mr. Shaw tell Resident A that he would “kick his ass”, however, Resident A and Mr. Shaw were “yelling” at each other as she was redirecting and keeping the other residents in their rooms. Ms. Robinson stated she managed to keep the residents, who were starting to come out of their rooms, in their rooms during the incident and got Resident A to go sit outside in an attempt to de-escalate the situation. Ms. Robinson stated in the meantime, her ride arrived, and they were sitting in the driveway waiting for her to come out as well as the police arrived. Ms. Robinson stated the police asked if she or Mr. Shaw wanted to press charges against Resident A, and they declined.

On 01/02/2025, I reviewed the IR (incident report) that was written on 11/10/2024, by Ms. Griswold and signed by Suzy Hunter, Licensee Designee. The incident occurred at 7:31p.m., staff involved is documented as Jaekwon Shaw. The IR documented the following information, *‘Staff member, Jaekwon Shaw, was verbally threatening (Resident A) while he was on the phone with the home manager. Home manager contacted local police department to assist. Home manager relieved Jaekwon from his shift and contacted Adult Protective Services and Network 180 Recipient Rights to report to both agencies what had occurred. Home Manager will continue to report any issues of abuse or neglect and assist with any investigations that occur from this report. The staff involved was sent home and is suspended pending investigation.’*

On 01/02/2025, I reviewed another IR that was written on 11/10/2024, 7:16p.m. The IR documented the following information, *‘(Resident A) was on the phone with the Walker home manager when he became upset and became verbally aggressive. (Resident A) was threating staff and calling staff racial slurs. (Resident A) then grabbed a butter knife and threw it at the wall leaving a hole in the wall. (Resident A) also grabbed the Beacon tablet and was attempting to break it. The second staff was attempting to encourage Bailey to use his coping skills with no success. Home manager did have to contact the local police department to assist. All staff will be retrained on (Resident A’s) behavior plan which states allowing (Resident A) space when he is showing signs of irritation and frustration. Staff will also continue to encourage (Resident A) to use the coping skills that he likes which help him calm down.’*

On 01/03/2025, I conducted an exit conference with Suzy Hunter, Licensee Designee. Ms. Hunter stated she agreed with the information, analysis, and conclusion of this applicable rule. Ms. Hunter stated an acceptable corrective action plan will be submitted and refresher training to all staff will be conducted.

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:	The complainant reported that on 11/10/2024, Resident A became verbally aggressive with Mr. Shaw and Ms. Robinson, dropped the phone, picked up a chair and a butter knife and then Mr. Shaw told Resident A, “I will beat your ass.” Staff did not deescalate the situation and the police were called to assist. Ms. Griswold stated she heard Mr. Shaw tell Resident A he would “kick his ass” while she was on the telephone with Resident A. Ms. Robinson and Ms. Griswold stated Ms. Robinson was attempting to deescalate Resident A’s behaviors. Resident A’s assessment plan and behavior treatment plan clearly document Resident A’s aggressive behaviors and what staff should do to deescalate the behaviors. Based on my investigative findings, there is a preponderance of evidence to show that on 11/10/2024, Mr. Shaw failed to follow Resident A’s behavior treatment plan to deescalate a situation and verbally threatened Resident A. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

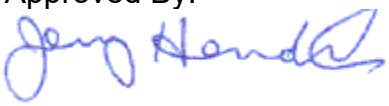
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

01/03/2025

Elizabeth Elliott, Licensing Consultant Date

Approved By:



01/03/2025

Jerry Hendrick, Area Manager Date