GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 3, 2021

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

RE: License #: AS140393999
Investigation #: 2021A1024037
Beacon Home At Niles

Dear Ms. VanNiman:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS140393999
Investigation #:	2021A1024037
Complaint Receipt Date:	06/11/2021
Investigation Initiation Date:	06/11/2021
Report Due Date:	08/10/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At Niles
Facility Address:	970 Ruth Layne Niles, MI 49120
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/08/2018
License Status:	REGULAR
Effective Date:	10/16/2019
Expiration Date:	10/15/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff allows a resident to assault Resident A.	No
Staff enters Resident A's bedroom without knocking when she is changing.	No

III. METHODOLOGY

06/11/2021	Special Investigation Intake 2021A1024037
06/11/2021	Special Investigation Initiated - Telephone left voicemail for mental health case manager Janelle Kassien
06/11/2021	Contact - Telephone call made with mental health case manager Janelle Kassien
06/14/2021	Contact - Telephone call made with district director Kimberly Howard
07/30/2021	Inspection Completed On-site with Residents A, B, C, D, home manager Aldreana Luster and direct care staff member Brianna Matamoros
07/30/2021	Exit Conference with licensee designee Nichole VanNiman

ALLEGATION:

Staff enters Resident A's bedroom without knocking when she is changing.

INVESTIGATION:

On 6/11/2021, I received this complaint though the Bureau of Community and Health systems online complaint system. This complaint alleged direct care staff members enter Resident A's bedroom without knocking.

On 6/11/2021, I conducted an interview with Resident A's mental health case manager Janelle Kassien regarding this allegation. Ms. Kassien stated Resident A has a history of making false complaints against others while residing in an adult foster care setting. Ms. Kassien further stated Resident A has reported to her in the past that staff has walked in her bedroom without knocking however Ms. Kassien is unsure if this actually happened and Ms. Kassien has no concern regarding how direct care staff members care for Resident A.

On 6/14/2021, I conducted an interview with district director and administrator Kimberly Howard who stated she has no knowledge that there have been any incidents of staff walking in Resident A's bedroom without knocking and no reports from any of the residents have been made to her regarding this. Ms. Howard stated she has not observed any direct care staff members walking in any resident bedrooms without knocking.

On 7/30/2021, I conducted an onsite investigation at the facility and interviewed Residents A, B, C, and D. Resident A stated a staff walked in her bedroom without knocking while she was changing her clothes however, she does not remember details of this incident or what staff member did this. Resident A stated she believes the staff members walks in every resident bedroom without knocking regularly.

Residents B, C, and D all stated they have not heard or seen any direct care staff member walk in a resident bedroom without knocking and believe they are provided with respect and privacy by direct care staff members.

I also interviewed home manager Aldreana Luster and direct care staff member Brianna Matamoros regarding this allegation who both stated they have no knowledge of any direct care staff member walking in any resident bedroom without knocking and stated that it is common practice for all direct care staff to knock before entering resident bedroom and resident bathrooms to ensure privacy and consideration is provided to the resident.

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 this investigation which included interviews with Resident A's mental health case manager Janelle Kassien, district director Kimberly Howard, home manager Aldreana Luster, direct care staff member Brianna Matamoros and Residents A, B, C, and D there is no evidence to support the allegation direct care staff enter Resident A's bedroom without knocking while she is changing. Resident A stated a staff entered a bedroom without knocking however could not remember details of this incident. Residents B, C, and D all stated they have no seen or heard about any direct care staff member entering a resident bedroom without knocking. Ms. Howard, Ms. Luster and Ms. Matamoros further also stated they have no knowledge of any staff member entering a resident bedroom without knocking and that it is common practice for staff members to knock before entering resident bedroom and bathrooms. Ms. Kassien stated Resident A has a history of making false accusations against others and she has no concern for direct care staff members at the facility. Resident A is treated with consideration and respect with due recognition of need for privacy.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff allows a resident to assault Resident A.

INVESTIGATION:

This complaint also alleged direct care staff members knowingly allowed a resident to assault Resident A.

On 6/11/2021, I conducted an interview with Resident A's mental health case manager Janelle Kassien regarding this allegation. Ms. Kassien stated she has been working with Resident A for two years and Resident A has a history of making false accusations against others. Ms. Kassien stated Resident A often complains about Resident B threatening her however she has not seen incident reports or gotten reports from staff members that there has been any physical fighting involving Resident A. Ms. Kassien stated Resident A often complained about the previous adult foster care home she resided in prior to relocating to Beacon at Niles in October of 2020.

On 6/14/2021, I conducted an interview with district director and administrator Kimberly Howard. Ms. Howard stated Resident A gets into arguments with Resident B about cigarettes regularly. Ms. Howard further stated there have not been any incidents of physical fighting between Resident A and Resident B. Ms. Howard

stated the direct care staff members are usually able to de-escalate the situation by body positioning themselves in between the two residents when they are arguing and using verbal prompting to redirect the residents to remove themselves from the situation.

On 7/30/2021, I conducted an onsite investigation at the facility and interviewed Residents A, B, C, and D. Resident A stated she believed she is being physically abused because Resident B "hits her every day and all day and staff does not do anything but sit there and watch." Resident A stated sometimes she gets along with Resident B and they are friends when they smoke cigarettes together however Resident B gets mad when she runs out of cigarettes and will argue with her about cigarettes. Resident A stated she does not feel safe and does not want to live in an adult foster care setting as she wants to live independently on her own.

Resident B stated she gets along with Resident A however Resident A "picks with her" and this will make her upset. Resident B stated she and Resident A argues sometimes however they have not had any physical fights. Resident B further stated she does not hit anyone in the home and she gets along with the other residents in the home. Resident B stated the staff talks to all of them about getting along and tries to protect all the residents. Resident B stated she feels safe and protected in the home.

Residents C and D stated they have not seen any physical fighting between Resident A and Resident B and staff does a good job trying to keep them from physically fighting. Residents C and D stated they have seen staff make attempts to talk to Resident B when she is upset however sometimes Resident B does not want to listen to staff. Residents C and D also stated they have seen staff get in between Resident A and Resident B to prevent them from physically fighting and have heard staff members talk to all the residents about getting along and ignoring negative behaviors. Resident C and Resident D both stated they feel protected by staff.

I also interviewed home manager Aldreana Luster and direct care staff member Brianna Matamoros. Ms. Luster stated the staff members have a hard time keeping Resident A and Resident B away from each other because often times Resident A and Resident B present as if they are friends and hang out with each other. Ms. Luster stated Resident A and Resident B argue regularly about cigarettes and Resident B will argue with all the residents in the home when she is upset about not having cigarettes. Ms. Luster stated there was one incident Resident B became upset and hit Resident A on her hand when she was upset about running out of cigarettes. Ms. Luster stated the staff members continue to try to encourage Resident B to utilize her coping skills instead of taking her frustration out on the other residents in the home. Ms. Luster stated staff members will position themselves in between Resident A and Resident B when they have any type of conflict and will talk to both residents to de-escalate the situation. Ms. Luster believe they have taken the necessary steps to keep all the residents safe in the home.

Ms. Brianna Matamoros stated Resident A and Resident B are friends however they argue regularly over cigarettes. Ms. Matamoros stated there was one incident Resident A hit Resident B on the hand during an argument however staff was able to quickly intervene by stepping in between the two residents and persuaded the two residents to walk away from each other. Ms. Matamoros further stated verbal prompting and verbal redirecting is a behavior technique that is successfully used to prevent further escalation of physical aggression between Resident A and Resident B.

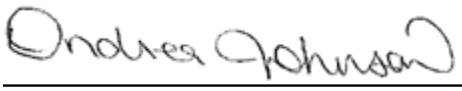
While at the facility, I reviewed *AFC Licensing Division-Incident/Accident Report* dated 5/30/2021 written by Amanda Houser. According to this report, Resident B threatened to kill a resident in the home, and she was observed to hit Resident A. According to the report, staff redirected Resident B immediately and Resident B began yelling at the staff. Resident B also began picking on her other peers despite staff's attempts to redirect her. The report stated, staff encouraged Resident B to utilize positive coping skills and one of the residents called the police.

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:	Based on this investigation which included interviews with Resident A's mental health case manager Janelle Kassien, district director Kimberly Howard, home manager Aldreana Luster, direct care staff member Brianna Matamoros, Residents A, B, C, and D there is no evidence to support the allegation staff allows a resident to assault Resident A. Ms. Luster, Ms. Matamoros, Residents B and C, all stated staff intervenes when Resident B has conflict with other residents and Residents B, C, and D believe they are protected by staff. According to the AFC Licensing Division-Incident/Accident Report, when Resident B hit Resident A staff immediately intervened and tried to encourage Resident B to utilize her coping skills. Resident A's personal needs, including protection and safety are attended to at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 7/30/2021, I conducted an exit conference with licensee designee Nichole VanNiman. I informed Ms. VanNiman of my findings and allowed her an opportunity to make comments or ask questions.

IV. RECOMMENDATION

I recommend the current status remain unchanged.



08/2/2021

Ondrea Johnson — Date
Licensing Consultant

Approved By:

08/03/2021

Dawn N. Timm — Date
Area Manager