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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 4, 2021

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

RE: License #: AS800242668
Investigation #: 2021A1024043
Beacon Home at Highland

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, 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 #:	AS800242668
Investigation #:	2021A1024043
Complaint Receipt Date:	08/06/2021
Investigation Initiation Date:	08/06/2021
Report Due Date:	10/05/2021
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 Highland
Facility Address:	56838 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	01/22/2002
License **Status:**	REGULAR
Effective Date:	07/08/2021
Expiration Date:	07/07/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

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II. ALLEGATION(S)

	Violation Established?
On 8/3/2021 Resident A was physically removed from the kitchen by staff member Maria Garcia.	No

III. METHODOLOGY

08/06/2021	Special Investigation Intake 2021A1024043
08/06/2021	Special Investigation Initiated – Letter with APS Specialist Mike Hartman
08/23/2021	Inspection Completed On-site with home manager Paula Brown, direct care staff member Britini Smith, and Resident A
09/27/2021	Contact-Telephone call made with direct care staff member Maria Garcia
09/27/2021	Exit Conference with licensee designee Nichole VanNiman

ALLEGATION:

On 8/3/2021, Resident A was physically removed from the kitchen by staff member Maria Garcia.

INVESTIGATION:

On 8/6/2021, I received this complaint through the Bureau of Community and Health Systems online complaint system. This complaint alleged that on 8/3/2021, Resident A was physically removed from the kitchen by staff member Maria Garcia.

On 8/6/2021, I received an email from Adult Protective Services (APS) Mike Hartman who stated this allegation was investigated and no substantial evidence was found. Mr. Hartman further stated Resident A refused to make a complaint with law enforcement.

On 8/23/2021, I conducted an onsite investigation at the facility with home manager Paula Brown, direct care staff member Britini Smith and Resident A regarding this allegation. Ms. Brown stated she has no knowledge of any direct care staff member including Maria Garcia using any physical intervention towards Resident A. Ms. Brown stated when she arrived to work on the morning of 8/4/2021, Ms. Garcia

informed her that Resident A went into the kitchen around 11pm and was asleep by 11:30pm. Ms. Brown stated Ms. Garcia did not mention of any incidents that took place with Resident A. Ms. Brown and Ms. Smith both stated Resident A made no complaints of any issues with Ms. Garcia and Resident A usually does a good job reporting any concerns she may have to staff. Ms. Brown and Ms. Smith also stated Resident A has a history of making false accusations towards staff members when she is upset about something.

Resident A stated she has a "poor memory" and does not remember if any staff member physically removed her from the kitchen. Resident A further stated she has been working on her behaviors and she believes her current placement, Beacon at Highland, is the best place for her and she believes she is safe and protected by all staff members.

On 9/27/2021, I conducted an interview with direct care staff member Maria Garcia who stated on 8/3/2021 she worked with Resident A and there were no incidents that took place during the time she worked. Ms. Garcia stated she observed Resident A in the kitchen around 11pm and asleep in her bedroom by 11:30pm. Ms. Garcia stated she did not physically remove Resident A from the kitchen or use any form of physical intervention towards Resident A.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	Based on this investigation which included interviews with APS Specialist Mike Hartman, home manager Paula Brown, direct care staff member Britini Smith and Resident A there is no evidence to support the allegation that on 8/3/2021, Resident A was physically removed from the kitchen by staff member Maria Garcia. Ms. Garcia stated there were no incidents that took place with Resident A who was observed in the kitchen at 11pm and asleep in her bedroom by 11:30pm. Ms. Garcia stated she did not physically remove Resident A from the kitchen or physically touch Resident A in any way. Ms. Brown and Ms. Smith both stated Resident A made no complaints to them about Ms. Garcia physically touching her and Resident A is usually good about reporting her concerns. Mr. Hartman stated during his APS investigation he found no substantial evidence to support this allegation. Resident A stated she does not remember if a staff member physically removed her from the kitchen but believe she is safe and protected by all staff members. Resident A has not been mistreated by any direct care staff member.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 9/27/2021, 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 license status remain unchanged.

9/27/2021

Ondrea Johnson
Licensing Consultant

Date

Approved By:

10/04/2021

Dawn N. Timm
Area Manager

Date