GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 22, 2021

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

RE: License #: AL800278708
Investigation #: 2021A0462050
Beacon Home at Wave Crest

Dear Ms. VanNiman:

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) 284-9730.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

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

THIS REPORT CONTAINS QUOTED SEXUALLY EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AL800278708
Investigation #:	2021A0462050
Complaint Receipt Date:	08/30/2021
Investigation Initiation Date:	08/30/2021
Report Due Date:	10/29/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Israel Baker
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Wave Crest
Facility Address:	28840 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	03/21/2006
License Status:	REGULAR
Effective Date:	04/25/2021
Expiration Date:	04/24/2023
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED

	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided with adequate supervision when on 08/26/2021, he engaged in sexual acts with Individual A at a neighboring AFC facility.	No
Resident B was not provided with adequate supervision when on 09/09/2021, he engaged in sexual acts with Individual A at a neighboring facility.	No
Additional finding.	Yes

III. METHODOLOGY

08/30/2021	Special Investigation Intake 2021A0462050 Special Investigation Initiated - Email correspondence with administrator Israel Baker. Contact- Requested and received documentation. Unannounced Investigation onsite. Separate face-to-face interviews with Resident A, assistant home manager Teresa Merritt, BSLS employee Ginger Muniz and Individuals A and B.
09/13/2021	Contact- Received IR via email.
09/16/2021	Contact- Requested and received police report. Second unannounced investigation onsite. Separate face-to-face interviews with assistant home manager Teresa Merritt, Resident B, Individuals A and B, and administrator Israel Baker.
09/17/2021	Contact- Requested and received police report.
09/19/2021	Contact- Requested and received Individual A’s updated assessment plan.
09/20/2021	Contact- Requested Resident A and B’s assessment plans and CMH TP.
10/20/2021	Face-to-face exit conference with licensee designee Nichole VanNiman.

ALLEGATIONS:

- **Resident A was not provided with adequate supervision when on 08/26/2021, he engaged in sexual acts with Individual A at a neighboring AFC facility.**

- **Resident B was not provided with adequate supervision when on 09/09/2021, he engaged in sexual acts with Individual A at a neighboring AFC facility.**

INVESTIGATION: On 08/26/2021 I received an email from facility administrator Israel Baker. Via email, Mr. Baker informed me Resident A reported that on 08/26 he was sexually assaulted by Individual A in the neighboring AFC facility where Individual A resided. According to Mr. Baker, facility staff members reported the allegation to the Van Buren County Sherriff's Department (VBCSD). On 08/26 an officer with the VBCSD responded to the facility and the neighboring AFC facility, and interviewed both Resident A and Individual A.

On 08/30 I conducted an unannounced investigation at the Beacon Home at Wave Crest facility and interviewed assistant home manager Teresa Merritt and Resident A, face-to-face. Ms. Merritt stated Resident A was an acquaintance of Individual A, and often hung out at the neighboring AFC facility where Individual A resided.

According to Resident A, on 08/26 Individual A asked him if he would go into the woods behind the neighboring AFC facility to help him find his missing wallet. Resident A stated that once in the woods, Individual A told him, "I want to suck your dick." According to Resident A, he did not want Individual A to do this. However, Resident A stated Individual A 'threw him on the ground", pulled his pants down, and performed oral sex on him until he ejaculated. According to Resident A, he tried to "fight Individual A off" but was unable to do so before he orgasmed. Resident A stated Individual B, who also resided at the neighboring AFC facility, witnessed the sexual assault. Resident A confirmed he was interviewed by an officer with the VBCSD, and advised to stay away from Individual A.

I conducted an unannounced investigation at the neighboring AFC facility and interviewed Individuals A and B face-to-face, separately. Individual A stated that on 08/26 it was Resident A who requested assistance with locating his missing wallet in the woods located behind the neighboring AFC facility. According to Individual A, Resident A asked to give him oral sex. Individual A admitted to performing oral sex on Resident A until he orgasmed but stated the sexual act was consensual. Individual A denied the allegation Resident A attempted to "fight him off" and stated Resident A "enjoyed it." Individual A confirmed Individual B was the only witness to the incident. Individual A also confirmed Resident A frequently visited the neighboring AFC facility. Individual A stated that during these occasions, Resident A attempted to "kiss him and stuff." Individual A disclosed he was previously charged and convicted of first and third degree sexual misconduct. Individual A confirmed he

was interviewed by an officer with the VBCSD, and was advised to stay away from Resident A.

Individual B stated that on 08/26 he saw Resident A and Individual A go into the woods located behind the neighboring AFC facility, together. According to Individual B, he followed them into the woods to “spy” on them. Individual B stated he witnessed Resident A laying on the ground with his pants off, while Individual A “jerked him off.” According to Individual B, Individual A then performed oral sex on Resident A. Individual B stated the sexual act appeared to be consensual and Resident A did not attempt to “fight (Individual A) off of him.” According to Individual B, both Resident A and Individual A eventually noticed he was watching them. Subsequently, Individual B “ran away” and informed a facility staff member of what he had witnessed. Individual B stated he had never previously witnessed Individual A engage in sexual acts with others at the neighboring AFC facility nor was he aware of any occasions when Individual A made sexually inappropriate comments and/or requested sexual favors from others.

I conducted a search of the Michigan State Police Sex Offender Registry. I was unable to locate Individual A listed on the registry as a convicted sex offender.

I requested and reviewed a copy of Resident A and Individual A’s Community Mental Health (CMH) Treatment Plans (TP) and *Assessment Plans for AFC Residents* (assessment plan). There was no documentation in either Resident A’s CMH TP or Resident A’s assessment plan restricting Resident A’s independent access in the community, and Resident A was able to leave the Beacon Home at Wave Crest facility without facility staff members’ supervision. There was also no documentation in either Resident A’s CMH TP or Resident A’s assessment plan indicating Resident A was unable to control inappropriate sexual behavior.

Individual A’s CMH TP confirmed Individual A had a history of predatory sexual behavior towards minors, as well as a history of making inappropriate sexual comments to male housemates. Subsequently, Individual A “required monitoring in community living situations”. Documentation on Individual A’s assessment plan indicated Individual A was to be monitored while around minors.

On 09/13 the facility submitted to the department an additional IR. Documentation on the IR indicated Resident B reported that on 09/09 Individual A sexually assaulted him behind the neighboring AFC facility’s garage. According to documentation on the IR, an officer with the VBCSD responded to the facility and the neighboring AFC facility, and interviewed both Resident B and Individual A.

On 09/16 I conducted a second unannounced investigation at the Beacon Home at Wave Crest facility and asked to interview Resident B who was not present, as he was visiting peers at the neighboring AFC facility. Ms. Merritt arranged for Resident B to return to the facility to be interviewed face-to-face. Resident B was difficult to understand. Subsequently, Resident B agreed to allow Ms. Merritt to assist with

translating. Resident B stated that on 09/09, behind the neighboring AFC facility's garage Individual A forced him to perform oral sex on him while Individual A "jacked him off." According to Resident B, he did not ejaculate. Resident B stated Individual A threatened to harm him if he did not comply. According to Resident B, Individual B also witnessed this incident. Resident B confirmed he was interviewed by an officer with the VBCSD on the day the incident occurred. According to Resident B, the officer advised him to stay away from Individual A. However, Resident B admitted that following the incident he continued to visit with Individual A and others at the neighboring AFC facility. Following my interview with Resident B, Ms. Merritt informed me she was not aware of this incident/allegation. According to Ms. Merritt, Resident B had a history of being dishonest.

I conducted separate face-to-face interviews with Individuals A and B in Mr. Baker's office. According to Individual A, on 09/09 Resident B came to the neighboring AFC facility and flirted with him, told him he loved him, and told him he wanted to be Individual A's boyfriend. Individual A stated that behind the neighboring AFC facility's garage, Resident B "sucked his dick" while Resident A "jacked him off". Contrary to Resident B's statements, Individual A stated Resident B ejaculated. Individual A denied the allegation he forced Resident B to participate in the sexual act. According to Individual A, Resident B stated that if Individual A agreed to engage in the sexual act, Resident B wouldn't tell anybody and Individual A wouldn't get in trouble. Individual A stated "(Individual B) caught me again!" Throughout my interview with Individual A, he continued to blame Resident B for the incident stating Resident B "gave him flashbacks." Individual A stated, "I shouldn't have done it but [Resident B] kept telling me he loved me". Individual A confirmed he was interviewed by an officer with the VBCSD regarding this incident. According to individual A, following the incident Resident B continued to come to the neighboring AFC facility to visit with him and others, even though an officer with the VBCSD advised Resident B to stay away from Individual A.

Individual B denied witnessing Resident B and Individual A engage in any sexual acts on 09/09. Individual B stated Resident B told him about the incident/allegation immediately after it occurred. According to Individual B, he went with Resident B to report the allegation to facility staff members.

After my separate face-to-face interviews with Individuals A and B, Mr. Baker conducted a search of the Michigan State Police Sex Offender Registry and was also unable to locate Individual A listed on the registry as a convicted sex offender.

I requested and reviewed a copy of Resident B's CMH TP and assessment plan. There was no documentation in either Resident B's CMH TP or assessment plan restricting Resident B's independent access in the community, and Resident B was able to leave the Beacon Home at Wave Crest facility without facility staff members' supervision. There was no documentation in Resident B's CMH TP indicating Resident B was unable to control inappropriate sexual behavior. However,

documentation in Resident B's assessment plan indicated facility staff members were to remind Resident B of inappropriate sexual relationships and threats.

I requested and reviewed the VBCSD's police reports regarding both incidents on 08/26 and 09/09. Documentation in both reports were consistent with the statements Resident A, Resident B, Individual A, and Individual B provided to me during my interviews with them. The VBCSD police report regarding the 08/26 incident, which was written by Officer Chris Orr on 08/27, indicated that following his interviews with Resident A, Resident B, Individual A, and Individual B on 08/26, Officer Orr did not have enough probable cause to arrest Individual A. However, Officer Orr submitted his findings to the prosecutor's office. The VBCSD police report regarding the 09/09 incident, which was written by Deputy J. Blankenship on 09/10, indicated that following his interviews with Resident A, Resident B, Individual A, and Individual B on 09/09, Deputy Blankenship attempted to "run" Individual A through the Michigan State Police Sex Offender Registry. However, the registry was "down at the time". According to documentation on this report, Deputy Blankenship also submitted his findings to the prosecutor's office.

On 10/18 I conducted a third search of the Michigan State Police Sex Offender Registry and was unable to locate Individual A listed on the registry as a convicted sex offender.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based upon my investigation it has been established that on 08/26, Resident A engaged in sexual acts with Individual A at the neighboring AFC facility. On 09/09 Resident B engaged in these same sexual acts with Individual A, also while at the neighboring AFC facility. However, there is not enough evidence to substantiate the allegations Residents A and B were forced to engage in these sexual acts with Individual A. On both occasions, Residents A and B left the Beacon Home at Wave Crest facility unsupervised and subsequently engage in sexual acts with Individual A at the neighboring AFC facility where Individual A resided. According to documentation in both Resident A's and B's assessment plans, Resident A and Resident B had no restrictions on their community access and could leave the Beacon Home at Wave Crest facility without facility staff members' supervision. Therefore, there is no evidence to substantiate the allegation Resident A and Resident B were not provided with supervision as specified in their assessment

	plans, when Resident A engaged in sexual acts with Individual A on 08/26, and Resident B engaged in sexual acts with Individual A on 09/09, while at the neighboring AFC facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: The corrective measures documented on the IR submitted to the department regarding the incident between Resident B and Individual A on 09/09 while at a neighboring AFC facility, indicated that on 09/09 lead direct care worker Khristine McPike “asked” Resident B to stay away from the neighboring AFC facility and to notify facility staff members if Individual A requested further sexual favors. The corrective measures documented on the IR indicated facility staff members from both Beacon Home at Wave Crest and the neighboring AFC facility were informed of the incident and instructed to keep Resident B as safe as possible by encouraging him to not return to the neighboring AFC facility. However, during my second unannounced investigation at Beacon Home at Wave Crest on 09/16, I discovered Individual B was not present in the facility, as he was allowed to walk to the neighboring AFC facility to socialize with Individual A and others. I conducted a face-to-face interview with assistant home manager Teresa Merritt who stated she had no knowledge of the incident between Resident B and Individual A at the neighboring facility on 09/09, which resulted in Resident B accusing Individual A of sexual assault. However, she always encouraged Resident B not to go over to the neighboring facility.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: **(f) The corrective measures that were taken to prevent the accident or incident from happening again.**
ANALYSIS:	The documented corrective measures taken to prevent the 09/09 incident between Resident B and Individual A at the neighboring AFC facility from happening again were for facility staff members from both Beacon Home at Wave Crest and the neighboring AFC facility to keep Resident B as safe as possible by encouraging him to not go to the neighboring AFC facility. As evidenced by Beacon Home at Wave Crest assistant home

	manager Teresa Merritt's admission of having no knowledge of the 09/09 incident between Resident B and Individual A at the neighboring facility, during my interview with her on 09/16, it has been established the documented corrective measures taken to prevent this incident from occurring again, were not adequately communicated to Ms. Merritt, who was in part responsible for carrying out these corrective measures. Subsequently, during my unannounced investigation at Beacon Home of Wave Crest on 09/16, I discovered Resident B was not present, as he was allowed to walk to the neighboring AFC facility to socialized with Individual A and others. While Resident B has no current restrictions on his community access, it has been established Beacon Home at Wave Crest facility staff members could have implemented more effective measures to prevent Resident B from going to the neighboring AFC facility and placing himself or others at risk.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/20 I conducted a face-to-face exit conference with licensee designee Nichole VanNiman and shared with her the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

Michele Streeter 10/21/2021

Michele Streeter Date
Licensing Consultant

Approved By:

Dawn Timm 10/22/2021

Dawn N. Timm Date
Area Manager