GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 21, 2021

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

RE: License #: AS800343665
Investigation #: 2021A0462049
Beacon Home at Bayview

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 #:	AS800343665
Investigation #:	2021A0462049
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 Bayview
Facility Address:	29320 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-0288
Original Issuance Date:	10/07/2013
License Status:	REGULAR
Effective Date:	04/04/2020
Expiration Date:	04/03/2022
Capacity:	6
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 on the property with Individual A, who resides in a neighboring AFC facility.	Yes
Resident A was not provided with adequate supervision when on 09/09/2021, he engaged in sexual acts on the property with Individual B, who resides in the same neighboring AFC facility as Individual A.	Yes
Additional findings.	Yes

III. METHODOLOGY

08/26/2021	Contact- Email from administrator Israel Baker.
08/30/2021	Special Investigation Intake 2021A0462049 Special Investigation Initiated - Email exchange with administrator Israel Baker. Contact- Requested and received documentation. Unannounced Investigation onsite. Separate face-to-face interviews with BSLS' employee Teresa Merritt, Individual A, direct care worker Ginger Muniz and Residents 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 BSLS' employee Teresa Merritt, Individual B, Residents A and B, and administrator Israel Baker.
09/17/2021	Contact- Requested and received police report. Contact- Requested and received Resident A's updated assessment plan.

09/19/2021	Contact- Requested and received Resident A's updates assessment plan.
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 on the property with Individual A, who resides in a neighboring AFC facility.**

- **Resident A was not provided with adequate supervision when on 09/09/2021, he engaged in sexual acts on the property with Individual B, who resides in the same neighboring AFC facility as Individual A.**

INVESTIGATION: On 08/26/2021 I received an email from facility administrator Israel Baker. Via email, Mr. Baker informed me that individual A, who resided in a neighboring AFC facility, reported that on 08/26 he was sexually assaulted by Resident A. 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 neighboring facility and Beacon Home at Bayview facility, and interviewed both Individual A and Resident A.

Documentation on the *AFC Licensing Division Incident/Accident Report* (IR) regarding this allegation, which was submitted to the department on 08/27, indicated that on 08/27 Resident A's legal guardian, CMH case manager, and the Office of Recipient Rights were all notified of the allegation.

On 08/30 I conducted an unannounced investigation at the neighboring AFC facility and interviewed assistant home manager Teresa Merritt and Individual A, face-to-face. Ms. Merritt stated Individual A was friends with Resident A, as well as with other residents who resided at the facility, and frequently visited with them at the facility.

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

I conducted an unannounced investigation at the facility and interviewed Resident A and Resident B face-to-face, separately. Resident A stated that on 08/26 it was Individual A who requested assistance with locating his missing wallet in the woods located behind the facility. According to Resident A, Individual A asked to give him oral sex. Resident A admitted to performing oral sex on Individual A until he orgasmed but stated the sexual act was consensual. Resident A denied the allegation Individual A attempted to "fight him off" and stated Individual A "enjoyed it." Resident A confirmed Resident B was the only witness to the incident. Resident A also confirmed Individual A frequently visited the facility. Resident A stated that during these occasions, Individual A attempted to "kiss him and stuff." Resident A disclosed that approximately two weeks ago, he was charged with sexually assaulting his nephew while not at the facility. Resident A also stated he was previously convicted of first and third degree criminal sexual conduct. Subsequently, Resident A was scared this incident would result in him being sentenced to time in jail. Resident A confirmed he was interviewed by an officer with the VBCSD, and was advised to stay away from Individual A.

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

While at the facility, I interviewed direct care worker Ginger Muniz. According to Ms. Muniz, she was not aware of Resident A having any behavioral issues, including those sexual in nature, since he moved into the facility.

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

I requested and reviewed a copy of Resident A's and Individual A's Community Mental Health (CMH) Treatment Plans and *Assessment Plans for AFC Residents* (assessment plan). Resident A's CMH TP indicated Resident A was diagnosed with an intellectual disability, ADHD, and unspecified [affective] disorder. Documentation on Resident A's CMH TP indicated Resident A was legally appointed a public guardian. Documentation on Resident A's CMH TP indicated that in February of 2013 Resident A was accused of criminal sexual conduct towards a 15-year old girl. In March of 2013 Resident A was also accused of having a five-year-old male family member perform oral sex on him. According to documentation on Resident A's CMH

TP, Resident A was incarcerated for molesting this family member and was placed in the Kalamazoo Psychiatric Hospital, where it was eventually determined Resident A was "incompetent." Resident A's CMH TP indicated Resident A was not to have contact with children. According to documentation on Resident A's CMH TP, Resident A also had a history of making sexually inappropriate comments to male housemates. Subsequently, Resident A "required monitoring in community living situations". Documentation on Resident A's assessment plan indicated facility staff members would accompany and monitor Resident A for safety while not at the facility. According to documentation on Resident A's assessment plan, Resident A was restricted from being around children without supervision.

There was no documentation in either Individual A's CMH TP or assessment plan restricting Individual A's independent access in the community so Individual A was able to leave the neighboring AFC facility without facility staff members' supervision. There was also no documentation in either Individual A's CMH TP or assessment plan indicating Individual A was unable to control inappropriate sexual behavior.

On 09/10 the facility submitted to the department an additional IR. Documentation on the IR indicated Individual B, who resided in the same neighboring AFC facility as Individual A, reported that on 09/09 Resident A sexually assaulted him behind the facility's garage. According to documentation on the IR, an officer with the VBCSD responded to the neighboring facility and the facility, and interviewed both Individual B and Resident A.

On 09/16 I conducted a second unannounced investigation at the neighboring AFC facility and asked to interview Individual B who was not present, as he was visiting peers at the facility. Ms. Merritt arranged for Individual B to return to the neighboring AFC facility to be interviewed face-to-face. Individual B was difficult to understand. Subsequently, Individual B agreed to allow Ms. Merritt to assist with translating. Individual B stated that on 09/09, behind the facility's garage, Resident A forced him to perform oral sex on him while Resident A "jacked him off". According to Individual B, he did not ejaculate. Individual B stated Resident A threatened to harm him if he did not comply. According to Individual B, Resident B also witnessed this incident. Individual B confirmed he was interviewed by an officer with the VBCSD on the day the incident occurred. According to Individual B, the officer advised him to stay away from Resident A. However, Individual B admitted that following the incident, he continued to visit with Resident A and others at Beacon Home at Bayview.

I conducted separate face-to-face interviews with Resident A and Resident B in Mr. Baker's office. According to Resident A, on 09/09 Individual B came to the facility and flirted with him, told him he loved him, and told him he wanted to be Resident A's boyfriend. Resident A stated that behind the facility's garage, Individual B "sucked his dick" while Resident A "jacked him off." Contrary to Individual B's statements, Resident A stated Individual B ejaculated. Resident A denied the allegation he forced Individual B to participate in the sexual act. According to Resident A, Individual B stated that if Resident A agreed to engage in the sexual act,

Individual B wouldn't tell anybody and Resident A wouldn't get in trouble. Resident A stated "[Resident B] caught me again!" Throughout my interview with Resident A, Resident A continued to blame Individual B for the incident stating Individual B "gave me flashbacks." Resident A stated, "I shouldn't have done it but [Individual B] kept telling me he loved me". Resident A confirmed he was interviewed by an officer with the VBCSD regarding this incident. According to Resident A, following the incident Individual B continued to come to the facility to visit with him and other residents even though an officer with the VBCSD advised Individual B to stay away from Resident A.

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

I conducted a separate face-to-face interview with Mr. Baker. According to Mr. Baker, Resident A moved into a third neighboring AFC facility on 03/16/2020. While residing at this facility, Resident A was often bullied by other residents who had a history of aggressive verbal and physical behaviors. Due to an extended period of Resident A engaging in little to no behavioral issues, including those sexual in nature, it was established Resident A was more compatible with the residents in Beacon Home at Bayview facility. Subsequently, Resident A was transferred to the facility on 04/01/2020. Mr. Baker stated that since transferring to the facility, Resident A had no reported significant behavioral issues, including those sexual in nature, until just recently. Mr. Baker stated that based upon documentation in Resident A's CMH TP, he believed Resident A was a convicted sex offender. However, during our interview, Mr. Baker conducted a search of the Michigan State Police Sex Offender Registry and was also unable to locate Resident A listed on the registry as a convicted sex offender.

I requested and reviewed a copy of Individual B's CMH TP and assessment plan. There was no documentation in either Individual B's CMH TP or assessment plan restricting Individual B's independent access in the community, and Individual B was able to leave the neighboring AFC facility without facility staff members' supervision. There was no documentation in Individual B's CMH TP indicating Individual B was unable to control inappropriate sexual behavior. However, according to documentation in Individual B's assessment plan, facility staff members at the neighboring AFC facility were to remind Individual B of sexually inappropriate 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 Individual A, Individual B, Resident A, and Resident 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 Individual A, Resident A, and Resident B on 08/26, Officer Orr did not have enough

probable cause to arrest Resident 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 Individual B, Resident A and Resident B on 09/09, Deputy Blankenship attempted to "run" Resident 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 Resident A listed on the registry as a convicted sex offender.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	Based upon my investigation, it has been established Resident A, who has a diagnosis of a mental illness and intellectual disability, had a history of predatory sexual behavior towards minors, as well as a history of making sexually inappropriate comments to male housemates. Other than documentation in Resident A's CMH TP, I was unable to find any evidence Resident A was a convicted sex offender. It has been established Resident A engaged in sexual acts at the facility with Individual A on 08/26 and then engaged in these same sexual acts with Individual B at the facility 14 days later, on 09/09. However, there is not enough evidence to substantiate the allegations Individual A and Individual B were forced to engage in these sexual acts with Resident A. According to documentation on Resident A's CMH TP, due to a history of predatory sexual behavior towards minors and making inappropriate sexual comments to male housemates, Resident A "required monitoring in community living situations." It has been established Resident A's protection and safety needs were not attended to in accordance with his CMH TP when Resident A engaged in sexual acts on 08/26 and 09/09 with Individuals A and B on facility property, which ultimately resulted in Resident A being accused of sexual assault on both occasions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: The corrective measures documented on the IR submitted to the department regarding the incident between Resident A and Individual A on 08/26 read, “monitor [Resident A] closely and continue to encourage him to try to avoid Individual A.” However, during my face-to-face interview with Ginger Muniz, the only facility staff member present at the facility on 08/30, Ms. Muniz stated she not aware of the 08/26 incident between Resident A and Individual A in a wooded area behind the facility, which resulted in Resident A being accused of sexual assault. Ms. Muniz stated she did not work at the facility on 08/26 and admitted to not reading Resident A’s “past case notes.”

It was established that 14 days after Resident A and Individual A engaged in sexual acts while on the facility’s property on 08/26, which resulted in Resident A being accused of sexually assaulting Individual A, Resident A engaged in the same sexual acts with Individual B at the facility on 09/09. Subsequently, Individual B also accused Resident A of sexually assaulting him.

The corrective measures documented on the IR submitted to the department regarding the incident between Resident A and Individual B on 09/09 indicated facility staff members were to encourage Resident A to avoid Individual B and to monitor Resident A when around Individual B. However, during my second unannounced investigation at the neighboring AFC facility on 09/16, I discovered Individual B was not present in the neighboring AFC facility, as he was allowed on facility property to socializes with Resident A and others. Neighboring AFC facility home manager Teresa Merritt stated she had no knowledge of the incident between Resident A and Individual B on 09/09, which resulted in Individual B accusing Resident A of sexual assault. However, she did frequently encourage Individual B not to walk over to the facility.

During my interview with Mr. Baker on 09/16, I brought to his attention that documentation on Resident A’s CMH TP indicated that due to a history of criminal sexual conduct and making inappropriate sexual comments to male housemates, Resident A “required monitoring in community living situations.” Resident A’s assessment plan, dated 03/31/2021, did not include documentation regarding the methods used to provide Resident A with supervision and monitoring while he was at the facility. I informed Mr. Baker that based upon information collected during an AFC assessment of Resident A, the facility was to establish what type of supervision and monitoring Resident A required while at the facility. I advised Mr. Baker to establish this, and then update Resident A’s assessment plan to include these specific methods. I further advised Mr. Baker to ensure all facility staff members responsible for the supervision and monitoring of Resident A were made aware of these methods.

On 09/19 Mr. Baker emailed me a copy of Resident A’s revised assessment plan. A second update to Resident A’s assessment plan read, “when going outside, staff is

to be eyes on due to hx of sexual predatory behavior. If he goes out of sight staff will be with him."

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 08/26 incident between Resident A and Individual A at the facility from happening again read, "monitor [Resident A] closely and continue to encourage him to try to avoid Individual A." As evidenced by direct care worker Ginger Muniz' admission of having no knowledge of the 08/26 incident and/or the allegation made against Resident A during my interview with her on 08/30, it has been established the documented corrective measures taken were not adequately communicated to Ms. Muniz, who was responsible for carrying out these corrective measures. It has been established that following the 08/26 incident between Resident A and Individual A, facility staff members did not closely monitor Resident A as indicated in the documented corrective measures taken to prevent the incident from occurring again, when 14 days later Resident A engaged in the same sexual acts with Individual B as he did with Individual A at the facility on 08/26. Subsequently, Individual B accused Resident A of sexually assaulting him as well. In addition to this, while the facility's documented corrective measures taken to prevent the 08/26 incident between Resident A and Individual A from happening again may have prevented Resident A from engaging in sexual acts with Individual A in the future, it did little to prevent Resident A from engaging in these same sexual acts with other individuals. The corrective measures taken to prevent the 09/09 incident between Resident A and Individual B at the facility from happening again were for facility staff members to encourage Resident A to avoid Individual B and to monitor Resident A when around Individual B. However, on 09/16 it was established

	Individual B was still allowed to go over to the facility and socialized with Resident A and others.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
R 400.14102	**Definitions.**
	(d) "Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services, taking into account the preferences and competency of the individual.
ANALYSIS:	According to documentation on Resident A's CMH TP, Resident A "required monitoring in community living situations." However, documentation on Resident A's initial assessment plan, dated 03/31/2021, did not include the methods for providing supervision and monitoring to Resident A while he was at the facility. The need for specific methods for the supervision and monitoring of Resident A on his assessment plan became even more evident when Resident A engaged in sexual acts with Individual A at the facility on 08/26, resulting in Individual A accusing Resident A of sexually assaulting him. Following this incident, Resident A's assessment plan was not updated to include the methods for providing supervision and monitoring to Resident A while he was at the facility. Subsequently, Individual B accused Resident A of sexually assaulting him at the facility on 09/09, just 14 days after Resident A was accused of sexually assaulting Individual A. Per my advisement on 09/16, on 09/19 administrator Israel Baker updated Resident A's assessment plan to include specific and adequate methods for providing supervision and monitoring to Resident A while he was at the facility.

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.

10/20/2021

Michele Streeter Date
Licensing Consultant

Approved By:

10/21/2021

Dawn N. Timm Date
Area Manager