GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 17, 2021

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

RE: License #: AM280299145
Investigation #: 2022A0230006
Beacon Home at Silverview

Dear Ms. Goldammer:

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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM280299145
Investigation #:	2022A0230006
Complaint Receipt Date:	11/04/2021
Investigation Initiation Date:	11/04/2021
Report Due Date:	01/03/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110, 890 N. 10th St., Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home at Silverview
Facility Address:	4024 Wyatt Road, Traverse City, MI 49684
Facility Telephone #:	(231) 922-9791
Original Issuance Date:	04/15/2010
License Status:	REGULAR
Effective Date:	10/16/2020
Expiration Date:	10/15/2022
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was punched in the back by staff member Carinne VanLoon	Yes

III. METHODOLOGY

11/04/2021	Special Investigation Intake 2022A0230006
11/04/2021	Special Investigation Initiated - On Site Interview with staff members Danni- Mae Courville and Corinne VanLoon observation of Resident A
11/04/2021	APS Referral
11/05/2021	Contact - Telephone call made staff member Christoval Sanchez
11/05/2021	Contact - Telephone call made staff member Kim Thompson
11/05/2021	Contact - Telephone call made Licensee Designee Roxanne Goldammer
11/05/2021	Contact-Telephone call Micah Haven Facility manager
11/15/2021	Exit Conference With Licensee Designee Roxanne Goldammer

ALLEGATION: Resident A was punched in the back by staff member Carinne VanLoon

INVESTIGATION: On 11/04/2021, I conducted an on-site investigation at the facility along with Adult Protective Service Worker Adam Bragg. We observed Resident A but could not interview him as he has a diagnosis of Autism and is non-verbal.

Jointly we interviewed staff member Danni-Mae Courville. She stated she was just finishing her third and final job shadow shift on 11/03/2021 as she was a new staff at the facility. She had worked that evening with staff members Corinne VanLoon, Christoval Sanchez and Kim Thompson.

Ms. Courville explained that she had learned through her training and through reading Resident A's assessment plan that Resident A has a behavior referred to as "food aggression." She described that he attempts to grab at plates of food that do not belong to him or grabs food out of the microwave.

On the evening of 11/03/2021 Resident A walked into the kitchen, opened up the microwave and grabbed food off another resident's plate. At this time Ms. Courville and Ms. VanLoon went into the kitchen to redirect Resident A. Ms. VanLoon slammed the microwave door. Ms. Courville described that after Ms. VanLoon slammed the microwave door, Ms. Courville was slowly coaching Resident A out of the kitchen when Ms. VanLoon punched Resident A in the middle of his back and said, "Oh I'm so mad!" Ms. Courville described it as "loud enough I could hear the impact." Resident A then went straight to his bedroom. Ms. Courville was visibly shaken and tearing up while describing the incident. She stated she immediately went and called Recipient Rights, Adult Protective Services, and her manager. Ms. Courville stated no other residents were present, but Mr. Sanchez and Ms. Thompson were both nearby and Ms. Thompson later approached her and said "Thank you for reporting that. You did the right thing."

On 11/04/2021, Adult Protective Services (APS) worker Mr. Bragg and I interviewed staff member Corrinne VanLoon at another Beacon facility where she was working for the day. Regarding the allegation of Ms. VanLoon punching Resident A, she stated that the previous evening Resident A went into the kitchen to take another resident's food when she and Ms. Courville went in the kitchen to get him out and redirect him toward the dining room. She stated, "I was frustrated because this was the third or fourth time, he had stolen a resident's meal." Ms. VanLoon stated "I swung my open hand at him, but I did not make contact. But I did say "Oh he makes me so made sometimes I just want to smack him!"

On 11/05/2021, I spoke with home manager Micah Haven who stated he was aware of the allegations and had sent Ms. VanLoon to work at another facility until investigations were completed. He stated he looked at Resident A's back and did not observe any marks, but Resident A does have a lot of hair on his back, so it was hard to see anything.

On 11/05/2021, I spoke with staff member Kim Thompson. She stated she had worked the evening of 11/03/2021 and observed the incident between Ms. VanLoon and Resident A. She described that Ms. Courville and Ms. VanLoon had both gone into the kitchen together because Resident A was grabbling food out of the microwave. She thought it was resolved as Ms. Courville was walking Resident A out of the kitchen and speaking softly to him when suddenly Ms. VanLoon jumped up at Resident A's back and hit Resident A between the shoulder blades. She stated "It was very quick and shocking. It looked like big time wrestling. I couldn't believe it happened." Ms. Thompson stated she was still shocked and upset by the incident.

On 11/05/2021, I spoke with staff member Christoval Sanchez regarding the allegation. He stated that he was working on 11/03/2021 and had been in the dining room on the computer doing resident charting. He noticed Resident A in the kitchen and two staff Ms. Courville and Ms. VanLoon went in to stop him from grabbing food. “I thought they had it handled and out of the corner of my eye I saw Carinne swing her arm at (Resident A) and I heard a slap.” He noted Resident A then ran out of the kitchen. “Danni looked shocked, and I couldn’t believe it either.”

On 11/05/2021, I spoke with Licensee Roxanne Goldammer and told her what was reported to me by all the staff. She stated Ms. VanLoon was not scheduled to work in any of the facilities for another week and agreed she should not come back to work for the Beacon Corporation.

On 11/15/2021, I conducted a final exit conference with Ms. Goldammer and reviewed the findings of the investigation. She stated that Ms. VanLoon’s employment had officially been terminated as a result of the incident with Resident A. She will provide a plan of correction.

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:	Three separate staff members observed Ms. VanLoon hit Resident A and heard the impact of the strike on his back. Although Ms. VanLoon denies making physical contact on Resident A, she states she struck at him and stated she wanted to hit him. Resident A was not treated with dignity including protection and safety at all times as there is a preponderance of evidence existing to substantiate the allegation that Ms. VanLoon punched Resident A in the back.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Three separate staff members observed Ms. VanLoon hit Resident A and heard the impact of the strike on his back. Although Ms. VanLoon denied making physical contact on Resident A, she acknowledged that she struck at him and stated she wanted to hit him. There is a preponderance of evidence existing to substantiate the allegation that Resident A was mistreated by direct care staff Carinne VanLoon as she deliberately inflicted pain on him when she struck him in the back.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction I recommend the status of this license remain unchanged.

11/17/2021

Rhonda Richards Date
Licensing Consultant

Approved By:

11/17/2021

Jerry Hendrick Date
Area Manager