



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2021

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

RE: License #: AS370405093
Investigation #: 2021A1029027
Beacon Home At Mt Pleasant

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 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 (231) 922-5309.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Browning". The script is cursive and fluid, with the first letter of each word being capitalized and larger than the others.

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov
(989) 444-9614

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

License #:	AS370405093
Investigation #:	2021A1029027
Complaint Receipt Date:	09/08/2021
Investigation Initiation Date:	09/08/2021
Report Due Date:	11/07/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Emily Fairris
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home At Mt Pleasant
Facility Address:	4659 S Leaton Rd Mt Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/16/2020
License Status:	REGULAR
Effective Date:	05/16/2021
Expiration Date:	05/15/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member, Kristin Lewis called one resident an “asshole” and another resident a “retard.”	Yes

III. METHODOLOGY

09/08/2021	Special Investigation Intake 2021A1029027
09/08/2021	Contact - Telephone call received from Angela Wend, Community Mental Health Office of Recipient Rights (CMH-ORR).
09/08/2021	Special Investigation Initiated – Letter - Sent email to Emily Fairris requesting training documents.
09/09/2021	Contact - Face to Face Teams interview with Ms. Fairris, Ms. Wend (CMH-ORR), and direct care staff member, Ms. Lewis
09/09/2021	Contact - Document Received - Emily Fairris sent training records
09/21/2021	Contact - Telephone call to direct care staff member, Malinda Hepinstall
09/21/2021	Contact - Telephone call to direct care staff member Angie Himebaugh. Left a voicemail.
09/21/2021	Contact - Telephone call to Kelly Halstead
09/21/2021	Contact - Face to Face with direct care staff members, Angie Himebaugh, Willa Rice, Resident B, C, D, and home manager, Dana Sprague
09/29/2021	Exit Conference with licensee designee, Roxanne Goldammer

ALLEGATION:

Direct care staff member, Kristin Lewis called one resident an “asshole” and another resident a “retard.”

INVESTIGATION:

On September 8, 2021, a complaint was received via the BCAL online complaint system alleging that direct care staff member Kristin Lewis called residents names such as calling Resident B an “asshole”, Resident A “retarded”, and told Resident C to go to their room stating she was “sick of them.”

On September 8, 2021, I received a call from Angela Wend, Recipient Rights. She stated Resident D also reported direct care staff member Kristin Lewis yelled at him because he was upset that his beef stick and gum were missing from his room. Ms. Wend also reported Ms. Lewis yelled at Resident D stating that it was Resident D’s responsibility to lock his own door. Ms. Wend reported Resident D stated that she yelled at him about it and then brought it up the next morning. There is going to be a Microsoft Teams interview with direct care staff member Kristin Lewis and the decision was made to interview her together.

Other direct care staff members also confirmed with Ms. Wend overhearing direct care staff member Kristin Lewis being disrespectful to the residents by calling them “retarded” and saying that Resident A was “being a dick” on September 7, 2021. Direct care staff member Malinda Hepinstall reported to Ms. Wend that she overheard the conversation and tried to educate Ms. Lewis that it was not appropriate to call a resident “retarded” but Ms. Lewis said, “it’s all the same in my book.” Ms. Wend confirmed direct care staff member Kristin Lewis referred to Resident B as an “asshole” and also stated that his parents were being “assholes” for not managing the behaviors.

On September 9, 2021, a joint interview was done using Microsoft Teams with Recipient Rights, Angela Wend, Beacon administrator Emily Fairris, direct care staff member, Kristin Lewis, and I. Ms. Lewis stated Resident B was not displaying any acting out behaviors until his parents came and then he was acting out toward his parents. Ms. Lewis stated Resident B’s behaviors included: trying to get into the vans, throwing objects and overall acting erratically. Ms. Lewis stated the thrown objects nearly hit her in the head twice so she was keeping distance but not trying to be too far out of the way. During the incident, Ms. Lewis stated Resident B scratched her in several places so she tried to calm him down by giving him a popsicle. Ms. Lewis stated it was an intense situation and she did not want Resident B to get hurt or go further out toward the driveway. Normally, Ms. Lewis stated she is able to redirect Resident B but this time it was a lot more difficult. Ms. Lewis stated her coworkers told her that “that was probably one of the worst” outbursts because normally Resident B’s mother shows up but since both parents were there, he may have been triggered making his behaviors more intense. Ms. Lewis stated she did the best she could because he was a very strong individual sharing that the clothes dryer is bolted to the ground now because at

one point during the incident, he picked up the dryer and threw it. She stated that she could have called him an “asshole” because she was hurt but everything was such a blur that she could not remember.

Ms. Lewis stated she could have also called Resident B’s parents “assholes” because they did not stop the behaviors. Ms. Lewis stated no one was stepped in to help the situation. She felt her coworkers should have assisted to de-escalate the matter.

Ms. Lewis stated she did call Resident A “retarded” because, “she doesn’t use this word as a negative.” Ms. Lewis stated she uses this word loosely and even tells her son “stop being retarded” or calls her devices that when they are not working. She tries to remind herself that it is not appropriate because she knows it was an “ugly word years ago.” Ms. Wend informed her that this word should not be used around the residents and it is still not appropriate because it could have a negative impact on the residents.

Ms. Lewis said that she is mad at herself for being in this position. She stated she will take whatever punishment comes her way but, in that moment, she was not thinking and just reacted. Ms. Lewis claimed she needs to learn to breathe through these situations and not react to it.

Ms. Lewis explained that on September 7, 2021, Resident C started to have behaviors and she was trying to deescalate the behaviors. She thought other direct care staff members found her being too authoritarian in the situation but she was trying to help him not escalate further. Ms. Lewis stated she followed Resident C into his room to redirect him with the behaviors. Ms. Lewis admitted she told him “I am tired of you and dealing with this, go to your room.”

Ms. Wend asked Ms. Lewis if she knew much about autism and she said, “not as much as I need to know.” Ms. Wend advised her to do some additional research with Ms. Fairris to help learn the best techniques to deescalate these situations. Ms. Lewis stated she attended training and job shadowed other direct care staff members. Ms. Lewis said she is willing to learn more about how to work with the residents. Ms. Lewis stated she also completed Crisis Prevention Institute (CPI) training as part of her new employee training however admitted that she did not use this training when faced with these incidents.

On September 9, 2021, Emily Fairris emailed the training log for Ms. Lewis from her employee record. Ms. Fairris stated that Ms. Lewis is a new employee hired on August 9, 2021 and started working with residents around August 27, 2021. The below trainings would have guided her understanding of appropriate interactions with residents.

August 9, 2021	Person Centered Plan / Self determination Cultural Diversity and Awareness
August 10, 2021	Crisis Prevention and Intervention Working with People and positive techniques

Culture of Gentleness

August 20, 2021 Recipient Rights new hire training

On September 21, 2021, I interviewed direct care staff member, Malinda Hepinstall. She stated that she has worked there since May 2021 and typically works with two or three other staff during her shift. She has worked with Ms. Lewis who is typically the one on one staff for Resident B. Ms. Hepinstall stated she worked with Ms. Lewis during a shift where Ms. Lewis was scratched by Resident B during an incident. After the incident, Ms. Lewis referred to Resident B as an “asshole” according to Ms. Hepinstall. Ms. Hepinstall stated Ms. Lewis also told her that Resident A was “retarded.” Ms. Hepinstall stated she told her “no, he’s autistic” and explained to her about not using that word. Ms. Lewis responded, “it’s all the same thing in my book.” On September 11, 2021, Ms. Himebaugh heard her call Resident A “a dick” while she was working with him. Ms. Hepinstall denied hearing other comments like this from other direct care staff members while she has worked there. During initial training for Beacon Home at Mt. Pleasant, Ms. Hepinstall stated she attended Resident Rights, Gentle Teaching, and shadowed experienced direct care staff members for three days which would have shown Ms. Lewis this was not the way to respond in situations. Ms. Hepinstall stated she has heard Ms. Lewis make negative comments about other employees behind their backs as well.

On September 21, 2021, I interviewed direct care staff member, Ms. Himebaugh at Beacon Home at Mt. Pleasant. Ms. Himebaugh stated she heard Ms. Lewis call Resident B an “asshole” and she was not sure if Resident B heard this but it was possible because he was walking around the living room. A couple days after that, Ms. Himebaugh heard Ms. Lewis call Resident B “a dick” because he scratched her the day before during a behavioral episode. Ms. Himebaugh stated she has never observed Ms. Lewis be physically aggressive with any of the residents, but her demeanor and the words she says is concerning. Ms. Himebaugh stated was not aware if Ms. Lewis said anything about Resident B’s parents when they were visiting.

Ms. Himebaugh reported that during another incident, Resident D was throwing items around the home. She told him that he would have to go to his room and then told him to “drop his attitude.” Resident D is a newer resident in the home and he told her that when Ms. Lewis is working, he does not like to come out of his room.

I interviewed Resident D. Direct care staff member, Willa Rice was also outside during the interview and Resident D stated he wanted her to remain outside. He stated that he has heard a staff member, Kristin Lewis, be disrespectful to the residents during the previous week. Resident D stated that there was one incident where his door was not locked when he was gone and upon return to the facility, he found his beef sticks on the floor. He was upset about this because another resident went into his room when he was gone. Ms. Lewis yelled at him and told him it was his responsibility to shut his own door. Resident D stated that he works at a program on Mondays and he does not want to be by her when she is working or talk to her. He has no concerns with any of the

other direct care staff member and feels they are all nice. He has never been called any names by any of the direct care staff members.

Residents A, B, and C are all nonverbal and were unable to complete an interview regarding the concerns. I attempted to interview Resident C but he was unable to answer questions and just answered with facts about various topics.

I interviewed the home manager, Mr. Sprague. He stated that he heard from other direct care staff member what occurred but he did not observe her saying anything to the residents and he has had no concerns with her. Mr. Sprague stated it is never their procedure during an incident to send a resident to their room.

APPLICABLE RULE	
R 400.14304	Resident rights; licensee responsibilities.
	<p>(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:</p> <p>(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.</p> <p>(2) A licensee shall respect and safeguard the resident’s rights specified in subrule (1) of this rule</p>
ANALYSIS:	<p>All four residents residing at Beacon Home at Mt. Pleasant were not treated with dignity and respect by direct care staff member Kristin Lewis after Ms. Lewis used profane and derogatory language when speaking with Resident A and Resident B. She sent Resident C to his room telling him “I am tired of this – go to your room” and Resident D felt that Ms. Lewis yelled at him and actively avoids being around Ms. Lewis when she works at Beacon Home at Mt. Pleasant due to her disposition.</p> <p>Ms. Lewis admitted to using both profane and derogatory language when referring to and talking to residents in their home and during her work shifts.</p> <p>Ms. Lewis was not treating the residents with dignity and was not attending to their personal need of protection and safety by speaking to them in this manner.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action, I recommend no change in the license.

Jennifer Browning

9/30/2021

Jennifer Browning
Licensing Consultant

Date

Approved By:

Dawn Timm

10/25/2021

Dawn N. Timm
Area Manager

Date