GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

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

March 16, 2022

RE: License #: AM800299049
Investigation #: 2022A1030030
Beacon Home at Woodland

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 (616) 356-0183.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM800299049
Investigation #:	2022A1030030
Complaint Receipt Date:	03/07/2022
Investigation Initiation Date:	03/07/2022
Report Due Date:	05/06/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Woodland
Facility Address:	56832 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	09/12/2016
License **Status:**	REGULAR
Effective Date:	03/12/2021
Expiration Date:	03/11/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff were not providing appropriate supervision to Resident A and Resident B.	No
Additional Findings	Yes

III. METHODOLOGY

03/07/2022	Special Investigation Intake 2022A1030030
03/07/2022	Special Investigation Initiated - Telephone Interview with complainant
03/08/2022	Contact - Face to Face Interview with Caitlin Baltazar
03/08/2022	Contact - Face to Face Interview with Cheyenne McGetrick
03/08/2022	Contact - Face to Face Interview with Kim Howard
03/08/2022	Contact - Face to Face Interview with Resident A
03/08/2022	Contact - Face to Face Interview with Resident B
03/08/2022	Contact - Face to Face Interview with Kole Pueblo-Donavan
3/8/2022	Contact- Document Received Received and reviewed Resident A's Behavior Assessment and Treatment Plan
3/9/2022	Exit Conference Exit Conference by phone with Licensee
03/09/2022	Contact - Document Received Received and reviewed police report #1181-22

03/13/2022	Exit Conference Exit Conference by phone

ALLEGATION:

Staff were not providing appropriate supervision to Resident A and Resident B.

INVESTIGATION:

On 3/7/2022, I interviewed the complainant by phone. The complainant reported Resident A made several statements about having a black eye as she blamed another resident and then a male visitor who she declined to name.

On 3/7/2022, I interviewed direct care staff member (DCSM) Caitlin Baltazar at the home. Ms. Baltazar reported she was working on 3/2 and 3/3/2022. Ms. Baltazar reported Resident A did not have a black eye when she left for the night at 8:00pm and had a black eye when she got to on the next morning. Ms. Baltazar reported Resident A initially reported she fell out of bed, then she told another DCSM that she fell while in the bathroom. Ms. Baltazar reported the story then changed and she indicated Resident B assaulted her and further indicated Resident B came to her bedroom window, asked for her debit card, and then hit her when she said no. Ms. Baltazar reported the final story provided by Resident A was an individual named Jerome visited her that night and assaulted her. Ms. Baltazar reported they monitor visitors very closely and Resident A did not have any visitors during the evening hours. Ms. Baltazar reported the resident that was named lives in another cottage on the property and could have walked down to this home and assaulted her though the window without being observed by DCSM. Ms. Baltazar reported Resident A and Resident B have a “weird relationship” and they do not allow them to have face to face contact.

On 3/8/2022, I interviewed DCSM Cheyenne McGetrick at the home. Ms. McGetrick reported she worked on 3/2/2022 and 3/3/2022 and is aware that Resident A had a black eye on 3/3/2022. Ms. McGetrick reported Resident A provided multiple stories as to how it occurred, however Ms. McGetrick believes it was a “self-injury” as she has a history of that behavior. Ms. McGetrick reported Resident A did not have any visitors therefore could not have been injured by a male visitor and does not believe Resident B could have walked down to this home and assaulted Resident B without any DCSM from his home or hers witnessing the event.

On 3/8/2022, I interviewed program manager, Kim Howard at the home. Ms. Howard reported Resident A does have a history of injuring herself and then blaming others. Ms. Howard reported she noticed Resident A “picking” under her right eye on 3/2 which is where the black eye was located on 3/3. Ms. Howard reported Resident A and Resident B are on a “watch list” meaning they are watched closely by DCSM to ensure they do not have any face-to-face contact. Ms. Howard also reported that based on

where the home is located (¾ of a mile off 48th Avenue) it would not be possible for a person to visit Resident A without the knowledge of any of the staff.

On 3/8/2022, I interviewed Resident A at the home. During the interviewed I noted a small amount of discoloration under Resident A's right eye and a scratch on her cheek bone. Resident A reported "a demon" hit me which caused the black eye but admitted scratching herself. Resident confirmed several times that neither Resident B nor a male visitor assaulted her. I observed Resident A's bedroom and checked her window to determine it was possible for her to be assaulted if the window was opened and found that it had been screwed shut. Resident B denied ever having the ability to open her window. I then inspected all the bedroom windows and windows in the common areas and found the windows screwed shut in bedroom 4, in the window near the staff office and the window across the room overlooking the front porch. I immediately informed Kim Howard and indicated they need to be removed today due to safety concerns. Ms. Howard reported she would call her maintenance person and have them fixed.

On 3/8/2022, I interviewed Resident B at her home. Resident B denied leaving her cottage and walking to Resident A's cottage and assaulting her. Resident B reported that Resident A has made false accusations about her in the past after injuring herself.

On 3/8/2022, I interviewed DCSM Kole Pueblo-Donavan at the home. Ms. Pueblo-Donavan reported she works both cottages and knows both Resident A and Resident B very well. Ms. Pueblo-Donavan reported she was working on the evening of 3/2 at the Meadowland Home and denied that Resident B left the home and walked down to the other home where Resident A resides. Ms. Pueblo-Donavan also reported that the window in Resident A's bedroom has been screwed shut for a "long time."

On 3/8/2022, I received and reviewed Resident A's Interim *Behavior Assessment and Treatment Plan* (TP) dated 1/31/2022. Resident A's TP indicated she has history of "false reporting" of assaults.

On 3/9/2022, I received and reviewed police report # 1181-22 from the Van Buren County Sherriff's Office regarding the alleged assault of Resident A. The police report indicated that Resident A provided three different accounts of how she received a black eye including that Resident B hit her while her bedroom window was open.

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:	Resident A reported several scenarios to various sources as to how she received the facial injury. All of which, posed serious questions to the authenticity of her claim. In addition, Resident A has a history of self-injurious behaviors. While it is unknown for certain how the injuries occurred, interviews with Resident A and B, staff, and review of the police report confirm a lack of evidence that she was assaulted by someone other than herself.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my inspection of the home I noted the windows in bedrooms two and four were screwed shut. I also observed two windows in the common areas screwed shut. Ms. Howard acknowledged she was aware of the windows screwed shut and contacted their maintenance department to repair the windows. Resident A moved into the home during January 2022 and denied ever able to open the window.

APPLICABLE RULE	
R 400.14408	**Bedrooms generally.**
	(7) Bedrooms shall have at least 1 easily openable window.
ANALYSIS:	During an investigation it was noted that two bedrooms had windows that were screwed shut thereby making it impossible to open them.
CONCLUSION:	**Violation Established**

On 3/9/2022, I shared the findings of my investigation with licensee Nichole VanNiman. Ms. VanNiman acknowledged the findings and reported they will make the windows operable.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the current licensee status.

3/14/2022

Nile Khabeiry Date
Licensing Consultant

Approved By:

3/16/2022

Russell B. Misiak Date
Area Manager