GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 26, 2022

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

RE: License #: AS390405404
Investigation #: 2022A1024028
Beacon Home at Schoolcraft North

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,

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390405404
Investigation #:	2022A1024028
Complaint Receipt Date:	04/05/2022
Investigation Initiation Date:	04/07/2022
Report Due Date:	06/04/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Howard
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Schoolcraft North
Facility Address:	10713 S. 12th Street Portage, MI 49087
Facility Telephone #:	(269) 372-4820
Original Issuance Date:	09/01/2021
License **Status:**	REGULAR
Effective Date:	03/01/2022
Expiration Date:	02/29/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff member Tyanna Hefferman put her foot on Resident A's walker to prevent resident from moving it.	Yes

III. METHODOLOGY

04/05/2022	Special Investigation Intake 2022A1024028
04/07/2022	Special Investigation Initiated – Telephone with home manager Denise Rogers
04/07/2022	Contact - Telephone call made with district director Kimberly Howard
04/07/2022	Contact - Document Received review of incident report
05/23/2022	Contact - Telephone call made with assistant manager Luann Scott
05/23/2022	Contact - Telephone call made with direct care staff member Adam Tissue
05/23/2022	Contact - Telephone call made with direct care staff member Heather Davidson
05/23/2022	Inspection Completed On-site With Resident A
05/23/2022	Inspection Completed-BCAL Sub. Compliance
05/23/2022	Exit Conference with licensee designee Nichole VanNiman
05/25/2022	Contact-Document Received-*Health Care Appraisal*

ALLEGATION:

Staff member Tyanna Hefferman put her foot on Resident A's walker to prevent resident from moving it.

INVESTIGATION:

On 4/5/2022, information was provided to the department that staff member Tyanna Hefferman put her foot on Resident A's walker to prevent Resident A from moving it.

On 4/7/2022, I conducted an interview with home manager/direct care staff member Denise Rogers. Ms. Rogers stated on 3/30/2022 it was reported by direct care staff Luann Scott that staff member Tyanna Hefferman asked Resident A to move to a different area of the home because Ms. Hefferman was talking to other staff members and did not want Resident A to hear this information. Ms. Rogers stated Resident A continued to move in the area near Ms. Hefferman therefore, Ms. Hefferman placed her foot on Resident A's walker to prevent her from moving. Ms. Rogers stated Resident A attempted to continue to move forward however was not able to due to Ms. Hefferman's foot placed on the walker. Ms. Rogers stated Resident A eventually walked away and Ms. Scott intervened and gave Resident A permission to move freely throughout the home. Ms. Rogers stated she was recommending for Ms. Hefferman to be terminated because she is not nice however Ms. Rogers has not seen any specific incidents of Ms. Hefferman not being nice. Ms. Rogers stated after this incident took place, Ms. Hefferman voluntarily terminated her employment.

On 4/7/2022, I conducted an interview with administrator Kimberly Howard who stated that this allegation was reported to her on 3/30/2022 by home manager Ms. Rogers. Ms. Howard stated Ms. Hefferman is no longer working at the facility as she voluntarily terminated her employment.

On 4/7/2022, I reviewed *AFC Licensing Division-Accident/Incident Report* dated 3/30/2022. According to this report, Resident A was sitting on her walker in the room between the medication room and the dining room. Ms. Hefferman told Resident A to go to her room or dining room. The report stated Resident A said, "no I want to sit here." Ms. Hefferman was in a seated position and placed her feet on Resident A's walker. Resident A then put both of her feet all the way to the floor and tried to scoot forward towards Ms. Hefferman however Resident A could not make the walker move. Ms. Scott then told Ms. Hefferman that Resident A could sit in that room if she wanted to because it is her house at which time Ms. Hefferman took her feet off the walker.

On 5/23/2022, I conducted interviews with assistant home manager Luann Scott, direct care staff members Adam Tissue and Heather Davidson. Ms. Scott stated she witnessed Ms. Hefferman prohibit Resident A from moving by placing her feet on Resident A's walker. Ms. Scott stated Resident A was in an appropriate area of the home however Ms. Hefferman stated to her that she did not want Resident A in close proximity to her. Ms. Scott stated after she informed Ms. Hefferman to allow Resident A to sit near her, Ms. Hefferman complied and removed her feet from Resident A's walker.

Mr. Tissue stated while he was talking with Ms. Hefferman, Resident A attempted to sit near Ms. Hefferman however Ms. Hefferman told Resident A that she was not

able to be in the room with her and asked her to leave. Mr. Tissue stated Resident A refused to leave and continued to move closer to Ms. Hefferman at which time Ms. Hefferman stopped Resident A from moving closer to her by placing her feet on Resident A's walker. Mr. Tissue stated Resident A eventually moved back into the living room area of the home and then returned to the area with staff members. Mr. Tissue stated he worked regularly with Ms. Hefferman and observed she did not interact much with the residents while working in the home.

Ms. Davidson stated she observed Ms. Hefferman ask Resident A to leave the room when Resident A sat on her walker near Ms. Hefferman. Ms. Davidson stated when Resident A refused to leave, Ms. Hefferman placed her foot on Resident A's walker to stop Resident A from moving closing to her. Ms. Davidson stated Resident A attempted to ambulate with her walker however was not able to do so due to Ms. Hefferman's feet being placed on Resident A's walker. Ms. Davidson stated she immediately got up to inform her manager of the incident.

On 5/23/2022, I conducted an onsite investigation at the facility with Resident A. Resident A was not able to answer any of my questions due to her cognitive ability therefore I was unable to conduct an interview with Resident A. Resident A was observed sitting in a walker.

On 5/25/2022, I reviewed Resident A's *Health Care Appraisal* dated 11/22/2021. According to this appraisal Resident A is diagnosed with Paranoid Schizophrenia, COPD, Hypertension, GERD and uses a walker.

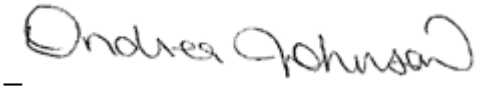
APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(b) The right to exercise his or her constitutional rights, including the right to vote, the right to practice religion of his or her choice, the right to freedom of movement, and the right of freedom of association.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule**

ANALYSIS:	Based on my investigation which included interviews with home manager Denise Rogers, assistant home manager Luann Scott, direct care staff members Adam Tissue and Heather Davidson and review of incident report there is evidence direct care staff member Tyanna Hefferman put her foot on Resident A's walker to prevent Resident A from moving about the facility. Ms. Scott, Mr. Tissue and Ms. Davidson all stated they observed Ms. Hefferman place her feet on Resident A's walker to prevent her from moving because Ms. Hefferman did not want Resident A near her. Ms. Rogers and Ms. Howard also stated this allegation was reported to them at the time the incident occurred. The home did not respect and safeguard resident's right to have freedom of movement.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/23/2022, I conducted an exit conference with licensee designee Nichole VanNiman. I informed Ms. VanNiman of my findings and allowed her an opportunity to ask questions and make comments.

IV. RECOMMENDATION

Upon an acceptable corrective action plan, I recommend the current license status remain unchanged.



5/25/2022

Ondrea Johnson — Date
Licensing Consultant

Approved By:

05/26/2022

Dawn N. Timm — Date
Area Manager