GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 28, 2022

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

RE: License #: AM800267885
Investigation #: 2023A0579011
Beacon Home at Anchor Point North

Dear Nichole 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,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

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 #:** | AM800267885 |
| | |
| **Investigation #:** | 2023A0579011 |
| | |
| **Complaint Receipt Date:** | 11/21/2022 |
| | |
| **Investigation Initiation Date:** | 11/21/2022 |
| | |
| **Report Due Date:** | 01/20/2023 |
| | |
| **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 Anchor Point North |
| | |
| **Facility Address:** | 28720 63rd Street, Bangor, MI 49013 |
| | |
| **Facility Telephone #:** | (269) 427-8400 |
| | |
| **Original Issuance Date:** | 08/03/2005 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 04/24/2022 |
| | |
| **Expiration Date:** | 04/23/2024 |
| | |
| **Capacity:** | 10 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, TRAUMATICALLY BRAIN INJURED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Residents were mistreated by direct care worker, Bryce Guthrie. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 11/21/2022 | Special Investigation Intake<br>2023A0579011 |
| 10/17/2022 | Special Investigation Initiated – Document received<br>Israel Baker, Direct Care Worker ("DCW") |
| 10/18/2022 | Contact- Face to face<br>Resident A, Resident B, Israel Baker (DCW), Bryce Guthrie (DCW), Haley Cripps (DCW) |
| 11/10/2022 | Contact- Document received<br>Israel Baker, DCW |
| 11/16/2022 | Contact- Face to face<br>Resident C, Israel Baker (DCW), Bryce Guthrie (DCW), Henry Ellis (DCW), and Thomas Frame (DCW) |
| 11/22/2022 | Contact- Face to face<br>Resident D, Resident E, and Israel Baker (DCW) |
| 1/9/2022 | Exit Conference<br>Nichole VanNiman, Licensee Designee |

**ALLEGATION:**

**Residents were mistreated by direct care worker, Bryce Guthrie.**

**INVESTIGATION:**

On 11/21/22, I entered this referral into the Bureau Information Tracking System after receiving multiple referrals for resident mistreatment by direct care worker (DCW), Bryce Guthrie.

On 10/17/22, I received a Recipient Rights complaint form from Israel Baker, DCW/ Home Manager. The complaint form was completed by Resident A and stated Mr. Guthrie twisted Resident A's arm behind his back and then yelled at him. Mr. Guthrie

then punched Resident A in the chest three times. This allegedly occurred on 10/10/22.

On 10/18/22, I completed an unannounced on-site investigation at the home. Interviews were completed with Resident A, Resident B, Mr. Baker, Mr. Guthrie, and DCW Haley Cripps.

Mr. Baker advised me that he has concerns Resident A was influenced to complete the report by another DCW because Mr. Guthrie lives with a few other DCWs and they have been involved in personal conflict outside of work, regarding a woman, from what he has heard. He stated it is also bizarre that Resident A reported something that allegedly happened some time ago instead of reporting it immediately when it occurred as he typically would. He denied direct knowledge of any incidents occurring between Mr. Guthrie and Resident A.

Resident A stated Mr. Guthrie has punched him, pushed him, slapped him in the face. He stated Mr. Guthrie swears at residents and accused residents of "disrespecting women" when they don't obey female staff. He stated there was one incident, he could not recall when, when Mr. Guthrie twisted Resident A's arm behind his back and then punched him in the chest one time. He stated recently, Mr. Guthrie got into a physical altercation where he punched Resident B. He stated he would also like to report that DCW Haley Cripps, called him "a bitch" this morning.

Resident B reported Mr. Guthrie used Crisis Prevention Institute (CPI) physical management protocol with him recently. He stated Mr. Guthrie antagonized him by following him around when he became upset and said, "You're not going nowhere." He stated he became so angry, he blacked out. He stated he accidentally swung to hit Mr. Guthrie and Mr. Guthrie "slammed" him on his back.

DCW Mr. Benjamin Sowa-Green was providing Resident B's 1:1 staffing as I spoke to him. Resident B requested that Mr. Sowa-Green remain present during our interview. Mr. Sowa-Green advised Resident B to be honest about what occurred because he was not saying what actually occurred. Resident B stated Mr. Guthrie used physical management with him but instigated it by saying, "Do you want to have a pillow fight?" He stated he swung a pillow at Mr. Guthrie and Mr. Guthrie grabbed his legs. He stated he blacked out, but he did not kick or knee Mr. Guthrie. Mr. Sowa-Green asked Resident B why Mr. Guthrie was in the staff office in tears because he was kicked in the genitals, if Resident B had not kneed or kicked him during the hold Mr. Guthrie was doing. Resident B stated he forgives Mr. Guthrie.

Ms. Cripps stated she has never called Resident A "a bitch." She stated this morning she dropped her phone, breaking the screen, and uttered, "Well, that's a bitch" when she saw her phone screen was broken. She stated Resident A must have overheard her, but she was not calling him "a bitch", she was just upset about her phone. Ms. Cripps denied witnessing Mr. Guthrie being aggressive, using maneuvers outside of CPI, or antagonizing residents.

Mr. Guthrie stated he believes he used CPI physical management with Resident A one time 2.5 to 3 months ago. He stated he does not remember what maneuvers specifically because it was so long again. He stated he has had no reason to physically manage Resident A outside of that one incident of CPI. He denied ever twisting Resident A's arm behind his back or punching him and reported he only uses maneuvers consistent with appropriate CPI. He denied swearing at or slapping any resident. He stated he does not antagonize residents.

Mr. Guthrie stated he recently had to use physical management with Resident B. He stated Resident B was agitated and was aggressively trying to hit him and others with a pillow. He stated he used a "lower-level hold" with Resident A's arms at his sides, when Resident A kicked him in the genitals. He stated that caused him so much pain, he left the hall and went into the staff office.

On 11/10/22, I received an *Incident/Accident Report* form from Mr. Baker. It was completed by Henry Ellis, DCW. It stated Mr. Ellis was Resident C's 1:1 staff. He had to go into the kitchen and Mr. Guthrie offered to be Resident C's 1:1 staff. Mr. Ellis finished in the kitchen and went to Resident C's room where he found Resident C standing by Mr. Guthrie crying. Mr. Ellis asked Resident C what was wrong. Resident C said Mr. Guthrie called him names. Resident C continued crying and Mr. Guthrie said, "That's why I got to do this" and ripped up Resident C's dollar bill. Mr. Guthrie then said, "It's okay, it was ripped already anyway." Mr. Ellis encouraged Resident C to leave the room, assured him the money would be replaced, and assisted him with filing a Recipient Rights complaint.

On 11/16/22, I completed an unannounced on-site investigation. Interviews were completed with Resident C, Mr. Baker, Mr. Guthrie, Mr. Ellis, and DCW Thomas Frame.

Resident C stated Mr. Guthrie ripped a dollar bill after taking it out of Resident C's wallet. He stated Mr. Ellis was his 1:1 staff that day, but Mr. Guthrie was his 1:1 staff for a few minutes when Mr. Ellis was somewhere else. He stated Mr. Guthrie called him "a piece of shit" because he "touches people." He stated that made him upset. He stated he was crying in his room and Mr. Guthrie grabbed his wallet and took a dollar out of it and ripped it, saying that he had to rip it because Resident C "touches people." He stated Mr. Ellis came back to his room as Mr. Guthrie was ripping his money and saw it happen. He stated Mr. Frame was in the home too, but he did not see what happened, he just assisted Resident C and Mr. Ellis with completing a Recipient Rights complaint.

Mr. Baker reported Mr. Ellis and Resident C reported Mr. Guthrie ripped a dollar bill in front of Resident C to make him upset. He denied direct knowledge of this but reported Mr. Ellis stated he witnessed this occur. He denied that Mr. Ellis and Mr. Guthrie have any conflict with each other that he is aware of or any reason why Mr.

Ellis would falsely report that this occurred. Mr. Baker reported he replaced Resident C's dollar bill when he was next at the home following the alleged incident.

Mr. Guthrie denied knowing why I may be present to speak with him again. He said based off our last interview; he thinks Resident C made false allegations that Mr. Guthrie abused him but Resident C is very sensitive so you don't need to physically manage him, you can talk to him, and he responds very well to praise. He stated he feels like he is targeted by residents because he is firm with them. When asked, he reported he did not rip Resident C's dollar bill. He stated Resident C's dollar bill was ripped when Resident C dropped it on the floor when residents were having a dance party at the house next door the day prior to this incident. He stated he brought the ripped dollar bill into Resident C's room when they returned to the home and forgot to replace it after promising he would do so. He stated on the day he assisted Mr. Ellis as Resident C's 1:1 staff, Resident C was emotional, they were talking, and Resident C began crying when talking about his mom. He stated he saw Resident C's ripped dollar bill and thought replacing it may make him feel better, so he grabbed the pieces and was going to go out to his car to grab an intact dollar bill to give to Resident C once Mr. Ellis returned. He stated Mr. Ellis returned when he had the pieces in his hand and assumed he ripped it. He stated Mr. Frame and Mr. Ellis were helping Resident C fil out a form so he did not replace the dollar bill as he had planned. He denied ripping Resident C's money as punishment.

Mr. Ellis stated he was Resident C's 1:1 staff but Mr. Guthrie assisted him while he was in the kitchen. He stated when he left the kitchen, he went to Resident C's room where he found Resident C whimpering next to Mr. Guthrie. He stated he witnessed Mr. Guthrie with Resident C's dollar bill in his hand, and he said, "This is why I have to do this" as he ripped Resident C's dollar bill. He stated he escorted Resident C away from Mr. Guthrie and he and Mr. Frame assisted Resident C with competing a Recipient Rights complaint. Mr. Ellis explained he has heard rumors that Mr. Guthrie has been mistreating Resident C. He said he heard Mr. Guthrie told Resident C he had to stand against a wall. Mr. Frame had to intervene to tell Resident C that he did not need to stand against the wall and tell Mr. Guthrie he could not tell Resident C to stand against the wall. He denied directly witnessing that incident or any mistreatment outside of Mr. Guthrie tearing the dollar bill.

Mr. Frame stated he has not directly witnessed Mr. Guthrie mistreating Resident C, but he did become involved when Resident C was crying and said that Mr. Guthrie told him that he can't sit down, he needs to stand against the wall. He stated he told Resident C that staff cannot tell him to stand against the wall or that he can't sit down, and Resident C left the wall and went to sit down. He stated another time, Resident C came to him and told him that Mr. Guthrie hit him in the chest and told him he is a "piece of shit" but he did not see that occur. He stated he also did not see the incident with Resident C's money, but he became involved to assist Mr. Ellis and Resident C with completing a Recipient Rights report. He stated he found Mr. Guthrie's behavior as they were writing the report to be bizarre. He stated Mr. Guthrie "tousled" Resident C's hair and patted his shoulder as he wrote the report,

which he felt was to intimidate or influence Resident C as he wrote the report. He stated Mr. Ellis had to tell Mr. Guthrie to go away and leave Resident C alone.

Mr. Frame stated he has heard Mr. Guthrie being verbally aggressive with residents including Resident C. He reported there was an alleged incident where Resident C followed a more vulnerable resident into the bathroom and while it is not believed that anything sexual occurred, Resident C may have had sexual intentions when he followed the other resident into the bathroom. He stated he feels Mr. Guthrie is very protective of the vulnerable resident, as he is very protective of female staff and will accuse residents of “disrespecting women” when they do not obey female staff. He stated he feels Mr. Guthrie may be mistreating Resident C in retaliation for what allegedly happened with the other resident in the bathroom and mistreating other residents when he feels they have done something wrong.

On 11/22/22, I completed on-site investigation relating to different allegations at the home. While interviewing Resident D about those allegations, he reported he and Resident E have been mistreated by Mr. Guthrie. Interviews were completed with Resident D, Resident E, and Mr. Baker. Mr. Guthrie was not available for interviewing at that time.

Resident D stated he has concerns with Mr. Guthrie’s treatment of him and Resident E. He stated Mr. Guthrie has hit him in the throat with a closed hand which made his throat sore. He stated Mr. Guthrie has restrained him with his arms behind his back which made his arm “pop”. He showed me a scrape on one of his knees that appeared consistent with severe rug burn. He stated he received that injury when Mr. Guthrie “took [him] down” during CPI recently. He stated Mr. Guthrie has also intentionally poured water over him. He stated he did not know exact dates for any of these incidents. He stated Mr. Guthrie has not been allowed in this home because of his mistreatment of Resident E “a couple of days ago.”

Resident E was reluctant to speak with me, initially preferring to only nod yes or no. He stated Mr. Guthrie “yells at you” when he says, “you’ve made him mad.” He stated Mr. Guthrie has “put [him] on [his] ass” when he has “tackled” him when Mr. Guthrie was upset before. He stated Mr. Guthrie has hit him in the ribs, on his neck, and on the side of his body. He stated Mr. Guthrie has called him a “piece of shit.” He denied knowing when these incidents occurred or if the physical incidents left marks or bruises.

Mr. Baker denied knowing that Resident D had an injury on his knee and denied that Resident D reported it to anyone other than me. He was not certain when Resident D was last physically managed by Mr. Guthrie. He stated he was aware that Resident E claimed Mr. Guthrie hit him in the chest, but he had no marks or bruises and could not say when it occurred.

On 12/28/22, I reviewed *Incident/Accident Report* (IR) forms sent to me by Mr. Baker. An IR completed on 11/21/22 confirmed Mr. Guthrie was involved in the use

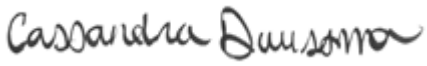
of physical management with Resident D on 11/20/22 which was two days prior to Resident D reporting the injury to his knee came from Mr. Guthrie physically managing him. It was reported Mr. Guthrie used a “lower-level hold” on Resident D during the incident. Another IR completed on 11/20/22, confirmed Mr. Guthrie had used physical management with Resident E on 11/19/22. It was reported Mr. Guthrie used a “lower-level hold” on Resident E. Resident E later reported Mr. Guthrie choked and punched him and law enforcement was contacted.

| **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:** | Resident A, Resident B, Resident C, Resident D, and Resident E all reported being mistreated, physically and/or verbally, by Mr. Guthrie. Mr. Ellis reported directly witnessing an incident of mistreatment, where Mr. Guthrie ripped Resident C’s money as a form of punishment. Mr. Frame reported comforting Resident C after Mr. Guthrie told Resident C he could not sit and had to stand against a wall. Over the course of multiple interviews on varying dates with varying residents and direct care workers, patterns were noticed for allegations of Mr. Guthrie hitting residents in their chest or neck, twisting their arms behind their backs, taking them down to the ground, calling them a “piece of shit”, or accusing residents of “disrespecting women.” Based on my observation of the residents and the varying nature of the interviews, it is not believed five residents conspired or had the cognitive abilities to conspire to make false allegations against Mr. Guthrie over the course of several weeks or that Mr. Ellis or Mr. Frame conspired with residents regarding the allegations.<br><br>Based on the interviews completed there is sufficient evidence to support allegations that Mr. Guthrie mistreated residents through intentional action or omission and exposing residents to physical or emotional harm or deliberate infliction of pain by any means. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 1/9/23, I completed an exit conference with Ms. VanNiman who did not dispute my findings or recommendations at that time.

## IV. RECOMMENDATION

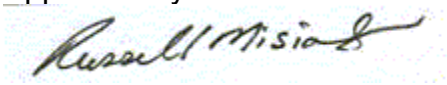
Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.



12/28/22

Cassandra Duursma Date
Licensing Consultant

Approved By:



1/5/23

Russell B. Misiak Date
Area Manager