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

December 10, 2022

RE: License #: AS800343665
Investigation #: 2023A0579013
Beacon Home at Bayview

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

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS800343665
Investigation #:	2023A0579013
Complaint Receipt Date:	11/22/2022
Investigation Initiation Date:	11/22/2022
Report Due Date:	01/21/2023
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 Bayview
Facility Address:	29320 63rd Street, Bangor, MI 49013
Facility Telephone #:	(269) 427-0288
Original Issuance Date:	10/07/2013
License Status:	REGULAR
Effective Date:	04/04/2022
Expiration Date:	04/03/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED/ AGED/ DEVELOPMENTALLY DISABLED/MENTALLY ILL/ TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A sexually assaulted Resident B while in the community unsupervised.	Yes

III. METHODOLOGY

11/22/2022	Special Investigation Intake 2023A0579013
11/21/2022	Contact- Document received Israel Baker, Direct Care Worker
11/22/2022	Special Investigation Initiated - Face to Face Resident B Israel Baker, Direct Care Worker
11/23/2022	Contact- Document received Israel Baker, Direct Care Worker
1/11/2023	Exit Conference Nichole VanNiman, Licensee Designee

ALLEGATION:

Resident A was sexually assaulted outside of the home while unsupervised.

INVESTIGATION:

On 11/21/22, I received an *Incident/Accident Report* form which read Resident B reported that at 12:00 a.m. on 11/18/22, Resident B was outside of the home when he was asked by Resident A to pull his pants down so Resident A could "suck his penis" and Resident A asked Resident B "if he was gay." Resident B complied with taking his pants down and allowing Resident A to perform oral intercourse on him. Resident B advised Resident A he was "not gay" and did not want to continue. Resident A asked Resident B to go into the woods with him. While in the woods, Resident A told Resident B to pull his pants down further so Resident A could engage in anal intercourse with him. Resident B complied but again stated he did not want to continue. Resident A then told Resident B to allow him to perform oral intercourse, "forced himself on [Resident B] and stuck his tongue down [Resident B's] throat." Resident B stated he pulled his pants up because he heard staff approaching.

After Resident B disclosed this, he was transported to the hospital for a sexual assault examination. Michigan State Police was contacted, and a report was filed. Resident A was arrested. Throughout Resident B's reporting of the incident, the day it allegedly occurred changed from 11/18/22 to 11/19/22. I received confirmation of a police report filed and a copy of Resident B's discharge instructions from the hospital noting Resident B was seen for a sexual assault examination. No further details were noted regarding the sexual assault examination.

On 11/22/22, I entered this referral into the Bureau Information Tracking System after receiving notification from Mr. Baker that Resident A was arrested for sexually assaulting Resident B, who lives in a different home. Resident A would not discuss the allegations and Resident B did not know when the incident occurred, but it was believed to be during the night on either 11/17/22, 11/18/22, or 11/19/22. He wrote Resident B reported this at 11:00 a.m. on 11/20/22 and did not say anything to night staff on the night it allegedly occurred. Resident B was taken to the hospital for a sexual assault examination.

On 11/22/22, I completed an unannounced on-site investigation. Interviews were completed with Israel Baker, direct care worker/ "DCW", and Resident B. Resident A was reported to still be incarcerated.

Mr. Baker confirmed the allegations as reported in the *Incident/Accident Report* form. He stated he initially believed Resident B was reporting something that occurred overnight from 11/19/22 to 11/20/22. Mr. Baker stated he thought it was odd that Resident B did not report the incident immediately after it happened and instead reported it to dayshift on 11/20/22. Mr. Baker stated as he and others have spoken to Resident B about the incident, the date has changed from during the night of 11/17/22, to 11/18/22, to 11/19/22.

He stated both Resident A and Resident B require 1:1 supervision while they are awake, but not overnight. He stated he has spoken to third shift staff on 11/17/22, 11/18/22, 11/19/22, and 11/20/22 and no one at this home has reported Resident A leaving the home during the night or that they were outside of the home and observed Resident A and Resident B in the woods as alleged. He stated staff at Resident B's home also denied Resident B leaving his home on any of those nights. He denied either resident's 1:1 staff on each of those days stating Resident A and Resident B were ever unsupervised while they were present. He stated although he does not know when this occurred, he believes this incident did occur, as Resident A and Resident B both say it did occur. He stated, however, he doubts that it was nonconsensual. He stated Resident B wants other residents to believe he is in a gang and tough, so he believes Resident B possibly thought someone; staff or resident, saw it and is now claiming he did not consent, so residents do not think Resident B "is gay." He stated he has spoken to Resident B about how it is important to be honest, especially with law enforcement, if he engaged in this behavior because he wanted to since Resident A is now incarcerated for this.

Resident B stated this incident occurred around midnight one night. He stated he did not recall the exact night. Later in the interview he claimed it was after a DCW used physical management with him, which was confirmed by *Incident/Accident Report* to have occurred on 11/20/22, which would have been overnight from 11/20/22 to 11/21/22, which was after Resident B had already reported the allegations. He could not recall who was working when he left the home and encountered Resident A. It could not be determined when the incident occurred.

Resident B stated the night of the incident, he left the home and Resident A approached from behind the garage. He stated Resident A told him to pull down his pants and "pull his thing out." He clarified that he'd prefer to call his penis his "thing" as he did not want to use the word "penis" when speaking to me. He stated once he pulled his pants down, Resident A "started sucking on his thing." He stated he told Resident A to stop because he has a girlfriend. He stated Resident A asked him if he wanted a boyfriend and he said no. He said he told Resident A to stop because he thought someone may have seen them and he did not want to continue. He stated Resident A then asked him if he wanted to go see his fort in the woods behind the home. He stated they went around the shed on the property and into the woods where Resident A had made a fort out of trees, rope, and a piece of wood. He stated Resident A asked him to pull down his pants and underwear so he could engage in anal intercourse and Resident A "put his thing up [his] butt." He stated he told Resident A to stop, and Resident A asked to "suck [his] thing" again or "play with it." He stated Resident A again engaged in oral intercourse with him, but he told Resident A to stop because he thought staff was approaching. He stated he returned to his home without alerting staff and did not immediately report what happened. He stated he later told direct care workers on a dayshift who reported the incident to police and Mr. Baker.

Resident B stated he was taken to the hospital for an exam. He stated when he got back, “the cops” were there and he spoke to them. He stated he told them what happened and showed them the fort. He stated they asked if he wanted to press charges. He stated he did press charges.

On 11/23/22, I reviewed Resident A’s *Assessment Plan for AFC Residents* which was completed on 11/5/21. Regarding independent movement in the community, it was noted Resident A needs “eyes on” staff supervision in the community due to his history of predatory sexual behavior. I also reviewed Resident B’s *Assessment Plan for AFC Residents* which was completed on 7/28/22. Regarding independent movement in the community, it was noted Resident B needs 1:1 supervision 24 hours a day.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
For Reference: R 400.14102	**Definitions.**
	(d) "Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services, taking into account the preferences and competency of the individual.
ANALYSIS:	Resident A was unavailable for interviewing due to incarceration. Mr. Baker confirmed Resident A was incarcerated due to this incident. Resident B reported he was involved in sexual behaviors with Resident A outside of the home at night while unsupervised. Mr. Baker stated Resident B confirmed he and Resident A were involved in sexual behaviors together in the community one night. Mr. Baker and I could not determine when the incident occurred, but Mr. Baker reported believing the incident did occur. Mr. Baker reported he spoke to staff who worked in this

	home and Resident B's home on 11/17/22 to 11/20/22 who all deny that either resident was unsupervised or left the home at night. The plan lacked specific detail required for staff to sufficiently protect Residents. Resident A's assessment plan read he needs "eyes on" supervision while in the community due to his history of sexual predatory behaviors. There was no timeframe listed (such as waking hours) for when this supervision was required, so it is believed to be a 24-hour requirement. Based on interviews completed and documentation reviewed, there is sufficient evidence to support that Resident A was not receiving "eyes on" supervision in the community as specified in his assessment plan when he was able to engage in unsupervised, sexual behaviors with Resident B in the community, leading to his arrest.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/11/23, I completed an exit conference with Ms. VanNiman who did not dispute my findings or recommendations. She reported she has already met with Mr. Baker and discussed updating assessment plans for residents.

IV. RECOMMENDATION

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

Cassandra Duursma 12/28/22

Cassandra Duursma Date
Licensing Consultant

Approved By:

Russell Misiak 1/11/23

Russell B. Misiak Date
Area Manager