GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 15, 2023

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

RE: License #: AS390406170
Investigation #: 2023A0578018
Beacon Home at Wolf Lake

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

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 #:	AS390406170
Investigation #:	2023A0578018
Complaint Receipt Date:	01/25/2023
Investigation Initiation Date:	01/25/2023
Report Due Date:	03/26/2023
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 Wolf Lake
Facility Address:	10633 W. J Ave. Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-1809
Original Issuance Date:	05/05/2021
License Status:	REGULAR
Effective Date:	11/05/2021
Expiration Date:	11/04/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff Jasmine Burton used vulgar language and threatened Resident A with physical violence.	Yes
Direct care staff Jasmine Burton grabbed Resident A by the hood of her clothing and pulled Resident A's head back.	Yes
Direct care staff Jasmine Burton pulled Resident A from a couch by the wrist and dragged Resident A across a room.	Yes
Direct care staff Jasmine Burton pushed Resident A down a flight of stairs.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/25/2023	Special Investigation Intake 2023A0578018
01/25/2023	Special Investigation Initiated - Telephone
01/25/2023	APS Referral
01/31/2023	Contact-Telephone -Interview with direct care staff Jasmine Burton.
02/01/2023	Special Investigation Completed On-site -Interview with staff member Andrea Jackson, interview with Resident A, Resident C and Resident D. Interview with direct care staff Andrea Reese.
02/01/20223	Contact-Document Received, -*After Visit Summary* for Resident A, dated 01/19/2023.
02/02/2023	Contact-Telephone -Interview with Resident E.
02/02/2023	Contact-Telephone -Interview with direct care staff Sabrina Loehr.
02/03/2023	Contact-Telephone -Allegan County Recipient Rights Director Kelsey Newsome.
02/03/2023	Contact-Telephone -Interview with administrator Kim Howard.
02/21/20123	Document Reviewed -*Case Report Summary* #2023-00002112.

02/27/2023	Special Investigation Completed On-site
02/27/2023	Contact-Telephone -Interview with direct care staff Andrea Jackson.
03/02/2023	Exit Conference -With licensee designee Nichole VanNiman.

ALLEGATION:

- Direct care staff Jasmine Burton used vulgar language and threatened Resident A with physical violence.

- Direct care staff Jasmine Burton grabbed Resident A by the hood of her clothing and pulled Resident A's head back.

- Direct care staff Jasmine Burton pulled Resident A from a couch by the wrist and dragged Resident A across a room.

- Direct care staff Jasmine Burton pushed Resident A down a flight of stairs.

INVESTIGATION:

On 01/25/2023, I received an *AFC Licensing Division Incident / Accident Report* dated 01/19/2023 and completed by direct care staff Sabrina Loehr. This *AFC Licensing Division Incident / Accident Report* documented that on 01/19/2023, around 5PM, Resident A was sitting on the couch when she asked for direct care staff Jasmine Burton. According to the *AFC Licensing Division Incident / Accident Report,* Resident A and Resident B began to argue when Ms. Burton commented*,* "this is not what the fuck we are going to do today" and "we are not doing this again [Resident A] you need to take your ass back downstairs where you belong." The *AFC Licensing Division Incident / Accident Report* documented that both Resident A and Resident B were redirected by staff to separate when Resident A and Resident B continued to argue. *The AFC Licensing Division Incident / Accident Report* documented that Resident A began commenting about using derogatory language when Ms. Burton responded, "don't you fucking say it, I told you yesterday to stop saying that fucking word." The *AFC Licensing Division Incident / Accident Report* documented that after using making this comment, Ms. Burton grabbed Resident A by the hood of Resident A's outfit and pulled Resident A's head back and screamed in Resident A's face that if Resident A was going to "start this shit again" Ms. Burton would "throw her on the couch like she did yesterday." The *AFC Licensing Division Incident / Accident* Report documented that shortly thereafter, Ms. Burton grabbed Resident A by the arm and pulled her off a couch and dragged Resident A to a flight of stairs and pushed Resident A down the stairs. The *AFC Licensing Division*

Incident / Accident Report documented that when Ms. Loehr went to check on Resident A, Ms. Burton commented that she was not “Fucking doing this tomorrow” and that if Resident A thought this was bad, to “wait until then.”

This *AFC Licensing Division Incident / Accident Report* documented corrective measures as contacting the district director, law enforcement, guardian, case manager and licensing.

On 01/25/2023, I contacted administrator Kim Howard regarding the allegations. Ms. Howard reported that Ms. Jasmine Burton was placed on leave immediately and has not been heard from since. Ms. Howard reported Resident A was assessed for injuries and had no visible injuries but was brought to Bronson Lakeview Hospital. Ms. Howard reported that Resident A’s hand may possibly be fractured but a fracture was unable to be determined during Resident A’s initial exam. Ms. Howard reported Resident A had a follow up medical appointment scheduled. Ms. Howard reported Kalamazoo County Sheriff’s Department had responded to the allegations.

On 02/01/2023, I completed an unannounced investigation on-site at this facility and interviewed staff member Andrea Jackson regarding the allegations. Ms. Jackson reported serving as the home manager for this facility. Ms. Jackson acknowledged being aware of the allegations and reported Resident A had a follow up appointment regarding her wrist as the initial x-ray was not clear enough to diagnose a bone fracture. Ms. Jackson reported an additional exam and x-ray was scheduled to see if healing was occurring which would confirm Resident A’s wrist was broken. Ms. Jackson reported that as soon as staff reported the incident to her, she immediately came to the facility and contacted Ms. Kim Howard. Ms. Jackson reported direct care staff Jasmine Burton was sent home and she accompanied Resident A to Bronson Immediate Care of Paw Paw. Ms. Jackson reported when she spoke to Resident A, Resident A disclosed that Ms. Burton had grabbed her by the hood of her sweatshirt and had pulled Resident A off the couch by the arm and pushed Resident A down the stairs. Ms. Jackson reported Resident A was visibly shaking when she arrived.

Ms. Jackson added staff reported hearing Ms. Burton comment, “you don’t want me to body slam you on the couch like I did yesterday.” Ms. Jackson identified the staff working with Ms. Burton on 01/18/2023 as direct care staff Andrea Reese.

On 02/01/2023, I interviewed Resident A regarding the allegations. Resident A reported living at this facility for more than a year. Resident A initially denied recalling the incident but then disclosed that her wrist might be broken. When asked how her wrist became injured, Resident A reported direct care staff Jasmine Burton pulled Resident A by the wrist and tried to push Resident A down the stairs. Resident A added that Ms. Burton had pulled Resident A by the “hoodie” of her clothing as well. Resident A clarified that she did not fall down the stairs but walked down the stairs on her own. Resident A denied injuring her wrist in any other way.

Resident A denied that Ms. Burton or any other staff member used verbally aggressive language or expletives or vulgar language with her or any other resident.

Resident A did not recall this type of behavior occurring before and denied ever being pushed or pulled by Ms. Burton or any other staff before. Resident A did not recall any incident occurring the day before on 01/18/2023. I noted that Resident A was hesitant in answering questions. Resident A reported that she was afraid on the night of the incident but denied being afraid currently. Resident A reported feeling currently safe at this facility. I observed Resident A with no visible signs of abuse or neglect and noted that she was not wearing any type of brace or cast on her left wrist.

On 02/01/2023, I interviewed Resident C regarding the allegations. Resident C reported living at this facility for over 12 years. Resident C acknowledged being present on the day of the reported allegations. Resident C reported Resident A kept calling Resident B, the “n-word”. Resident C reported Resident A kept using the “n-word” until direct care staff Jasmine Burton got “tired of it” and picked up Resident A and “threw her downstairs.” Resident C described that Resident A was sitting on the couch when Ms. Burton grabbed her with one hand, pulled Resident A off the couch and continued to pull Resident A by the wrist of her left hand to the stairs. Resident C demonstrated how she observed Ms. Burton use the motion of both arms to push Resident A down the stairs and ended this motion with her arms over her head. Resident C reported she heard Resident A land on a surface at the bottom of the stairs but did not see Resident A land and could not describe how Resident A landed or what Resident A landed on. Resident C described how when she saw Resident A a short time later, Resident A was holding her left wrist next to her chest and was visibly upset. Resident C denied ever observing this type of incident before and did not recall any vulgar or derogatory language other than the language used by Resident A.

On 02/01/2023, I interviewed Resident D regarding the allegations. Resident D acknowledged being present on the day of the reported allegations. Resident D reported she observed direct care staff Jasmine Burton pull Resident A by the hood of her sweatshirt and pull Resident A by the wrist, “very hard.” Resident D reported Ms. Burton commented to Resident A, “if you don’t get off this f’n couch, I’m pulling you off this couch”, before grabbing Resident A by the wrist and yanking on Resident A’s arm “very hard.” Resident D reported that she heard Resident A’s wrist crack but was unsure if Resident A’s wrist is broken as she has not observed Resident A wearing a cast. Resident D reported hearing Ms. Burton comment to Resident A, “Get the fuck up off the couch” and “If you don’t get off the f’n couch, I’m pulling you off the couch”. Resident D denied ever observing this type of incident before and denied having any additional concerns.

While at the facility, I attempted to interview Resident B and Resident B declined to be interviewed. I observed Resident B with no visible signs of abuse or neglect.

While at the facility, I observed the staircase referenced by the allegations and noted this flight of stairs consisted of seven individual steps.

On 02/01/2023, I interviewed direct care staff Andrea Reese regarding the allegations. Ms. Reese acknowledged being aware of the allegations but clarified that she never observed similar behavior displayed by direct care staff Jasmine Burton. Ms. Reese clarified the day before the incident, on 01/18/2023, she had heard Ms. Burton describe how she had thrown Resident A on the couch earlier in the shift and grabbed Resident A by the “hoodie” of her sweatshirt and told Resident A, “Do you not like this? Chill out then.” Ms. Reese reported that Ms. Burton was “really worked up” when she recalled these events at the end of their shift when overnight direct care staff Charise McDonald had arrived. Ms. Reese denied observing Ms. Burton grab Resident A by the hood or throw Resident A on the couch and reported these events could have occurred when she was redirecting Resident D and had her back turned to Ms. Burton and Resident A or when she was downstairs folding laundry. Ms. Reese denied completing any type of report related to Ms. Burton’s comments but clarified that she had made a verbal report to direct care staff Andrea Jackson, home manager for this facility on 01/20/2023.

On 02/02/2023, I interviewed direct care staff Sabrina Loehr regarding the allegations. Ms. Loehr reported working for the licensee for over two years but clarified working at this facility for only two shifts, the day of the allegations being one of them. Ms. Loehr reported direct care staff Jasmine Burton was in a “crabby mood” on the day of the allegations and clarified that Ms. Burton had reported being hit in the head with a water bottle the previous day when Resident A and Resident D were arguing. Ms. Loehr reported that Ms. Burton had slept part of the shift and reported that she was leaving her shift early that day.

Ms. Loehr reported that Resident A and Resident B had been arguing with each other throughout the day when Resident A had asked for Ms. Burton’s assistance in deescalating another argument between Resident A and Resident B. Ms. Loehr reported that Ms. Burton had approached Resident A and began talking to her and asking Resident A what was wrong. Ms. Loehr reported Resident A and Resident B began to verbally argue when Ms. Burton commented, “This is not what the fuck is going on today” and “If stuff starts getting thrown, I will throw you on the couch like I did yesterday.” Ms. Loehr reported she questioned Ms. Burton about this comment immediately and Ms. Burton replied, “yeah, I threw her on the couch three times.” Ms. Loehr reported she informed Ms. Burton this was not CPI and was illegal when Resident A began commenting “should I say it?” Ms. Loehr clarified that Resident A was threatening to use the word “nigger” to upset Resident B and Ms. Burton. Ms. Loehr reported that Ms. Burton replied, “don’t fucking say it, you know I don’t fucking like that word.” Ms. Loehr reported that Resident A waited until Ms. Burton had moved away from the couch before saying, “nigger.” Ms. Loehr reported that Ms. Burton ran towards Resident A from behind the couch and grabbed Resident A by the hood of Resident A’s “cow onesie” and pulled Resident A on the couch and

yelled at Resident A, “I told you not to fucking say it, why do you keep fuckin’ saying that word!”

Ms. Loehr reported that Resident B threw a DVD case at Resident A and missed, which prompted Resident A to throw the DVD case back at Resident B. Ms. Loehr reported that she was attempting to redirect Resident B when Ms. Burton went around the couch and commented, “you need to go back fuckin’ downstairs” and “you know what, fuck this” and Ms. Loehr reported that Ms. Burton grabbed Resident A between the wrist and the forearm on her left side and jerked Resident A from the couch and walked Resident A to the stairs before standing Resident A up and pushed Resident A down the stairs. Ms. Loehr reported that Resident A fell down the stairs but was able to catch herself.

Ms. Loehr reported that shortly thereafter Resident A was playing music in her room when she went to check on Resident A and Ms. Burton followed her. Ms. Loehr reported that she checked on Resident A who denied being in pain and denied observing any obvious bruising on Resident A. Ms. Loehr reported that Ms. Burton commented, “I told you, you gotta stop fuckin’ saying that word, if you think today was bad, tomorrow will be worse.”

Ms. Loehr stated she reported the incident to Ms. Kim Howard and Ms. Nicole VanNiman as well as Recipient Rights and law enforcement. Ms. Loehr reported that Resident A initially didn’t want to go to the hospital but agreed to do so after Ms. Andrea Jackson arrived. Ms. Loehr reported hearing later that Resident A’s wrist was possibly broken or needed to be “reset” and not knowing more until a follow up x-ray within three weeks.

Ms. Loehr reported that Resident A was “terrified” and remained downstairs to watch television and could be heard crying. Ms. Loehr reported Resident A usually lays down on her left side but was now lying on her right side and still denied being in any sort of pain. Ms. Loehr denied Resident A slammed her hand on the floor or on her radio when she went downstairs shortly after the incident.

Ms. Loehr reported Resident D and Resident E commented being afraid of providing information regarding the allegations for fear of retaliation in some way. Ms. Loehr reported prompting residents with reminders that nothing would change unless they reported what happened. Ms. Loehr commented Ms. Burton did not know who she was and was surprised that Ms. Burton had no problem with telling her that she had thrown Resident A on the couch three times and engaged in this behavior in front of her.

On 02/02/2023, I interviewed Resident E regarding the allegations. Resident E reported living at this facility for over one month. Resident E initially reported she could not recall the allegations. Resident E disclosed Resident A was using the “n-word” and telling residents and staff they needed to “die.” Resident E reported Ms. Burton had informed Resident A that if Resident A said that word one more time, she

would have to go downstairs. Resident E denied that any kind of vulgar language or profanity was used during this incident. Resident E reported she had observed direct care staff Jasmine Burton picking up Resident A and bringing her to the stairs. Resident E reported that she was sitting at the table in the kitchen so she did not directly observe Ms. Burton push Resident A down the stairs but this was what she was informed had happened shortly thereafter. Resident E reported she thought Ms. Burton had picked up Resident A and brought her to the stairs to keep Resident A from getting assaulted. Resident E denied being in any kind of physical altercation with Resident A and reported staff at this facility “baby” Resident A and that she gets special treatment like not being “sent to jail.” I noted Resident E acknowledged being recently incarcerated due to violating the conditions of her bond for being in a physical altercation with Resident A and engaging in “harassing behavior.” I noted Resident E was concerned about returning to this facility and returning to jail. Resident E denied having any additional information related to the allegations.

On 01/31/2023, I interviewed direct care staff Jasmine Burton regarding the allegations. Ms. Burton reported working at this facility since December 2022. Ms. Burton reported that Resident A and Resident B had been frequently fighting and, on this day, had thrown DVDs, remotes and books at each other. Ms. Burton commented that Resident A had been “trained” to use the “N-word” and will often use it to make Resident B upset. Ms. Burton reported that on the day of the allegations, Resident A had commented, “should I say it?” in reference to the “N-word” and Ms. Burton had prompted Resident A to not use the word by commenting that if Resident A has to ask whether or not she should say a word, then she probably shouldn’t. Ms. Burton commented that she had to use all of her “coping mechanisms taught at Beacon” when attempting to redirect Resident A from using derogatory language. Ms. Burton reported she was stepping outside the facility to use her vaping device when Resident A called Resident B “nigger bitch” repeatedly. Ms. Burton reported she stood behind Resident A who was sitting on the couch and “hovered” over Resident A and told Resident A that was “not very nice.” Ms. Burton reported that both staff and residents have told Resident A to not use this type of language. Ms. Burton reported Resident A and Resident B began to argue again when Resident A attempted to get up from a seated position. Ms. Burton reported that Resident A has poor balance and fell and tripped last week, so Ms. Burton provided Resident A with assistance by using her arm to assist Resident A to a standing position. Ms. Burton reported Resident A attempted to hit her and was continuing to do so as Ms. Burton guided Resident A to the stairs. Ms. Burton reported Resident A was still arguing and attempting to hit her when she provided Resident A with assistance with the first step of this stairwell when Resident A walked the rest of the way down the stairs. Ms. Burton reported various direct care staff members were saying Resident A had fallen down the stairs, but Ms. Burton reiterated she had watched Resident A walk down the stairs. Ms. Burton reported she then walked away as Resident A slammed her bedroom and bathroom door. Ms. Burton reported she later checked on Resident B and then Resident A. Ms. Burton reported when she went to do so, Resident A slammed her hand on the floor and then slammed her hand on the radio to turn it off and responded, “what!” very

loudly. Ms. Burton reported Resident A “added fuel to the fire” and that Resident B is only nice to Resident A and that Resident A’s behavior hurts Resident B’s feelings. Ms. Burton reported that she told Resident A that “we are not going to do this tomorrow” and told Resident A that she “loves” her and that Resident A responded back by saying that she “loves” Ms. Burton.

When asked if Ms. Burton had used any vulgar language with Resident A, Ms. Burton replied that she did not remember. When asked to clarify why she did not remember, Ms. Burton clarified that she did not use vulgar language. When asked why someone reported that she did use vulgar language, Ms. Burton acknowledged that if she did, it was when she was outside the facility and not directed at any resident. Ms. Burton denied ever threatening Resident A with “throwing” or “body slamming” Resident A on the couch like she “did yesterday” or any other verbal threats. Ms. Burton denied ever throwing Resident A on the couch on 01/18/2023 and reported not knowing anything about this allegation. Ms. Burton clarified that Resident A and Resident B were the aggressors, and she received a thermal cup thrown at the side of her head as a result. I noted Ms. Burton’s progression from not recalling using vulgar language to using vulgar language but only outside the facility.

Ms. Burton denied ever grabbing Resident A by her hood or anything else on Resident A’s clothing, stating that Resident A was wearing a “onesie” and not wearing a belt or belt loops or anything else she could grab onto. Ms. Burton denied dragging Resident A to the stairs and clarified that she was “helping” Resident A to the stairs with one arm under Resident A’s arm pit.

When asked how Resident A had reset or possibly broken her hand, Ms. Burton reiterated Resident A had slammed her hand on the floor and on her radio to turn off her music. Ms. Burton stated Resident A did not report any kind of injury and “loves” Ms. Burton. When asked if Resident A’s use of derogatory language made Ms. Burton upset, Ms. Burton responded she is “Black in America” and has heard this type of derogatory language used before.

On 02/01/2023, I reviewed the *After Visit Summary* for Resident A, provided by Bronson Lakeview Hospital on 01/19/2023 and related to the allegations. The *After Visit Summary* for Resident A documented that Resident A’s “Reason for Visit” was “wrist pain.” The *After Visit Summary* for Resident A documented that Resident A was to have an appointment in two weeks with her primary care doctor for a repeated x-ray of her wrist. The *After Visit Summary* for Resident A documented that Resident A’s pain is near her scaphoid bone which has a “tendency to hide fractures on the first x-ray.”

On 02/01/2023, I reviewed the *Health Care Appraisal* for Resident A, dated 12/01/2022. The *Health Care Appraisal* for Resident A identified Resident A as “fully ambulatory.”

On 02/01/2023, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 12/20/2022. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A does not need any assistance walking or being ambulatory.

On 02/21/2023, I reviewed the *Case Report Summary* provided by the Kalamazoo County Sheriff's Office for case number 2023-00002112, related to the allegations. The *Case Report Summary* documented that on 01/19/2023, Kalamazoo County Sheriff's Deputy Matthew Kirkey was dispatched to this facility and interviewed direct care staff member Sabrina Loehr, who advised Deputy Kirkey she had witnessed staff member Jasmine Burton physically assault Resident A by grabbing Resident A by the hood, yelling at her, and then carrying her over to the stairs where she pushed Resident A down the set of stairs. The *Case Report Summary* documented Deputy Kirkey interviewed Resident A, who advised him Resident A and another resident got into a verbal argument when Ms. Jasmine Burton intervened by grabbing Resident A by the hood and yelled at her, then pulled Resident A over to the staircase and pushed Resident A down the staircase. The *Case Report Summary* documented Deputy Kirkey was unsuccessful in physically interviewing Ms. Jasmine Burton at her last known address, leaving a note for Ms. Burton to contact the Kalamazoo County Sheriff's Office, as Ms. Burton refused to provide her current location. The *Case Report Summary* documented that Ms. Burton contacted Deputy Kirkey by telephone and stated to Deputy Kirkey that she was afraid she would be arrested. The *Case Report Summary* documented Deputy Kirkey was able to interview Ms. Burton by telephone regarding the incident and Ms. Burton stated she didn't do anything to physically harm Resident A and stated she did not push Resident A down the stairs. The *Case Report Summary* documented Ms. Burton still refused to provide Deputy Kirkey with her location as she stated again, she was afraid she would be arrested. The *Case Report Summary* documented Deputy Kirkey was attempting to obtain consent to release Resident A's medical records to document the full extent of Resident A's injuries before submitting to the prosecuting attorney's office for charges of assault for direct care staff Jasmine Burton.

On 02/27/2023, I interviewed direct care staff Andrea Jackson regarding the allegations. Ms. Jackson reported that Resident A completed her follow-up appointment and was not diagnosed as having a broken wrist. Ms. Jackson reported that no documentation was provided by Borgess of Paw Paw at the time of Resident A's appointment but confirmation of the results of this appointment would be submitted to the department once they were obtained.

As of the date of this report, documentation related to the follow-up appointment for Resident A's injury to her wrist have not been provided.

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:	During an interview, direct care staff Sabrina Loehr confirmed observing direct care staff Jasmine Burton grab Resident A by the wrist, pull Resident A off a couch and drag Resident A to a flight of stairs where Ms. Burton pushed Resident A down the stairs. In an interview, administrator Kim Howard reported Resident A was treated at Bronson Lakeview Hospital for possible fracture in her wrist as result of the physical force used by direct care staff Jasmine Burton. In an interview, Resident A reported direct care staff Jasmine Burton pulled her by the wrist and tried to push Resident A down the stairs, resulting in injury to Resident A's wrist. Resident A also described how she felt scared on the day of the allegations. I reviewed the *After Visit Summary* for Resident A, provided by Bronson Lakeview Hospital on 01/19/2023 which documented Resident A's "Reason for Visit" was "wrist pain." Based on this Resident A was not treated with dignity and her personal need for protection and safety was not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(f) Subject a resident to any of the following:** **(iv) Threats.**

ANALYSIS:	During an interview, direct care staff Sabrina Loehr confirmed observing direct care staff Jasmine Burton using vulgar and threatening language with Resident A, grabbing Resident A by the hood of Resident A's clothing and pulling Resident A's head back and threatening Resident A with throwing her on the couch. Ms. Loehr reported Ms. Burton ran towards Resident A from behind the couch and grabbed Resident A by the hood of Resident A's "cow onesie" and pulled Resident A off the couch by grabbing Resident A between the wrist and the forearm and walked Resident A to the stairs before standing Resident A up and pushed Resident A down the stairs. Ms. Loehr's interview was consistent with the interview she provided to Kalamazoo County Sheriff's Deputy Matthew Kirkey as documented in *Case Report Summary* #2023-00002112. In an interview, Resident A reported that direct care staff Jasmine Burton pulled her by the wrist and tried to push Resident A down the stairs. Resident A added that Ms. Burton had pulled her by the hood of her clothing as well. Resident A's interview was consistent with the interview she provided to Kalamazoo County Sheriff's Deputy Matthew Kirkey as documented in *Case Report Summary* #2023-00002112. In an interview, Resident D confirmed that direct care staff Jasmine Burton used vulgar language and threatening language toward Resident A when she swore at her and threatened to get her off the couch forcefully. In an interview, direct care staff Jasmine Burton denied using any type of physical force with Resident A but acknowledged commenting to Resident A that "we are not going to do this tomorrow." Ms. Burton reported only providing Resident A with assistance in getting up from the couch and with assistance to the stairs, but the *Assessment Plan for AFC Residents* for Resident A documented that Resident A doesn't need any assistance walking or being ambulatory. As such, there is enough evidence that direct care staff Jasmin Burton used unnecessary physical force to pull Resident A's head back with the use of the hood of Resident A's clothing, grabbed Resident A by her wrist and pulled her from a seated position on a couch, moved Resident A by physical force to a set of stairs in this facility where she physically attempted to push Resident A down the stairs, and made several verbally

	threatening comments to Resident A before and after Ms. Burton's use of physical force.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 02/01/2023, direct care staff Andrea Reese clarified the day before the incident, on 01/18/2023, she had heard Ms. Burton describe how she had thrown Resident A on the couch earlier in the shift and grabbed Resident A by the hood of her sweatshirt and told Resident A, "Do you not like this? Chill out then." Ms. Reese reported that she had completed an *Incident Report* on 01/18/2023 regarding aggressive behavior displayed by Resident A and Resident D but did not include in this incident report the comments made by Ms. Burton. Ms. Reese denied completing any type of report related to Ms. Burton's comments but clarified that she had made a verbal report to direct care staff Andrea Jackson, home manager for this facility on 01/20/2023.

On 02/03/2023, I reviewed reporting requirements with licensee designee Kim Howard. Ms. Howard acknowledged that reporting requirements for suspected abuse or neglect were expected to be reported immediately by direct care staff.

On 02/03/2023, I reviewed the allegations with Allegan County Recipient Rights Director Kelsey Newsome. Ms. Newsome confirmed that reporting requirements stipulated by their contract with this facility included meeting mandatory reporting requirements and identified these requirements as reporting suspected abuse or neglect immediately.

APPLICABLE RULE	
R 400.14207	**Required personnel policies.**
	(1) A licensee shall have written policies and procedures that include all of the following: **(a) Mandatory reporting, including reporting that is required by law.**
ANALYSIS:	During an interview, direct care staff Andrea Reese acknowledged being informed by direct care staff Jasmine Burton that Ms. Burton had disclosed throwing Resident A on the couch and grabbing Resident A by the hood of her clothing on 01/18/2023, but Ms. Reese did not report this information or complete mandatory reporting requirements until 01/20/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

03/02/2023

Eli DeLeon — Date
Licensing Consultant

Approved By:

03/14/2023

Dawn N. Timm — Date
Area Manager