GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 9, 2024

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

RE: License #: AS140393268
Investigation #: 2024A1030009
Beacon Home At Red Mill

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.

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
Unit 13, 7th Floor
350 Ottawa, N.W.
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 #:	AS140393268
Investigation #:	2024A1030009
Complaint Receipt Date:	12/12/2023
Investigation Initiation Date:	12/12/2023
Report Due Date:	02/10/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator/ Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At Red Mill
Facility Address:	51721 Red Mill Road Dowagiac, MI 49047
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/15/2018
License Status:	REGULAR
Effective Date:	04/13/2023
Expiration Date:	04/12/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was put in a head lock by staff during a physical intervention incident.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/12/2023	Special Investigation Intake 2024A1030009
12/12/2023	APS Referral
12/12/2023	Special Investigation Initiated - Telephone Interview with complainant
12/14/2023	Contact - Face to Face Interview with Resident A
12/14/2023	Contact - Document Received Documents received and reviewed
12/15/2023	Contact - Face to Face Interview with Tony Giancaspro
12/15/2023	Contact - Face to Face Interview with Dorothy Artist
12/15/2023	Contact - Document Received Documents received and reviewed
12/20/2023	Contact - Face to Face Interview with Kentravous Boatright
12/21/2023	Contact - Telephone call made Interview with Kimberly Howard by phone
12/21/2023	Contact - Document Received Document received and reviewed
01/05/2024	Contact - Telephone call made

	Interview with Toby Ward
01/05/2024	Exit Conference Exit conference by phone

ALLEGATION:

Resident A was put in a head lock by staff during a physical intervention incident.

INVESTIGATION:

On 12/12/23, I interviewed the complainant by phone. The complainant reported the incident occurred on 12/1/23 and that Resident A was upset and went outside. The complainant reported that direct care staff member (DCSM) Kentravous Boatright "put him in a headlock." The complainant reported that Mr. Boatright was suspended pending the investigation and the incident was witnessed by one other DCSM.

On 12/14/23, I interviewed Resident A via Microsoft Teams. Also present in the interview with ORR staff member Suzie Suchyta. Resident A is cognitively impaired and has communication deficits but was able to answer direct questions. Resident A reported DCSM Kentravous Boatright "KT" put his arm around his neck. Resident A reported this occurred outside of the home. Resident A reported DCSM Dorothy Artist "Dorothy" was also working and witnessed the incident. Resident A reported he has not seen 'KT" since the incident occurred.

On 12/14/23, I received and reviewed an Incident Report (IR) dated 12/1/23 authored by Mr. Boatright. The IR indicated Resident A became angry with DCSM when they prompted him to go to another room as the conversation, he was having over the phone was loud and disruptive to the other residents. The IR indicated Resident A then began cursing at the DCSM and went outside while and the staff followed him outside the home. While outside of the home Resident A continued to curse at the two DCSM who had followed him outside and Resident A then began pushing one of the DCSM and hitting him in the face. The DCSM then "detained" Resident A while he continued to be assaultive. Ms. Artist then tried to assist Mr. Boatwright and calm Resident A down as Mr. Boatwright and Resident A were separated. DCSM then called law enforcement and the home manager about the situation and Resident A began to calm down and eventually apologized to the staff.

On 12/14/23, I received and reviewed an *Emergency Use of Physical Intervention Reported* (EUPIR) dated 12/1/23 authored by Mr. Boatright. The EUPIR indicated physical intervention was used in the form of "one arm support/restraint while standing and side hug support/restraint while standing."

On 12/15/23, I interviewed home manager Tony Giancaspro via Teams. Also present was ORR investigator Suzie Suchyta. Mr. Giancaspro reported the incident actually occurred on 11/27/23 however the IR indicted the date it occurred was 12/1/23. Mr. Giancaspro reported he is unsure why the IR was not dated for the correct date. Mr. Giancaspro reported he was informed about the incident on 11/30/23 when he had a meet with Resident A and his case manager. Mr. Giancaspro reported Mr. Boatright completed the IR and sent it to the Office of Recipient Rights (ORR) on 12/5/23. Mr. Giancaspro indicated Mr. Boatright and was suspended on 12/7/23 due to concerns that he "detained" Resident A which is not an acceptable form of physical management. Mr. Giancaspro reported Ms. Arist was also written up because she failed to document the incident appropriately.

On 12/15/23, I interviewed DCSM Dorothy Artist via Teams. Also present was ORR Investigator Suzie Suchyta. Ms. Artist reported she has worked at the home for two and a half years. Ms. Artist reported that on the day in question (11/27/23) she was working with Mr. Boatright, and he was having a problem with his car as he had a flat tire. Ms. Artist reported Mr. Boatright was unable to find anyone to help him with his tire so she called her mother to provide some help. Ms. Artist reported her mother came to the home but did not get out of her car and instead Mr. Boatright went outside and got some tools from her to get his tire changed. Ms. Artist reported that while Mr. Boatright was outside she was inside with the residents. Ms. Artist reported Resident A was on the phone yelling at his girlfriend and was asked to end his conversation or move to another location as not to disrupt the other residents while they were eating dinner.

Ms. Artist reported Resident A got angry and went outside. Ms. Artist reported she followed him outside because her mother was outside with Mr. Boatright. Ms. Artist reported Mr. Boatright then got the tools from her mother and she asked her mother to leave the home. Ms. Artist reported Resident A went to the side of the home and Mr. Boatright followed him however she was unable to see what was happening. Ms. Artist reported she heard yelling coming from the side of the home where Resident A and Mr. Boatright were and she went to see what was going on. Ms. Artist reported when she came around the corner Mr. Boatright had Resident A in some kind of a hold and was behind him as they were both on the ground. Ms. Artist reported Resident A "broke away" from Mr. Boatright and punched him in the face several times. Ms. Artist reported Mr. Boatright walked away from Resident A when she came around the corner and asked her to call the police. Ms. Artist reported she noted Mr. Boatright had a swollen nose. Ms. Artist reported she called 911 while Mr. Boatright called the assistant home manager, Arquilla Lewis.

Ms. Artist was asked to provide more detail the type of hold Mr. Boatright had on Resident A when she came around the corner of the home. Ms. Artist reported "it looked like a choke hold but she was unsure because it was dark." Ms. Artist reported the incident occurred between 6:30pm and 7:00pm. Ms. Artist reported Mr. Boatright completed the IR and the EUPIR however could not explain why the date was incorrect or why it was not completed within 24 hours as is the requirement.

On 12/15/23, I received and reviewed Resident A's Behavior Support Plan (BSP) dated 10/5/23. Resident A's BMP indicated Resident A has a history of "impulsivity and unpredictable and explosive behaviors." The BMP also indicated that Resident A has "freedom of movement throughout his home and grounds without staff monitoring him."

On 12/15/23, I received and reviewed a miscellaneous note authored by Mr. Boatright dated 11/27/23. The note was almost identical to the IR also authored by Mr. Boatright.

On 12/20/23, I interviewed Kentravous Boatright via Teams. Also present was ORR investigator, Suzue Suchyta. Mr. Boatright reported he was working on 11/27/23 with DCSM Dorothy Artist. Mr. Boatright reported he was having some car problems as his car had a flat tire and had been "stuck" at the home for a few days. Mr. Boatright reported Resident A was talking on his phone during dinner time and was being loud and disruptive to the other residents and was asked to end his conversation or go to another location. Mr. Boatright reported Resident A "blew up" and stormed out of the home. Mr. Boatright reported he followed Resident A asking him to calm down. Mr. Boatright reported Ms. Artist was outside of the home at the time when Resident A went outside. Mr. Boatright reported Resident A went to the side of the home and Ms. Artist went to check on the other residents inside of the home. Mr. Boatright reported he went to the side of the home where Resident A went and continued to try and verbally de-escalate him.

Mr. Boatright reported he was n Reearsident A and he "took a swing" at Mr. Boatright. Mr. Boatright reported he increased the distance between himself and Resident A and then continued to try verbally redirect him. Mr. Boatright reported he again moved closer to Resident A and Resident tried to punch and kick him. Mr. Boatright reported he blocked the punch and used CPI to "detain" Resident A. Mr. Boatright provided more detail about the detainment of Resident A and indicated he used a "modified" form of CPI as he has other types of training (military) and trapped Resident A's right arm between his forearm and bicep and went behind Resident A while using his weight to bring Resident A to the ground. Mr. Boatright reported Resident A's left arm was free and he was punched several times in the face. Mr. Boatright reported Ms. Artist came back around to the side of the home and yelled at Resident A to "stop." Mr. Boatright reported his arm was around Resident A's neck for a short time but would not call it a "headlock." Mr. Boatright reported after he heard Ms. Artist yell at Resident A and he was able to release his hold on Resident A and got back to his feet. Mr. Boatright reported Ms. Artist then took Resident A for a walk so he could calm down. Mr. Boatright reported he called the assistant home manger and Ms. Artist called law enforcement.

Regarding his documentation of the situation, Mr. Boatright reported he tried to complete an IR however the home's computer system was not working so he completed the miscellaneous note on 11/27/23 and completed an IR two days later. I remined Mr. Boatright that the IR was dated 12/1/23 and signed on 12/5/23. Mr. Boatright was unable to explain why he did not document the date accurately on the IR but did confirm the incident occurred on 11/27/23. Regarding the EUPIR, Mr. Boatright documented he

used “one arm support/restraint while standing and side hug support/restraint while standing” which was not accurate according to his account of what occurred. Mr. Boatright agreed and indicated he chose the option that was closest to what happened. It should be noted that the EUPIR form provides a section called “other” to document physical intervention used which could have been used in this situation.

Mr. Boatright reported he has been trained on how to implement Resident A’s BSP and that he is aware that Resident A has “freedom of movement throughout his home and grounds without staff monitoring him.” Mr. Boatright reported he did not follow Resident A’s BSP because he was trying to “coach him out of the behaviors” and “talk to him personally.” Mr. Boatright reported he was also concerned for Resident A because it was “cold outside” and wanted him to calm down so he could go back inside the home. Mr. Boatright reported that things could have “possibly ended differently” if he implemented Resident A’s BSP.

On 1/5/24, I interviewed Resident A’s case manager, Toby Ward by phone. Mr. Ward reported he is aware of the investigation and is also concerned about the incident with Resident A and Mr. Boatright. Mr. Ward reported the incident occurred on 11/27/23 and he was not informed of it until 11/30/23 during a routine home visit and meeting with Resident A and the home manager. Mr. Ward reported he should have received a phone call followed by a written IR and EUPIR due to the use of physical intervention. Mr. Ward reported he received the IR on 12/5/23 and never received the EUPIR. Mr. Ward reported the legal guardian was made aware of the situation and he is working with her to try and move Resident A to a new home.

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:	It was alleged Resident A was put in a head lock by staff during a physical intervention incident. Based on interviews and review of documents this violation will be established. On 11/27/23, Resident A became angry with Direct Care Staff Member, Dorothy Artist and went outside. Direct Care Staff Member Kentravous Boatright followed Resident A and while trying to verbally deescalate him, initiated a physical intervention. During the physical intervention, Mr. Boatright ended up behind him with his arm around his neck and Resident A's right arm pinned between his forearm and bicep while he used his weight to bring Resident A to the ground. Although Mr. Boatright denied referring to his technique as a headlock, he did have his arm around his neck to gain control of Resident A. In addition, Resident A and Ms. Artist reported Mr. Boatright had Resident A in a headlock.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/21/23, I interviewed district director Kimberly Howard by phone. Ms. Howard reported all staff are trained to use “CPI” and are not permitted to use any other formal or informal training to physically manage residents that are having behavioral problems.

On 12/21/23, I received and reviewed Kentravous Boatright’s most current CPI Non-Violent Crisis Intervention training record ad noted he successfully completed the training on 4/4/23.

Mr. Boatright reported to being trained on Resident A’s Behavior Management Plan (BMP) and admitted that if he had followed the plan things could have “possibly ended differently.” Mr. Boatright also reported he used a “modified form” of CPI and that he “detained” Resident A during the physical intervention.

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare, and rights of the resident are adequately protected. If a specialized intervention is needed to address the

	unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	During the investigation I reviewed Resident A's Behavior Management Plan which permits him to have freedom of movement inside and outside of the home without being monitored by staff. By all accounts Resident A was upset but did not pose a danger to himself or anyone else while outside of the home. Mr. Boatright admitted to not following Resident A's BMP and continued to engage him unnecessarily thereby increasing Resident A's stress level. Mr. Boatright also admitted to using a modified form of CPI which is not approved in Resident A's BMP.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

An Incident Reported (IR) was authored by Kentravous Boatright on 12/5/23 and sent to the Office of Recipient Rights on 12/6/23 of an incident of hostility that resulted in physical intervention by Mr. Boatright. The IR indicated the incident occurred on 12/1/23. While conducting interviews related to this incident it was discovered the incident actually occurred on 11/27/23 and the home did not make attempts to contact Resident A's case manager or the adult foster care licensing division within 48 hours of the incident.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency and the adult foster care licensing division within 48 hours of the following : **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility**

ANALYSIS:	During the investigation I reviewed an Incident Report (IR) and an Emergency Use of Physical Intervention Reported (EUPIR) related to an incident involving a physical intervention with Mr. Boatright and Resident A. Both documents reported the incident occurred on 12/1/23 however the documents were not submitted until 12/5/23. While interviewing the home manager it was discovered the incident occurred on 11/27/23 and not on 12/1/23. Both staff members present confirmed the incident occurred on 11/27/23 however they were unable to explain why the IR and EUPIR did not accurately reflect the date of the incident or why Resident A's designated representative and the adult licensing foster care division was not informed within 48 hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/5/24, I shared the findings of my investigation with licensee Nichole VanNiman by phone. Ms. VanNiman acknowledged my findings and agreed to submit a corrective action plan.

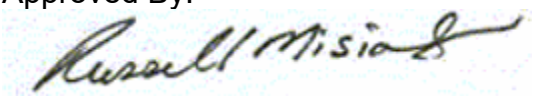
IV. RECOMMENDATION

Based on the submission of an approved corrective action plan, I recommend no change in the current license status.

1/11/24

Nile Khabeiry Date
Licensing Consultant

Approved By:



1/11/24

Russell B. Misiak Date
Area Manager