GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 24, 2024

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

RE: License #: AS370413382
Investigation #: 2024A1029015
Beacon Home At Nottawa

Dear Roxanne Goldammer:

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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

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 #:	AS370413382
Investigation #:	2024A1029015
Complaint Receipt Date:	11/29/2023
Investigation Initiation Date:	11/29/2023
Report Due Date:	01/28/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St., Suite 110, Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home At Nottawa
Facility Address:	7302 S Nottawa Rd, Mount Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/14/2022
License Status:	REGULAR
Effective Date:	05/14/2023
Expiration Date:	05/13/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On November 25, 2023, direct care staff member Ms. Gammage hit Resident A on the hand because he wanted to get his coffee cup from the dishwasher and then later told everyone that Resident A hit her and broke her nail.	No
Direct care staff member Ms. Gammage is disrespectful to the residents because she will yell, swear, and intimidate them which causes more behavioral concerns when she is working.	Yes

III. METHODOLOGY

11/29/2023	Special Investigation Intake 2024A1029015
11/29/2023	Special Investigation Initiated – Telephone call to direct care staff member Eva Haack
11/30/2023	APS Referral made to Centralized Intake.
11/30/2023	Contact - Telephone call made to Sarah Watson ORR
12/19/2023	Inspection completed on-site - Contact - Face to Face with direct care staff members Joyce Human, Lauren Lora, Resident A, Resident B at Beacon Home at Nottawa
01/02/2024	Contact - Document Sent - Emails to Sarah Watson ORR
01/09/2024	Contact - Telephone call received from Resident B
01/09/2024	Contact - Document Sent to Marlo Derry and Roxanne Goldammer
01/10/2024	Contact – Telephone call to Roxanne Goldammer, Naomi Vorhees, Email sent to Marlo Derry.
01/11/2024	Contact – Telephone call to Beacon Specialized Living RN Chasidy Campbell, direct care staff member Veronica Gammage, email to Isabella County Sherrif Department Detective Fall. Received and reviewed Police Report.
01/17/2024	Exit conference with licensee designee Roxanne Goldammer

ALLEGATION: On November 25, 2023, direct care staff member Ms. Gammage hit Resident A on the hand because he wanted to get his coffee cup from the dishwasher and then later told everyone that Resident A hit her and broke her nail.

INVESTIGATION:

On November 29, 2023 a complaint was received with concerns direct care staff member Veronica Gammage hit Resident A on the hand because he wanted to get his coffee cup from the dishwasher but told everyone that Resident A hit her and broke her nail.

On November 29, 2023, I interviewed direct care staff member Eva Haack who reported concerns regarding the way Ms. Gammage treats the residents at Beacon Home at Nottawa. Ms. Haack stated direct care staff member Ms. Gammage hit Resident A on November 25, 2023 but she did not witness the incident. Ms. Haack stated Resident A reported the concerns to Beacon Specialized Living RN Chasidy Campbell and Naomi Vorhees. Ms. Haack stated Resident A also informed her he wanted to get into the dishwasher to get his coffee cup but Ms. Gammage did not want him to and he called her a “bitch” and Ms. Gammage slapped his hand away from it. Ms. Haack stated Ms. Gammage told her Resident A hit her and broke her nail.

On November 30, 2023, I interviewed Community Mental Health Office of Recipient Rights (ORR) advisor, Sarah Watson. Ms. Watson stated she spoke with Resident A and he stated she slapped him hard enough that one of her nails broke. Resident A informed Ms. Watson when she slapped him it hurt and it made her nail break. Ms. Watson stated she checked Resident A and he did not have any injuries.

On December 19, 2023, I completed an unannounced on-site investigation at Beacon Home at Nottawa and interviewed direct care staff members Lauren Lora and Joyce Human. Ms. Lora stated Ms. Gammage is no longer an employee at Beacon Home at Nottawa. Ms. Human stated she was working when Resident A informed her Ms. Gammage smacked his hand away while she was in the living room with another resident. Ms. Human stated she was informed by Resident A that he opened the dishwasher and Ms. Gammage smacked his hand away from it because she did not want him to open it. Ms. Human stated there were no other residents or direct care staff members in the kitchen when this incident occurred. Ms. Human stated she has never observed Ms. Gammage to physically harm a resident in the past.

On December 19, 2023, I interviewed Resident A. Resident A stated he was trying to get something out of the dishwasher around Thanksgiving and Ms. Gammage did not want him to so she slapped his hand away. Resident A stated he moved his hand away but she scratched the top of his hand with her nail and then yelled at him for breaking her nail. Resident A stated Ms. Gammage told people he hit her instead but he stated

he would not hit a female and he denied hitting her. Resident A stated he did not call Recipient Rights when this occurred but he did tell another Ms. Vorhees and RN Campbell. Resident A stated after Ms. Gammage hit him she told him it was her job to do the dishes and he did not need to be in there. Resident A stated this was the only time she has hit him. Resident A stated he, "knows I am not innocent" because he will sometimes cuss out the staff but he would never physically harm them. Resident A showed me a small round mark on the top of his left hand where he said the scratch was from her hitting him.

On December 19, 2023, I interviewed Resident C who stated he was not there for the incident but Resident A informed him Ms. Gammage hit him on two separate occasions within a couple weeks of each other. Resident C stated he has never observed Ms. Gammage physically harming any of the residents.

On January 10, 2024, I interviewed direct care staff member whose role is home manager, Naomi Vorhees. Ms. Vorhees stated Resident A informed her the dishwasher was running and Resident A went to grab something out of the dishwasher and Ms. Gammage did not want him in there so she slapped his hand away. Ms. Vorhees stated she did not see any marks on Resident A after this incident and she was not working when this occurred. Ms. Vorhees stated after this incident the incident was discussed with Ms. Gammage and she stated she did not hit or slap Resident A, but "maybe pushed his hand away."

On January 11, 2024, I interviewed former direct care staff member Veronica Gammage. Ms. Gammage stated she was the one who was hit in the kitchen. Ms. Gammage stated Resident A opened the dishwasher while it was still running and she told him the dishes were dirty and she did not want him to drink out of a cup that was still dirty. Ms. Gammage stated Resident A turned around, started yelling at her, then he walked over to the sink and swiped at her hand. Ms. Gammage stated the friction between the dishwasher and the counter broke her nail making it bleed so she told him "do not hit me" and he started yelling that he did not hit her and he was not a "woman beater." Ms. Gammage stated she talked to Resident A afterward and she thought it was resolved however she has been questioned by Recipient Rights and law enforcement regarding the concerns. Ms. Gammage stated Resident A has never physically harmed her before but he makes threats. Ms. Gammage stated she did not put her hand toward him or try to push Resident A's hand out of the way.

On January 11, 2024, I received an email from RN Chasidy Campbell who stated she was informed by Resident A four days after the incident. RN Campbell stated she documented the following nursing note regarding the incident:

> *"When I came into the home this morning, [Resident A] was in a good mood sitting at the table. [Resident A] informed me that one of the staff that is a dayshift employee has the day off today and he was excited about this and that he does not like her. He stated that she is mean and bossy. [Resident A] stated that she slapped this resident's hand when he was getting coffee and then when Naomi was informed they state*

she turned the story around and made it to be the residents fault. I emailed the home manager regarding this as I was told that a resident rights violation was reported."

On January 11, 2024, I received an email from Detective Sergeant Douglas Fall with the police report stating the investigation was complete and they would be forwarding the concerns to the Prosecutors Office for review. I reviewed the police report written by Officer Moeggenborg from the Isabella County Sherrif Office. Officer Moeggenborg reported the following account of his interview with Resident A:

"[Resident A] stated that he had been getting a cup from the dishwasher to get himself a drink of water when Veronica came up and hit his hand and closed the dishwasher. [Resident A] stated it did hurt and that there had been a bruise but did not need to seek medical attention. [Resident A] stated he wanted to press charges.

Interview with Ms. Gammage:

I made contact with Veronica via telephone. Veronica stated that from her time of hire she had been having issues with the residents not respecting her and ignoring whatever she had to say to them. She believes this is due to another staff member, Lauren, telling residents that they did not have to pay attention to what Veronica had to say and do not do what Veronica was instructing them to do. On the incident in question Veronica stated that [Resident A] was attempting to get a cup from the dishwasher while Veronica was helping another resident across the kitchen. Veronica told [Resident A] that the dishes were dirty and the dishwasher was running to which he responded by yelling at Veronica and calling her a "cunt". [Resident A] then retrieved a glass and was rinsing it out at the sink when Veronica went over to shut the dishwasher and restart it so there would be clean dishes for lunch. Veronica states [Resident A] came over and "swiped" her hand hard enough that it broke her nail off and drew a little blood. He then proceeded to yell and cuss at Veronica before walking away."

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.**

ANALYSIS:	Based on interviews with direct care staff member Ms. Haack, Ms. Lora, and Ms. Vorhees there was not enough corroborating evidence to determine if Ms. Gammage harmed Resident A while he was in the kitchen. There were no other residents or direct care staff members in the room to witness whether Ms. Gammage hit Resident A's hand while he was trying to get a coffee cup out of the dishwasher nor was there any injury to Resident A. Ms. Vorhees stated Ms. Gammage described it to her as "pushing his hand away." Resident A reported both to Officer Moeggenborg, RN Campbell, and I that he did not hit Ms. Gammage but she did hit him on the hand because he did not want her to get a coffee cup out of the running dishwasher.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Ms. Gammage is disrespectful to the residents because she will yell, swear, and intimidate them which will cause more behavioral concerns when she is working.

INVESTIGATION:

On November 29, 2023 a complaint was received with concern that direct care staff member Ms. Gammage treats the residents in a disrespectful manner by swearing at them and being rude to them. According to the allegations, Ms. Gammage is rude to all the residents but primarily targets Resident A and Resident D.

On November 29, 2023, I interviewed direct care staff member Ms. Haack who reported concerns regarding the way Ms. Gammage treats the residents at Beacon Home at Nottawa. Ms. Haack stated Ms. Gammage enjoys writing reports so she will provoke behaviors the residents because she enjoys writing the *AFC Incident / Accident Reports*. Resident B does not require one on one staffing coverage and Ms. Gammage will stand in the door making rude comments to provoke him until he has a behavior and then she will write it up. Ms. Haack stated Ms. Gammage mostly targets Resident A and Resident D because she will say statements like, "are you smoking in your fucking room?" or "get up and take your fucking meds." Ms. Haack stated there are more behavioral concerns from the residents on days Ms. Gammage is working.

On November 30, 2023, I interviewed Community Mental Health Office of Recipient Rights (ORR) advisor, Ms. Watson. Ms. Watson stated Resident E informed her that Ms. Gammage is "the wicked witch of the west" and informed her he had corrected her for her behavior and one of the things she is doing to him is to wake him up all night long so he cannot sleep throughout the night and Ms. Gammage has also called him "stupid and dumb ass."

On November 30, 2023, I interviewed licensee designee Ms. Goldammer. Ms. Goldammer stated Ms. Gammage is no longer an employee there due to an unrelated

issue. Ms. Goldammer stated the residents did not like Ms. Gammage because she had a “different personality” that was difficult to bond with. Ms. Goldammer stated, “she didn’t mesh” well with the residents or the direct care staff members. Ms. Goldammer stated she has never observed Ms. Gammage swearing at the residents or physically harming the residents or she would have been terminated before then.

On December 19, 2023, I completed an unannounced on-site investigation at Beacon Home at Nottawa and interviewed direct care staff member Ms. Lora. Ms. Lora stated she would describe Ms. Gammage as “snooty, mean, and only worked here about a month.” Ms. Lora stated Ms. Gammage had a bad attitude toward both Resident A and Resident D. Ms. Lora stated she has never heard Ms. Gammage swear at the residents but she had a lot of “smart remarks.” Ms. Lora stated no one was able to get along with her and the residents did have more behaviors when she was working. Ms. Lora stated she would often make negative comments and pick on Resident A until he was mad at her. Ms. Lora stated Ms. Gammage would constantly correct Resident A until he was upset with her.

On December 19, 2023, I interviewed direct care staff member Ms. Human. Ms. Human stated she has worked with Ms. Gammage on several occasions and she feels that Ms. Gammage would “set off the residents” with her disrespectful attitude toward them. Ms. Human stated Resident B has punched holes in the walls in the past due to being upset with Ms. Gammage and she noticed Resident A and Resident B would have increased behaviors when she was working. Ms. Human stated she did not know if Ms. Gammage swore at the residents but would often swear around them making statements such as, “You can’t fucking do that.”

On December 19, 2023, I interviewed Resident A. Resident A stated Ms. Gammage was “not right for the job” because all she did was yell at the residents. Resident A stated she was mostly mean to Resident B and himself because she would stand by the door and wait for him to do or say something wrong and then have an attitude with Resident B. Resident A stated she would often cuss in front of them at and them telling them what they could or could not do. Resident A stated he feels safer now that Ms. Gammage is no longer an employee at Beacon Home at Nottawa.

On December 19, 2023, I interviewed Resident C. Resident C stated he could tell within the first two nights with Ms. Gammage worked that she clashed with the staff and he observed “cattiness and drama with her.” Resident C stated she blamed her actions on her autism diagnosis but he did not believe that was the case. Resident C described Ms. Gammage as being “arrogant and verbally demanding of the residents because she would harass and belittle them.” Resident C stated Ms. Gammage swore often while she was working, but he does not remember what she said because “he also swears a lot and it's just another word.” Resident C stated he did not feel comfortable or safe while Ms. Gammage was working.

On January 10, 2024, I called direct care staff member whose role is home manager, Naomi Vorhees. Ms. Vorhees stated Ms. Gammage was “very black and white” and

she explained to her several times there was a lot of gray areas working with residents at Beacon Home at Nottawa but Ms. Gammage continued to have a hard time relating to the residents. Ms. Vorhees stated Ms. Gammage told her she knew she was not able to change her ways. Ms. Vorhees stated she was "very short with the residents" with how she talked with them when she was around.

On January 11, 2024, I interviewed former direct care staff member Ms. Gammage. Ms. Gammage stated on a daily basis she worked each day Resident A would tell her that he hated her and he was going to "get her ass fired" and would blame anything that went wrong on her. Ms. Gammage stated she did not talk to the residents in a disrespectful manner but stated she was firm with them. Ms. Gammage stated she never swore at the residents or gave them orders that would be considered threatening or disrespectful. Ms. Gammage stated Resident A would yell at her often and tell her she was a liar. Ms. Gammage stated Resident A targeted her more than others. Ms. Gammage stated she has never spoken to any of the residents in this manner. Ms. Gammage stated she only worked there for three weeks and there was a direct care staff member who "had it out for her" since she started who would train her incorrectly, talk about residents behind her back, and try to turn people against her.

On January 11, 2024, I received an email from RN Chasidy Campbell who sent the following nursing note.

> *"[Resident A] along with another resident state that she stands in front of them and they feel she (Ms. Gammage) is intimidating them when she stares at them while standing in their doorways. What started this conversation this morning was that she was not working today and they were all talking with each other about how they were excited that she was not going to be there today. 4 of the 5 residents were involved in this conversation this morning all stating the same things."*

APPLICABLE RULE	
R 400.14308	**Resident rights; licensee responsibilities.**
	Rule 304. (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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	Based on the interviews with Ms. Lora, Ms. Human, Resident A, and Resident C, direct care staff member Ms. Gammage did not treat the residents with respect and dignity while she was employed at Beacon Home at Nottawa. Resident C described Ms. Gammage as being "arrogant and verbally demanding of the residents because she would harass and belittle them." Resident A and Resident C both stated Ms. Gammage yelled often and used swear words and both felt safer living at Beacon Home at Nottawa because she was no longer employed there.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning _____01/17/2024_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 01/24/2024

_____

Dawn N. Timm Date
Area Manager