GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 4, 2024

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

RE: License #: AL800278708
Investigation #: 2024A1031011
Beacon Home at Wave Crest

Dear Licensee Designee:

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,

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503+

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

I. IDENTIFYING INFORMATION

License #:	AL800278708
Investigation #:	2024A1031011
Complaint Receipt Date:	12/06/2023
Investigation Initiation Date:	12/06/2023
Report Due Date:	02/04/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Israel Baker
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Wave Crest
Facility Address:	28840 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	03/21/2006
License Status:	REGULAR
Effective Date:	04/25/2023
Expiration Date:	04/24/2025
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff slapped Resident A in the face.	Yes

III. METHODOLOGY

12/06/2023	Special Investigation Intake 2024A1031011
12/06/2023	Special Investigation Initiated - Letter Documents requested.
01/04/2024	Inspection Completed On-site
01/04/2024	Contact - Face to Face Interview with Resident A, Cassandra Cruz, and Kristine McPike.
01/08/2024	Contact – Documents Requested, Received, and Reviewed.
01/11/2024	Contact - Voicemail left with Brooklyn Rybarcyk and Ashley Williams.
01/17/2024	Contact - Voicemail left with Brooklyn Rybarcyk and Ashley Williams.
01/22/2024	Contact - Voicemail left with Brooklyn Rybarcyk and Ashley Williams.
01/30/2024	Contact - Telephone Interview with Ashley Williams.
01/30/2024	Contact – Telephone Interview with Brooklyn Rybarcyk and Israel Baker.
01/30/2024	Exit Conference held with Nichole VanNiman.

ALLEGATION:

Staff slapped Resident A in the face.

INVESTIGATION:

On 12/6/23, I received an incident report via email from Israel Baker dated 12/6/23. The report read Resident A reported he was slapped on the cheek by direct care worker (DCW) Brooklyn Rybarcyk.

On 1/4/24, I interviewed DCW Cassandra Cruz and Kristine McPike in the home. They reported they did not have any information pertaining to the allegations.

On 1/4/24, I interviewed Resident A in the home. Resident A reported he got into an argument with another resident and DCW Brooklyn Rybarcyk intervened. Resident A reported Ms. Rybarcyk slapped him in the face when she went to grab his arm.

On 1/8/24, I requested a police report from Van Buren Sherriff's Department. The report read the police responded to the home for an alleged assault. Resident A reported to the officer that he was slapped by Ms. Rybarcyk. DCW Ashley Williams was interviewed by the police officer and reported she did observe Ms. Rybarcyk smack Resident A after Resident A tried to bite her. Ms. Rybarcyk reported to the officer that she may have accidently scratched Resident A on the face when she intervened between Resident A and another resident when they were in an altercation. Ms. Rybarcyk reported to the officer that she did get into an argument with Resident A after he tried to spit on her.

On 1/30/24, I interviewed DCW Ashley Williams via telephone. Ms. Williams reported she was sitting at the table in the dining room when she heard Resident A "going off". Ms. Williams reported Ms. Rybarcyk was redirecting Resident A and then he became more escalated. Ms. Williams reported Ms. Rybarcyk did slap Resident A on the face. Ms. Williams reported Ms. Rybarcyk slapped him lightly and it appeared to be in response to Resident A trying to harm her. Ms. Williams reported she was shocked when this occurred, and Ms. Rybarcyk appeared to be shocked at her own actions.

On 1/30/24, I interviewed administrator Israel Baker via telephone. Mr. Baker reported he spoke to Ms. Rybarcyk regarding the allegations, and she denied slapping Resident A in the face.

On 1/30/24, I interviewed Ms. Rybarcyk via telephone. Ms. Rybarcyk reported Resident A and another resident got into an altercation and she intervened. Ms. Rybarcyk reported Resident A slapped her on the shoulder/arm area. Ms. Rybarcyk reported she did not slap Resident A in the face. Ms. Rybarcyk reported she did utilize CPI on Resident A due to the altercation with another resident.

On 1/30/24, I conducted an exit conference with licensee designee Nichole VanNiman. Ms. VanNiman reported she understood the reasoning for the findings and would be addressing this concern with the administrator and staff member involved.

APPLICABLE RULE	
R 400.15305	**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:	Based on interviews and the review of documentation, there is sufficient evidence to support that Resident A was not treated with dignity by staff. Resident A and another staff member were consistent in reporting that Resident A was slapped by staff. Staff also reported to the police that they did get into a verbal argument with Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the license remain unchanged.

1/30/24

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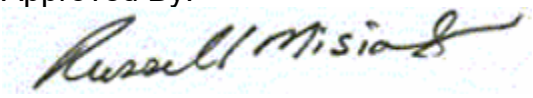
Kristy Duda
Licensing Consultant

Date

Approved By:



1/30/24

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Russell B. Misiak
Area Manager

Date