GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 8, 2024

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

RE: License #:	AS700297560
Investigation #:	2024A0356040
	Beacon Home at Trolley Center

Dear Ms. Hunter:

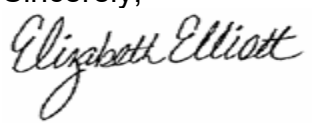
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700297560
Investigation #:	2024A0356040
Complaint Receipt Date:	06/12/2024
Investigation Initiation Date:	06/13/2024
Report Due Date:	08/11/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St. Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Suzy Hunter
Licensee Designee:	Suzy Hunter
Name of Facility:	Beacon Home at Trolley Center
Facility Address:	320 64th Ave. North Coopersville, MI 49404
Facility Telephone #:	(616) 384-3141
Original Issuance Date:	02/25/2009
License **Status:**	REGULAR
Effective Date:	08/25/2023
Expiration Date:	08/24/2025
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct Care Workers Chenan Trouillet and Katrina Hathcock pulled Resident A by her arms.	Yes

III. METHODOLOGY

06/12/2024	Special Investigation Intake 2024A0356040
06/13/2024	APS Referral
06/13/2024	Special Investigation Initiated - Telephone Briana Jackson, ORR recipient rights, Kalamazoo County CMH.
06/27/2024	Contact - Telephone call made Felisha Battice, home manager.
06/27/2024	Inspection Completed On-site
07/03/2024	Contact - Document Received IR, facility documents.
07/03/2024	Contact - Telephone call made Suzy Hunter, Licensee Designee.
07/11/2024	Contact - Telephone call made DCW's Chenan Trouilett and Katrina Hathcock.
07/15/2024	Contact - Document Received Facility doc/staff statement via text. Kalamazoo Co. ORR investigative report.
08/07/2024	Contact - Telephone call made Briana Jackson, ORR Kalamazoo County.
08/07/2024	Contact - Telephone call made DCWs Ginger West, Selina Johnson, Chenan Trouilett.
08/08/2024	Exit Conference-Licensee Designee, Suzy Hunter.

ALLEGATION: Direct Care Workers Chenan Trouillet and Katrina Hathcock pulled Resident A by her arms.

INVESTIGATION: On 06/12/2024, I received a BCAL (Bureau of Children and Adult Licensing complaint. The complainant reported facility staff, Chenan Trouillet and Katrina Hathcock grabbed Resident A by her arms and drug her to her room after Resident A threw herself to the ground at the facility.

On 06/27/2024, I conducted an unannounced inspection at the facility and interviewed home manager, Felisha Battice. Ms. Battice stated this incident occurred on April 11, 2024, at approximately 7:12p.m. Ms. Battice stated staff at the facility today are new and were not working at the facility at the time of this alleged incident, so they are unable to provide any information to support or refute the allegation. Ms. Battice stated staff, Selina Johnson reported to her (Ms. Battice) on 04/11/2024, that she, Ms. Trouillet and Ms. Hathcock were working at the facility, and Ginger West had just arrived for her shift when Resident A began to have "a behavior." Ms. Battice stated Ms. Johnson reported that Resident A began to have a behavior in the dining area of the facility and that Ms. Trouillet and Ms. Hathcock held onto Resident A's arms and dragged her to her room. Ms. Battice stated Ms. Johnson reported that Ms. West also was a witness to the incident and that Ms. West witnessed Resident A on the floor, heard someone say, "you're dragging her" and witnessed Resident A standing up, pulling her shirt down as though she had been dragged causing her shirt to slide up. Ms. Battice stated both staff are fully trained including CPI training (Crisis Prevention and Intervention) Ms. Battice stated she was not at the facility and was not a witness to the incident, but staff, Ms. Trouillet and Ms. West are on leave pending the outcome of the Kalamazoo County Office of Recipient Rights (ORR) investigation being conducted by Briana Jackson.

On 06/27/2024, Resident A was not able to provide pertinent information to this investigation due to cognitive deficiency.

On 07/03/2024, I received and reviewed the IR (incident report) written by DCW Ginger West and signed by Licensee Designee, Suzy Hunter. The IR was dated 04/11/2024, 7:12p.m. The IR documented other person(s) involved was Ms. Trouillet and Ms. Hathcock. The IR documented the following information: *'On 4/11/24 incoming staff Ginger was in the kitchen doing shift change and (Resident A) was getting up and pulling down her shirt, incoming staff told them do not drag her. Staff was able to prompt her into her room to calm down. Incoming staff then called recipient rights at 8:30am on 4/12/24. Staff involved in the allegation have been suspended pending the investigation. While in the kitchen heard (Resident A) having a behavior, during that behavior incoming staff Ginger overheard a staff say your dragging her and when staff came out.'*

On 07/03/2024, I interviewed Suzy Hunter, Licensee Designee via telephone. Ms. Hunter stated Ms. Trouillet and Ms. Hathcock had been suspended pending the

ORR investigation and that she has terminated their employment due to the substantiation by ORR of this allegation.

On 07/11/2024, I attempted to interview Ms. Hathcock and Ms. Trouillet via telephone. I left voice mail messages, but as of the date of this report, my messages were not returned.

07/15/2024, I received and reviewed a text message sent to me from Ms. Battice, written on 04/12/2024 by Ms. Hathcock that stated the following, *'All we did was bring her from banging her head in (sic) the floor anymore after I tried to redirect her after she was hitting her head on the cabinet, then she threw herself on the floor and proceeded to hit her head, so I asked Chenan to help me get her to a safe place so she grabbed one arm, and I did to and we got her to the beanbag by her room. For her own safety, we couldn't lift her up, and we didn't want her to continue to bang her head.'*

On 07/15/2024, I received and reviewed the ORR investigative findings report dated 07/02/2024 written by Briana Jackson, Recipient Rights Officer with Kalamazoo Community Mental Health. Ms. Jackson documented an IR received written by Ms. Johnson on 04/12/2024. The IR dated the incident occurrence as 04/11/2024 at 7:00p.m. The IR documented the following information, *'(Resident A) wanted a TV show on. Katrina Hathcock and Chenan Trouillet said no to the TV show, (Resident A) had a tantrum about it. (Resident A) went after one of the other residents when (Resident A) was told to let go, (Resident A) put herself on the floor. Katrina and Chenan said (Resident A) go to your room then she just sat on the floor. Katrina had one of (Resident A's) arms and Chenan had the other arm and dragged (Resident A) to her room.'*

On 07/15/2024, I reviewed Resident A's Individual Plan of Service (IPOS) dated 04/10/2023 documented, *'Staff will follow (Resident A's) behavior support plan (BSP) including 1:1 staffing, 12 hours a day. Caregivers will help (Resident A) display better anger control by way of verbal prompts, gentle teaching, hands on assistance, modifying environment, redirection. Staff will not office chips unless (Resident A) asks for them, as chips can be something that (Resident A) fixates on and can be a trigger, leading to aggression. Staff will follow proactive and reactive strategies as outlined in the BSP.'*

On 07/15/2024, I reviewed Resident A's Behavioral Support Plan (BSP) dated 11/30/2023. The BSP documented target behaviors such as, *'biting others/attempting to bite others, pinching others, property destruction, layering clothing and self-injurious behavior. The self-injurious behavior is defined as head banging against objects causing redness and/or bruising.'* The proactive strategies documented in *Resident A's BSP include, 'staff should become familiar with (Resident A's) antecedents, if staff do not respond quickly to (Resident A's) antecedents she is known to bite staff so hard that it will break the skin, pinch, hit,*

scream, throw tables, headbang which results in property destruction and potential injury to staff as well as (Resident A).'

The BSP documented, *'Reactive Strategies for Self-Injurious Behavior, (Resident A) engages in headbanging when she is upset. This behavior does not usually cause her harm however, if that area that she is hitting becomes red, the staff will place an object, pillow, or other soft item, between (Resident A) and the object for safety. Once (Resident A) begins to calm down, no longer emitting target behaviors, the staff will talk to her in a calm relaxed voice demonstrating no emotion as they speak to her. Acknowledge (Resident A's) feelings and try to understand how she is feeling. Staff should stand slightly to her side and at least arm's length plus a few inches away from her. Never corner (Resident A) and never allow yourself to be cornered by (Resident A).'* The BSP documented Resident A's enhanced staffing dated 03/09/2023 and showed (Resident A) now has *'1:1 staff during awake hours (Resident A's) awake hours are on the overnight shift which is where the extra staff was added.'* The BSP did not document any restrictions to Resident A's TV in any way.

On 08/07/2024, I interviewed Ms. Johnson via telephone. Ms. Johnson stated that she was working at the facility on 04/11/2024 when the incident occurred. Ms. Johnson stated she, Ms. Trouillet, Ms. Hathcock were working, and Ms. West had just come in to work and was in the kitchen putting things away. Ms. Johnson stated it was in between shifts and their shifts go from 7:00a.m.-7:00p.m. and 7:00p.m.-7:00a.m. so this was just after 7:00p.m. when the incident occurred. Ms. Johnson stated Resident A was in the dining room area of the facility when she began to "throw a fit." Ms. Johnson stated one of the involved staff, either Ms. Hathcock or Ms. Trouillet would not give Resident A her TV remote and that is what started the behavior. Ms. Johnson stated Resident A loves to watch her TV shows especially the Teletubbies. Ms. Johnson described Resident A as non-verbal and Ms. Hathcock or Ms. Trouillet told Resident A to go to her room. Resident A was on the bench at the table when she slid to the floor from the bench. That is when Ms. Trouillet and Ms. Hathcock took Resident A, each holding one of Resident A's arms and "dragged" her along the floor to her room. Ms. Johnson reported that Resident A was placed in her room and the door closed. Ms. Johnson stated Resident A hit the door a couple of times because she wanted to get out.

On 08/07/2024, I interviewed Ms. West via telephone. Ms. West stated she had worked at the facility for 2 years on 3rd shift and had just gotten to work for her 7:00p.m.-7:00a.m. shift at the facility on 04/11/2024 and went into the kitchen. Ms. West stated she, Ms. Trouillet, Ms. Hathcock, Ms. Johnson and Jerry Longmire were at the facility as it was shift change. Ms. West stated while in the kitchen she heard one of the staff say something like "you are dragging her" but she (Ms. West) stated she is not sure who said that and (Ms. West) saw Resident A getting up off the floor in the living room, pulling her shirt down and it appeared to Ms. West, that she had just been dragged. Ms. West stated she did not see the beginning of the incident but saw Ms. Hathcock standing next to Resident A in the living room and said "hey, you

can't drag her" to Ms. Hathcock. Ms. West stated Ms. Hathcock stated she did not think she was doing anything wrong, and she was using CPI to prevent Resident A from harming herself.

On 08/07/2024, I attempted to interview Ms. Hathcock and Ms. Trouillet via telephone and left voicemail messages. To date I have not been able to interview either former DCW.

On 08/07/2024, I reviewed Ms. Jacksons documented interviews with Ms. Hathcock and Ms. Trouillet in her ORR report. Ms. Jackson's interview with Ms. Hathcock took place on 04/24/2024, 04/25/2024 and 05/01/2024. Ms. Jackson's report documented the following information from those interviews*, 'Katrina Hathcock stated on 04/11/2024 she worked in the home from 7:00a.m.-7:00p.m. It was not a "good day" for (Resident A). The staff prior said she was up at midnight and stayed up most of the night until 4:00a.m. All day on 04/11/2024, (Resident A) wanted to watch repeated Teletubbies TV and Teletubbies is one of the shows (Resident A) obsesses over. (Resident A) did the most head banging she had ever seen her do since she started working there 7 months ago. Early in the day she was banging her head on a door. Later she tried to bite and bang staff and other residents. She bit and pinched another resident that day. (Resident A) had been in her room after lunch from 1:00p.m.-3:00p.m. with her TV on and when she came out of her room, her behavior progressed. (Resident A) was agitated because they turned on Teletubbies, but seemed it was not the episode she wanted, (Resident A) did more banging her head on the dining room walls. By the time the 7:30p.m. shift change was happening, (Resident A's) attitude was "over the top." She was banging her head in the dining room on cabinets. She did not want to go to her room and watch other shows on TV. She sat at the dining room table and (Katrina) sat on the other side of (Resident A). (Resident A) got up from the dining room table, began banging her head again on the cabinets, Katrina tried to redirect (Resident A) by tapping (Resident A) on the shoulder and asked her to stop banging her head and offered to go to her room with watch Christmas music. She held her hand and (Resident A) snatched it away, moved away from Katrina and threw herself on the dining room floor and began banging her head on the dining room floor. Katrina was worried for (Resident A's) safety and asked staff for help, Chenan (Trouillet) assisted, and they asked (Resident A) to stand up and she continued to bang her head on the floor. Katrina and Chenan used a physical technique they learned holding her under her arm and at her elbow but (Resident A) did not get off the floor. They held her arms while she used her feet to walk backwards, they gently pulled her to help her get to the bean bag (in the living room). (Resident A) would not stand for them and Katrina described that they "cat walked her backwards" and as they were getting (Resident A) on the bean bag, Ginger (West) stuck her head out of the kitchen and said, "don't drag her." Katrina responded and said she was not dragging her; she was worried about her and did not know what else to do. Katrina said she had never experienced that amount of behavior and headbanging with (Resident A) before and she was not trying to hurt (Resident A) she was trying to keep her safe but thinking back, she thinks maybe she could have gotten a pillow for (Resident A). Katrina stated they did*

*not drag (*Resident A) *but rather "gently pulled her to a safe space off the floor." They took her to a bean bag and not her room. (*Resident A*) got up off the bean bag and went into her bedroom on her own. Before Katrina left for the day, she went to (*Resident A's*) room and gave her a hug, told her it was going to be okay, and they will get through this. Katrins stated they did not see any bleeding or bruising on (*Resident A*). When the investigator (*Ms. Jackson*) asked her about the BSP mentioning the use of a pillow or other option, Katrina stated she was aware of the plan for self-injurious behavior of head banging but she "freaked out" and panicked because she had never seen (*Resident A*) act out like this before. She stated she did not use a pillow or soft object in between her and the floor and they probably should have but she was concerned about getting her to a safe place.'*

Ms. Jackson's interview with Ms. Trouillet was conducted on 04/24/2024 and 04/25/2024 and documented the following information, *'Chenan stated she worked 04/11/2024 from 7:00a.m.-7:00p.m. All day long (Resident A) was having bad moods between Teletubbies and Barney Marching Band space episodes on her TV, if she has these shows, she becomes obsessed, it amplifies her behaviors, she starts pacing, hands start shaking and obsessive when the shows are not on. Chenan stated after 4:00p.m. medications, (Resident A) started pacing in between her bedroom and the kitchen wanting the TV but every time staff would change the channel, it was not good enough for her and she was upset. Chenan stated just before the 7:30p.m. shift change, other staff Ginger (West) and Jerry (Longmire) were inside the kitchen, Salina (Johnson) was in the bathroom and (Resident A) kept coming up to Chenan while she was doing charting work. Chenan told (Resident A) something was on her TV to watch. Chenan thought other staff were handling the situation with (Resident A) and was not exactly sure what was happening. Chenan does not recall (Resident A) sitting at the dining room table, Chenan did not tell (Resident A) to go to her room. She heard Katrina tell (Resident A) not to grab at people, she heard Katrina ask (Resident A) to get up, then Katrina asked if someone could help her with (Resident A) because she was on the floor banging her head and kicking. No other staff helped but Chenan, and she helped Katrina help (Resident A) to the bean bag when she (Resident A) was on the ground in front of the kitchen doorway. (Resident A) would not stand up but had her feet on the floor, Chenan took (Resident A) by the elbow and underarm like she had been taught while (Resident A) was not fully standing but had her feet on the floor, Katrina has her other arm and they guided her to the bean bag in the living room near her bedroom. (Resident A) sat there about 30 seconds and then went to her bedroom by herself without pinching or grabbing at anyone and it was over. Chenan stated she and Katrina did the physical management after verbal redirection was tried and did not work. They said, "(Resident A) come on, let's get off the floor," they tried to help her up off the floor, but she resisted. They did not want her to hurt herself by banging her head on the floor, so they helped her to the bean bag. None of the other staff who were watching said anything to them. No one said they shouldn't do it that way until the end when Ginger said I don't think this is the way to do that. Katrina said to her, "what else you want us to do? She was banging her head on the ground." Chenan stated she and Katrina did not drag (Resident A), they did not take her to her*

bedroom, they did not tell her to go to her room and she (Chenan) did not tell her to stay in her bedroom after she went into her bedroom on her own. Chenan stated she does not force anyone to stay in their room and she did not hear or see any other staff do this. Chenan stated she was not aware the BSP mentions using a pillow or soft object during head banging. She states she may not have read that part of the BSP so did not follow this. She panicked and did not want (Resident A) to get hurt. Chenan stated they did not do anything to hurt (Resident A) and she would never do anything to harm her.'

Ms. Jackson interviewed Mr. Longmire on 04/23/2024 and documented the following information, *'Mr. Longmire stated he did not see or hear anything other than when (Resident A) was in her room, he reportedly heard one of the staff say, "we got it." Mr. Longmire reported he was in the kitchen with Ms. West at the beginning of the shift and by the time he came out of the kitchen, (Resident A) was in her bedroom. Mr. Longmire reported he did not know anything had happened and he has worked at the facility approximately three weeks at that time and had not seen any incidents occur between (Resident A) and staff that were concerning or out of the ordinary.'*

Ms. Jackson's report documented that she consulted with the CPI Trainer through Beacon (Michelle, last name unknown) on 07/21/2024 and the CPI trainer reported, *'once the individual hits the floor, staff should not have done physical management. Lifting the individual could hurt them and/or staff. CPI training does not involve picking up individuals off the floor. If there was self-injurious behavior of banging head on an object, staff should use a pillow or soft object to soften the blow.'*

On 08/08/2024, I conducted an exit conference with Licensee Designee, Suzy Hunter via telephone. Ms. Hunter stated staff involved are no longer working at the facility. Ms. Hunter stated ongoing training with staff will continue and an acceptable corrective action plan will be submitted.

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:	The complainant reported staff, Chenan Trouillet and Katrina Hathcock grabbed Resident A by her arms and dragged her to her room after Resident A threw herself to the floor. Based on investigative findings, there is a preponderance of evidence to show that on 04/11/2024, Resident A's behaviors increased, and Resident A began banging her head on the floor and cabinets in the facility. As a result, staff Ms. Trouillet and

	Ms. Hathcock performed an unapproved physical intervention that is not part of Crisis Prevention and Intervention training or Resident A's Behavioral Supports Plan. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

08/08/2024

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

08/08/2024

Jerry Hendrick — Date
Area Manager