GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 30, 2024

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

RE: License #: AS390406166
Investigation #: 2024A0581039
Beacon Home at Schoolcraft South

Dear Nichole 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.

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

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 #:** | AS390406166 |
| | |
| **Investigation #:** | 2024A0581039 |
| | |
| **Complaint Receipt Date:** | 09/19/2024 |
| | |
| **Investigation Initiation Date:** | 09/19/2024 |
| | |
| **Report Due Date:** | 11/18/2024 |
| | |
| **Licensee Name:** | Beacon Specialized Living Services, Inc. |
| | |
| **Licensee Address:** | Suite 110<br>890 N. 10th St.<br>Kalamazoo, MI 49009 |
| | |
| **Licensee Telephone #:** | (269) 427-8400 |
| | |
| **Administrator:** | Kimberly Howard |
| | |
| **Licensee Designee:** | Nichole VanNiman |
| | |
| **Name of Facility:** | Beacon Home at Schoolcraft South |
| | |
| **Facility Address:** | 10745 S. 12th Street<br>Schoolcraft, MI 49087 |
| | |
| **Facility Telephone #:** | (269) 488-7657 |
| | |
| **Original Issuance Date:** | 07/08/2021 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 01/08/2024 |
| | |
| **Expiration Date:** | 01/07/2026 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION

| | **Violation Established**? |
|---|---|
| On or around 09/06/2024, direct care staff shouted and swore at Resident A. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/19/2024 | Special Investigation Intake 2024A0581039 |
| 09/19/2024 | Referral - Recipient Rights - No referral necessary, ISK investigating. |
| 09/19/2024 | APS Referral - made via email. |
| 09/19/2024 | Special Investigation Initiated – Letter - Email with ISK, Kate Koyak. |
| 09/27/2024 | Inspection Completed On-site - Interviewed staff and residents |
| 10/16/2024 | Contact - Telephone call made - Attempted contact with direct care staff, Amber Patton. Left voicemail. |
| 10/16/2024 | Contact - Telephone call made - Attempted contact with Seth Brunn. Left voicemail. |
| 10/16/2024 | Contact - Telephone call received - Interview with Mr. Brunn. |
| 10/16/2024 | Inspection Completed-BCAL Sub. Compliance |
| 10/17/2024 | Contact – Telephone call made – Attempted contact with Ms. Patton. Left voicemail. |
| 10/17/2024 | Exit conference with the licensee designee, Nichole VanNiman. |
| 10/17/2024 | Contact – Document Received – Email from Ms. Koyak. |
| 10/17/2024 | Contact – Document Received – Email from Ms. Scott. |

**ALLEGATION: On or around 09/06/2024, direct care staff shouted and swore at Resident A.**

**INVESTIGATION:** On 09/19/2024, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on 09/06/2024, Resident A, and direct care staff, Amber Patton and Heather Bond-Davidson, got into an argument because Resident A accused Ms. Patton of making his dinner wrong. The complaint alleged Resident A called Ms. Patton a liar and Ms. Patton responded to Resident A by saying "don't call me a fucking liar".

The complaint alleged Resident A contacted 911 on 09/06/2024 and when Emergency Medical Services (EMS) arrived, another argument ensued between Resident A, Ms. Patton and Ms. Bond-Davidson over which local hospital Resident A should go to for treatment. The complaint alleged Ms. Bond-Davidson told EMS to take Resident A to Borgess Hospital versus Bronson Hospital because his primary physician was located at Borgess Hospital. The complaint further alleged when Resident A refused to go to the hospital, Ms. Patton said to Resident A, “Fuck you, you’re going”. The complaint also alleged while Ms. Patton continued to yell at Resident A, Ms. Bond-Davidson had to put her arm around Ms. Patton and pull her away from the situation. The complaint alleged another direct care staff, Seth Brunn, was present when Ms. Patton swore at Resident A. The complaint alleged both Ms. Bond-Davidson and Ms. Patton admitted to shouting and swearing at Resident A when they become frustrated with him.

On 09/19/2024, I received an email from Integrated Services of Kalamazoo (ISK) Recipient Rights Officer, Kate Koyak, which documented she interviewed Resident A, Resident B, Ms. Patton and Ms. Bond-Davidson. According to Ms. Koyak’s email, Resident A identified Ms. Bond-Davidson as the staff swearing at him; however, all three staff present for the incident, including Ms. Patton, reported Ms. Patton was the staff primarily swearing. Ms. Koyak documented in her email that Ms. Patton and Ms. Bond-Davidson reported Resident A is disrespectful and should not be allowed to talk to them in the way he does. Ms. Koyak documented Ms. Patton and Ms. Bond-Davidson indicated to her that shouting and swearing at Resident A is what Resident A deserves when he provokes them. Ms. Bond-Davidson reported to Ms. Koyak Resident A is infatuated with Ms. Patton and deliberately provokes her to get her attention and then blames Ms. Bond-Davidson for his behavior because he does not like her.

Ms. Koyak documented in her email Ms. Bond-Davidson and Ms. Patton both reported to her they struggle controlling their tempers with Resident A and often end up shouting at him. She documented they both reported swearing at him. Ms. Koyak documented Ms. Bond-Davidson “seemed to understand her behavior was wrong”; however, she documented Ms. Patton did not.

Ms. Koyak documented there were several residents present when the incident occurred; however, she documented only Resident B would speak to her regarding

the incident. She documented “[Resident B] more or less refused to say anything negative about the staff”.

On 09/27/2024, I conducted an unannounced inspection at the facility and interviewed Ms. Bond-Davidson. Ms. Bond-Davidson’s statement to me was consistent with the allegations and Ms. Koyak’s email. She stated the incident with Resident A started around 5 pm on 09/06/2024 when Resident A accused Ms. Patton of not blending all of his breakfast food into a puree. Ms. Bond-Davidson stated Ms. Patton told Resident A she did blend all his food, but he called her a liar. Ms. Bond-Davidson stated Ms. Patton said to Resident A, “Are you really calling me a fucking liar?” Ms. Bond-Davidson stated she tried separating Ms. Patton and Resident A, but they continued to bicker back and forth. Ms. Bond-Davidson stated Resident A also yelled at her accusing her of setting Ms. Patton up to yell at him because he is black.

Ms. Bond-Davidson stated after Resident A became upset, he went into his bedroom and contacted 911. She stated after EMS arrived at the facility; Resident A refused to go in the ambulance. She stated Ms. Patton told Resident A, “Great, you wasted everyone’s time” and then asked if he was proud of that. Ms. Bond-Davidson stated Ms. Patton raised her voice while speaking to Resident A, but denied she screamed at him. Ms. Bond-Davidson stated Ms. Patton often gets mad at Resident A because he lies and “makes things up”. Ms. Bond-Davidson stated Ms. Patton could have walked away from the situation and calmed down. She stated she also reminded Resident A of his coping skills. Ms. Bond-Davidson stated she may have raised her voice when she made this suggestion to Resident A, but she denied screaming or swearing at him. Ms. Bond-Davidson stated since the incident occurred, she ensures another staff is with her when she is interacting with Resident A.

I interviewed the facility’s home manager, Luann Scott, who’s statement to me was consistent with information documented in Ms. Koyak’s email; however, Ms. Scott stated she was not present when the incident occurred. Ms. Scott stated on 09/24/2024, Ms. Patton received retraining on recipient rights.

I interviewed Resident A who initially stated he “forgot” about the incident between him, Ms. Patton and Ms. Bond-Davidson, but then stated an incident occurred between him, Ms. Patton and Ms. Bond-Davidson because they did not puree all his breakfast foods. He stated Ms. Bond-Davidson “cussed” at him; however, he was unable to recall exactly what she said. Resident A denied Ms. Patton swearing at him. Resident A stated Ms. Bond-Davidson was yelling at him because she thought he was going to hurt Ms. Patton, but he denied he would have done that. Resident A denied calling 911 and denied an ambulance coming to the facility. He was unable to provide any additional information regarding what transpired between him, Ms. Patton and Ms. Bond-Davidson on 09/06/2024. He stated the incident was the first time anything like that had occurred before and he stated his interactions with Ms. Patton and Ms. Bond-Davidson had been fine ever since. He stated he feels safe in the facility and stated his food is being purred, as required.

I also interviewed Resident B who confirmed he was present when the incident between Resident A, Ms. Patton and Ms. Bond-Davidson occurred on or around 09/06/2024. Resident B stated Resident A received all his breakfast food pureed as required, but Resident A was accusing staff of not putting all his food in the blender. Resident B stated Resident A got mad and started screaming at Ms. Patton and Ms. Bond-Davidson “for no reason”. Resident B stated both Ms. Patton and Ms. Bond-Davidson tried explaining to Resident A how he all his food had been purred. Resident B stated he neither heard Resident A swearing at Ms. Patton or Ms. Bond-Davidson nor did he hear Ms. Patton or Ms. Bond-Davidson swear at Resident A. He stated both staff raised their voices, but he denied it being to the level of Resident A’s voice. Later in my interview with Resident B, he stated Resident B called Ms. Patton and Ms. Bond-Davidson both liars. He stated he heard Ms. Patton and Ms. Bond-Davidson both reply, “You’re a fucking liar”. Resident B stated eventually Ms. Patton and Ms. Bond-Davidson calmed down, but Resident A remained agitated. Resident B was unable to provide any additional information regarding the incident. Resident B stated he feels both safe in the facility and respected by staff.

On 10/16/2024, I interviewed direct care, Seth Brunn. Mr. Brunn stated on or around 09/06/2024 he arrived to work at 7 pm for the overnight shift. He stated he was the sole staff for that shift. Mr. Brunn stated upon coming into work he observed both Ms. Patton and Ms. Bond-Davidson were “irritated”. He stated he knew they were irritated based on the tones of voice and their demeanors. He stated Ms. Patton and Ms. Bond-Davidson "gave him a rundown” of their shift and reported to him Resident A exhibited “behaviors” to both; which consisted of him swearing and calling them liars.

Mr. Brunn stated upon arriving to work he recalled Resident A sitting by the facility’s medication room. Mr. Brunn stated he observed Ms. Patton go up to Resident A and ask him if he was going to the hospital or not. Mr. Brunn stated after Resident A told her yes, Ms. Patton became irritated and walked away. He stated he later observed Resident A, Ms. Patton and Ms. Bond-Davidson all go outside. He stated after he administered resident medications, he also went outside to observe Resident A, Ms. Patton, and Ms. Bond-Davidson as EMS had arrived. Mr. Brunn stated he observed Resident A and Ms. Patton arguing with one another as to what hospital Resident A should be sent to, but then Mr. Brunn stated Resident A changed his mind about even going to the hospital. Mr. Brunn stated he heard Ms. Patton tell Resident A, “You’re fucking going”; however, Mr. Brunn stated the EMS personnel told staff and Resident A they could not force Resident A to go to the hospital. Mr. Brunn stated he had no concern Ms. Patton was going to physically harm Resident A; however, he stated she was being disrespectful based on the tone of her voice, behavior, demeanor and how she was interacting with Resident A. Mr. Brunn could not recall the content of what Ms. Bond-Davidson said to Resident A during the whole interaction. Mr. Brunn stated Ms. Patton continued to yell and shout at Resident A despite Ms. Bond-Davidson pulling her away from the situation. Mr. Brunn stated he was only present for the incident from approximately 7 pm until 7:30 pm.

On 10/17/2024, I reviewed the facility's *AFC Licensing Division – Incident / Accident Report* (IR), which was completed by Mr. Brunn on 09/06/2024. According to the IR, at approximately 7 pm, Mr. Brunn arrived to work and observed Resident A outside the facility smoking a cigarette. Mr. Brunn documented Resident A came inside the facility and sat by the facility's entrance waiting for an ambulance to arrive, which Mr. Brunn documented Resident A called for prior to Mr. Brunn arriving to work. Mr. Brunn documented while Resident A was waiting for the ambulance, he refused his medications and reported to Mr. Brunn he would not be taking them for the night. The IR documented Resident A was upset because he believed he did not receive his full meal at dinner. Mr. Brunn documented in the IR Resident A was being verbally aggressive and swearing at staff. He documented once the ambulance arrived, Resident A went outside with the staff from the previous shift, identified in the IR as Ms. Patton and Ms. Bond-Davidson. The IR documented Resident A's refusal to leave in the ambulance. Mr. Brunn documented hearing Ms. Patton say, "You're fucking going" with Resident A responding, "You want to bet?". The IR documented Ms. Patton stated, "Do you want to bet[sic]". The IR documented Resident A once again became verbally aggressive with staff, but eventually went inside the facility. Mr. Brunn documented in the IR how he spoke to staff about using procedures to de-escalate behaviors from residents. He also documented the facility's home manager came in to speak with Resident A and was able to encourage him to take him evening medications. According to the IR, Ms. Patton was reminded of using proper de-escalating and acceptable ways of handling similar situations.

I also reviewed an IR completed by Ms. Patton, dated 09/06/2024. According to this IR, at approximately 1 pm, staff was in the facility's kitchen preparing dinner, which consisted of scrambled eggs, sausage, and waffles. The IR documented staff put all these items in a blender to puree for Resident A to eat. The IR documented after having his dinner, Resident A asked what he had again, and the staff reported he had what everyone else had. The IR documented Resident A began arguing with staff telling her she didn't put eggs in his blended meal. The IR documented staff continued to explain she did put eggs in his meal; however, Resident A became aggressive telling staff they did not. The IR documented staff asked Resident A to walk and stop arguing with staff, but Resident A told staff he could do whatever he wanted and said they were lying. The IR documented Resident A; despite walking away from staff, kept engaging in arguing. The IR documented Resident A contacted 911 reporting staff were trying to kick him out and requested an officer to remove both staff. The IR documented staff would be reminded on redirecting verbal aggression and using proper de-escalation techniques.

As of the date of this report, Ms. Patton, did not return any of my phone calls; therefore, I was unable to interview her for this investigation.

| APPLICABLE RULE | |
|---|---|
| **R 400.14304** | **Resident rights; licensee responsibilities.** |
| | **(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:**<br>**(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**<br>**(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.** |
| **ANALYSIS:** | Based on my investigation, which included email correspondence with Integrated Services of Kalamazoo Recipient Rights Officer, Kate Koyak, interviews with direct care staff, Heather Bond-Davidson, Seth Brunn, and Luann Scott, and interviews with Resident A and Resident B, there are multiple corroborating statements supporting the allegations Ms. Bond-Davidson and Ms. Patton engaged in disrespectful behavior towards Resident A on or around 09/06/2024. Both staff and resident statements were consistent either Ms. Patton or both Ms. Patton and Ms. Bond-Davidson swore and yelled at Resident A after he accused them of lying to him and while determining which hospital to transport him to for treatment. Consequently, when Ms. Patton and Ms. Bond-Davidson were swearing, yelling and engaging in bickering type behavior towards Resident A they were not treating him with dignity and respect, as required. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 10/17/2024, I conducted my exit conference with the licensee designee, Nichole VanNiman, via telephone. Ms. VanNiman acknowledged my findings. She stated she and the Administrator have talked to Ms. Patton and the facility's other staff about appropriately engaging with residents. She stated she's also discussed with staff the importance of decompressing after difficult incidences with residents to prevent issues like this complaint.

## IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

10/29/2024

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Cathy Cushman — Date
Licensing Consultant

Approved By:

10/30/2024

_____

Dawn N. Timm — Date
Area Manager