GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 19, 2024

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

RE: License #: AM800267886
Investigation #: 2024A1031058
Beacon Home at Anchor Point South

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
350 Ottawa, N.W. Unit 13, 7th Floor
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 #:	AM800267886
Investigation #:	2024A1031058
Complaint Receipt Date:	09/09/2024
Investigation Initiation Date:	09/10/2024
Report Due Date:	11/08/2024
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 Anchor Point South
Facility Address:	28720 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/03/2005
License Status:	REGULAR
Effective Date:	04/24/2024
Expiration Date:	04/23/2026
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff caused physical harm to Resident A.	Yes

III. METHODOLOGY

09/09/2024	Special Investigation Intake 2024A1031058
09/10/2024	Special Investigation Initiated - On Site
09/10/2024	Contact - Face to Face Interview with Israel Baker, Benjamin Sowa-Green, Jerome White, and Yvonne Cruz.
09/10/2024	APS Referral
09/17/2024	Contact - Document Sent Email Exchange with Tasha Stewart.
10/14/2024	Contact - Document Sent Email Exchange with Tasha Stewart.
10/17/2024	Inspection Completed On-site
10/30/2024	Contact - Document Sent Email Exchange with Tasha Stewart.
10/30/2024	Contact - Telephone Interview with Andre Stewart.
10/30/2024	Contact - Document Received.
10/30/2024	Exit Conference with Nichole VanNiman.
10/30/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Staff caused physical harm to Resident A.

INVESTIGATION:

On 9/10/24, I interviewed the district manager Israel Baker and the facility manager Benjamin Sowa-Green at the facility. They both reported Resident A was demonstrating significant behavioral concerns due to a recent change in medications. They reported they did observe Resident A to have a large cut on their chin. They reported Resident A went to the hospital and received stitches. They both talked with the alleged staff member Andre Stewart that caused the abrasion. They reported Mr. Stewart informed them that he utilized CPI due to Resident A having aggressive behaviors and Resident A fell to the floor. Resident A had a metal tobacco pipe in his pocket that caused the injury to his chin. Mr. Stewart denied throwing Resident A to the ground. Mr. Baker reported he felt that appropriate CPI was not used due to the extent of Resident A's injury. They reported Resident A was not available to be interviewed as he was admitted into the hospital for psychiatric treatment.

On 9/10/24, I interviewed direct care worker (DCW) Jerome White at the facility. Mr. White reported Resident A was being physically and verbally aggressive towards Mr. Stewart. Mr. White reported Resident A's behaviors have been extreme lately which resulted in him having a two staff to supervise him. Mr. White report he and Mr. Stewart were assigned as his 2:1 staff. Mr. White reported Resident A was elevated and was cussing and spitting at Mr. Stewart. Mr. White reported he did not witness Mr. Stewart throw Resident A to the floor but saw Resident A on the floor. Mr. White reported he noticed a metal pipe on the floor and the Resident A had injured their chin. Mr. White was asked how he did not see anything happen as he was assigned as Resident A's 2:1 staff. Mr. White reported all he knew was that Mr. Stewart was upset because Resident A spit on him.

On 9/10/24, I interviewed DCW Yvonne Cruz at the facility. Ms. Cruz reported she was down the hall when she heard an incident happen. Ms. Cruz reported she heard a "thud" and went to the day room. Ms. Cruz noticed that Resident A was in a manic state and went to talk with Resident A. Ms. Cruz reported that is when she noticed Resident A had blood in his beard from a cut on his chin. Mr. Cruz reported she assisted Resident A with cleaning up his chin and medical was contacted for further assessment.

On 9/17/24, I exchanged emails with recipient rights officer Tasha Stewart. Ms. Stewart reported she had concerns regarding staff at the facility using excessive force against Resident A.

On 10/17/24, I conducted an unannounced visit to the facility. I was informed that Resident A was no longer residing in the home as his caseworker found a new home for him due to concerns regarding his physical injury.

On 10/30/24, I interviewed Mr. Stewart via telephone. Mr. Stewart reported he and Mr. White were assigned to provide 2:1 supervision for Resident A. Mr. Stewart reported Resident A became verbally and physically aggressive towards him. Mr. Stewart reported Resident was calling him inappropriate names, pushing him, and

spit in his face. Mr. Stewart reported he asked Mr. White for assistance as Resident A was targeting him. Mr. Stewart reported Mr. White did not provide assistance. Mr. Stewart admitted that he did not handle the situation well as he was frustrated with Resident A assaulting him and Mr. White's inability to provide intervention. Mr. Stewart reported he did push Resident A off of him and did not use appropriate behavioral intervention. Mr. Stewart reported he did not intend for Resident A to get hurt. Mr. Stewart reported after Resident A fell, he noticed a metal tobacco pipe on the ground and that Resident A had a cut on his chin.

On 10/30/24, I conducted an exit conference with licensee designee Nichole VanNiman. Ms. VanNiman was informed that there was evidence found to support that staff did not ensure Resident A's safety and protection. Ms. VanNiman reported she agreed with the findings of the investigation.

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:	Based on interviews with staff, it has been determined that Resident A was not treated with dignity and staff was not able to provide appropriate protection and safety as Resident A was injured which required stitches for an abrasion on their chin.
CONCLUSION:	**VIOLATION ESTABLISHED**

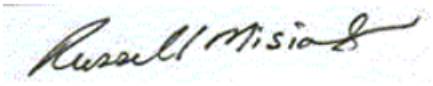
IV. RECOMMENDATION

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

10/30/24

Kristy Duda — Date
Licensing Consultant

Approved By:



11/18/24

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Russell B. Misiak Date
Area Manager