GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 19, 2021

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

RE: License #: AM800267885
Investigation #: 2021A0462035
Beacon Home at Anchor Point North

Dear Mr. 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,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

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 #:	AM800267885
Investigation #:	2021A0462035
Complaint Receipt Date:	05/25/2021
Investigation Initiation Date:	05/26/2021
Report Due Date:	07/24/2021
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 Anchor Point North
Facility Address:	28720 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/03/2005
License Status:	REGULAR
Effective Date:	04/24/2020
Expiration Date:	04/23/2022
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED

	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
During a confrontation on 05/23/2021, direct care worker Jessie Ballard acted inappropriately towards Resident A.	No
Additional finding.	Yes

III. METHODOLOGY

05/25/2021	Special Investigation Intake 2021A0462035
05/26/2021	Special Investigation Initiated – Email to Complainant.
05/28/2021	Unannounced investigation onsite. Separate face to face interviews with administrator Israel Baker, Resident A, DCW Jessie Ballard, DCW Jaydon Williams, and DCW Robert Page.
06/07/2021	Contact - Face to face interview with DCW Desean Brown via Microsoft Teams. Requested and received documentation.
06/08/2021	Contact- Requested and received documentation.
07/02/2021	Contact- Email correspondence with administrator Israel Baker. Contact- Requested and received documentation.
07/06/2021	Exit conference with licensee designee Nichole VanNiman via telephone.
07/07/2021	Contact- Referral made to APS.

ALLEGATION: During a confrontation on 05/23/2021, direct care worker Jessie Ballard acted inappropriately towards Resident A.

INVESTIGATION: On 05/26/2021 the Bureau of Community and Health Systems' (BCHS) received this complaint via the BCHS' online complaint system. According to the written complaint, Resident A reported that on 05/23 he became upset with another resident. Resident A attempted to talk to direct care worker (DCW) Jessie

Ballard, and the two began to argue. The written complaint indicated Resident A reported Mr. Ballard “went up to him” (Resident A), who was laying on the ground, and began pointing his finger. According to the written complain, Resident A reported Mr. Ballard said, “get your ass up.” When Resident A refused to get up, Resident A reported that Mr. Ballard “CPI’d” [sic] him to the ground. The written complaint indicated Resident A told Mr. Ballard to “go fuck his mother.” Resident A reported that Mr. Ballard responded by saying, “you say that again, I’ll slam your head against the concrete.” According to the written compliant, Resident A requested Mr. Ballard’s employment be suspended.

On 05/26 I informed Complainant via email exchange I was assigned to investigate this allegation.

On 05/28 I conducted an unannounced investigation onsite and interviewed administrator Israel Baker, Resident A, Mr. Ballard, and DCWs Jaydon Williams and Robert Page, separately. Mr. Baker stated that approximately one month ago, the facility decreased the amount of time Resident A received 1:1 enhanced supervision, due to a decrease in destructive behaviors displayed by Resident A, which were associated with his diagnosis of a mental illness. However, according to Mr. Baker, on 05/23, after becoming upset with another resident, Resident A began displaying extremely erratic and destructive behaviors, including tearing the siding off the interior of the facility. Mr. Baker stated he became aware of the allegation when it was reported to him by the Kalamazoo County Office of Recipient Rights.

Resident A confirmed that “last Sunday”, (05/23) he became upset with another resident. According to Resident A, Mr. Ballard disrespected him by telling him to “let it go.” Resident A admitted to pulling the facility’s fire alarm and eloping from the facility. Resident A stated he laid in the middle of the road and refused to get up. However, according to Resident A, “no cars came.” Resident A stated Mr. Ballard followed him out and into the road and began pointing his finger at him. According to Resident A, Mr. Ballard stated, “get your lazy ass up” and “you are causing a lot of trouble.” Resident A stated he told Mr. Ballard to “go fuck your mother.” According to Resident A, Mr. Ballard responded by threatening to slam his head into the ground. Resident A stated that at some point Mr. Ballard sat on his stomach and held his hands. According to Resident A, this was because he was physically fighting Mr. Ballard. Resident A stated no other residents witnessed the incident. However, Mr. Page and DCW Desean Brown were present when the incident occurred. Resident A did not report receiving any injuries due to the incident, nor did I observe any signs of injuries on Resident A during my interview with him.

Mr. Ballard confirmed that on 05/23, Resident became upset when another resident began teasing him. At approximately 11:00PM, Resident A pulled the facility’s fire alarm, eloped from the facility and laid down in the road. Mr. Ballard stated he followed after Resident A. Once to the road, Mr. Ballard reported he listened to Resident A and validated his feelings. According to Mr. Ballard, he was able to convince Resident A to come back to the facility. However, at approximately

12:00AM on 05/24, Resident A pulled the facility's fire alarm and eloped from the facility for a second time. According to Mr. Ballard, Resident A ripped siding off the interior of the facility and then proceeded to lay down in the middle of the road. Mr. Ballard stated he and Mr. Brown followed after Resident A and tried to convince him to get up and come back to the facility. According to Mr. Ballard, he was concerned Resident A would get struck by a passing vehicle. Mr. Ballard stated Resident A was "extremely upset", unable to deescalate, and refused to get up. According to Mr. Ballard, Resident A grabbed his legs. At some point, Resident A got up, began spitting at Mr. Ballard, and then started "swinging." Mr. Ballard stated he attempted to use a physical crisis intervention technique to prevent Resident A from hitting him. However, both he and Resident A fell to the ground. Mr. Ballard stated that while on the ground, Resident A began pinching him. According to Mr. Ballard, he tried multiple times to communicate to Resident A that he was not trying to "take him down." Mr. Ballard denied the allegation he used inappropriate language with Resident A. Mr. Ballard confirmed Resident A told him to "go fuck his mother." Mr. Ballard denied responding to this by threatening to slam Resident A's head into the ground. According to Mr. Ballard, he did inform Resident A that his mother had passed away. Mr. Ballard denied sitting on Resident A's stomach and stated he only held Resident A's arms down briefly to prevent Resident A from hitting and pinching him. According to Mr. Ballard, he was eventually able to walk away from Resident A. Mr. Ballard stated that as he was walking away from Resident A, Mr. Page responded to offer assistance. Mr. Ballard confirmed Mr. Brown witnessed the entire incident and that no other residents witnessed the altercation.

According to Ms. Williams, she was working in the facility at the time the incident occurred. Ms. Williams confirmed that on the evening of 05/23, Resident A began to display disruptive behaviors after becoming upset with another resident. However, Ms. Williams reported being inside the facility when the incident occurred on 05/24 and stated she did not witness the altercation. According to Ms. Williams, she had never previously witnessed Mr. Ballard be inappropriate to Resident A and/or other residents.

Mr. Page also confirmed that on the evening of 05/23, Resident A began to display disruptive behaviors after becoming upset with another resident. According to Mr. Page, at some point during his overnight shift, Mr. Brown used his personal cellular telephone from outside to call Mr. Page and request his assistance out by the road. Mr. Page stated that by the time he got to the road, "it was over." According to Mr. Page, "when I got out there Jessie had just released him." Mr. Page stated he observed Resident A swearing at Mr. Ballard. However, Resident A appeared to be "calming down." According to Mr. Page, he did not witness Mr. Ballard do or say anything to Resident A that was inappropriate. Mr. Page stated Mr. Brown, who was present during the incident, also did not mention anything to him regarding Mr. Ballard addressing the incident inappropriately.

On 06/07 I conducted a face-to-face interview with Mr. Brown via Microsoft Teams. Mr. Brown confirmed that on the evening of 05/23 and early morning hours of 05/24,

Resident A began to display disruptive behaviors after becoming upset with another resident. Mr. Brown denied the allegation. Mr. Brown's statements regarding the incident between Resident A and Mr. Ballard on 05/24 were consistent with the statements Mr. Ballard provided to me. According to Mr. Brown, he witnessed Mr. Ballard use a crisis intervention technique on Resident A called "wrist control." Mr. Brown confirmed Resident A told Mr. Ballard to "go fuck his mother", to which Mr. Ballard responded by informing Resident A that his mother had passed away. Mr. Brown confirmed he called Mr. Page from his personal cellular telephone and requested his assistance. Mr. Page also confirmed no other residents witnessed the incident.

On 07/02, via email exchange with Mr. Baker, I requested and reviewed written verification that on 10/21/2020, Mr. Ballard had completed and passed a three-hour long Crisis Prevention Institution's (CPI) Crisis Intervention Training.

On 07/07, via email, I referred this allegation to Adult Protective Services.

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: **(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 upon my investigation, which consisted of interviews with multiple facility staff members and Resident A, it has been established that on the evening of 05/23 and in the early morning hours of 05/24, after becoming upset with another resident, Resident A began displaying extremely erratic and destructive behaviors, including pulling the facility's fire alarm, tearing the siding off the interior of the facility, and laying down in the middle of the road and refusing to get up. It has been established that on 05/24, DCWs Jessie Ballard and Desean Brown followed Resident A to the road and attempted to convince Resident A to return to the facility. According to Mr. Ballard and Mr. Brown, when Resident A became physically violent, Mr. Ballard attempted to use a physical crisis intervention technique to prevent Resident A from hitting him. However, both he and Resident A fell to the ground. Mr. Ballard admitted to holding Resident A's arms down briefly to prevent

	Resident A from hitting and pinching him. Mr. Brown, who witnessed the entire incident, confirmed Mr. Ballard's statements. There is not enough evidence to substantiate the allegation that on either the evening of 05/23, or early morning hours of 05/24, DCW Jessie Ballard acted inappropriately towards Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION: I reviewed an *AFC Licensing Division Incident/Accident Report* (IR) written by Mr. Ballard on 05/24 and submitted to the department on 05/25. According to documentation on this IR, at 12:30AM on 05/24, Resident A pulled the fire alarm, pulled the siding off the interior of the facility, and "hit windows". Documentation on the IR indicated Resident A attacked an unidentified facility staff member, assumed to be Mr. Ballard, by biting him between the legs, and by also grabbing and punching him. Documentation on this IR confirmed Resident A laid down in the middle of the road and refused to get up. According to documentation on this IR, Resident A yelled at a facility staff member, assumed to be Mr. Ballard, and stated he hoped his mother "rotted in hell". Documentation on the IR indicated that "after several minutes", Resident A eventually calmed down, returned to the facility, and went to bed.

During my interviews with Resident A, Mr. Ballard, Mr. Page, and Mr. Brown, they all confirmed that in the early morning hours of 05/24, Mr. Ballard used a physical crisis intervention technique on Resident A to address his physically aggressive behavior and to prevent him from harming himself or others. However, there was no documentation on the IR submitted to the department on 05/25 indicating the use of this intervention.

On 06/08, via email correspondence with Mr. Baker, I requested and reviewed Resident A's 05/23 and 05/24 progress notes through the facility's electronic software system Nextstep. Documentation on the 05/24 progress notes was consistent with the documentation on the IR submitted to the department on 05/25. There was no documentation on these progress notes indicating that on 05/24 Mr. Ballard used a physical crisis intervention on Resident A to address Resident A's physically aggressive behaviors and to prevent him from harming himself or others.

On 07/02, via an email to Mr. Baker, I requested a copy of the facility's written report of Mr. Ballard's use of a physical crisis intervention on Resident A on 05/24. Via this email exchange Mr. Baker informed me that to his knowledge, no physical crisis intervention was utilized on Resident A on the evening of 05/23 and early morning hours of 05/24. According to Mr. Baker, it was his understanding that on 05/24

facility staff members only “followed after” Resident A when Resident A tore siding off the interior of the facility and laid in the road.

APPLICABLE RULE	
R 400.14309	**Crisis intervention.**
	(6) All uses of crisis intervention shall be noted in the resident's record. This notation shall include all of the following information: **(a) The nature of the crisis intervention used and the duration of use.** **(b) The reasons for the use of the crisis intervention.** **(c) The types of less restrictive alternatives that were tried, the duration, the number of trials, and the results obtained.** **(d) The name of the person who authorized the crisis intervention.** **(e) The times and dates that the crisis intervention was used and who implemented the crisis intervention.** **(7) A licensee shall make available reports of all uses of crisis intervention when requested by the resident or his or her designated representative, the responsible agency, or the department.**
ANALYSIS:	Based upon my investigation, it was established that on 05/24, DCW Jessie Ballard used a physical crisis intervention technique on Resident A to address his physically aggressive behaviors and to prevent Resident A from harming himself and others. Resident A’s behaviors were subsequently documented on an IR submitted to the department on 05/25. However, there was no documentation on the IR indicating Mr. Ballard’s use of physical crisis intervention on Resident A. There was also no documentation in Resident A’s 05/24 Nextstep progress notes indicating Mr. Ballard’s use of a physical crisis intervention on Resident A. According to administrator Israel Baker, it was his understanding that on 05/24 no physical crisis intervention was utilized on Resident A. Mr. Baker believed that on 05/24, facility staff members only “followed after” Resident A when Resident A pulled the fire alarm, tore siding off the interior of the facility, and laid in the road. Subsequently, the facility had no written record of the physical crisis intervention Mr. Ballard used on Resident A to address his behavior and to prevent Resident A from harming himself and others.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/06 I conducted an exit conference with licensee designee Nichole VanNiman and shared with her the findings of this investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

07/07/2021

Michele Streeter — Date
Licensing Consultant

Approved By:

07/19/2021

Dawn N. Timm — Date
Area Manager