GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 3, 2021

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

RE: License #: AM800267885
Investigation #: 2022A0462006
Beacon Home at Anchor Point North

Dear Ms. 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 #:	2022A0462006
Complaint Receipt Date:	10/27/2021
Investigation Initiation Date:	10/27/2021
Report Due Date:	12/26/2021
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?
On 10/26/2021 direct care worker Jesse Ballard used inappropriate and disrespectful language towards Resident A.	Yes

III. METHODOLOGY

10/27/2021	Special Investigation Intake 2022A0462006 Special Investigation Initiated – Email exchange with administrator Israel Baker. Contact- Document Received.
11/01/2021	Inspection Completed On-site. Face-to-face interviews with Residents A and B.
11/30/2021	Contact - Telephone interview with DCW Jesse Ballard.
12/03/2021	Referral made to Van Buren County APS. Exit conference with licensee designee Nichole VanNiman

ALLEGATION: On 10/26/2021 direct care worker Jesse Ballard used inappropriate and disrespectful language towards Resident A.

INVESTIGATION: On 10/27/2021 facility administrator Israel Baker forwarded me an email he received from Relative A1 on 10/27. According to Relative A1's email, on the evening of 10/26 Relative A1 was on a "three-way" telephone call with Resident A and Resident A's father. Via his email, Relative A1 informed Mr. Baker that during this call he overheard direct care worker (DCW) Jesse Ballard yell and swear at Resident A. According to Relative A1's email, he heard Mr. Ballard tell Resident A, "get the fuck of the phone and let other people use it". According to Relative A1, Resident A responded by telling Mr. Ballard, "leave me the fuck alone and stop harassing me". Mr. Ballard then told Resident A, "you ain't shit and ain't ever gonna be shit". Via his email, Relative A1 informed Mr. Baker he called Mr. Ballard and spoke with him about he had heard. According to Relative A1, Mr. Ballard became defensive and eventually hung up on Relative A1.

Mr. Baker email me an *AFC Licensing Division Incident/Accident Report* (IR), written by home manager Benjamin Sowa- Green on 10/27, regarding the allegation. Documentation on the IR indicated that the allegation was also reported to the

Sanilac County Office of Recipient Rights and to Resident A's legally appointed guardian. According to documentation on the IR, management staff members would assist with any investigations regarding this allegation as requested and would keep Mr. Ballard and Resident A separated throughout the duration of any investigations.

On 11/01 I conducted an unannounced investigation at the facility and interviewed Resident A, who confirmed the allegation. According to Resident A, on the evening of 10/26, while talking to Relative A1 and his father on the resident telephone, Resident B requested to use the resident telephone and became upset when Resident A wouldn't end his telephone call. Resident A's statements regarding the allegation against Mr. Ballard were consistent with Relative A1's 10/27 email to Mr. Baker. Resident A stated Resident B witnessed the allegation. However, according to Resident A, he doubted Resident B would tell the truth if interviewed, as Resident B liked Mr. Ballard.

I conducted a separate face-to-face interview with Resident B. According to Resident B, on the evening of 10/26 Resident A was on the resident telephone for almost an hour. Resident B stated he was frustrated because he only needed to use the resident telephone for a "few seconds" and Resident A refused to end his telephone call. Resident B admitted to witnessing the allegation against Mr. Ballard. According to Resident B, Mr. Ballard was rude to Resident A and threatened his life. Resident B stated he overheard Mr. Ballard say he didn't care if he lost his job. According to Resident B, while it was true that he liked Mr. Ballard, he also understood Mr. Ballard should not have spoken to Resident A in that manner.

On 11/30 I conducted a telephone interview with Mr. Ballard who stated that per his Community Mental Health Behavior Treatment Plan, Resident A had restrictions on his telephone usage. Subsequently, on the evening of 10/26 he requested Resident A end his telephone call after being on the resident telephone for too long. Mr. Ballard denied the allegation he ever used inappropriate and disrespectful language towards Resident A when making this request.

On 12/03 I forwarded the allegation to Van Buren County Adult Protective Services.

According to Special Investigation Report (SIR) #2020A0462008, dated 01/06/2020, the facility was in violation of AFC administrative licensing rules 400.14304(1)(o) and 400.14304(2) when it was established DCW Linda Graham was disrespectful when communicating with another resident (identified as Resident A in SIR #2020A0462008), which contributed to the resident engaging in aggressive and disruptive behaviors that placed him and others at risk. According to the facility's approved corrective action plan addressing these violations, dated 01/10/2020, Ms. Graham received additional training on "Gentle Teaching" and de-escalation. To ensure future compliance with rules 400.14304(1)(o) and 400.14304(2), licensee designee Nichole VanNiman would confirm with the facility's District Director (administrator) Israel Baker that all facility staff members were properly trained.

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 multiple interviews and a review of pertinent documentation relevant to this investigation, there is enough evidence to support the allegation that on the evening of 10/26, DCW Jesse Ballard used inappropriate and disrespectful language towards Resident A when he requested Resident A get off the resident telephone.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED**

On 12/03 I conducted an exit conference with licensee designee Nichole VanNiman via telephone and shared this her the findings of this investigation.

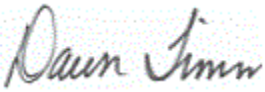
IV. RECOMMENDATION

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

12/03/2021

Michele Streeter — Date
Licensing Consultant

Approved By:



12/03/2021

Dawn N. Timm — Date
Area Manager