GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 24, 2022

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

RE: License #: AS140393268
Investigation #: 2022A1024017
Beacon Home At Red Mill

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 was required. On February 17, 2022, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

NOTE: THIS REPORT CONTAINS QUOTED EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AS140393268
Investigation #:	2022A1024017
Complaint Receipt Date:	01/05/2022
Investigation Initiation Date:	01/05/2022
Report Due Date:	03/06/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Melissa Williams
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At Red Mill
Facility Address:	51721 Red Mill Road Dowagiac, MI 49047
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/15/2018
License Status:	REGULAR
Effective Date:	04/13/2021
Expiration Date:	04/12/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A direct care staff member was rude and rushed Resident A out of the bathroom.	Yes

III. METHODOLOGY

01/05/2022	Special Investigation Intake 2022A1024017
01/05/2022	Special Investigation Initiated – Letter email correspondence with Recipient Rights Officer Kathy Smyser
02/01/2022	Contact - Telephone call made with district director Kimberly Howard
02/11/2022	Inspection Completed On-site with home manager Tony Giancaspro, direct care staff member Victoria Morales, Paul Reed and Resident A
02/11/2022	Inspection Completed-BCAL Sub. Compliance
02/11/2022	Exit Conference with licensee designee Nichole VanNiman
02/23/2022	Corrective Action Plan Requested and Due on 02/24/2022
02/17/2022	Corrective Action Plan Received
02/17/2022	Corrective Action Plan Approved

ALLEGATION:

A direct care staff member was rude and rushed Resident A out of the bathroom.

INVESTIGATION:

On 1/5/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged a direct care staff member was rude and rushed Resident A out of the bathroom.

On 1/5/2022, I spoke to Recipient Rights Officer (RRO) Kathy Smyser who stated on 1/3/2022 Resident A notified her that direct care staff member Dorothy Artist rushed

him out of the bathroom because another resident needed to use the bathroom. Ms. Smyser stated Resident A informed her that Ms. Artist told him “if this person shits on the floor [Resident A] will have to clean it up”. Ms. Smyser stated Resident A believes Ms. Artist mistreated him by making a threat towards him.

On 1/12/2022, I conducted an interview with district director Kimberly Howard regarding this allegation. Ms. Howard stated she has worked in the home with Ms. Artist and has never observed Ms. Artist to mistreat any of the residents. Ms. Howard stated she learned of this allegation when she heard Resident A speaking with RRO Ms. Smyser. Ms. Howard stated Resident A often swears and jokes around when he speaks to direct care staff members and Ms. Howard believes Ms. Artist spoke to Resident A in this manner to try to be more “relatable” with Resident A. Ms. Howard stated she has observed Ms. Artist to carry out her responsibilities to care for the residents in a quality manner and has never observed any inappropriate interactions between Ms. Artist and the residents.

On 2/11/2022, I conducted an onsite investigation at the facility with home manager Tony Giancaspro, direct care staff members Victoria Morales, Paul Reed and Resident A. Mr. Giancaspro stated he was notified by Resident A and Ms. Morales that Ms. Artist rushed Resident A out of the bathroom and made a rude statement to him. Mr. Giancaspro stated he is in the process of determining the appropriate disciplinary action that should be implemented for Ms. Artist as direct care staff members are not allowed to swear and be rude to any residents. Mr. Giancaspro further stated under any circumstance would a resident be required to take over staff’s responsibilities of cleaning the home. Mr. Giancaspro stated Ms. Artist is a very good staff member and he has never seen her mistreat any of the residents.

Ms. Morales stated she works regularly with Ms. Artist and has never seen her mistreat any of the residents. Ms. Morales stated she was not working on 1/3/2022 however she was informed by Ms. Artist that “she had an argument with [Resident A]” however Ms. Artist did not go into details and Ms. Morales did not ask any questions about the argument. Ms. Morales stated she usually observes Resident A to be in good spirits and to have positive interactions with Ms. Artist. Ms. Morales stated Resident A did not make any complaints to her regarding Ms. Artist mistreating him.

Mr. Reed stated on 1/3/2022, he observed Resident A come out of the bathroom and state “I’m not cleaning that up because it’s a rights violation.” Mr. Reed stated Resident A then informed him that Ms. Artist stated to him that “[Resident A] would have to clean up shit” if another resident has a bowl movement on the floor due to Resident A not moving quickly enough out of the bathroom. Mr. Reed stated Resident A further stated that Ms. Artist informed him that she is not going to clean up any feces because it will make her sick. Mr. Reed stated when Ms. Artist came out of the bathroom, she informed Mr. Reed that the other resident did not have a bowl movement on the floor however, Ms. Artist did admit to informing Resident A that “he would have to clean the shit off the floor if the other resident didn’t make it to

the toilet in time." Mr. Reed stated he saw Resident A call his RRO Ms. Smyser after this incident but did not hear Resident A speak about this incident for the remainder of the day. Mr. Reed stated he has never observed Ms. Artist to mistreat any of the residents and was surprised that Ms. Artist made such a rude comment to Resident A.

Resident A stated on 1/3/2022, he was rushed out of the bathroom by direct care staff member Ms. Artist because another resident needed to immediately use the bathroom. Resident A stated while he was leaving Ms. Artist stated, "if this resident shits on the floor, you will be cleaning it up." Resident A stated he became very upset by this comment and informed Ms. Artist that this would be a violation of his rights. Resident A further stated he immediately went outside to call ORR Ms. Smyser as he believed Ms. Artist mistreated him which is a violation of his rights. Resident A stated he has a good relationship with Ms. Artist, and he has never been mistreated in the past. Resident A further stated he has not had any other issues since this incident, and he feels safe in the home.

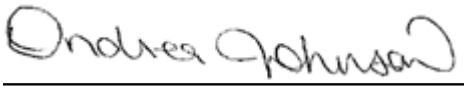
APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	Rule 304. (1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the 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 on my investigation which included interviews with RRO Kathy Smyser, district director Kimberly Howard, home manager Tony Giancaspro, direct care staff members Victoria Morales, Paul Reed and Resident A, Resident A was not treated with dignity or respect by direct care staff member Ms. Artist after she made a rude comment to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/14/2022, I conducted an exit conference with licensee designee Nichole VanNiman. I informed Ms. VanNiman of my findings and allowed her an opportunity to ask questions and make comments.

On 2/17/2022, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was approved; therefore, I recommend the current license status remain unchanged.



2/23/2021

Ondrea Johnson — Date
Licensing Consultant

Approved By:

02/24/2022

Dawn N. Timm — Date
Area Manager