GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

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

March 9, 2022

RE: License #: AS800404242
Investigation #: 2022A1031001
Beacon Home at Hartford

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 (616) 356-0183.

Sincerely,

K Duda

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AS800404242
Investigation #:	2022A1031001
Complaint Receipt Date:	02/11/2022
Investigation Initiation Date:	02/11/2022
Report Due Date:	04/12/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Ramon Nigel
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Hartford
Facility Address:	68134 CR 372 Hartford, MI 49057
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/27/2020
License Status:	REGULAR
Effective Date:	02/27/2021
Expiration Date:	02/26/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident B was not treated with dignity by a staff member.	No
A staff member pushed Resident B.	Yes

III. METHODOLOGY

02/11/2022	Special Investigation Intake 2022A1031001
02/11/2022	Special Investigation Initiated – Telephone Interview with Complainant
02/11/2022	APS Referral Not Needed - APS made Referral to LARA
02/14/2022	Contact - Voicemail left with Deputy A. Turner at Van Buren County Sheriff's Department.
02/14/2022	Contact - Voicemail Left with Kim Howard - District Director for Beacon Home at Hartford
02/14/2022	Contact – Separate Face to Face Interviews with Resident B, Home Manager - Crystal Jennings, and DCW Rae Anna Brumley.
02/16/2022	Contact - Separate Telephone Interviews with DCW Michael Gearhart and DCW Pamela Falkiewicz.
02/18/2022	Contact - Email sent to APS Specialist, Michael Hartman.
02/22/2022	Contact - Email Received from APS Specialist - Michael Hartman.
02/22/2022	Contact - Requested and Received Documentation via Email.
02/23/2022	Contact - Telephone Interview with Kim Howard - District Director of Beacon Home at Hartford.
02/23/2022	Contact - Requested and Received Documentation via Email.
3/01/2022	Exit Conference Held via Telephone with Licensee Designee, Nichole VanNiman.

ALLEGATION:

Resident B was not treated with dignity by a staff member.

INVESTIGATION:

On 2/11/22, I interviewed recipient rights Suzie Suchyta by telephone. Ms. Suchyta reported Resident B has been diagnosed with Autism with self-injurious behaviors. Ms. Suchyta reported direct care worker (DCW) Michael Gearhart admitted to putting his arm around Resident B and kissing Resident B on the forehead. Ms. Suchyta reported DCW Rae Anna Brumley reported she witnessed Michael Gearhart put his left arm around Resident B and kiss him on the forehead.

On 2/14/22, I interviewed Resident B at the home. Resident B reported Mr. Gearhart has been "getting a little too close" to him. Resident B reported this made him feel very uncomfortable and he did not like that this happened to him. Resident B reported he spoke with Mr. Gearhart the next day about how this incident made him feel. Resident B reported Mr. Gearhart has never done anything like this to him before and they would just give each other "side hugs".

On 2/14/22, I interviewed house manager Crystal Jennings at the home. Ms. Jennings reported she was not present when the incident happened, however, she read the incident report that was completed. Ms. Jennings reported she spoke with Resident B and the details of the report were verified. Ms. Jennings reported she then had a conversation with Mr. Gearhart, and he admitted to her that he had kissed Resident B on the forehead. Ms. Jennings reported Mr. Gearhart remains employed by the home but is no longer assigned as Resident B's one-on-one staff. Ms. Jennings reported there has not been any incidents like this before between Mr. Gearhart and any of the other residents in the home. Ms. Jennings provided for my review a copy of the 1/29/22 incident report. The report was as described.

On 2/14/22, I interviewed DCW Rae Anna Brumley at the Ms. Brumley reported she was in the kitchen when Resident B and Mr. Gearhart were talking to each other. Her statement was consistent with Resident B's. Ms. Brumley reported Resident B took a step back and she heard him ask Mr. Gearhart why he did that to him. Ms. Brumley reported hearing Mr. Gearhart reply to Resident B, "because I love you, man". Ms. Brumley reported Resident B later pulled her aside in his bedroom to express to her that what Mr. Gearhart did to him made him feel uncomfortable. Ms. Brumley reported Resident B approached Michael to express how he felt about what had happened. Ms. Brumley reported she has not witnessed anything like this occur before. Ms. Brumley reported she informed management and completed an incident report for what she had observed.

On 2/16/22, I interviewed DCW Michael Gearhart by telephone. Mr. Gearhart reported he is Resident B's one-on-one staff. Mr. Gearhart reported he did put his arm around Resident B and kiss him on the top of his forehead. Michael reported his action was

platonic and there was no intent behind what he did. Mr. Gearhart reported as soon as he kissed Resident B, he knew he "had crossed the line". Mr. Gearhart reported he is new to working with this population of individuals and is still learning how to work with the residents. Mr. Gearhart reported his action was an attempt to show affection towards Resident B. Mr. Gearhart reported he has been working with Resident B for approximately one year and nothing like this has occurred before. Mr. Gearhart reported he regrets what he did and understands that he should not have kissed Resident B. Mr. Gearhart reported Resident B spoke to him about what occurred, and he apologized to Resident B as he understands why this made Resident B uncomfortable.

On 2/22/22, the home provided by email Mr. Gearhart's training record for my review. I verified that Mr. Gearhart had received training titled *Trauma Informed Care, Gentle Teaching, Introduction to Community Residential, Working with People, and Working with People – Positive Techniques*.

On 2/26/22, I interviewed Beacon Specialized Living Services district director Kim Howard by telephone. Kim reported she was informed about the incident and assured Mr. Gearhart was provided with additional training including recipient rights training.

On 2/23/22, the home provided by email Mr. Gearhart's criminal history clearance documents for my review. Mr. Gearhart was determined to be eligible and approved to work at the home.

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:	Interviews with Resident B and staff revealed the incident did occur. Mr. Gearhart admitted to kissing Resident B on the forehead and acknowledged that this was not an appropriate behavior to exhibit towards a resident. While Mr. Gearhart's actions did make Resident B uncomfortable, it was not meant to be harmful and there is no evidence that this was anything other than an isolated incident. In addition, the home took reasonable steps to ensure Resident B's dignity was validated, he was protected, and provided additional training to Mr. Gearhart to work with this population more effectively.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A staff member pushed Resident B.

INVESTIGATION:

On 2/14/22, I interviewed Resident B at the home. Resident B reported he kicked the wall. Resident B reported this made DCW Pamela Falkiewicz upset and she then went into Resident B's bedroom. Resident B reported Ms. Falekiewicz got close to him and he "felt threatened". Resident B reported he pushed Ms. Falekiewicz and then Ms. Falekiewicz pushed him back. Resident B reported he was not hurt and did not experience any injuries as a result of the incident.

Ms. Jennings reported she was not present when the incident happened. Ms. Jennings reported Ms. Falekiewicz admitted that she did push Resident B back when she was pushed by Resident B. Ms. Jennings reported Ms. Falekiewicz did not handle the situation appropriately nor utilize the behavior intervention techniques, they are supposed to use to manage behaviors. Ms. Jennings reported there was not an incident report submitted to the department for the incident that occurred between Ms. Falekiewicz and Resident B.

Ms. Jennings provided for my review Ms. Falekiewicz's note where she wrote about the occurrence on 2/9. The note read that Resident B was having behavioral outbursts and staff tried to calm him down, but Resident B started yelling at staff. Resident B then threatened staff and then Resident B pushed staff. The note did not document that a staff member had been in an altercation with Resident B.

On 2/16/22, I interviewed DCW Pamela Falkiewicz by telephone. Ms. Falkiewicz reported Resident B had returned home from the hospital after a behavioral incident and started putting holes in the wall. Ms. Falkiewicz reported Resident B was in his bedroom upset and yelling loudly. Ms. Falkiewicz reported she went to Resident B's room at which time Resident B held up a fist to her like he was going to hit her. Ms. Falkiewicz reported Resident B then pushed her real hard and she reacted by pushing Resident B back. Ms. Falkiewicz reported that she has completed *Gentle Touch training* which is a training to teach her how to appropriately manage behaviors. Ms. Falkiewicz reported she did not utilize learned techniques as she "got scared and reacted". Ms. Falkiewicz acknowledged that she did not handle the situation appropriately.

On 2/22/22, the home provided by email Ms. Falkiewicz's training record for my review. It was verified that Ms. Falkiewicz had received training titled *Trauma Informed Care, Gentle Teaching, Introduction to Community Residential, Working with People, and Working with People – Positive Techniques*.

On 2/23/22, the home provided by email Ms. Falkiewicz's criminal history clearance documents for my review. Ms. Falkiewicz was determined to be eligible and approved to work at the home.

Ms. Howard reported all staff receive annual training titled Gentle Touching to understand how to manage resident behaviors appropriately. Ms. Howard reported Ms. Falkiewicz was to receive additional training because of the incident.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Resident B, self admittedly, was demonstrating behavioral outbursts that included damaging the walls of the home. Interviews with staff revealed the home sought offsite help for Resident B but that upon his return he resumed his destructive and threatening behavior. While Resident B instigated the pushing of Ms. Falkiewicz, her response of pushing back was inconsistent with the homes policy, training, and this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

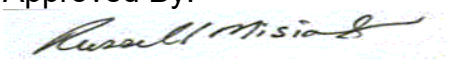
On 3/1/22, I shared the findings of this report with licensee designee Nicole VanNiman by telephone. She stated she agreed with the outcome of the investigation.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

Kristy Duda Date
Licensing Consultant

Approved By:



3/9/22

Russell B. Misiak Date
Area Manager