GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 15, 2022

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

RE: License #: AM030402101
Investigation #: 2022A0350034
Beacon Home at Hammond

Dear Mr. Beltran:

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 contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an

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) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM030402101
Investigation #:	2022A0350034
Complaint Receipt Date:	07/13/2022
Investigation Initiation Date:	07/13/2022
Report Due Date:	08/12/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Melissa Williams
Licensee Designee:	Ramon Beltran, II
Name of Facility:	Beacon Home at Hammond
Facility Address:	318 East Hammond Street Otsego, MI 49078
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	07/09/2020
License Status:	REGULAR
Effective Date:	01/26/2022
Expiration Date:	01/25/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A currently has a very large bruise on her left arm from one of the workers "manhandling" her.	No
Additional Findings	Yes

II. METHODOLOGY

07/13/2022	Special Investigation Intake 2022A0350034
07/13/2022	Special Investigation Initiated - Letter On 07/12, through emails, I arranged to meet Michael McClellan, Adult Protecrive Services investigator, at the home on the following day
07/13/2022	Contact - Face to Face I made an onsite inspection and met with Mr. McClellan, Officer McGehee, staff and residents
07/13/2022	Contact - Telephone call made Mr. McClellan made a speakerphone call to Alisha Berens, DCW, in the presence of Officer McGehee and me
07/14/2022	Contact - Telephone call made Mr. McClellan made a speakerphone call to Alaina Sanutelli, DCW, in the presence of Officer McGehee and me
07/14/2022	Contact - Document Received Mr. McClellan sent me an email with a photo and videos attached
07/14/2022	Contact - Telephone call made I made a follow-up call to Ms. Berens
07/15/2022	Exit conference – Held with Ramon Beltran, II, Licensee Designee

ALLEGATION: Resident A currently has a very large bruise on her left arm from one of the workers "manhandling" her.

INVESTIGATION: On 07/12/2022, through emails, I arranged to meet Michael McClellan, Adult Protective Services (APS) investigator, at this home.

On 07/13/2022, I met Mr. McClellan and Allegan Police Officer Donald McGehee at this home. We all spoke with Jamara White, District Director, and Tamika McGovernor, Home Manager. Ms. White provided Mr. McClellan, Officer McGehee and me with Incident Reports, Resident A's Face Sheet, and the phone numbers of the two staff members who worked during this alleged incident, Alisha Berens and Alaina Sanutelli.

On 07/13/2022, Mr. McClellan, Officer McGehee and I interviewed Resident A. I asked her if something happened on Monday evening and she reported that she was upset and started hitting Alisha Berens, Direct Care Worker (DCW), who was "rough with me." Resident A reported that during this incident, Ms. Berens "put me on the floor" and somehow she got bruises on her arm. She didn't say exactly how she got the bruises. Resident A showed us her inner left forearm, which had odd bruising to it. One part of the bruising was circular in shape, about the size of a silver-dollar, and had two tiny red dots in the middle. The other bruising was the shape of a square about 1 ½ on each side with a small scratch in the middle of it, and a smaller mark next to that bruise. These marks did not appear to be caused from being grabbed too hard, but more like from hitting an object of some sort, such as her walker. Resident A said she did not have any other red marks or bruises on her.

On 07/13/2022, Mr. McClellan, Officer McGehee and I went outside the home and called Ms. Berens on speakerphone. Ms. Berens stated that Resident A became upset because she asked for a cigarette but wasn't given one (We later learned that Resident A used to be a smoker, but now has lung cancer and it is in her treatment/care plan that she is not allowed to have cigarettes). Ms. Berens reported that Resident A "was coming at me with her walker" and started "swinging at me and clawing me" She said that Resident A was also "flailing" her arms around. Ms. Berens informed us that during this situation Resident A began to fall and she got behind her and lowered her to the ground using open hands. Ms. Berens stated that she video recorded some of the incident on her phone, and Mr. McClellan asked her to send it to his phone, and she said she would.

On 07/13/2022, Mr. McClellan, Officer McGehee and I spoke with Alaina Sanutelli, DCW, on speakerphone. Ms. Sanutelli reported that Resident A has "bad anxiety" and was very upset on Monday evening when she asked for a cigarette and was denied one. Ms. Sanutelli stated that Resident A is not allowed to have cigarettes according to her treatment/care plan because she has lung cancer. Ms. Sanutelli said that Resident A was anxious and started hitting Ms. Berens with her arms and walker and was also hitting herself. Ms. Sanutelli said that Resident A "threw herself to the floor" and was spitting at and scratching her and Ms. Berens. Ms. Sanutelli reported that as Resident A was falling, Ms. Berens tried to ease her to the floor by grabbing her arms. She also told us that Resident A was trying to punch herself and she and Ms. Berens were putting their hands up to try to block her from hitting herself. Ms. Sanutelli said that eventually Resident A calmed down and there were no more issues that evening.

On 07/14/2022, I received an email from Mr. McClellan that had the picture of Resident A's bruises he took the day before as well as the cell phone videos he received from Ms. Berens. In one video, Resident B can be heard, but not seen, saying that Resident A was making her feel unsafe. In the other video, Ms. Berens can be heard but not seen as she says to Resident A, who could be seen in the video, "You mean, you're done swinging at us and trying to spit in our faces and scratching us?" To which Resident A responds, "I'm done."

On 07/14/2022, I called Ms. Berens to double-check if at any time during this incident she grabbed Resident A's arms. Ms. Berens stated that neither she nor Ms. Sanutelli grabbed Resident A's arms, even when catching her and easing her to the ground when she was falling. Ms. Berens also denied that either she or Ms. Sanutelli threatened or swore at Resident A.

On 07/15/2022, I called and held an exit conference with Ramon Beltran, II, Licensee Designee. I informed Mr. Beltran that I was not citing violation of this rule. Mr. Beltran thanked me and had no further comments.

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 A had fresh bruising on her inner left forearm that was not indicative of being grabbed too hard, but rather from her arm hitting an object. Resident A became upset and violent when refused a cigarette on the evening of 07/11, when Ms. Berens and Alaina Sanutelli, DCW, were working. Resident A was hitting, punching, scratching, and spitting on staff. Resident A, who uses a walker, also caused herself to fall to the floor at least once during this incident. Ms. Berens got behind Resident A while she was falling and lowered her to the floor using the approved behavioral management technique of assisting with open hands. As the bruising on Resident A's forearm has an unusual shape and has two tiny red dots in the middle of it, she most likely hit her arm on an object when she was swinging her arms at staff or when she fell. These staff also attempted to block Resident A from hitting her own head by putting their hands in the way to

	block the blows. The bruise on her arm does not appear to be caused from that, however. My findings do not support that this rule had been violated.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Alisha Berens, Direct Care Worker, video recorded Resident A without her permission.

INVESTIGATION: On 07/13/2022, Mr. McClellan, Officer McGehee and I went outside the home and called Ms. Berens on speakerphone. Ms. Berens stated that she video recorded some of the incident on her phone, and Mr. McClellan asked her to send it to his phone, and she said she would.

On 07/14/2022, I received an email from Mr. McClellan that had the picture of Resident A's bruises he took the day before as well as the cell phone videos he received from Ms. Berens. In one video, Resident B can be heard, but not seen, saying that Resident A was making her feel unsafe. In the other video, Ms. Berens can be heard but not seen as she says to Resident A, who could be seen in the video, "You mean, you're done swinging at us and trying to spit in our faces and scratching us?" To which Resident A responds, "I'm done."

On 07/15/2022, I called and held an exit conference with Ramon Beltran, II, Licensee Designee. I informed Mr. Beltran that I was citing a violation of this rule. Mr. Beltran agreed with this finding and stated that he was going to have all staff reeducated on this rule (video recording residents is prohibited).

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:	Alisha Berens, Direct Care Worker, used her cell phone to video record Resident A without there being an approved variance that would allow her to. My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

July 15, 2022

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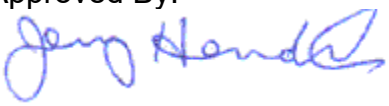
Ian Tschirhart Date
Licensing Consultant

Approved By:



July 15, 2022

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Jerry Hendrick Date
Area Manager