GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 18, 2022

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

RE: License #: AS800404242
Investigation #: 2022A1031004
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,

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 #:	2022A1031004
Complaint Receipt Date:	02/25/2022
Investigation Initiation Date:	03/01/2022
Report Due Date:	04/26/2022
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 Beltran II
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 A stabbed himself while unsupervised.	Yes

III. METHODOLOGY

02/25/2022	Special Investigation Intake 2022A1031004
03/01/2022	APS Referral Not Needed - APS Submitted Referral to LARA.
03/01/2022	Special Investigation Initiated - Telephone Call to APS Specialist Michael Hartman
03/01/2022	Contact - Telephone interview completed with licensee designee Nicole VanNiman
03/02/2022	Contact - Telephone interview completed with recipient rights officer Suzie Suchyta
03/04/2022	Contact - Face to Face Interview completed with Resident A
03/09/2022	Contact - Documents Requested via Email
03/09/2022	Contact - Telephone interview completed with DCW Thomas Mason
3/10/2022	Contact - Documents Requested via Email
3/15/2022	Contact - Documents Requested via Email
3/17/2022	Contact - Documents Requested and Received via Email
3/17/2022	Exit Conference with Licensee Designee

ALLEGATION:

Resident A stabbed himself while unsupervised.

INVESTIGATION:

On 3/1/22, I interviewed APS specialist Michael Hartman by telephone. Mr. Hartman reported Resident A claimed that he stole a fork from the kitchen and hid it in his coat. In addition, Resident A claimed staff left him alone while in the shower which resulted in Resident A injuring himself with the fork. Mr. Hartman reported direct care worker (DCW) Thomas Mason admitted that he had left Resident A alone while he was his one-on-one staff.

On 3/1/22, I interviewed licensee designee Nichole VanNiman by telephone. Ms. VanNiman reported Resident A is currently hospitalized due to ongoing self-injurious behaviors. Ms. VanNiman reported Resident A is to be discharged from the home due to his dangerous behaviors. Ms. VanNiman reported the home is no longer able to manage Resident A's self-injurious behaviors.

On 3/2/22, I interviewed recipient rights officer Suzie Suchyta via telephone. Ms. Suchyta reported there have been issues with staff providing proper care for Resident A. Ms. Suchyta reported the home is receiving additional funding to provide Resident A with one-on-one staffing. Ms. Suchyta reported she completed an interview with DCW Thomas Mason and he admitted to leaving Resident A alone when he was in the bathroom.

On 3/4/22, I interviewed Resident A at Lakeland Hospital. Resident A reported he recently injured himself by stabbing himself. Resident A reported he stole a fork from the kitchen. Resident A reported the fork was not locked up like it should have been. Resident A reported "Thomas" left him alone while he was in the bathroom taking a shower to go outside to smoke. Resident A reported he then stabbed himself in the leg with the fork while in the shower. Resident A reported he went to the hospital and received one stitch in his leg.

On 3/9/22, I interviewed DCW Thomas Mason by telephone. Mr. Mason reported he is no longer employed at the home. Mr. Mason reported he was informed the day after Resident A's incident that he was "let go". Mr. Mason reported he was assigned as Resident A's one-on-one staff for that shift. Mr. Mason reported he was supervising Resident A while he was showering and then went outside to smoke. Mr. Mason reported he was outside for "less than 3-4 minutes". Mr. Mason reported he did not ask for another staff member to supervise Resident A in his absence. Mr. Mason reported he came back inside and that is when he saw Resident A had injured himself. Mr. Mason reported he was aware of Resident A's behavior management plan and did not follow it.

On 3/9/22, the home provided by email Mr. Mason's training record for my review. It was verified that Mr. Mason had received training titled *Trauma Informed Care, Gentle Teaching, Introduction to Community Residential, Working with People, and Working with People – Positive Techniques.*

On 3/17/22, I received Resident A's behavior management plan. I reviewed the behavior management plan which read Resident A has a history of self-injurious behaviors which has resulted in previous hospitalizations. The plan indicates that Resident A currently has a one-on-one staff member twenty-four hours per day that was to provide constant supervision. The plan indicates that when Resident A is in the shower there is to be a staff member present in the bathroom.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Interviews with staff and Resident A revealed that appropriate supervision and protection were not provided to Resident A as specified in the resident's written assessment plan. Staff were aware of Resident A's behavior management plan which specified that he requires one-on-one supervision due to self-injurious behaviors. Staff did not follow the behavior management plan which resulted in Resident A injuring himself.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 3/17/22, an exit conference was held via telephone with licensee designee Nichole VanNiman.

IV. RECOMMENDATION

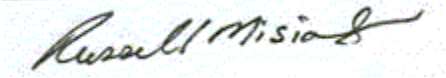
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

3/17/2022

Kristy Duda
Licensing Consultant

Date

Approved By:



3/17/2022

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Russell B. Misiak Date
Area Manager