GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 5, 2022

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

RE: License #: AS390396198
Investigation #: 2022A0581031
Beacon Home At Augusta

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 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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS SEXUALLY EXPLICIT LANGUAGE

I. IDENTIFYING INFORMATION

License #:	AS390396198
Investigation #:	2022A0581031
Complaint Receipt Date:	05/16/2022
Investigation Initiation Date:	05/16/2022
Report Due Date:	07/15/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At Augusta
Facility Address:	817 Webster St. Augusta, MI 49012
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/29/2018
License Status:	REGULAR
Effective Date:	05/29/2021
Expiration Date:	05/28/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Current and former direct care staff have developed an inappropriate relationship with Resident D.	No
Additional findings.	Yes

**To maintain the coding consistency of residents across several investigations, the resident in this special investigation will be identified as "Resident D"*

III. METHODOLOGY

05/16/2022	Special Investigation Intake 2022A0581031
05/16/2022	APS Referral APS denied the complaint for investigation
05/16/2022	Special Investigation Initiated - Telephone Interview with licensee's on-call behavior specialist, Joel Parish.
05/16/2022	Contact - Telephone call made Left voicemail with Resident D's public guardian, Guardian D1
05/16/2022	Contact - Document Sent Email sent to Guardian D1
05/16/2022	Contact - Document Sent Email to licensee's Human Resource Dept. requesting staff records.
05/16/2022	Contact – Telephone call made Interview with Guardian D1.
05/17/2022	Contact – Document Sent Email to licensee's Human Resource Dept. again.
05/17/2022	Inspection Completed On-site Interviewed direct care staff at Resident D's current facility. Resident D was sleeping at time of on-site inspection.
05/18/2022	Referral - Law Enforcement Confirmed with Augusta police they had received the allegations. Officer Miller was investigating.

05/18/2022	Referral - Recipient Rights Confirmed with ISK ORR that CMH for Central Michigan received the allegations and was investigating.
05/18/2022	Contact - Telephone call made Interview with Jane Gilmore, Recipient Rights Officer for CMHCM. She received allegations and is investigating.
05/18/2022	Contact - Telephone call made Interview with Resident D.
05/18/2022	Contact - Telephone call made Attempted to contact Officer Miller with Augusta police, but he was not working. Confirmed Augusta received the allegations.
05/18/2022	Contact – Telephone call made Interview with Guardian D1.
05/25/2022	Inspection Completed On-site Announced on-site at Beacon Home Augusta. Interviewed staff.
05/25/2022	Contact – Telephone call made Interviewed former direct care staff, Joshua Terpstra.
05/25/2022	Contact – Telephone call made Left voicemail with former direct care staff, Sarah Thorne.
05/25/2022	Contact – Document Sent Email to Ms. Gilmore.
06/09/2022	Exit conference with licensee designee, Ramon Beltran, via telephone.
06/10/2022	Contact – Document Sent Email to Ms. Gilmore.
06/10/2022	Contact – Document Received Email from Ms. Gilmore.
06/10/2022	Contact- Document Sent Email to Administrator, Aubry Napier.
06/10/2022	Contact – Telephone call made Left voicemail with Ms. Thorne.

ALLEGATION:

Current and former direct care staff have developed an inappropriate relationship with Resident D.

INVESTIGATION:

On 05/16/2022, I received this complaint through the Bureau of Community Health Systems (BCHS) on-line complaint system. The complaint alleged a former direct care staff, Sarah Thorne, is sending Resident D adult pornographic material. The complaint alleged Resident D consented to receiving the material; despite not having the cognitive ability to make his own decisions.

The complaint indicated Adult Protective Services also received the allegations but denied investigating.

On 05/16/2022, the licensee's Human Resource personnel, Danielle Lambrechts, confirmed Sarah Thorne was no longer an employee effective 04/04/2021 due to Ms. Thorne resigning without notice.

On 05/16/2022, I interviewed Resident D's public guardian, Guardian D1. Guardian D1's statement to me was consistent with the allegations. She indicated Ms. Thorne also purchased Resident D bedding, clothing, and had given him money. Guardian D1 indicated former direct care staff, Joshua Terpstra, was in contact with Resident D and there were current staff at Beacon Home at Augusta identified as Katrina Burr, Jessica Garten, and Jamie Kniss, who were still in contact with Resident D.

On 05/17/2022, Ms. Lambrechts confirmed Joshua Terpstra was no longer employed effective 12/24/2021 due to him being "discharged." She confirmed Katrina Burr, Jessica Garten, and Jamie Kniss were all active employees for Beacon Home at Augusta.

On 05/17/2022, I conducted an unannounced on-site inspection at another Beacon Specialized Living Services facility where Resident D was currently residing. During my on-site investigation, Resident D was sleeping; therefore, he was not interviewed. The direct care staff working at the facility had no concerns with the current staff at the facility being inappropriate with Resident D. The facility's home manager, Heather Juan, indicated all the staff identified in the complaint either worked or currently worked at Beacon Home at Augusta.

On 05/18/2022, I interviewed Resident D via telephone. Resident D stated he knew Sarah Thorne and that they were "friends". He confirmed she used to be a direct care staff at his previous facility. He denied them being anything more like a boyfriend and girlfriend. Resident D stated he and Ms. Thorne talk on the phone and through Facebook messenger, but he stated it was "once in a great moon." He stated she had purchased him a queen-sized mattress, a fish tank, and fish tank

décor. He was unable to report to me when these items were purchased for him. Resident D denied ever having to pay Ms. Thorne back or give her anything for the items she bought him. Resident D denied Ms. Thorne purchasing him a subscription for pornography. He also stated he did not know who had purchased his phone.

Resident D stated he talked on the phone to former direct care staff, Joshua Terpstra, but he stated it was "not often." Resident D was unable to report how often they talked. Resident D stated Mr. Terpstra purchased him food and drinks but denied Joshua Terpstra ever purchasing him any sexual toys or anything similar. He stated the food and drinks were purchased for him when he resided at Beacon Home at Augusta. Resident D stated he talks "almost every night" to direct care staff, Katrina Burr, Jessica Garten, and Jamie Kniss. He stated these direct care staff took him to the store when he resided at Beacon Home at Augusta and they also bought him food and drinks but he indicated these were the only items they purchased for him. He also denied any of these three staff or Mr. Terpstra ever asked him for anything in exchange for purchasing him food and drinks. He reported he got their phone numbers from direct care staff giving them to him.

On 05/17/2022, I reviewed Resident D's *Assessment Plan for AFC Residents* (assessment plan), dated 02/16/2022; however, there was no information in this assessment plan pertaining to the information provided in the complaint. I also reviewed Resident D's Community Mental Health Central Michigan (CMHCM) Person Centered Plan (PCP), dated 01/01/2022. According to this PCP, one of Resident D's goals was to "…get along with these guys most of the time" and the objective to this goal was to "…have appropriate social interactions with peer/staff on a daily basis as evidenced by no hitting; yelling; swearing; throwing objects etc. for 1 plan year".

On 05/18/2022, I interviewed Jane Gilmore, Recipient Rights Officer for CMHCM. She confirmed she had received the complaint and was investigating.

On 05/25/2022, I conducted an announced on-site inspection at the facility. In conjunction with Ms. Gilmore and Augusta police officer, Officer Jeff Miller.

I interviewed direct care staff, Jessica Garten, Katrina Burr, Jamie Kniss, and home manager, Marie Ulrich.

Direct care staff, Ms. Garten, Ms. Burr, and Ms. Kniss denied giving Resident D their telephone numbers. They all stated Resident D got their phone numbers from the facility's caller ID on the home's cordless phone. They all acknowledged Resident D had contacted them by calling or via text; however, they denied contacting him. They also all stated they had since blocked Resident D's phone number to prevent him from contacting them. They all indicated the text messages received by Resident D were short and benign in nature. They indicated Resident D texted them about moving into his current placement, how he missed Beacon Home at Augusta, or to say goodnight.

Ms. Garten, Ms. Burr, and Ms. Kniss all stated Resident D and Ms. Thorne "acted like friends" when Ms. Thorne was a staff at the facility because the two of them engaged in "food fights" and were observed "rough housing." They indicated this behavior was done in a joking or playful manner, rather than in hostility. They all described numerous incidences where Ms. Thorne and Resident D would throw peanut butter and bananas at one another. Ms. Burr indicated the food throwing became such an issue; peanut butter was no longer purchased for a while due to it being misused. All three direct care staff acknowledged that, in hindsight, this behavior was inappropriate.

Additionally, none of staff had direct knowledge of Ms. Thorne's or Mr. Terpstra's purchases for Resident D. None of the direct care staff reported concerns about Mr. Terpstra's behavior towards Resident D either.

I also interviewed the facility's home manager, Marie Ulrich. Ms. Ulrich acknowledged direct care staff reporting Ms. Thorne and Resident D throwing food at one another, specifically peanut butter, and smearing it in each other's hair, but thought the behavior was "harmless" so she did not address it with Ms. Thorne. Ms. Ulrich stated direct care staff were not to buy gifts for residents or contact residents after working hours. She stated she was not aware of Ms. Thorne purchasing specific gifts for Resident D or direct care staff talking to Resident D after work hours until the investigation.

On 05/25/2022, I interviewed former direct care staff, Josh Terpstra, via telephone. Mr. Terpstra confirmed he worked at the facility starting 01/2020 until he was fired in 12/2021. He stated he and Resident D's relationship was "good, very jokey and fun loving." He stated Resident D had issues with boundaries and would engage in horseplay with him and other direct care staff by partaking in water gun fights, throwing food at staff, and covering direct care staff in markers. Mr. Terpstra stated he observed Ms. Thorne and Resident D throwing food at one another, including peanut butter. Mr. Terpstra stated he and other direct care staff would buy items for all residents, including Resident D, which consisted of "socks, snacks, and pop", but once staff discovered this was infringement on the licensee's policy they stopped. Mr. Terpstra denied purchasing anything inappropriate for Resident D including, but not limited to, sexual toys, cock rings, or porn subscriptions as alleged by Complainant. Mr. Terpstra denied purchasing food or drinks for Resident D in exchange for anything in return from Resident D. Mr. Terpstra denied giving his phone number to Resident D. He indicated Resident D got it from staff phone numbers being posted at work. Mr. Terpstra stated Resident D has contacted him via telephone since he left the facility; however, he indicated these conversations were benign in nature. For example, he stated Resident D contacted him to report when he received his money or to tell him when he spoke to relatives.

On 05/25/2022 and 06/10/2022, I attempted to interview former direct care staff, Sarah Thorn; however, I was unable to reach her, and she did not return my voicemails.

On 06/10/2022, I received an email from Ms. Gilmore, which stated it was her understanding that while there were identified areas of concern in Resident D's PCP, there was not, at the time he was at the facility, a formalized behavior support plan in place. She stated in her email it was her understanding Community Mental Health Case Management had requested a Behavioral Assessment be done and then a plan was expected to come out of that. Ms. Gilmore indicated she would not be substantiating the allegations.

According to SIR #2022A0462005, dated 12/17/2021, the facility was again in violation of certification of specialized programs rule 330.1806(1) when it was established a resident's Behavior Treatment Plan included a "freedom of movement restriction", but direct care staff did not implement the supervision and protection protocols as specified in the resident's Behavior Treatment when on 10/17/2021 the resident eloped from the facility unsupervised, went to the neighbors' home, and was transported back to the facility by a police officer.

Additionally, the investigation established two direct care staff, Robert Lovely and Joshua Terpstra, and four residents left the facility to go trick-or-treating before one of the resident's required 1:1 enhanced supervision ended at 6:00 PM. Based the investigation, there should have been at least three facility staff members with the four residents when leaving the facility; two direct care staff to provide two residents with 1:1 enhanced supervision and enhanced 1:1 supervision with "continuous attention" and at least one additional direct care staff to provide supervision and protection to the remaining two residents. Therefore, it was established when Mr. Lovely, Mr. Terpstra, and the four residents left the facility to go trick-or-treating on 10/31/2021, there was not a sufficient number of direct care staff to implement the supervision protocols indicated in two of the resident's Behavior Treatment Plans, and to provide supervision and protection to the remaining two residents.

The facility's approved Corrective Action Plan (CAP), dated 01/04/2022, stated direct care staff, Mr. Lovely, resigned from employment on 11/05/2021 and Mr. Terpstra was terminated effective 12/23/2021. The CAP stated all direct care staff were retrained on the resident's Behavior Treatment Plans and the requirements for supervision as outlined in their plan by 01/18/2022. The CAP indicated all staff would sign training acknowledgments which would be maintained in their personnel files. Additionally, the CAP stated the home manager, Marie Ulrich, would be retrained on scheduling by 01/18/2022 to ensure adequate staffing and ratios were maintained, at all times, with the enhanced staffing needs of several residents and to cover outings and appointments. The CAP stated Ms. Ulrich would sign a training acknowledgment, which would also remain in her personnel file. The licensee submitted Mr. Lovely's and Mr. Terpstra's "Change of Status" forms confirming they were no longer employed with the licensee. Additionally, the licensee submitted

training verification for direct care staff at the facility relating to specific resident Behavior Treatment Plans, mandatory reporting, and “line of sight” for specific residents.

According to SIR #2021A0462046, dated 10/08/2021, the facility was again in violation of certification of specialized programs rule 330.1806(1) when it was established two residents were not provided with their required 1:1 enhanced supervision, per their Behavior Treatment Plans, during the facility’s first shift. It was established the facility did not consistently schedule a sufficient number of direct care staff to provide this enhanced supervision, and also provide for the supervision, personal care, and protection of the facility’s other residents. The facility’s approved CAP, dated 10/22/2021, indicated the facility’s home manager received written “progressive disciplinary action” for not maintaining appropriate staffing ratios in the facility. A copy of this disciplinary action was received by the Department to verify compliance with the CAP.

According to SIR #2020A0462058, dated 10/01/2020, the facility was again in violation of certification of specialized programs rule 330.1806(1) when it was established after a review of pertinent documentation and photographs relevant to the investigation, as well as interviews with the licensee designee at that time, Patricia Miller, and home manager, Marie Ulrich, that according to a resident’s Behavior Support Plan, the resident was to be supervised by direct care staff while away from the facility; however, Resident D eloped from the facility unsupervised on 09/15/2020 and then again on 09/24/2020.

The facility’s approved CAP, dated 10/15/2020, stated the topic and importance of resident supervision and completing appropriate checks was reviewed by the facility’s home manager, Marie Ulrich and the facility’s District Director, Navi Kaur, at a meeting on 10/06/2020. Additionally, the licensee indicated the resident was in the transition of transferring to another facility with a fenced yard and more rural setting, but until the transfer took place the resident would be provided with enhanced 1:1 staffing. The CAP stated that going forward, the licensee would ensure staff have appropriate training on IPOS’ and BTP’s and that the licensee’s leadership team would explore additional staffing or other placement options for the resident should it be medically or clinically necessary after the resident was transferred.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.

ANALYSIS:	Based on my investigation, there is not enough evidence to indicate current or former direct care staff at the facility, including Joshua Terpstra, Sarah Thorne, Katrina Burr, Jamie Kniss, and/or Jessica Garten, exploited Resident D morally, socially or financially while working with him. Though Ms. Burr, Ms. Kniss and Ms. Garten acknowledged Resident D obtained their phone numbers and subsequently called/texted them after work hours, there was not enough to indicate these interactions or conversation were more than quick and benign conversations. All three direct care staff acknowledged subsequently blocking Resident D's phone number to prevent further contact. Additionally, while there was indication Ms. Thorne purchased several items for Resident D there was no evidence she purchased these items prior to ending her employment at the facility. There was also no evidence she purchased any items in exchange for anything from Resident D, which could further indicate exploitation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 303.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.

ANALYSIS:	Resident D's Community Mental Health Central Michigan *Person Centered Plan* (PCP), dated 01/22/2022, stated one of Resident D's goals was to "…get along with these guys most of the time" and the objective to this goal was to "…have appropriate social interactions with peer/staff on a daily basis as evidenced by no hitting; yelling; swearing; throwing objects etc. for 1 plan year". Despite this goal and objective being stated in Resident D's PCP, my interviews with direct care staff, Joshua Terpstra, Katrina Burr, Jamie Kniss, and Jessica Garten, and home manager, Marie Ulrich, indicated former direct care staff, Sarah Thorne, engaged in "food throwing" and horseplay with Resident D while he resided at the facility. All the staff I interviewed stated both Ms. Thorne and Resident D would both throw and smear peanut butter at and on one another indicating Ms. Thorne was not only not implementing Resident D's PCP but was an active participant in him not following his PCP.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[SEE SIR #2022A0462005, DATED 12/17/2021 AND CAP, DATED 01/04/2022]** **[SEE SIR #2021A0462046, DATED 10/08/2021 AND CAP, DATED 10/22/2021]** **[SEE SIR #2020A0462058, DATED 10/01/2020 AND CAP, DATED 10/15/2020]**

IV. RECOMMENDATION

Upon receipt on an acceptable plan of correction, I recommend no change in the current license status.

06/15/2022

Cathy Cushman — Date
Licensing Consultant

Approved By:

07/05/2022

Dawn N. Timm — Date
Area Manager