GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 6, 2022

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

RE: License #: AS370405093
Investigation #: 2022A0783035
Beacon Home At Mt Pleasant

Dear Ms. Goldammer:

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,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370405093
Investigation #:	2022A0783035
Complaint Receipt Date:	03/28/2022
Investigation Initiation Date:	03/29/2022
Report Due Date:	05/27/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home At Mt Pleasant
Facility Address:	4659 S Leaton Rd Mt Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/16/2020
License Status:	REGULAR
Effective Date:	05/16/2021
Expiration Date:	05/15/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Kristin Lewis locked residents out of the facility bathrooms.	Yes
Direct care staff member Kristin Lewis restricted Resident B's access to the telephone.	No
Direct care staff member Kristin Lewis forced Resident C to take a shower.	Yes
Direct care staff member Kristin Lewis used a "bossy" and "condescending" tone while speaking to residents.	Yes

III. METHODOLOGY

03/28/2022	Special Investigation Intake – 2022A0783035
03/29/2022	Special Investigation Initiated – Telephone call with Complainant
04/13/2022	Contact – Document Received – Second Complaint
04/22/2022	Contact - Face to Face with staff members Kevin Miley, Melinda Hepinstall, and Naomi Vorhees
04/22/2022	Contact - Face to Face interview with Resident B and attempted interviews with Residents A and D, unsuccessful
04/22/2022	Inspection Completed On-site
04/22/2022	Contact - Telephone call made to former direct care staff member Kristin Lewis, unsuccessful
04/22/2022	Contact - Document Received – Each resident's assessment plan, *Person Centered Plan*, and *Behavior Treatment Plan*
04/28/2022	Contact - Telephone call made to direct care staff member Angie Himebaugh
04/28/2022	Contact - Telephone call made to Kristin Lewis, unsuccessful
05/04/2022	Contact - Telephone call made to Kristin Lewis, unsuccessful

05/04/2022	Contact - Telephone call made to Relative B1
05/04/2022	Exit Conference with Roxanne Goldammer

ALLEGATION:

Direct care staff member Kristin Lewis locked residents out of the facility bathrooms.

INVESTIGATION:

On March 29, 2022, I received a complaint via centralized intake that stated direct care staff member Kristin Lewis has locked the bathroom doors not allowing the residents who live in the home to use the bathrooms.

On March 29, 2022, I spoke to Complainant who said she spoke to direct care staff member Angie Himebaugh and was told that direct care staff member Kristin Lewis locked one of the two facility bathroom doors because Resident A takes multiple baths throughout the day and gets water all over the bathroom, which Ms. Lewis did not want to clean so she locked the bathroom door where the bathtub is located so Resident A would not be able to take a bath. Complainant said she is familiar with the residents in the home and that Resident A and Resident C would not be able to "recant" anything that happened in the past and that Resident B has limited communication skills.

On April 28, 2022, I spoke to direct care staff member Angie Himebaugh who said on multiple occasions she worked with Ms. Lewis when she locked the bathroom door where the bathtub is located to prevent Resident A from getting into the bathtub because Resident A would get water all over the floor and Ms. Lewis did not want to clean the water. Ms. Himebaugh denied that Resident A nor any resident currently admitted to the facility has any restrictions or limits on bathing in his/her written assessment plan, person centered plan, nor treatment plan.

On April 22, 2022, I interviewed direct care staff member Kevin Miley who said he worked with Ms. Lewis on April 12, 2022, when she locked both bathroom doors which are designated for residents and the four residents who reside in the home did not have access to a bathroom. Mr. Miley said Ms. Lewis locked both bathroom doors because Resident A takes multiple baths daily and, in the process, gets water on the floor which Ms. Lewis did not want to clean. Mr. Miley said he told Ms. Lewis that she could not lock residents out of both bathrooms and that at least one bathroom needs to remain open. Mr. Miley said Ms. Lewis did not respond and "while [Ms. Lewis] was busy doing other things," Mr. Miley unlocked one of the two bathroom doors. Mr. Miley said throughout the shift Ms. Lewis continued to lock both

bathroom doors and he continued to go behind her and unlock one of the doors so that residents had access to a bathroom. Mr. Miley said Ms. Lewis was not aware that he was unlocking the doors. Mr. Miley denied that Resident A nor any resident currently admitted to the facility has any restrictions or limits on bathing in his/her written assessment plan, person centered plan, nor treatment plan.

On April 22, 2022, I interviewed direct care staff member Melinda Hepinstall who stated she was working with direct care staff member Kristin Lewis on April 12, 2022, when Ms. Lewis locked both bathroom doors designated for resident use at the facility leaving residents with no access to a bathroom. Ms. Hepinstall said April 12, 2022, was not the only day she worked with Ms. Lewis and observed that she locked both bathroom doors. Ms. Hepinstall said Ms. Lewis locked the bathroom doors because Resident A prefers to take multiple baths daily which gets water on the floor and Ms. Lewis did not want to clean the water. Ms. Hepinstall said she did not have keys to unlock the bathroom doors but on April 12, 2022, direct care staff member Kevin Miley unlocked one of the bathroom doors. Ms. Hepinstall denied that Resident A nor any resident currently admitted to the facility has any restrictions or limits on bathing in his/her written assessment plan, person centered plan, nor treatment plan.

On May 4, 2022, I spoke to direct care staff member Gage Lynch who said while he never directly observed Ms. Lewis lock the resident bathroom doors, she told him that she locked one bathroom door to prevent Resident A from bathing multiple times daily because he got water on the floor while bathing.

On April 22, 2022, I interviewed direct care staff member and assistant home manager Naomi Vorhees who stated she never observed Ms. Lewis lock either bathroom designated for resident use. Ms. Vorhees said other staff members reported that Ms. Lewis locked both bathroom doors designated for residents. Ms. Vorhees denied that Resident A nor any resident currently admitted to the facility has any restrictions or limits on bathing in his/her written assessment plan, person centered plan, nor treatment plan.

On April 22, 2022, I interviewed Resident B who stated he knew direct care staff member Kristin Lewis and confirmed that she “locks [residents] out of the bathroom,” but was not willing or able to provide any additional information. On the same day I attempted to interview Resident A, who is expressively non-verbal, Resident C who was not home, and Resident D who was playing cards and refused to participate in an interview.

On April 22, 2022, April 28, 2022, and May 4, 2022, I telephoned former direct care staff member Kristin Lewis and was not able to reach her. Ms. Lewis has not returned my call as of the date of this report.

On April 22, 2022, I reviewed each resident’s written *Assessment Plan for AFC Residents*, *Person Centered Plan* from Community Mental Health of Central

Michigan, and *Behavior Treatment Plan*, if relevant. I noted that Resident A, nor any other resident admitted to the facility, had any restrictions placed on access to the facility bathroom nor the bathtub.

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:	Based on statements from Complainant, Ms. Himebaugh, Ms. Hepinstall, Mr. Miley, Mr. Lynch, Ms. Vorhees and Resident B along with written documentation in each resident's resident record, I determined that on multiple occasions at least one of the two facility bathroom doors were locked and specifically the bathroom containing the bathtub where Resident A prefers to bathe. There were no restrictions or limitations placed on any resident's access to the shower or bathtub and thus when Ms. Lewis locked the bathroom door, she restricted each resident's access to the bathroom and did not provide protection, personal care, and supervision according to the residents' written assessment plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care staff member Kristin Lewis restricted Resident B's access to the telephone.

INVESTIGATION:

On March 29, 2022, I received a complaint via centralized intake that stated direct care staff member Kristin restricted Resident B's access to the telephone by only allowing him to call family at certain times.

On March 29, 2022, I spoke to Complainant who said Ms. Lewis only allows Resident B to call Relative B1 at 10:00 am, 3:30 pm, and 7:30 pm which violates Resident B's right to have reasonable access to a telephone. Complainant said Resident B will at times attempt to call Relative B1 early in the morning which she requested he not do, and that staff members can attempt to redirect Resident B but not restrict him to only call Relative B1 at 10:00 am, 3:30 pm, and 7:30 pm.

On April 22, 2022, I interviewed direct care staff member Kevin Miley who said he worked with direct care staff member Kristin Lewis on several occasions and never observed that she restricted Resident B's telephone access "unless [Resident B] was trying to call [Relative B1] at 10:00 o'clock at night."

On April 22, 2022, I interviewed direct care staff member Melinda Hepinstall who said Relative B1 requested that Resident B call her at 10:00 am, 3:00 pm and 7:00 pm so staff members would encourage Resident B to call Relative B1 at those times per her request. Ms. Hepinstall said if Resident B insisted on calling Relative B1 outside of the hours she requested all staff members would redirect Resident B to at least wait until 10:00 am to call Relative B1 as Resident B would often want to call early in the morning. Ms. Hepinstall said she heard Ms. Lewis tell Resident B that he needed to wait a half hour to call Relative B1 per Relative B1's request. Ms. Hepinstall denied that Ms. Lewis restricted Resident B's telephone access other than asking Resident B to wait and call at the times requested by Relative B1.

On May 4, 2022, I spoke to direct care staff member Gage Lynch who stated he worked with Ms. Lewis "quite a few times" and that Ms. Lewis told him Resident B was "supposed to" call Relative B1 at prearranged times throughout the day. Mr. Lynch said Ms. Lewis "never refused" to allow Resident B to use the telephone but that she was "bossy" and "stern" about asking Resident B to wait and call at the prearranged times.

On April 22, 2022, I interviewed direct care staff member and assistant home manager Naomi Vorhees who said all staff members were asked by Relative B1 to redirect Resident B from calling before 10:00 am. Ms. Vorhees denied that she ever saw Ms. Lewis restrict Resident B's access to the telephone other than asking him to wait if he wanted to call Relative B1 before 10:00 am.

On April 22, 2022, I interviewed Resident B who said all staff members "ask [him] to wait" if he wants to call Relative B1 "too early." Resident B denied that Ms. Lewis nor any other staff member restricted has access to the telephone in any way except for asking him to wait until 10:00 am to call per Relative B1's request.

On May 4, 2022, I spoke to Relative B1 who confirmed she requested that Resident B wait until at least 10:00 am to call her and that she also requested that he call her at 3:00 pm and 7:00 pm so that she would be prepared to speak to Resident B. Relative B1 said staff members encourage Resident B to call her at the prearranged times but that they cannot restrict his access to the telephone and he has called her outside of the prearranged times on many occasions. Relative B1 said Resident B has also telephoned her many more times than three times daily because staff members can only "remind" or "encourage" him to call three times daily at the prearranged times.

On April 22, 2022, April 28, 2022, and May 4, 2022, I telephoned former direct care staff member Kristin Lewis and was not able to reach her. Ms. Lewis has not returned my call as of the date of this report.

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: **(e) The right of reasonable access to a telephone for private communications. Similar access shall be granted for long distance collect calls and calls which otherwise are paid for by the resident. A licensee may charge a resident for long distance and toll telephone calls. When pay telephones are provided in group homes, a reasonable amount of change shall be available in the group home to enable residents to make change for calling purposes.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on statements from Mr. Miley, Ms. Hepinstall, Mr. Lynch, Ms. Vorhees, Resident B, and Relative B1 I determined that staff members encouraged Resident B to contact Relative B1 after 10:00 am, and at approximately 3:00 pm and 7:00 pm per Relative B1's request but Ms. Lewis nor any other staff member removed Resident B's access to the telephone and he was able to call Relative B1 more than three times daily and at any time he insisted on calling her despite being redirected.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff member Kristin Lewis forced Resident C to take a shower.

INVESTIGATION:

On April 13, 2022, I received a second complaint via centralized intake that stated during the evening shift on April 12, 2022, direct care staff member Melinda Hepinstall was assigned to work one-on-one with Resident C and observed as direct

care staff member Kristin Lewis forced Resident C to take a shower after he refused. The written complaint stated Ms. Hepinstall was attempting to get Resident C to take a shower when staff member Kristen Lewis stepped into the bathroom and said to Resident C, "Get in the shower, get in the shower or you are not going to school tomorrow," or something similar. The complaint stated Ms. Hepinstall told Ms. Lewis that it was Resident C's "right to refuse" to take a shower which she wanted to respect. The complaint stated Ms. Lewis responded, "No, he is being stubborn and I can be stubborn too." The complaint stated Ms. Hepinstall reported that the bathroom door was closed and Ms. Lewis stood in front of the door and said to Resident C, "You are not leaving until you take a shower." The written complaint said Ms. Hepinstall reported that Ms. Lewis left the bathroom and came back with a plastic bowl and used it to shower Resident C "over the drain, outside of the shower where he was standing."

On April 13, 2022, I spoke to Complainant 2 who confirmed the allegations in the written complaint and stated there were no additional details to provide.

On April 22, 2022, I interviewed direct care staff member Melinda Hepinstall who stated on April 12, 2022, she was assigned to work one-on-one with Resident C and that when she arrived at 3:00 pm Ms. Lewis informed her that Resident C needed to take a shower after medication was administered and snack was served. Ms. Hepinstall said at approximately 7:45 pm she went into the bathroom with Resident C to assist him with a shower and Resident C was standing outside the shower with his head down and would not get into the shower. Ms. Hepinstall said she verbally prompted Resident C to get into the shower several times before Ms. Lewis opened the door and asked what was going on. Ms. Hepinstall said she told Ms. Lewis that Resident C refused to take a shower and that he had taken one the day before so she "wasn't going to push it." Ms. Hepinstall said Ms. Lewis stated, "if [Resident C] wants to be stubborn I can be stubborn too" and left the bathroom. Ms. Hepinstall said Ms. Lewis returned to the bathroom and told Resident C that he would not be able to go to school the following day if he did not take a shower and that he would not be "the stinky kid at school." Ms. Hepinstall said Ms. Lewis told Resident C that she was not leaving the bathroom until Resident C took a shower and stood in front of the door, blocking Resident C from leaving the bathroom. Ms. Hepinstall said Ms. Lewis left the bathroom and returned with a mixing bowl which she filled with cold water and dumped over Resident C's head as he stood outside the shower. Ms. Hepinstall said Resident C appeared "terrified," and that he was "cowering" as Ms. Lewis poured water over Resident C's head. Ms. Hepinstall said after that she quickly washed Resident C's body and Ms. Lewis poured water in Resident C to rinse him. Ms. Hepinstall said after that Resident C got into the shower and Ms. Lewis "threw water on" Resident C again as he stood in the shower.

On April 22, 2022, I interviewed direct care staff member Kevin Miley who stated he worked at the facility with Ms. Hepinstall and Ms. Lewis on April 12, 2022. Mr. Miley said he observed that Ms. Hepinstall was in the bathroom with Resident C and that she was "having problems" getting Resident C into the shower so Ms. Lewis went

into the bathroom. Mr. Miley said he heard Ms. Lewis tell Resident C that if he did not shower, he would not be allowed to attend school the following day. Mr. Miley said he heard Ms. Lewis tell Resident C that she would not let him out of the bathroom until he took a shower. Mr. Miley said while speaking to Resident C Ms. Lewis was “mean, rude, and disrespectful.” Mr. Miley said he observed Ms. Lewis come into the kitchen and that she took a large bowl and returned to the bathroom with the bowl. Mr. Miley said after Ms. Hepinstall, Resident C and Ms. Lewis came out of the bathroom he asked to speak to Ms. Hepinstall in private and she confirmed that Ms. Lewis told Resident C that if he did not take a shower he could not go to school and that she would not leave the bathroom until he took a shower. Mr. Miley said Ms. Hepinstall told him that Ms. Lewis “forced [Resident C] to take a shower against his will,” and that she “dumped” water on Resident C’s head which she said she “did because she could.”

On April 22, 2022, I interviewed direct care staff member and assistant home manager Naomi Vorhees who said on April 13, 2022, staff member Kevin Miley reported to her that he heard Ms. Lewis tell Resident C that if he did not shower, he would not be allowed to attend school the following day and that Ms. Lewis would not let Resident C out of the bathroom until he took a shower. Ms. Vorhees said Mr. Miley reported that Ms. Lewis poured cold water on Resident C, essentially forcing him to take a shower when he refused. Ms. Vorhees said after the alleged incident Resident C refused to shower for “a couple of days,” and stated that he was “afraid” to shower, which he had never said before. Ms. Vorhees said Resident C also started refusing to have his hair washed.

On May 4, 2022, I spoke to direct care staff member Gage Lynch who stated he was not present when Resident C was forced to take a shower and had water poured in his head but said he was aware that happened and that staff member Kristin Lewis was responsible. Mr. Lynch said since that time Resident C has been “nervous” about getting in the shower in general and especially reluctant to allow staff members to wash his hair.

On May 4, 2022, I attempted to interview Resident C by telephone but he was unwilling or unable to successfully participate in the interview and I was not able to gather any information from Resident C.

On April 22, 2022, April 28, 2022, and May 4, 2022, I telephoned former direct care staff member Kristin Lewis and was not able to reach her. Ms. Lewis has not returned my call as of the date of this report.

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: **(m) The right to refuse treatment and services, including the taking of medication, and to be made aware of the consequences of that refusal.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on statements from Complainant, Ms. Hepinstall, Mr. Miley, and Mr. Lynch I determined that direct care staff member Kristin Lewis did not observe Resident C's right to refuse treatment and services when she tried to coerce him into taking a shower by threatening that he would not be able to attend school and that he would not be able to leave the bathroom as she stood in front of the door. Further, Ms. Lewis poured water over Resident C's head as he stood outside the shower, thereby forcing him to take a shower after he clearly indicated he did not want to take a shower. Finally, although she later reported the incident, direct care staff member Melinda Hepinstall was also responsible for not observing Resident C's right to refuse a shower when she "quickly washed him up" after Ms. Lewis poured water on Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care staff member Kristin Lewis used a "bossy" and "condescending" tone while speaking to residents.

INVESTIGATION:

On March 29, 2022, I received a complaint via centralized intake that stated direct care staff member Kristin Lewis used a "bossy" and "condescending tone" while speaking to the residents at the facility.

On March 29, 2022, I spoke to Complainant who said direct care staff member Kristin Lewis was described as "mean, rude, controlling, and bossy" toward the residents. Complainant said Ms. Lewis has a history of being substantiated for violating residents' rights.

On April 28, 2022, I spoke to direct care staff member Angie Himebaugh who described direct care staff member Kristin Lewis's tone toward residents as "bossy" and "condescending." When asked to provide examples Ms. Himebaugh said Ms.

Lewis told Resident C to go to his bedroom when he was sitting quietly on the couch and that she told Resident A to “go sit down” when he was walking which is a method Resident A uses to regulate his emotions.

On April 22, 2022, I interviewed direct care staff member Kevin Miley who said he worked with direct care staff member Kristin Lewis on many occasions and observed her to be “rude and condescending” toward residents and that she “treats them like children.” Mr. Miley was not able to provide any specific examples of Ms. Lewis being “rude and condescending.”

On April 22, 2022, I interviewed direct care staff member Melinda Hepinstall who said staff member Kristin Lewis was “rude and condescending” toward residents on a regular basis. Ms. Hepinstall stated she reported these instances to the office of recipient rights and that Ms. Lewis commented that the residents were “dirty,” called Resident A a derogatory name, and stated the residents should have been physically disciplined when they were children.

On May 4, 2022, I spoke to direct care staff member Gage Lynch who said Ms. Lewis spoke to residents in a “loud voice,” and was very “demanding.” When asked to provide specific examples Mr. Lynch said he worked as a correctional officer in the past and did not hear coworkers speak to inmates in the tone that Ms. Lewis used with residents.

On April 22, 2022, I interviewed direct care staff member and assistant home manager Naomi Vorhees who said she never heard Ms. Lewis speak to residents in a “bossy,” “rude,” nor “condescending” tone.

On April 22, 2022, April 28, 2022, and May 4, 2022, I telephoned former direct care staff member Kristin Lewis and was not able to reach her. Ms. Lewis has not returned my call as of the date of this report.

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:	Based on statements from Complainant, Ms. Himebaugh, Mr. Miley, Ms. Hepinstall, and Mr. Lynch there was consistent reporting that staff member Kristin Lewis was regularly "rude," "bossy," and "condescending" toward residents, which is a violation of the residents' right to be treated with consideration and respect.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Leslie Herrguth 05/04/2022

Leslie Herrguth Date
Licensing Consultant

Approved By:

Dawn Timm 05/06/2022

Dawn N. Timm Date
Area Manager