GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 21, 2022

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

RE: License #:	AM610088673
Investigation #:	2022A0356033
	Beacon Home at Morton Terrace

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM610088673
Investigation #:	2022A0356033
Complaint Receipt Date:	08/12/2022
Investigation Initiation Date:	08/15/2022
Report Due Date:	10/11/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St., Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Suzy Hunter
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home at Morton Terrace
Facility Address:	3929 Hess Street Norton Shores, MI 49444
Facility Telephone #:	(231) 733-2751
Original Issuance Date:	02/01/2000
License Status:	REGULAR
Effective Date:	08/01/2022
Expiration Date:	07/31/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, TRAUMATICALLY BRAIN INJURED, DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive proper supervision from facility staff.	Yes

III. METHODOLOGY

08/12/2022	Special Investigation Intake 2022A0356033
08/12/2022	APS Referral-denied.
08/15/2022	Special Investigation Initiated - Telephone LaToya Hendricks, home manager.
08/17/2022	Inspection Completed On-site
08/17/2022	Contact - Face to Face Resident A, DCW, Carmen Mariadel Burns.
08/17/2022	Contact - Face to Face LaToya Hendricks, home manager.
08/19/2022	Contact - Document Received Facility documents.
09/20/2022	Contact-Telephone call made Amy Adamo, HealthWest supports coordinator. Emily Ketelhut MSW, Master Level Clinician, HealthWest
09/20/2022	Exit Conference-Licensee Designee, Roxanne Goldammer.

ALLEGATION: Resident A did not receive proper supervision from facility staff.

INVESTIGATION: On 08/12/2022, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported that Resident A was in Resident B's bedroom standing over her bed exposing himself. The complainant reported nothing happened beyond the exposure. Adult Protective Services denied this for investigation.

On 08/15/2022, I interviewed LaToya Hendricks, home manager via telephone. Ms. Hendricks stated this incident occurred approximately 1:00p.m. on 08/07/2022 and staff were cleaning up after lunch when Resident A used the bathroom next to

Resident B's room and went into her room after using the bathroom on her end of the hallway. Ms. Hendricks explained that typically Resident A uses the bathroom next to his own room, but the bathroom was occupied so he went down the hall to the bathroom next to Resident B's bedroom. Ms. Hendricks stated staff heard Resident B yell and Resident C informed staff that he saw Resident A in Resident B's room. Ms. Hendricks stated Resident B reported she woke up in her bed at the facility and Resident A was standing next her bed with his penis out of his pants. Ms. Hendricks stated Resident B yelled for staff, Resident A left the room and Resident B reported Resident A did not touch her and nothing sexual happened while Resident A was in her room. Ms. Hendricks stated staff redirected Resident A and he quickly left Resident B's room. Staff immediately implemented increased checks on Resident A. Ms. Hendricks stated Resident A is "line of sight" supervision while in the facility with 5-minute checks if he is outside in the enclosed backyard.

On 08/17/2022, I conducted an unannounced inspection at the facility and interviewed Resident B. Resident B stated Resident A "exposed himself to me." Resident B stated she was sleeping, and Resident A woke her up standing next to her bed and he said, "I had pretty eyes or how do you like these pretty eyes." Resident B stated Resident A did not touch her but "it seems like he has touched me before, it seems like he rubbed his penis on my mouth before." Resident B stated Resident A has, "done this before several times" (come into her room) and this time, "I yelled rape, rape, rape," and staff came and got him out of the room.

On 08/17/2022, Resident A was not available to be interviewed at the time of the inspection.

On 08/17/2022, I interviewed Ms. Hendricks while at the facility. Ms. Hendricks stated Resident A has never touched Resident B in a sexual way or put his penis is Resident B's face that she (Ms. Hendricks) has been made aware of. Ms. Hendricks stated Resident B will readily report things of that nature. Ms. Hendricks stated Resident A is considered "line of sight" supervision while in the facility and staff should know Resident A's whereabouts while in the facility.

On 08/17/2022, I interviewed Direct Care Worker (DCW) Carmen Burns. Ms. Burns stated she was working when this incident occurred. Ms. Burns stated she was working with two other DCW's, Sharie Dahl was in the common area assisting another resident and DCW Andre Banks was in the kitchen. Ms. Burns stated she was in the back office making copies and heard Resident B yell but did not hear Resident B yell "rape." Ms. Burns stated they responded to Resident B's room and found Resident A in her room. Ms. Burns stated Resident B reported that she looked up from her bed and Resident A was standing next to her bed with his penis out of his pants. Ms. Burns described Resident A's supervision needs as "line of sight."

On 08/19/2022, I reviewed the Incident Report (IR) dated 08/07/2022, written by DCW Sharie Dahl and signed by David Schmitz on 08/08/2022. The IR documented the following information: *'It was reported to staff at 2:10p.m. by a resident that*

*(*Resident A*) was in a female residents room, and he was exposing himself to her. When staff headed down the hallway (*Resident A*) was coming toward staff. Staff asked if he had been in the female resident's room he just stared and said nothing. Staff went to female residents room and asked her if something had just happened, she replied yes that (*Resident A*) had been in her room with his penis hanging out. It was stated that he did not touch this client he was just standing in the room. HM was notified of this incident. Action taken by staff: Staff had just seen (*Resident A*) going to his room, after a few minutes one of his housemates was heard yelling and staff went to see what was wrong. Staff verbally redirected (*Resident A*) and reminded him that going into someone else's room was not appropriate. (*Resident A*) did not respond to staff and walked to his room. Staff continued to monitor (*Resident A*) throughout the shift. Home Manager did call Adult Protective Services to report the incident. Staff will continue to complete checks on (*Resident A*) and verbally redirect when he engages in inappropriate sexual behavior. Staff reminded (*Resident A*) of appropriate interactions with others and that going into others rooms was not appropriate. Staff completed checks on (*Resident A*) and reported the incident. Home will also contact his behavior specialist to report the incident and follow all recommendations given.'*

On 08/19/2022, I received and reviewed Resident A's assessment plan for AFC residents. The document is signed by LD Roxanne Goldammer on 08/09/2022, Relative #1 on 08/08/2022, and Roshana Dotson, HealthWest on 07/21/2022. The document shows that Resident A does not control sexual behavior and describes the following; *'(Resident A) has restrictions in the community due to prior CSC (criminal sexual behavior) and inappropriate behaviors. Staff will follow his plan and will monitor (Resident A) for any signs of inappropriate behavior and redirect, document and report any issues.'*

On 08/19/2022, I received and reviewed Resident A's behavior treatment plan written and signed by Emily Ketelhut, LMSW, updated 07/20/2022. The behavior treatment plan documents on page 12 of the 13-page the following information:

- *Do not allow (*Resident A*) to be alone with any female housemates (this includes in the smoking area in the back yard).'*
- *If* (Resident A) *is alone in his bedroom, you can provide 15-minute checks instead of 5-minute checks.*
- *(*Resident A*) can independently use the restroom at the home.*
- *Provide (*Resident A*) with 5-minute checks when he is in the back yard. The gate to the fence in the backyard of the home is to be locked at all times.*
- *(*Resident A*) can visit with his HealthWest treatment team at the home without AFC staff providing line of sight supervision.*
- *Provide line of sight supervision if (*Resident A*) is outside out of the fenced in area.*

On 09/20/2022, I interviewed Ms. Ketelhut via telephone. Ms. Ketelhut stated staff at the facility should know Resident A's whereabouts in the facility and if staff know that Resident A is alone, such as in the bathroom or in his bedroom, he does not need to

be in line of sight but rather staff should check on him every 5-15 minutes depending on where he is. Ms. Ketelhut explained if Resident A is in the presence of other residents especially women, staff must have him in their line of sight. Ms. Ketelhut stated since this incident, she has updated Resident A's behavior treatment plan with more specific instructions for staff to follow for resident supervision. Ms. Ketelhut stated the plan includes some assistive devices such as door alarms to help staff monitor and keep track of Resident A's whereabouts better. Ms. Ketelhut stated Resident A is still not to be alone with female residents inside or outside of the facility.

On 09/20/2022, I conducted an Exit Conference with Licensee Designee, Roxanne Goldammer via telephone. Ms. Goldammer stated she will review the report and submit an acceptable corrective action plan.

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:	Resident A's assessment plan documents that Resident A is not able to control sexual behaviors and Resident A's behavior treatment plan documents that Resident A should not be alone with female residents. On 08/07/2022, Resident A entered Resident B's room at the facility and while alone with Resident B, Resident A exposed his genitals to Resident B and staff were made aware of the incident by Resident C and by Resident B shouting. There is a preponderance of evidence to show that Resident A was not properly supervised on this date as documented in his assessment and behavior treatment plan. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

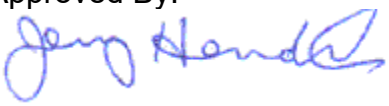
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

09/20/2022

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



09/21/2022

Jerry Hendrick — Date
Area Manager