GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 16, 2022

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

RE: License #: AS500387650
Investigation #: 2023A0604002
Beacon Home at Chesterfield

Dear Ms. Rawlings:

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 (248) 975-5053.

Sincerely,

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500387650
Investigation #:	2023A0604002
Complaint Receipt Date:	10/13/2022
Investigation Initiation Date:	10/14/2022
Report Due Date:	11/12/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 - 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Rawlings
Licensee Designee:	Kimberly Rawlings
Name of Facility:	Beacon Home at Chesterfield
Facility Address:	34205 24 Mile Road Chesterfield, MI 48047
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	09/13/2017
License Status:	REGULAR
Effective Date:	03/13/2022
Expiration Date:	03/12/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff, Dan Ganim, documented that he dispensed two units of insulin to Resident A, however, resident was not given any insulin.	Yes
Resident A went on an outing to Frankenmuth with the group home and had a lot of carbs and sugar against recommendations.	No
Additional Findings	Yes

III. METHODOLOGY

10/13/2022	Special Investigation Intake 2023A0604002
10/13/2022	APS Referral Intake indicates Adult Protective Services (APS) referral denied. Referred to licensing.
10/14/2022	Special Investigation Initiated - Telephone TC to Complainant. Left message
10/14/2022	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Home Manager, Pam Grawbarger and Resident A. Received diet prescription and reports regarding incident.
10/14/2022	Contact - Telephone call received TC from Complainant
10/14/2022	Contact - Telephone call made TC to Licensee Designee, Kimberly Rawlings. Voicemail full.
10/14/2022	Contact - Document Sent Email to Kimberly Rawlings
10/14/2022	APS Referral Made another referral to APS. Referral denied.
10/14/2022	Contact - Telephone call received Received message from Kimberly Rawlings. Staff will not be passing medications until retrained.

11/02/2022	Contact- Telephone call received TC from Recipient Rights, Johnna Kopah. New allegation that Staff, Dan Ganim, brought gun to home.
11/02/2022	Contact - Document Received Received return email from Kimberly Rawlings. She was unaware of new allegations re: gun
11/03/2022	Contact - Document Sent Email to and from Pamela Grawbarger re: onsite and received incident reports
11/04/2022	Inspection Completed On-site Interviewed Pam Grawbarger, Staff Kelly Rumohn, Resident A, Resident B Resident C and Resident D regarding additional allegations. Resident E did not want to be interviewed.
11/04/2022	Contact - Document Sent Email to and from Debra Johns and Johnna Kopah regarding additional allegations.
11/04/2022	Contact - Document Sent Email to Kimberly Rawlings requesting staff records.
11/14/2022	Contact - Document Received Email to and from Kimberly Rawling requesting employee record.
11/14/2022	Contact - Document Sent Received Daniel Ganim employee records from Joi Meeks
11/17/2022	Contact - Document Received Email from APS Worker, Debra Johns. Police will not be investigating as Dan Ganim is no longer working at home.
11/18/2022	Contact - Document Sent Email to and from Debra Johns. APS will be substantiating.
12/14/2022	Contact- Document Sent Email to Home Manger, Pamela Grawbarger
12/15/2022	Exit Conference Completed exit conference with Ramon Beltran by phone. Mr. Beltran’s is designated person during Licensee Designee, Kimberly Rawlings absence.

ALLEGATION:

- **Staff, Dan Ganim, documented that he dispensed two units of insulin to Resident A, however, resident was not given any insulin.**
- **Resident A went on an outing to Frankenmuth with the group home and had a lot of carbs and sugar against recommendations.**

INVESTIGATION:

I received a complaint regarding Beacon Home at Chesterfield on 10/13/2022. It was alleged that Resident A has a medical diagnosis of diabetes with insulin dependency, and high blood pressure. Resident A has a mental health diagnosis of bi-polar disorder-manic. Last Wednesday, Resident A went on an outing to Frankenmuth with the group home and had a lot of carbs and sugar against recommendations. Once the group returned to the home, staff forgot to bring the glucometer and insulin from the van. Staff, Dan Ganim elected to make up a number for Resident A's blood sugar instead of retrieving the meter from the van, and then indicated he dispensed two units of insulin. However, he did not dispense any medications because the medication was still in the van.

Staff, Dan Ganim received a write up regarding the incident and admitted that he lied about the medication and felt that it was no big deal. Resident A did not suffer any adverse effect from not having his blood sugar read or not receiving any insulin following the outing.

On 10/14/2022, I completed an unannounced onsite investigation at Beacon Home at Chesterfield. I Interviewed Home Manager, Pam Grawbarger and Resident A. I received diet prescription and reports regarding the incident.

On 10/14/2022, I interviewed Home Manger, Pam Grawbarger. She stated that residents were taken to Frankenmuth for an outing on 10/05/2022. When they returned home from the outing, staff brought in all the medications from the van, however, left Resident A's glucose meter and insulin in the van. Ms. Grawbarger stated that staff, Dan Ganim, was responsible for passing medications when they returned home. He did not retrieve glucose meter from van to check Resident A's insulin. Mr. Ganim made up a number and falsely documented Resident A's blood sugar and that he gave him two units of insulin. Ms. Grawbarger stated that they realized what occurred when staff found that Resident A's items were never retrieved from the van the next day. Ms. Grawbarger stated that Mr. Ganim was written up and recipient rights was notified. Mr. Ganim also falsified his coworkers name on the log by indicating a second staff confirmed insulin was given. Ms. Grawbarger stated that Human Resources indicated that they need to determine any disciplinary action for Mr. Ganim and whether he will continue to pass medications. Ms. Grawbarger stated that she has no indication that Mr. Ganim has done this before.

Ms. Grawbarger stated that Resident A was not prescribed a special diet prior to the outing. She believed he ate meat, potatoes, cottage cheese and applesauce in Frankenmuth. She stated that Resident A also bought taffy. He can choose what he eats and holds his own funds on a Trulink card. She stated that they follow the My25 meal plan at the home. They encourage Resident A to eat sugar free options. Ms. Grawbarger stated that Resident A received a prescription for special diet on 10/07/2022 after the incident occurred which indicates Resident A should not eat sugar or pasta and only eat complex carbohydrates.

On 10/14/2022, I interviewed Resident A. He stated that he was not given insulin after the trip to Frankenmuth because his kit was still in the car. He stated that staff thought the kit was missing so he asked staff, Dan, not to take his blood sugar and to forgot about it. He stated that he did not want his blood sugar checked. He stated that Dan scares him. He alleged that Dan crushes pills and snorts them. Resident A stated Dan is a thief and a drug addict. He also stated that Dan throws towels at people. Resident A stated that when he was in Frankenmuth, he had a hamburger and bought a case of taffy. Resident A stated that he was just put on a special diet.

The Home Manager, Pam Grawbarger stated that there has been no evidence of Dan using drugs. She stated that Resident A does have a history of saying things that are not true.

On 10/14/2022, I made another referral to APS regarding the additional allegations. The referral was denied.

On 10/14/2022, I was given a copy of Resident A's prescription dated 10/07/2022 for special diet. The prescription indicates no sugar, only complex carbohydrates, no pasta.

On 10/14/2022, I interviewed Complainant by phone. The Complainant stated that they were very concerned that Dan Ganim was not pulled from passing medications. She stated that Resident A has been having high blood sugar and not checking his blood sugar was very dangerous. Complainant does not feel that extra training is sufficient to address the incident with staff.

On 10/14/2022, I sent an email and attempted to leave a voicemail for licensee designee, Kimberly Rawlings regarding concerns with Mr. Ganim continuing to pass medications. I received a message from licensee designee, Kimberly Rawlings which indicated Dan Gamin would be removed from passing medications and he would be redoing medication training. Mr. Ganim was eventually terminated on 10/16/2022 due to the incident.

On 10/14/2022, I received a copy of Progressive Action Form for Staff, Dan Ganim dated 10/06/2022. The form indicated that Mr. Ganim was written up for failing to take Resident A's blood sugar on 10/05/2022 and falsely documenting that he was given two units of Novalog. The report also indicates that Mr. Ganim will no longer be Designated

Medication Administrator (DMA) until further notice. The form was signed by Dan Ganim and Pam Grawbarger. A second Progressive Action Form was provided dated 10/06/2022. The report indicates that on 10/06/2022, once Dan Ganim was given his progressive action for failure to give insulin, he went into the kitchen and became upset and loud, slamming his cell phone on the table. Home Manager, Pam Grawbarger asked him to leave the home. The form is signed by Pam Grawbarger.

On 10/14/2022, I received a copy of Second Staff Verification Form for October 2022. The form logs Resident A's blood sugar daily and units of insulin given. Two staff must verify on the form that insulin was given. Home Manager, Pam Grawbarger stated that Mr. Ganim falsified entry on 10/05/2022. The log indicates that Resident A had a blood sugar of 170 at 8 pm and was given two units of Novolog. The staff verifying is listed as Dan / Bill. However, Ms. Grawbarger stated that Dan falsified Bill's name on the log, and he was not present to verify insulin was given. Ms. Grawbarger also provided copy of the chart that staff use to determine how much insulin Resident A should be given. Chart indicates that Resident A is to be given two units of insulin if blood sugar is between 150-199.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A's insulin was not given as prescribed. On 10/05/2022, Staff Daniel Gamin failed to take Resident A's blood sugar and falsely documented that he was given two units of Novalog. Mr. Ganim was terminated on 10/16/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	There is not enough information to determine that the home gave Resident A carbs and sugar while in Frankenmuth against recommendations. Home Manager, Pamela Grawbarger, provided a copy of Resident A's special diet which was prescribed on 10/07/2022, after the trip to Frankenmuth on 10/05/2022. Resident A did purchase taffy while on the trip, however, holds his own funds and is able to spend his money

	how he chooses. Ms. Grawbarger stated that they try to encourage Resident A to choose sugar free options.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/02/2022, I received a phone call from Recipient Rights Specialist, Johnna Kopah. She stated that four residents reported that Dan Ganim brought a gun to THE home, unloaded it, and pointed it at Resident D. She stated that the four residents who saw the incident, smoke outside where the incident occurred. She stated that Home Manager, Pamela Grawbarger, was going to complete incident reports. Ms. Kopah stated that Dan Ganim has already been terminated due to the insulin incident.

On 11/02/2022, I received an email from APS Worker, Debra Johns. Ms. Johns stated that she has been assigned case regarding the gun allegation.

On 11/04/2022, I completed a second onsite investigation. I interviewed Home Manager, Pam Grawbarger, Staff Kelly Rumohn, Resident A, Resident B, Resident C and Resident D regarding additional allegations. Resident E did not want to be interviewed.

On 11/04/2022, I interviewed Home Manager, Pamela Grawbarger. She stated that Dan Ganim was terminated on 10/16/2022 due to the insulin incident. She stated that the home was contacted by a detective from the Chesterfield Police Department. Ms. Grawbarger completed incident reports once she became aware of the gun allegation.

On 11/04/2022, I interviewed Resident A. He stated that he had no concerns, and it is good Dan is no longer working at home. He stated that Dan pulled a gun from the back seat of the car. He did not see Dan point the gun at anyone. He stated that Dan told him he was in a gang. He alleged that Dan is addicted to Percocet and mixes pills with cocaine. He stated that Dan has used marijuana at the home and he saw Dan and Mike with something that looked like cocaine in the van. Resident A stated that Dan would make large, wet balls of paper towel and throw them at residents. He stated that Dan hit him with one of the paper towel balls when he was sleeping. Dan said he did it because he was bored.

On 11/04/2022, I interviewed Resident B. He stated that he receives all of his medications. He stated that Dan Ganim and Resident E threw paper towels at people. He stated that he did not see Mr. Ganim with a gun at the home.

On 11/04/2022, I interviewed Resident C. He stated that he receives all his medications. He stated that Staff, Dan, threw wet paper towels at residents including at their backs

and faces. Resident C stated that Dan pointed a gun at Resident D outside about a month and a half ago. He stated that Dan also pointed gun towards his eyes. Resident C indicated that on one occasion Dan took out brass knuckles and started swinging at residents. He stated that Dan had a pipe with weed and told him to take a puff. He stated that no other staff at home have done anything like this.

On 11/04/2022, I interviewed Resident D at the home. He stated that he likes living at the home and has no concerns. He stated that he is treated well by staff. He stated that he does not remember incident with gun. Resident D did not appear to want to answer any additional questions.

On 11/04/2022, I attempted to interview Resident E. He stated that the did not want to talk.

On 11/04/2022, I interviewed Staff, Kelly Rumohn, at the home. She stated that she has worked shifts with Dan Ganim. She stated that she did not see him do anything inappropriate while working with her. She never observed him with a gun, drugs, or throwing things at residents.

On 11/14/2022, I received employee records for Daniel Ganim. His start date was 03/28/2022. Mr. Ganim was fingerprinted and found to be eligible for employment on 03/23/2022. Mr. Ganim had completed required trainings including First/Aid CPR, recipient rights and medication administration. Employee record indicates that recruiter attempted to contact three references for Mr. Ganim on 04/06 and 04/11, however, only one reference was obtained.

On 11/17/2022, I received an email from APS Worker, Debra Johns. She stated that she filed a police report and was advised that since the alleged perp is no longer employed at the group home, they will not be investigating this matter.

On 11/18/2022, I received an email from APS Worker, Debra Johns. She stated that APS would be substantiating allegations.

I completed an exit conference with Ramon Beltran on 12/15/2022 by phone. Mr. Beltran is the designated person in licensee designee's Kimberly Rawlings absence. I informed Mr. Beltran of the violations found and that a copy of the special investigation report would be mailed once approved.

APPLICABLE RULE	
R 400.14208	**Direct care staff and employee records.**
	(1) Licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(f) Verification of reference checks.**

ANALYSIS:	Daniel Ganim's employee record did not have verification of two reference checks. His start date was 03/28/2022. Employee record indicates that recruiter attempted to contact three references for Mr. Ganim on 04/06 and 04/11, however, only one reference was obtained.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Staff, Daniel Ganim, did not treat residents with dignity or meet their needs for protection and safety. Resident A and Resident C stated that Mr. Ganim brought a gun into the home. Four residents reported seeing Mr. Ganim with a gun to Recipient Rights. Resident A, Resident B and Resident C indicated that Mr. Ganim threw paper towels at residents. Resident A described that Mr. Ganim would make large, wet balls of paper towel to throw them at residents because he was bored. Resident A and Resident C alleged seeing Mr. Ganim use drugs at the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1308	**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: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(iv) Threats.**

ANALYSIS:	Staff, Daniel Ganim, subjected residents to mental and emotional cruelty by throwing wet balls of paper towel at them. He also exhibited threating behavior by bringing a gun to the home. Mr. Ganim was terminated on 10/16/2022.
CONCLUSION:	**VIOLATION ESTABLISHED**

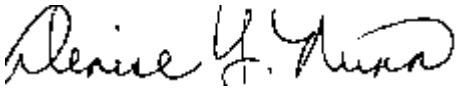
IV. RECOMMENDATION

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

12/15/2022

Kristine Cilluffo — Date
Licensing Consultant

Approved By:



12/16/2022

Denise Y. Nunn — Date
Area Manager