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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

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

February 7, 2023

RE: License #: AS800242668
Investigation #: 2023A1030024
Beacon Home at Highland

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.

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,

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS800242668
Investigation #:	2023A1030024
Complaint Receipt Date:	02/05/2023
Investigation Initiation Date:	02/05/2023
Report Due Date:	04/06/2023
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 Howard
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Highland
Facility Address:	56838 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	01/22/2002
License Status:	REGULAR
Effective Date:	07/08/2021
Expiration Date:	07/07/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
A staff member used inappropriate physical intervention on Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

02/05/2023	Special Investigation Intake 2023A1030024
02/05/2023	Special Investigation Initiated - Telephone Interview with Kim Howard
02/06/2023	Contact - Face to Face Interview with Resident A
02/06/2023	Contact - Face to Face Interview with Veronica Vance
02/06/2023	Contact - Face to Face Interview with Kim Howard
02/06/2023	Contact - Telephone call made Interview with Britini Smith
02/06/2023	Contact - Telephone call made Interview with Christine Browski
02/06/2023	Exit Conference Exit conference by phone

ALLEGATION:

A staff member used inappropriate physical intervention on Resident A.

INVESTIGATION:

On 2/5/23, interviewed district director Kim Howard by phone. Ms. Howard reported Direct Care Staff Member Christine Browksi used inappropriate physical intervention with Resident A twice by pulling her down to a sitting position by pulling her coat. Ms. Howard reported Ms. Browksi is aware of appropriate CPI techniques and went through the "Gentle Teaching" course with her in December 2022. Ms. Howard reported Ms. Browksi admitted this behavior and is now suspended pending the investigation.

On 2/6/23, I interviewed Resident A at the home. Resident A reported she and Resident B had a verbal argument and were face to face with each other. Resident A reported Ms. Browksi "grabbed her coat and pulled her down onto the bench" in the dining room. Resident A reported she and Resident B had a similar argument about thirty minutes later and she "did it again." Resident A reported she was upset with Ms. Browksi and spoke with the other staff on duty, Britini Smith and told her what happened. Resident A reported Ms. Browksi then was asked to go to the staff office in the basement and spoke with the home manager, Veronica Vance and district director, Kim Howard and was sent home.

On 2/6/23, I interviewed home manager, Veronica Vance at the home. Ms. Vance reported she was working on Friday 2/3/23 and was involved in the situation with Resident A and Ms. Browksi. Ms. Vance reported Ms. Browksi pulled Resident A by her coat twice in response to Resident A and Resident B having a verbal conflict. Ms. Vance reported Resident A informed Ms. Smith about the incident, and she was concerned about Ms. Browksi's behavior due to her just being recertified in CPI on January 31, 2022 and receiving "Gentle Teaching" training in December 2022. Ms. Vance reported she, Ms. Howard, and Nichole VanNiman (appearing via Teams) had a meeting with Ms. Browksi where Ms. Browksi admitted to pulling Resident A down to the bench by her coat. Ms. Vance reported Ms. Browksi was suspended and sent home pending the investigation.

On 2/6/23, I interviewed Ms. Howard at the home. Ms. Howard reported she personally assisted train Ms. Browksi in December 2022 and provided a copy of Ms. Browksi's CPI certification training on 1/31/23. Ms. Howard was unable to explain why Ms. Browksi would not use her training to defuse the situation other than "she just doesn't think."

On 2/6/23, I interviewed DCSM Britini Smith by phone. Ms. Smith reported she was downstairs when she heard from Resident A who informed her that Ms. Browksi pulled her by her coat two times. Ms. Smith reported she immediately informed Ms. Vance and Ms. Howard of what happened. Ms. Smith reported Ms. Browksi met with supervision and was suspended that day. Ms. Smith reported she works with Ms.

Browski occasionally and “always dreads those shifts” because Ms. Browski is rude, disrespectful and antagonizes the residents by the ways she speaks to them.

On 1/6/23, I interviewed Christine Browski by phone. Ms. Browski reported she was playing cards with a resident when Resident A and Resident B had a verbal altercation. Ms. Browski reported she “just reacted” to the situation and pulled Resident A down to the bench by her coat. Ms. Browski reported she should not have pulled her by her coat and instead should have paused her card game to deal with the situation appropriately. Ms. Browski admitted to recently completing “CPI and Gentle Teaching” provided by the home. Ms. Browski described her behavior as “dumb.” Ms. Browski admitted her mistake and was suspended. I asked if she pulled Resident A down by her coat once or twice on 2/3/23. Ms. Browski reported it only happened once. I informed Ms. Browski that it was reported that this happened twice in a thirty-minute span of time. Ms. Browski indicated she only pulled Resident A down once.

APPLICABLE RULE	
R 400.14307	Resident behavior interventions generally.
	(1) A licensee shall ensure that methods of behavior intervention are positive and relevant to the needs of the resident.
ANALYSIS:	Ms. Browski admitted to not using her training to defuse the situation and instead pulled Resident A down to a sitting position by her coat.
CONCLUSION:	VIOLATION ESTABLISHED

On 2/6/23, I shared the findings of the investigation with licensee designee Nichole VanNiman. Ms. VanNiman acknowledged and agreed to complete a corrective action plan.

IV. RECOMMENDATION

Contingent on the submission of an acceptable corrective action plan, I recommend no change in the current license.

Nile Khabeiry, LMSW

2/7/23

Nile Khabeiry
Licensing Consultant

Date

Approved By:

Russell Misiak

2/9/23

Russell B. Misiak
Area Manager

Date