GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 24, 2023

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

RE: License #: AM800267887
Investigation #: 2023A1031010
Beacon Home At Breakwater East

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. 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 (616) 356-0183.

Sincerely,

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM800267887
Investigation #:	2023A1031010
Complaint Receipt Date:	02/06/2023
Investigation Initiation Date:	02/06/2023
Report Due Date:	04/07/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Israel Baker
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At Breakwater East
Facility Address:	28730 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/03/2005
License Status:	REGULAR
Effective Date:	05/13/2022
Expiration Date:	05/12/2024
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A suffered a significant injury outside the home.	Yes
Additional Findings	No

III. METHODOLOGY

02/06/2023	Special Investigation Intake 2023A1031010
02/06/2023	Special Investigation Initiated - Email exchange with administrator Israel Baker.
02/06/2023	Contact - Documents requested and received.
02/06/2023	Contact - Telephone interview completed with home manager Roberta Clemons.
02/06/2023	APS Referral Submitted.
02/06/2023	Contact - Telephone interview completed with home manager Roberta Clemons.
02/08/2023	Contact - Voicemail left with Anthony Companion.
02/08/2023	Contact - Documents Reviewed.
02/08/2023	Contact - Telephone interview completed with Anthony Companion.
02/08/2023	Inspection Completed On-site
02/08/2023	Contact - Face to Face interviews held with Roberta Clemons, Israel Baker, Ashley Bowman, Trevor Getz, and Resident A.
02/09/2023	Contact - Telephone interviews completed with Montiece Sanders, Stacy Milliken, Brooke Perry, and Tina Williams.
02/09/2023	Contact - Telephone interview held with Licensee Designee Nichole VanNiman.

02/14/2023	Contact - Voicemail left with Deputy Weldon - Van Buren Sheriff's Department.
02/15/2023	Exit Conference held with Licensee Designee Nichole VanNiman.

ALLEGATION:

Resident A suffered a significant injury outside the home.

INVESTIGATION:

On 2/6/23, Mr. Baker reported by email that Resident A alleged on 2/3, direct care worker (DCW) Anthony Companion had pushed him and he fell into the air conditioner unit outside the home. Mr. Baker reported Resident A was taken to the emergency room and received 27 stitches. Mr. Baker reported Mr. Companion is not currently working pending an investigation. Mr. Baker reported the incident was not witnessed by anyone else. Mr. Baker reported DCW Gabriel Weis took Resident A to the hospital.

On 2/6/23, I interviewed the home manager Roberta Clemons via telephone. Ms. Clemons reported she was informed of the incident involving Resident A over the weekend. Ms. Clemons reported Resident A experienced significant injuries which resulted in 27 stitches to his nose and eye. Ms. Clemons reported Mr. Companion claimed Resident A slipped on ice and fell into the air conditioner unit. Ms. Clemons reported Resident A alleged Mr. Companion pushed him and he fell into the air conditioner unit. Ms. Clemons reported Mr. Companion has been pulled from the schedule due to the allegations made by Resident A. Ms. Clemons reported there were no other previous concerns regarding Mr. Companion mistreating residents in the home.

On 2/8/23, I reviewed the incident report dated 2/3/23 that was completed by Mr. Companion. The incident report “around 9pm when day shift were leaving site, [Resident A] tried to walk over towards the west side doors by the dumpsters where he slipped on the ice near the air conditioner and fell onto the corner of the ac unit where he cut open his nose and eye on the unit he fell near”. Mr. Companion reported staff called medical and EMS and then staff went with Resident A to the hospital where he received 27 stiches in his nose and eight stitches in his eye. Mr. Companion reported the corrective measure taken was that staff salted the sidewalks and warned residents of the slipping conditions.

On 2/8/23, I reviewed the hospital discharge paperwork for Resident A. Resident A was seen for a facial laceration, left eyelid laceration, and open fracture of the nasal bone due to a fall from ground level. Resident A received sutures for his injuries. Resident A was prescribed antibiotics and referred to Otolaryngology for follow-up care.

On 2/8/23, I interviewed Mr. Companion via telephone. Mr. Companion reported he went outside during shift change due to Resident A being out in the parking lot. Mr. Companion reported Resident A has a history of “messing” with staff vehicles and he was providing supervision during shift change as staff were heading to their vehicles. Mr. Companion reported he saw Resident A fall and he went over to check on him. Mr. Companion reported he noticed Resident A was injured because he had blood “gushing” from his face. Mr. Companion reported Resident A slipped on ice and hit his face on the corner of the air conditioner unit that was “jagged”. Mr. Companion reported he went into the home to tell the other staff what happened and contacted medical staff. Mr. Companion reported Resident A was taken to the hospital by ambulance and received multiple stitches. Mr. Companion reported DCW Gabriel Weis took Resident A to the hospital. Mr. Companion reported there were no other residents or staff outside to witness Resident A’s fall. Mr. Companion denied using any physical force against Resident A. Mr. Companion reported he salted the sidewalks following the incident as they were very icy to prevent other residents from falling.

On 2/8/23, I conducted an unannounced visit to the home. Ms. Clemons took me to the air conditioning units where Resident A had fallen. The home was observed to have a line of four air conditioner units outside the home. The air conditioner units were observed to be placed on top of a base that had raised legs for the units to sit on. Ms. Clemons showed me the air conditioner unit that Resident A had fallen into. The main unit was observed to have a large dent. Ms. Clemons reported that was previously damaged. Ms. Clemons showed the plastic leg on the platform where Resident A and Mr. Companion reported Resident A fell into. The plastic piece was observed to be broken and cracked in the direction Resident A demonstrated he was pushed. Ms. Clemons reported this was not previously broken prior to the incident. There were multiple areas around the air conditioner unit observed to have dried blood on the cement and plastic pieces from the unit in a nearby parking spot. The blood spots were bright and did not appear to be diluted by ice that melted that may have been on the sidewalk. The sidewalk around the home was observed to be heavily salted. The dumpsters for the home were viewed to be located across the parking lot and not close to the air conditioners.

On 2/8/23, I interviewed Resident A in the home. Resident A reported Mr. Companion is lying about him slipping on ice and hurting himself. Resident A was very adamant reporting he was pushed by Mr. Companion. Resident A reported he was outside during shift change. Resident A reported Mr. Companion “pushed me real hard” and then he extended his arms out in front of him. Resident A reported he fell forward into the air conditioner unit and hit his head on it. Resident A was observed to have multiple stitches on his face along with significant bruising and swelling. Resident A went outside to and reenacted the incident by the air conditioner units. Resident A had his body forward facing towards the air conditioner unit and showed where Mr. Companion came from around a corner of the building and pushed him. Resident A reported he did nothing wrong to Mr. Companion for

him to do this to him. Resident A reported he and Mr. Companion were the only people outside when the incident occurred.

On 2/8/23, I interviewed Mr. Baker at the home. Mr. Baker reported around 5-5:30pm on 2/3/23, he went to the home and observed ice on the cement near the gutter located around the corner from the air conditioner units. Mr. Baker reported he did not notice other areas around the home that needed to be salted. Mr. Baker reported he had staff salt the sidewalks around the home and the ice should have been melted by 9pm that evening. Mr. Baker reported the air conditioner base was not damaged prior to this incident occurring.

On 2/8/23, I interviewed Resident B and Resident C in the home; both denied being harmed by Mr. Companion.

On 2/8/23, I interviewed DCW Trevor Getz at the home. Mr. Getz reported he did not witness Resident A fall or Mr. Companion push Resident A. Mr. Getz reported he was leaving the home after his shift and noticed Resident A sitting on the ground next to the air conditioner unit. Mr. Getz reported Resident A was outside by himself and he noticed he was injured. Mr. Getz reported Resident A was disoriented and unable to explain what happened at that time. Mr. Getz reported he assisted Resident A up off the ground and took him into the house. Mr. Getz reported Mr. Companion left Resident A outside after he was injured. Mr. Getz reported he did not notice any ice by the air conditioner unit, and he did not slip at any point when assisting Resident A off the ground. Mr. Getz reported the sidewalks outside the home are regularly salted by staff during the winter.

On 2/8/23, I interviewed assistant home manager Ashley Bowman in the home. Ms. Bowman reported she did not witness the incident occur. Ms. Bowman reported Resident A has been very consistent when telling his perspective about what occurred with Mr. Companion.

On 2/9/23, I interviewed employees Stacy Miliken and Brooke Perry separately via telephone. Both reported they heard about the incident involving Resident A but did not witness it occur.

On 2/9/23, I interviewed Tina Williams via telephone. Ms. Williams reported she is Resident A's 1:1 staff throughout the day. Ms. Williams reported Resident A informed her that Mr. Companion pushed him, and he fell into the air conditioner unit. Ms. Williams reported she did not witness Resident A fall or Mr. Companion push Resident A. Ms. Williams reported she believes Resident A as he has been very consistent in telling her and other staff exactly what happened.
On 2/15/23, I interviewed Van Buren County Sheriff Deputy Derek Weldon. Deputy Weldon reported he submitted his police report to the prosecutor's office for review due to the severity of Resident A's injuries. Deputy Weldon reported a staff member who wanted to remain anonymous approached him when he visited the home. The

anonymous staff reports they believed Mr. Companion intentionally assaulted Resident A and there was validity to Resident A's allegations.

On 2/16/23, I reviewed the police report completed by Deputy Weldon. The report indicates Resident A reported he was pushed by Mr. Companion and an anonymous staff informed him they believed Resident A was intentionally assaulted. The report indicated that the case is being submitted to the prosecutor's office for review and handling.

On 2/22/23, I completed an exit interview with licensee designee Nichole VanNiman. Ms. VanNiman reported Mr. Companion's employment with Beacon Specialized Services was terminated because of this incident.

APPLICABLE RULE	
R 400.14305	**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.
For Reference: MCL 400.706	**Definitions P to Q**
	(5) "Protection", subject to section 26a(2), means the continual responsibility of the licensee to take reasonable action to ensure the health, safety, and well-being of a resident, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the licensee or an agent or employee of the licensee, or when the resident's assessment plan states that the resident needs continuous supervision.
ANALYSIS:	Resident A suffered a significant injury outside the home. Resident A claims Mr. Companion pushed him causing him to fall upon the outdoor unit, Mr. Companion claims that Resident A slipped on ice and fell uncontrollably onto the air conditioner unit by his own force. No other individual witnessed the event occur. Interviews with Mr. Baker and other staff members revealed no history of Mr. Companion demonstrating the behavior Resident A alleged. In addition, further interviews reveal a significant lack

	of evidence that ice on the sidewalk was in fact a contributing factor to Resident A's injury. While I could not determine with certainty how Resident A ended upon the air conditioning unit, it is known that Mr. Companion self admittedly was in the parking lot assessing vehicles during the night and not necessarily attending to Resident A's need for supervision. Mr. Companion was not reasonably supervising Resident A as his condition necessitated and was not able to protect him from injury as required by this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kristy Duda Date
Licensing Consultant

Approved By:

2/23/23

Russell B. Misiak Date
Area Manager