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.
Kalamazoo, MI 49009

RE: License #: AM800267888
Investigation #: 2023A1031011
Beacon Home at Breakwater West

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,

KDuda

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

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

I. IDENTIFYING INFORMATION

License #:	AM800267888
Investigation #:	2023A1031011
Complaint Receipt Date:	01/11/2023
Investigation Initiation Date:	01/12/2023
Report Due Date:	03/12/2023
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 West
Facility Address:	28730 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-8648
Original Issuance Date:	08/03/2005
License Status:	REGULAR
Effective Date:	09/18/2022
Expiration Date:	09/17/2024
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff leave residents unattended.	Yes
Staff do not let Resident A leave the home. Resident A was punched in the face by staff.	No
Additional Findings	No

III. METHODOLOGY

01/11/2023	Special Investigation Intake 2023A1031011
01/12/2023	APS Referral received
01/12/2023	Special Investigation Initiated - Email exchange with APS worker Mike Hartman.
01/12/2023	Contact - Email sent to Administrator Israel Baker.
01/19/2023	Contact - Face to Face interviews completed with Israel Baker, Roberta Clemons, Resident A, Resident B, DCW Jason Marr, and DCW Brooke Perry.
01/19/2023	Inspection Completed On-site - Unannounced visit to the home.
01/24/2023	Contact - Documents requested and received.
02/08/2023	Inspection Completed On-site - Unannounced visit to the home.
02/08/2023	Contact - Documents Reviewed.
02/08/2023	Contact - Face to Face interviews completed with Resident C, Resident D, and Resident E and Assistant Home Manager Ashley Bowman.
02/08/2023	Contact - Face to Face interview with Resident A.
02/09/2023	Contact - Documents Requested.

02/09/2023	Contact – Telephone interviews completed with Montiece Sanders, Trevor Getz, Stacy Milliken, Brooke Perry, and Tina Williams.
02/22/2023	Exit Conference held with licensee designee Nichole VanNiman.

ALLEGATION:

Staff leave residents unattended.

INVESTIGATION:

On 1/19/23, I interviewed administrator Israel Baker in the home. Mr. Baker reported there is at least one staff available at all times in the home. Mr. Baker reported he has not been informed that residents are being left unattended.

On 1/19/23, I interviewed the home manager Roberta Clemons in the home. Ms. Clemons reported there are always staff available to the residents. Ms. Clemons reported she was not informed that residents are being left unattended.

On 1/19/23, I interviewed Resident A in the home. Resident A reported staff will go outside to smoke or go into the kitchen and close the door. Resident A reported there are no staff available when this happens.

On 1/19/23, I interviewed Resident B in the home. Resident B reported “sometimes” staff will leave the building to go outside to smoke or they will go into the kitchen. Resident B reported the door to the kitchen is closed when staff go in there. Resident B reported they are left alone in the home when this happens.

On 1/19/23, I interviewed DCW Jason Marr in the home. Mr. Marr reported there is always staff available to the residents to provide appropriate supervision. Mr. Marr reported he has not observed the residents to be left unattended.

On 2/8/23, I interviewed Resident C in the home. Resident C reported “I have no clue” to all the questions asked during the interview process.

On 2/8/23, I interviewed Resident D in the home. Resident D was not able to answer questions during the interview process.

On 2/8/23, I interviewed Resident E in the home. Resident E reported staff will go into the kitchen or outside to smoke. Resident E reported he can get staff when needed if they are not in the main area of the home.

On 2/9/23, I Interviewed DCW Montiece Sanders via telephone. Mr. Sanders reported he will be the only staff working at times. Mr. Sanders reported the home is short on staff and there are not always multiple staff available each shift. Mr. Sanders reported there have been times where he goes into the kitchen or medication room and closes the door when preparing meals or medications. Mr. Sanders reported residents are left unattended for a brief period while he prepares meals or medications.

On 2/9/23, I interviewed DCW Trevor Getz via telephone. Mr. Getz reported there are times the home is short staffed due to high turnover or staff going on vacation. Mr. Getz reported this has not been an issue recently. Mr. Getz reported he has not observed residents to be left unattended.

On 2/9/23, I interviewed DCW Stacy Milliken via telephone. Ms. Milliken reported there is always two or three staff available each shift. Ms. Milliken reported she has not observed residents to be left unattended during her shifts.

On 2/9/23, I interviewed DCW Brooke Perry via telephone. Ms. Perry reported the home is short staffed occasionally and there will be one staff available to care for all the residents. Ms. Perry reported residents are left unattended at times when staff are preparing meals as they have to close the kitchen door.

On 2/9/23, I interviewed DCW Tina Williams via telephone. Ms. Williams reported the home is short staffed at times and there will only be one staff available to care for all the residents. Ms. Williams reported staff in the office will come out and assist at times. Ms. Williams reported residents are left unattended when staff are preparing meals or medications.

On 2/10/23, I reviewed five AFC Assessment plans. An assessment plan indicated one resident requires one on one staff 12 hours per day and another assessment indicated a resident is an AWOLP risk.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.

ANALYSIS:	As a result of interviews with staff and residents, it has been determined that residents are left unattended. Staff members have reported when there is one staff on shift, there are times when residents are left unattended while they prepare meals or medications. Residents have reported being left unattended when staff go into the kitchen. Staff are not able to provide appropriate supervision when they are in a closed room for a period of time. AFC assessments indicate multiple residents in the home require ongoing supervision due to their behavioral needs. The home is a specialized facility due to the residents in the home having high behavioral needs and requiring verbal redirection by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff do not let Resident A leave the home.

Resident A was punched in the face by staff.

INVESTIGATION:

On 1/19/23, An email exchange occurred with APS worker Mike Hartman. Mr. Hartman reported Resident A informed him that he was hit in the mouth by direct care worker (DCW) Montiece Sanders which resulted in a bloody nose. Mr. Hartman reported Resident B informed him that he witnessed staff Mr. Sanders conduct CPI on Resident A because there was an altercation. Resident B reported he was upset with how Resident A was acting towards staff. Mr. Hartman reported Mr. Sanders informed him that he utilized CPI due to Resident A becoming aggressive. Mr. Sanders denied assaulting Resident A. Mr. Hartman reported he did not substantiate Mr. Sanders for neglect or abuse against Resident A. Mr. Hartman reported Resident A appeared to utilize APS as a tool to move to a different AFC home.

Mr. Baker reported he was not aware of an altercation or allegations that Mr. Sanders assaulted Resident A.

Ms. Clemons reported she was not working when the alleged incident occurred. Ms. Clemons reported Resident A is not kept inside the home. Resident A does reside in the secured facility due to his needs but has access to the community.

Resident A reported he smashed Mr. Sanders phone and Mr. Sanders put him in a choke hold. Resident A then reported Mr. Sanders punched him in the face.

Resident A reported his mouth had some blood in it after the altercation. Resident A reported he did not seek medical treatment for his injury. Resident A then stated Mr. Sanders used CPI on him and this upset him. Resident A reported multiple times he wanted to live in a different home. Resident A reported he was very upset with Mr. Sanders and broke his phone. Resident A reported Resident B witnessed Mr. Sanders assault him. Resident A reported staff do not let him leave the home before 9am. Resident A reported this is because he needs his medications, and he wants to go to other homes on the campus, but this wakes up residents in the other homes. Resident A reported he gets upset when staff do not take him to the store right away when he wants to go. Resident A was observed during the visit to yell and curse at staff continuously when they were assisting other residents in the home. There were no injuries observed on Resident A.

Resident B reported Mr. Sanders did not punch Resident A in the face. Resident B reported Mr. Sanders used CPI on Resident A because Resident A was “acting up and needed it”. Resident B reported Resident A smashed Mr. Sanders phone. Resident B reported Mr. Sanders is nice to the residents in the home. Resident B reported Resident A leaves the home with staff “all the time”.

Mr. Marr reported he was not working when the incident occurred between Mr. Sanders and Resident A.

Ms. Perry reported she was not working when the incident occurred between Mr. Sanders and Resident A.

Mr. Sanders reported Resident A became aggressive towards staff and required CPI due to his aggressive behaviors. Mr. Sanders reported he conducted CPI on Resident A in efforts to redirect him. Mr. Sanders reported he did not punch Resident A in the face. Mr. Sanders reported Resident A did fling his head back during CPI and Resident A hit his head against Mr. Sander’s head. Mr. Sanders reported he did not observe any injuries to Resident A as a result of using CPI. Mr. Sanders reported Resident A is able to leave the home. Mr. Sanders reported he has not observed staff tell Resident A he cannot leave the home unless he requires staff to take him into the community.

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.

ANALYSIS:	There was no evidence found to support that staff punched Resident A in the face or they prevent him from leaving the home. Resident A reported he wanted to leave his home to visit other AFC homes on the campus and staff told him he could not go to the other homes. Resident A was not observed to have any injuries on his face. Resident B reported he witnessed Resident A receive CPI due to being aggressive and staff did not assault Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

2/13/23

Kristy Duda Date
Licensing Consultant

Approved By:

2/22/23

Russell B. Misiak Date
Area Manager