GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 10, 2023

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

RE: License #: AS370413382
Investigation #: 2023A0466020
Beacon Home At Nottawa

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 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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS370413382
Investigation #:	2023A0466020
Complaint Receipt Date:	01/13/2023
Investigation Initiation Date:	01/17/2023
Report Due Date:	03/14/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home At Nottawa
Facility Address:	7302 S Nottawa Rd Mount Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/14/2022
License Status:	TEMPORARY
Effective Date:	11/14/2022
Expiration Date:	05/13/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION:

	Violation Established?
Complainant reported on 01/12/2023, direct care worker (DCW) Gage Lynch got into Resident A's personal space and swore at him.	No
Additional Finding	Yes

III. METHODOLOGY

01/13/2023	Special Investigation Intake-2023A0466020.
01/17/2023	Special Investigation Initiated – Telephone Complainant interviewed.
01/17/2023	Referral - Recipient Rights-Sarah Watson assigned.
01/17/2023	Contact - Telephone call made to ORR Sarah Watson interviewed.
01/24/2023	Inspection Completed On-site.
02/22/2023	APS Referral.
03/10/2023	Exit conference with Roxanne Goldammer.

ALLEGATION: Complainant reported on 01/12/2023, direct care worker (DCW) Gage Lynch got into Resident A's personal space and swore at him.

INVESTIGATION:
On 01/13/2023, Complainant reported Resident A alleged that on 01/12/2023 DCW Gage Lynch got into Resident A's personal space and swore at him.

On 01/17/2023, I interviewed Office of Recipient Rights (ORR) Officer Sarah Watson who reported DCW Lynch is not currently working at the facility and he will not be working there until the investigation is completed.

On 01/24/2023, ORR officer Watson and I conducted an unannounced investigation and I reviewed a written *Recipient Rights Complaint* that was dated 01/13/2023 and signed by Resident A and DCW Kay O'Dell. In the "when did the alleged violation occur" section of the report documented "01/12/2023 at 6/7pm." In the "Describe what happened" section of the report it stated:

"DCW Thatcher and DCW Lynch asked for dirty laundry then asked for my bedding. I replied I want to wait for my bedding to be done tomorrow morning 01/13/2023 so I can get my bedding returned. DCW Lynch and myself started to argue, DCW Lynch said it was health hazard. I then started to ignore DCW Lynch. Then DCW Lynch got in my face and started swearing at me. I turned to on into my bedroom because DCW Thaher was walking into my bedroom. I kept ignoring DCW Lynch. Words procjected [sc] to me was fuck and I don't give a fuck."

In the "What would you like to have happen in order to correct the violation" section of the report it stated, "Would like for DCW Lynch to be written up for getting into my face and swearing at me."

I reviewed Resident A's resident record which contained a *Health Care Appraisal* dated 03/25/2022 which documented Resident A was 22 years and diagnosed with "Schizophrenia and obesity." Resident A's resident record also contained a *Person-Centered Plan Signature Form* that was signed by DCW Thatcher on 12/22/2022. DCW Lynch had not signed this document.

ORR officer Watson and I interviewed Resident A who reported that on 01/12/2023 the staff on duty wanted to do laundry and asked to change his bedding. Resident A reported that he was in the living room and saw DCW Thatcher and DCW Lynch at his bedroom door. Resident A reported that DCW Lynch swears too much and that he said to him on 01/12/2023, "You are not getting passed me mother fucker." Resident A reported he did not respond to DCW Lynch's statement. Although Resident A denied he charged or ran at DCW Thatcher to get to his bedroom before they changed his sheets, Resident A reported DCW Lynch could have thought he was charging DCW Thatcher and he was just protecting her from Resident A. Resident A reported he consented to his bedding being changed by DCW Thatcher after initially being opposed. Resident A reported when he learned that there were additional sets of clean sheets available for his bed, he agreed with his sheets being changed. Resident A reported that he was still upset about this situation on 01/13/2023 so he asked DCW O'Dell to help him file a *Recipient Rights Complaint.* Resident A reported that he told DCW O'Dell what happened because he could not write the complaint by himself. Resident A thought that Resident B might have witnessed this interaction.

ORR Officer Watson and I interviewed DCW Hannah Thatcher who reported she was on duty with DCW Lynch on 01/12/2023. DCW Thatcher reported house manager/DCW Naomie Voorhees asked all of the residents if everyone could take their sheets off the beds to be washed. DCW Thatcher reported Resident A did not want to take the linens off of his bed and asked her to do it. DCW Thatcher reported she was not able to enter Resident A's bedroom because the door was locked. DCW Thatcher reported Resident A started to run from the couch in the family room at her. DCW Thatcher reported DCW Lynch came out of the bathroom she was

cleaning and stood face to face between Resident A and her when Resident A was charging her. DCW Thatcher reported DCW Lynch told Resident A that “we don’t go after staff like that.” DCW Thatcher reported DCW Lynch had his hands at his side during the conversation with Resident A. DCW Thatcher reported DCW Lynch did not swear at Resident A rather all he said was “that was not appropriate.” DCW Thatcher reported Resident A went back to the couch, DCW Thatcher changed Resident A's bedding and DCW Lynch went back to cleaning the bathroom. DCW Thatcher reported there was no argument between Resident A and DCW Lynch. DCW Thatcher reported she did feel like Resident A charged her, she felt intimidated by the interaction and reported Resident A has never done anything like this before. DCW Thatcher reported she has worked with DCW Lynch before and she has never witnessed DCW Lynch act inappropriate with any resident. DCW Thatcher reported DCW Lynch is good at redirecting the residents as needed. DCW Thatcher reported she and DCW Lynch were the only staff on duty when this incident occurred. DCW Thatcher reported DCW Lynch is not a direct care worker that regularly works at this facility, typically there is an all-female staff that works at this home. DCW Thatcher reported she thought Resident A may have been intimidated by DCW Lynch because he was a male staff and Resident A typically only interacts with female staff. DCW Thatcher denied DCW Lynch got into Resident A’s personal space and swore at him.

ORR Officer Watson and I interviewed Resident B who reported he observed DCW Lynch to be rude, aggressive and having an attitude with Resident A on 01/12/2023. Resident B could not remember the words that were said but reported that it was counterproductive. Resident B could not recall if profanity was used Resident B reported that DCW Lynch “talks down” to Resident A all the time. Resident B reported that on 01/12/2023, DCW Lynch had his arms folded across his chest and he had asked Resident A, “do I look like I am having an attitude with you?” Resident B reported that Resident A responded by saying, “no.” Resident B reported that Resident A walked away and DCW Lynch followed him and kept “putting his two cents in.” Resident B reported this went on for at least 5-15 minutes. Resident B reported Resident A was not aggressive toward any DCW or resident. Resident B reported that eventually DCW Lynch stopped talking which ended the interaction. Resident B reported DCW Thatcher was in the kitchen but joined in on the conversation between DCW Lynch and Resident A by talking with Resident A about changing his bedding. Resident B reported that escalated Resident A because he did not want his bedding to be washed.

ORR Officer Watson and I interviewed DCW Lynch who reported he does not work at this facility much but that he did work on 01/12/2023 with DCW Thatcher. DCW Lynch reported that he was cleaning the bathroom when he asked Resident A to take the linens off his bed so that they could washed. DCW Lynch reported Resident A stated DCW Thatcher can do it. DCW Lynch reported he was cleaning the bathroom when he heard a loud noise and stepped out to see Resident A charging DCW Thatcher. DCW Thatcher stated he stepped out of the bathroom in between Resident A and DCW Thatcher. DCW Lynch reported Resident A puffed

his chest out and put it on his chest. DCW Lynch reported he told Resident A “we don’t charge staff.” DCW Lynch reported Resident A went back to the couch, DCW Thatcher finished making Resident A’s bed and he went back to cleaning the bathroom. DCW Lynch reported there was no swearing, no argument and no verbal altercation. DCW Lynch reported Resident B was also in the common area when this incident occurred. DCW Lynch denied that he ever talks down to Resident A or any other resident. DCW Lynch reported his body language was relaxed with his hands to his side. DCW Lynch denied having his arms crossed over his chest. DCW Lynch denied asking Resident, “do I look like I am having an attitude with you?”

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Although Complainant reported on 01/12/2023, direct care worker Lynch got into Resident A’s personal space and swore at him, there was not enough evidence to establish this allegation. Resident A reported DCW Lynch swore at him on 01/12/2023 but he did not describe or explain how DCW Lynch was in his personal space. DCW Thatcher denied that she observed DCW Lynch in Resident A’s personal space and she denied observing that DCW Lynch swore at Resident A. Resident B reported he observed DCW Lynch to be rude, aggressive and having an attitude with Resident A on 01/12/2023 however he could not remember the words that were said, nor did he explain how DCW Lynch was in Resident A’s personal space. DCW Lynch denied that he got into Resident A’s personal space and swore at him, therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:
On 01/24/2023, I interviewed DCW Lynch who reported that he worked at the facility on 01/12/2023 from 9am-9:30pm with DCW Thatcher. DCW Lynch reported he typically does not work at this facility but works for other facilities owned by the same company. DCW Lynch reported he did have access to the resident records while he was on shift and that he was familiar with Resident A, he just could not recall having any formal training on how to intervene with Resident A. DCW Lynch reported he did redirect Resident A on 1/12/2023.

I reviewed Resident A's resident record which contained a *Person-Centered Plan* and a *Person-Centered Plan Signature Form* documenting that each direct care staff member was trained in Resident A's Person Centered Plan. This document was signed by DCW Thatcher on 12/22/2022 but not by DCW Lynch. There was no other documentation verifying DCW Lynch had been trained in Resident A's *Person-Centered Plan.*

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility.
ANALYSIS:	DCW Lynch intervened with Resident A without having knowledge of his *Person-Centered Plan*. Additionally at the time of the unannounced investigation there was no documentation to support DCW Lynch had been trained in Resident A's *Person-Centered Plan* as the *Person-Centered Plan Signature Form* that was in Resident A's record was not signed by DCW Lynch.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/07/2023

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Julie Elkins Date
Licensing Consultant

Approved By:

03/10/2023

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Dawn N. Timm Date
Area Manager