GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 12, 2023

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

RE: License #: AM800084653
Investigation #: 2023A1030032
Beacon Home at Meadowland

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,

Nile Khabeiry, LMSW

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
WARNING REPORT CONTAINS PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM800084653
Investigation #:	2023A1030032
Complaint Receipt Date:	03/28/2023
Investigation Initiation Date:	03/28/2023
Report Due Date:	05/27/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St. Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Howard
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Meadowland
Facility Address:	56844 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 674-7306
Original Issuance Date:	09/28/1999
License **Status:**	REGULAR
Effective Date:	10/24/2021
Expiration Date:	10/23/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPEDEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
A staff member treated Resident A in a disrespectful manner.	Yes
Staff did not provide appropriate support and supervision to Resident A	No
Additional Findings	Yes

III. METHODOLOGY

03/28/2023	Special Investigation Intake 2023A1030032
03/28/2023	Special Investigation Initiated - Telephone
03/28/2023	Contact - Face to Face Interview with Kaitlyn Smith
03/28/2023	Contact - Face to Face Interview with Resident A
03/28/2023	Contact - Face to Face Interview with Resident B
03/28/2023	Contact - Face to Face Interview with Resident C
03/28/2023	Contact - Face to Face Interview with Resident D
03/29/2023	Contact - Telephone call received Interview with Kim Howard
03/29/2023	Contact - Telephone call made Interview with Caitlin Baltazar
04/03/2023	Contact - Telephone call made Interview with Lauren Strickland
04/04/2023	Contact - Telephone call made Interview with Carol Davis
04/05/2023	Exit Conference Exit Conference by phone

ALLEGATION:

A staff member treated Resident A in a disrespectful manner.

Staff did not provide appropriate support and supervision to Resident A.

INVESTIGATION:

On 3/28/23, I interviewed home manager Kaitlyn Smith at the home. Ms. Smith reported she is aware of the incident that occurred but was not working. Ms. Smith provided the names and contact information for the three Direct Care Staff Members (DCSM) that were working.

On 3/28/23, I interviewed Resident A at the home. Resident A reported DCSM Caitlin Baltazar was slamming the medication room door and yelling at the residents. Resident A reported there was a disagreement about medications between Ms. Baltazar and Resident B and she told Resident B that she should just wait until the next staff comes in and take the correct medication. Resident A reported Ms. Baltazar got upset with her interjecting herself into the situation and told her she was “going to write me up.” Resident A reported they then argued, and Ms. Baltazar threaten to call the police on her. Resident A reported the other DCSM working tried to calm her down and took her outside. Resident A reported Ms. Baltazar continued to yell at her and said, “nobody cares about you” and to “step the fuck up bitch” meaning she would be willing to fight her if necessary. Resident A reported Ms. Baltazar apologized at the end of her shift.

On 3/28/23, I interviewed Resident B at the home. Resident B reported Ms. Baltazar does not usually work in this home and thought she should have been given one additional medication. Resident B stated, “I know my medication” and that she and Ms. Baltazar argued about the discrepancy. Resident B reported Ms. Baltazar was screaming at the other residents. Resident B reported the other DCSM tried to calm Resident A down and she and Ms. Baltazar were yelling at each other.

On 3/28/23, I interviewed Resident C at the home. Resident C reported Resident A and Ms. Baltazar argued and Ms. Baltazar said she “hates all the staff” at the home. Resident C reported the other two DCSM tried to intervene and help calm down Resident A. Resident C reported Ms. Baltazar kept saying “do you want to go girl” to Resident A.

On 3/28/23, I interviewed Resident D at the home. Resident D reported there was a verbal conflict between Resident A and Ms. Baltazar and that the “staff started it by saying rude things.” Resident D reported she thinks Ms. Baltazar “tried to pick a fight”

with Resident A. Resident D reported there was two other DCSM working and they tried to get Resident A to calm down.

On 3/29/23, I interviewed Caitlin Baltazar by phone. Ms. Baltazar reported she was filling in at the home due to another staff calling off. Ms. Baltazar reported she was the most experienced staff so she was the DCSM who passed medications and was in more of a leadership role. Ms. Baltazar reported Resident A made a sexual comment about her "butt" and told her that was not appropriate. Ms. Baltazar reported she and Resident A had argued several times during the shift. Ms. Baltazar reported Resident A encouraged Resident B not to take her medication and they argued about the situation. Ms. Baltazar reported Resident A began threatening her and following her around the home. Ms. Baltazar reported she contacted the on-call supervisor and the clinical on call and informed them of Resident A's behavior.

Ms. Baltazar reported she was very frustrated about Resident A's behavior but was also frustrated that the two other DCSM did not provide her enough support during the situation. Ms. Baltazar reported the two other DCSM did take Resident A outside at one point to calm her down but wanted more support. Ms. Baltazar reported she did swear at Resident A and knows she was wrong and apologized.

On 4/3/22, I interviewed DCSM Lauren Strickland by phone. Ms. Strickland reported she was working on 3/25/23 when the conflict occurred between Resident A and Ms. Baltazar. Ms. Strickland reported Ms. Baltazar was filling in and was the most senior staff working. Ms. Strickland reported Ms. Baltazar was passing medication and had a disagreement with Resident B about her medication. Ms. Strickland reported Resident A encouraged Resident B to wait and discuss her medication concerns with the staff during the next shift. Ms. Strickland reported Ms. Baltazar "snatched" the medication cup from Resident B. Ms. Strickland reported Ms. Baltazar told Resident B that she would document her refusal to take her medication and would write up Resident A for telling her to not take her medication.

Ms. Strickland reported Resident A got angry and began yelling at Ms. Baltazar. Ms. Strickland reported she and DCSM Carol Davis took Resident A outside to calm down. Ms. Strickland reported the argument continued between Resident A and Ms. Baltazar and one point Ms. Baltazar went into the medication room and closed the door to get away from Resident A. Ms. Strickland reported Resident A threatened to "kick the door down" which prompted Ms. Baltazar to threaten to call the police. Ms. Strickland reported she and Ms. Davis remained close to Resident A and continued to verbally encourage her to stay calm and to stop yelling. Ms. Strickland reported that near the end of the shift Resident A was outside smoking and Ms. Baltazar took the garbage out while they continued to yell at each other, and Ms. Baltazar yelled "step the fuck up."

On 4/4/23, I interviewed DCSM Carol Davis by phone. Ms. Davis reported she was working the night Resident A and Ms. Baltazar had a major conflict. Ms. Davis reported the incident began due to a disagreement about medication between Resident B and Ms. Baltazar. Ms. Davis reported Resident A got involved and encouraged Resident B

to speak with the night staff about her medications. Ms. Davis reported M., Baltazar and Resident A began arguing and Ms. Baltazar "slammed the medication room door several times. Ms. Davis reported Resident A became somewhat verbally threatening and Ms. Baltazar threatened to call the police. Ms. Davis reported Ms. Baltazar also yelled derogatory comments about the staff at the home "not doing their jobs correctly." Ms. Davis reported Ms. Baltazar seemed to be taunting Resident A and said either "shut the fuck up or step the fuck up" when they were both outside of the home. Ms. Davis reported Ms. Baltazar did try and apologize at the very end of the shift. Ms. Davis reported she and Ms. Strickland tried to defuse the situation and encourage Resident A to remain calm and even took her outside to smoke as a means to calm her down.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	It was alleged Caitlin Baltazar treated Resident A in a disrespectful manner. It was also alleged Lauren Strickland and Carol Davis did not provide appropriate support and supervision to Resident A during an emotional outburst with Ms. Baltazar. Based on interviews, a video of the incident and Ms. Baltazar's admission, the violation concerning Ms. Baltazar will be established. Based on the same evidence the violation concerning Ms. Strickland and Ms. Davis will not be established. According to the information provided by all present Ms. Strickland and Ms. Davis provided encouragement and support to Resident A and even took her outside to calm down. In addition, Ms. Strickland and Ms. Davis maintained close proximity to Resident A in order to appropriately supervise Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/29/23, I received a phone call from district director Kimberly Howard. Ms. Howard reported DCSM Lauren Strickland recorded a portion of the verbal altercation between Resident A and Caitlin Baltazar. Ms. Howard authenticated the video and indicated the video captured Resident A.

Lauren Strickland was questioned about a video of the incident between Resident A and Ms. Baltazar Ms. Strickland reported she recorded that interaction between Resident A and Ms. Baltazar because she thought Ms. Baltazar was way out of line. Ms. Strickland reported that she should not have recorded Resident A due to a potential HIPPA violation.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule. **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	During the course of an investigation into an incident involving Resident A it was discovered that Lauren Strickland used her personal cell phone to record a portion of the incident. The video recording captured Resident A and a staff member having a verbal altercation. Ms. Strickland admitted to violating the home's policy regarding using her cell phone during her shift and the violation of Resident A's right to privacy. The video has since been deleted and to date there is no indication that the video was viewed by anyone other the myself and staff employed by the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/5/23, I shared the findings of my investigation with licensee, Nichole VanNiman. Ms. VanNiman acknowledged the findings and agreed to submit a correction action plan addressing the violations.

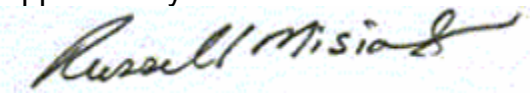
IV. RECOMMENDATION

Contingent upon the acceptance of an appropriate corrective action plan, I recommend no change in the current license status.

4/11/23

Nile Khabeiry Date
Licensing Consultant

Approved By:



4/12/23

Russell B. Misiak Date
Area Manager