GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

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

April 21, 2023

RE: License #: AS800404242
Investigation #: 2023A1030031
Beacon Home at Hartford

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.

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

I. IDENTIFYING INFORMATION

License #:	AS800404242
Investigation #:	2023A1030031
Complaint Receipt Date:	03/27/2023
Investigation Initiation Date:	03/27/2023
Report Due Date:	05/26/2023
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 Hartford
Facility Address:	68134 CR 372 Hartford, MI 49057
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/27/2020
License Status:	REGULAR
Effective Date:	02/27/2023
Expiration Date:	02/26/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was physically assaulted by a staff member.	Yes
Additional Findings	No

III. METHODOLOGY

03/27/2023	Special Investigation Intake 2023A1030031
03/27/2023	Contact - Face to Face Interview with Resident A
03/27/2023	Special Investigation Initiated - Telephone Interview with Kim Howard
03/27/2023	Contact - Face to Face Interview with Resident B
03/27/2023	Contact - Face to Face Interview with Resident C
03/27/2023	Contact - Face to Face Interview with Kimberly Howard
03/27/2023	Contact - Document Received Received and reviewed Incident Reports
03/28/2023	Contact - Telephone call made Interview with Resident D
03/30/2023	Contact - Telephone call made Interview with Jordan Braunn
04/17/2023	Contact - Document Received Received referral from APS regarding allegations already being investigated
04/20/2023	Exit Conference Exit conference by phone

ALLEGATION:

Resident A was physically assaulted by a staff member.

INVESTIGATION:

On 3/27/23, I attempted to interviewed Resident A at the home, however he declined to speak with me.

On 3/27/23, I interviewed Resident B at the home. Resident B reported he was in his bedroom but was awake and heard Direct Care Staff Member (DCSM) Jordan Brunn yelling at Resident A because he was slamming doors in the home. Resident B reported Resident A hit Mr. Brunn in the face and then Mr. Brunn grabbed him to restrain him. Resident B reported Resident A and Mr. Brunn were wrestling throughout the home and eventually went onto the front porch. Resident B reported he went into his bedroom and is unsure how it ended. Resident B reported Mr. Brunn has a bad temper and has had physical conflicts with him in the past and he threatened to “knock him out.”

On 3/27/23, I interviewed Resident C at the home. Resident C reported he was sleeping when he was awoken to a fight between Resident A and Mr. Brunn. Resident C reported he could hear them yelling at each other. Resident C reported Mr. Brunn knows marital arts and had Resident A in an “arm bar” and Resident A was screaming in pain. Resident C reported he has been assaulted by Mr. Brunn before in the garage where he was pushed to the ground and pinned down. Resident C was unsure when this occurred but that it was “a while ago.”

On 3/27/23, I interviewed administrator Kimberly Howard at the home. Ms. Howard reported they were concerned because Resident A indicated his arm was in pain and that Mr. Brunn “hurt him” the night before. Resident A was taken to the hospital for an examination and although nothing was broken, he “reaggravated” an old injury to his right arm. Ms. Howard reported Mr. Brunn was suspended pending an investigation. Ms. Howard reported several Incident Reports (IR) were written and will forward them later today. Ms. Howard reported she was told the altercation started in the home and ended up on the front porch where there was some damage noted to the wooden railing.

On 3/27/23, I received and reviewed an After Visit Summary (AVS) and Physical Assault Forensic Nurse Discharge Instructions (PAFNDI) from Spectrum Health Lakeland Hospital. Resident A’s right elbow and forearm wee x-rayed and the PAFNDI indicated there was “mid to distal diaphysis of the Ulna in the region of a previous fracture.

On 3/28/23, I interviewed Resident D by phone. Resident D reported he was awake in his bedroom when the altercation occurred between Resident A and Mr. Brunn. Resident D reported heard the “scuffling on the porch.” Resident D reported “Jordan waits until everyone goes to bed and then messes with Resident A.” Resident D reported Mr. Brunn does not like Resident A because he “slams doors.” Resident D reported Mr. Brunn has been physical with other residents in the past.

On 3/28/23, I received two Incident Reports (IR) regarding the altercation between Resident A and DCSM Jordan Braunn. IR#1 documented Resident D’s observation of the incident as he witnessed Resident A punch Mr. Braunn and the face. In response to being punched Mr. Braunn threatened to “fuck him up” and then they physically fought throughout the home and onto the porch during which time Mr. Braunn was grabbing and holding Resident A’s right arm.

The IR#2 documented Resident A’s conversation the home manager, Crystal Jennings the next day in which Resident A acted out the altercation while describing being choked and having his arm grabbed by Mr. Braunn. Resident A indicated he was in enough pain to request to be taken to the hospital for an evaluation.

On 3/30/23, I interviewed Jordan Brunn by phone. Mr. Brunn reported Resident A was upset about not getting his medication when he thought he should have been given it and “slammed some doors.” Mr. Brunn reported Resident A put his fingers in his face and then punched him. Mr. Brunn reported he used his blocking techniques to prevent any further attack and instructed Resident A not to do that again. Mr. Brunn reported he went outside to get an energy drink and the situation resolved itself. Mr. Brunn reported that he and Resident A went outside later and smoked together. Mr. Brunn denied ever using an” arm bar”, assaulting or threatening Resident A. Mr. Brunn reported Resident A has a history of seizures and could have hurt his arm while having a seizure. Mr. Brunn denied ever being assaultive towards any of the residents.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	It was alleged Resident A was assaulted by staff member, Jordan Brunn. Based on interviews and review of medical

	information and two incident reports this violation will be established. According to several residents there was a physical altercation between Resident A and Jordan Braunn and rather than deescalating the situation Mr. Braunn grabbed Resident A's arm to restrain him causing Resident A to reaggravate a previous injury. Mr. Braunn was suspended and subsequently resigned from the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

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

IV. RECOMMENDATION

Contingent upon receipt of an acceptable correction action plan, I recommend no charge in the current license status.

Nile Khabeiry, LMSW 4/21/23

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak 4/28/23

Russell B. Misiak Date
Area Manager