GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 29, 2023

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

RE: License #: AS390403202
Investigation #: 2023A0581040
Beacon Home at Kal-Haven

Dear Mr. Beltran:

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) 284-9730.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS390403202 |
| | |
| **Investigation #:** | 2023A0581040 |
| | |
| **Complaint Receipt Date:** | 06/13/2023 |
| | |
| **Investigation Initiation Date:** | 06/13/2023 |
| | |
| **Report Due Date:** | 08/12/2023 |
| | |
| **Licensee Name:** | Beacon Specialized Living Services, Inc. |
| | |
| **Licensee Address:** | Suite 110<br>890 N. 10th St.<br>Kalamazoo, MI 49009 |
| | |
| **Licensee Telephone #:** | (269) 427-8400 |
| | |
| **Administrator:** | Jamara White |
| | |
| **Licensee Designee:** | Ramon Beltran |
| | |
| **Name of Facility:** | Beacon Home at Kal-Haven |
| | |
| **Facility Address:** | 5359 N. 8th Street<br>Kalamazoo, MI 49009 |
| | |
| **Facility Telephone #:** | (269) 214-4341 |
| | |
| **Original Issuance Date:** | 05/05/2020 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 11/05/2022 |
| | |
| **Expiration Date:** | 11/04/2024 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Direct care staff, Olivia Kesselly, verbally assaulted Resident A on 06/12/2023. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 06/13/2023 | Special Investigation Intake<br>2023A0581040 |
| 06/13/2023 | Referral - Recipient Rights<br>Van Buren ORR is already investigating. No referral necessary. |
| 06/13/2023 | Special Investigation Initiated - On Site<br>Interviewed residents and direct care staff. Obtained resident documentation. |
| 06/13/2023 | Exit conference with licensee designee, Ramon Beltran. |
| 06/14/2023 | APS Referral<br>Referral made via email; however, APS denied assigning for investigation. |
| 06/14/2023 | Contact - Document Received<br>Email from Ms. Kinzler containing audio recording. |
| 06/22/2023 | Inspection Completed-BCAL Sub. Compliance |
| 06/29/2023 | Contact – Telephone call made<br>Interview with licensee designee, Ramon Beltran. |

**ALLEGATION:**

**Direct care staff, Olivia Kesselly, verbally assaulted Resident A on 06/12/2023.**

**INVESTIGATION:**

On 06/13/2023, Complainant reported to me Van Buren Community Mental Health (VBCMH) agency received an audio recording of direct care staff, Olivia Kesselly, verbally assaulting Resident A on 06/12/2023.

On 06/13/2023, I confirmed with VBCMH Recipient Rights Officer (RRO), Candice Kinzler, she received the allegations and was also investigating.

On 06/14/2023, Ms. Kinzler and I conducted an unannounced onsite investigation the facility. Both Ms. Kinzler and I interviewed Resident A during the investigation. Resident A stated the incident took place after he came out of the facility's main level bathroom. He stated he blew his nose in the kitchen area and threw the tissue in the kitchen's garbage can. It was at this point Resident A played the audio recording of the incident.

Upon hearing the recording, I established Ms. Kesselly verbally assaulted Resident A for approximately two minutes over Resident A blowing his nose in the facility's kitchen. Throughout the recording, Ms. Kesselly dominated the dialogue between her and Resident A and frequently interrupted Resident A while he spoke. Ms. Kesselly was heard using aggressive communication by swearing, screaming, and using name calling throughout the argument.

Resident A stated Resident B and Resident C were both present when the incident occurred. He stated direct care staff, Nichole Dickerson, had also been present, but did little intervention to de-escalate the situation. Resident A stated the incident did not turn physical and he stated this was the only time he had been verbally assaulted by any direct care staff from the facility.

Resident B and Resident C were interviewed during the inspection. Both Resident B's and Resident C's statements to me were consistent with one another. They confirmed an argument took place between Ms. Kesselly and Resident A on 06/12/2023. Both residents indicated they were in the vicinity of the argument; with Resident B on the facility's porch off the living room and Resident C in his bedroom located near the kitchen. Resident B stated he also heard Resident A call Ms. Kesselly and Ms. Dickerson names and swear at both of them. Resident C stated he had never been verbally assaulted by any staff within the facility and it was only Resident A who had ever been verbally assaulted.

Both direct care staff, Ms. Kesselly and Ms. Dickerson were working at the time of the inspection, and both were interviewed.  Ms. Kesselly's statement on how the argument started was consistent with Resident A's statement to me. Ms. Kesselly stated she's been working for the licensee for approximately three years. She stated Resident A is argumentative and disrespectful towards staff. She stated Resident A blew and then picked his nose, which is when she asked him to wash his hands. She stated the incident escalated when Resident A called both her and Ms. Dickerson, who is also Ms. Kesselly's daughter, a "bitch". She stated Ms. Dickerson tried calming Resident A down by using verbal redirection; however, Resident A continued being verbally assaultive towards her by calling her names and swearing at her. Ms. Kesselly stated the whole incident only lasted a few minutes and then Resident A ended up walking away. She stated after the incident occurred, she

refrained from talking to Resident A, but indicated she still “did [her] job” as she stated she still answered his questions relating to dinner that night.

Ms. Kesselly stated she’d been having verbal altercations with Resident A approximately three times per week. She stated she only has these types of incidences with Resident A and not any of the other residents. She stated the incident yesterday had been the only incident where she actually swore at Resident A. She stated during the other incidences she would only repeat the swear words Resident A said to her.

Ms. Dickerson’s statement to me was consistent with Ms. Kesselly’s statement to me. Ms. Dickerson stated after Ms. Kesselly asked Resident A to blow his nose in the bathroom rather than the facility’s common areas Resident A “got an attitude.” She stated she tried intervening between Ms. Kesselly and Resident A by telling them both to walk away and calm down. She stated Resident A then called her a “bitch”, which she indicated escalated the situation. Ms. Dickerson stated the whole incident only lasted “a few minutes.” Ms. Dickerson stated Resident A has called her a bitch multiple times. Ms. Dickerson stated she wasn’t aware of any other incidences between Ms. Kesselly and Resident A; however, she, herself, acknowledged arguing with Resident A on multiple occasions. She stated Resident A “can get in [her] face”, but she just walks away. She stated she has sworn and cussed at Resident A as well, and stated she needed to “work on [her] temper.” Ms. Dickerson stated she did not threaten Resident A but had told Resident A if he put his hands on her then she would restrain him. Ms. Dickerson denied Resident A ever being physical with her or Ms. Kesselly.

During the inspection, the licensee designee, Ramon Beltran, arrived. He stated he had also heard the audio recording and upon discovering Ms. Kesselly and Ms. Dickerson were working, he came to terminate Ms. Kesselly’s employment due to the severity of the audio recording. Mr. Beltran terminated Ms. Kesselly’s employment during the inspection, but I observed both her and Ms. Dickerson leave the facility.

On 06/14/2023, Ms. Kinzler forwarded me the audio recording between Resident A and Ms. Kesselly, which lasted one minute and 54 seconds. I attempted to transcribe the first minute of the audio recording, which included the following dialogue:

**Ms. Kesselly**: Leave everybody in this bitch the fuck alone, if you know what’s good for you! Why you sitting up here calling motherfuckers bitches? I could call your ass a bitch, but I fucking didn’t.
**Resident A**: Well, what… you know what…
**Ms. Kesselly**: Shut up talking to me! [inaudible speech]
***[inaudible screaming]***
**Ms. Kesselly**: I’m going to call my boss! I’m sick of your shit!

**Resident A**: [inaudible speech] Are you telling me that I can't fucking blow my nose in public?
**Ms. Kesselly**: I asked you to be neat and decent and go in the bathroom and wash your motherfucking dirty nose picking ass hands! That's what I asked you!
***[inaudible screaming]***
**Ms. Kesselly**: I don't give a fuck! I'm going to call my boss because you're harassing me!
***[inaudible screaming]***
**Ms. Kesselly**: I'm going to call your motherfucking caseworker!
***[inaudible screaming]***
**Resident A**: All I did was blow my nose. [inaudible speech]
**Ms. Kesselly**: [inaudible speech] I can talk just as loud as your ass! Get the fuck on!
**Resident A**: All I did was blew my nose!
**Ms. Kesselly**: And you're nasty!
**Resident A**: And you're bitching at me for it.
**Ms. Kesselly**: You called me a motherfucking bitch and you called her a bitch and you got me fucked up! Who you calling a bitch?
**Resident A**: I blew my nose!
**Ms. Kesselly**: Who you calling a bitch?! [inaudible speech] You called her a bitch! So you got me fucked up!
***[inaudible screaming]***
**Ms. Kesselly:** I don't give a fuck! I don't give a fuck! And I will call your case manager and tell her how you're so fucking disrespectful and you're disregarding…[inaudible speech].

| **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:**<br>**(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**<br>**(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.** |

| | |
|---|---|
| **ANALYSIS:** | On 06/13/2023, direct care staff, Olivia Kesselly, did not treat Resident A with respect when she verbally assaulted him over him blowing his nose in the facility's kitchen. Additionally, direct care staff, Nichole Dickerson, did not treat Resident A with respect when she admitted to swearing at Resident A on multiple occasions and not intervening to assist Resident A. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14308** | **Resident behavior interventions prohibitions.** |
| | **(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:**<br>**(f) Subject a resident to any of the following:**<br>**(i) Mental or emotional cruelty.**<br>**(ii) Verbal abuse.**<br>**(iii) Derogatory remarks about the resident or members of his or her family.**<br>**(iv) Threats.** |
| **ANALYSIS:** | On 06/13/2023, direct care staff, Olivia Kesselly, verbally assaulted Resident A when she engaged in aggressive dialogue after Resident A blew his nose in the facility's kitchen rather than the bathroom as Ms. Kesselly requested. An audio recording captured the verbal assault confirming Ms. Kesselly subjected Resident A to verbal abuse and derogatory remarks. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 06/13/2023, I conducted my exit conference with the licensee designee, Ramon Beltran, and explained my findings. Mr. Beltran agreed with my findings as he had also heard the audio recording. Mr. Beltran terminated Ms. Kesselly in person at the facility on 06/13/2023. In a follow-up exit conference on 06/29/2023, Mr. Beltran stated he would be writing Ms. Dickerson up because she failed to show Resident A dignity and respect. Mr. Beltran was encouraged to process the recent situations with Ms. Dickerson and Resident A to ensure Ms. Dickerson can continue providing Resident A with respect, despite being reprimanded. Mr. Beltran stated he will discuss resident rights at the facility's next staff meeting. He agreed to send me Ms. Dickerson's write up and a copy of the staff meeting agenda as corrective action plan compliance.

## IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

06/27/2023

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Cathy Cushman Date
Licensing Consultant

Approved By:

06/29/2023

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Dawn N. Timm Date
Area Manager