GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 5, 2024

Ms. Suzy Hunter
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #:	AS700297560
Investigation #:	2024A0356015
	Beacon Home at Trolley Center

Dear Ms. Hunter:

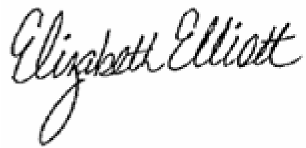
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS700297560
Investigation #:	2024A0356015
Complaint Receipt Date:	12/07/2023
Investigation Initiation Date:	12/07/2023
Report Due Date:	02/05/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St., Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Suzy Hunter
Licensee Designee:	Suzy Hunter
Name of Facility:	Beacon Home at Trolley Center
Facility Address:	320 64th Ave. North, Coopersville, MI 49404
Facility Telephone #:	(616) 384-3141
Original Issuance Date:	02/25/2009
License Status:	REGULAR
Effective Date:	08/25/2023
Expiration Date:	08/24/2025
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff Pauleysha Adams used unnecessary physical intervention on Resident A.	Yes

III. METHODOLOGY

12/07/2023	Special Investigation Intake 2024A0356015
12/07/2023	APS Referral P. Tyler Mihalatos, APS worker, Ottawa County DHHS.
12/07/2023	Special Investigation Initiated - Telephone Tyler Mihalatos, APS Worker.
12/08/2023	Contact - Document Sent Detective Dave DeWitt, Ottawa County Sheriff's Dept.
12/11/2023	Contact - Telephone call received. Detective Dave DeWitt, Ottawa County Sheriff's Office.
12/12/2023	Contact - Telephone call made. Felisha Battice, home manager. APS worker, Tyler Mihalatos, Ottawa Co. DHHS.
12/14/2023	Contact-Document received. Police Report
12/15/2023	Inspection Completed On-site Facility with Mr. Mihalatos. Face to Face with DCW Katrina Griswold.
12/19/2023	Contact - Face to Face Chenan Troulliet, DCW. Resident A.
12/19/2023	Contact - Document Received Training document for staff, Pauleysha Adams. Facility documents reviewed for Resident A.
12/19/2023	Telephone call made-Pauleysha Adams, left message.
01/29/2024	Exit Conference-Suzy Hunter, Licensee Designee.

ALLEGATION: Staff Pauleysha Adams used unnecessary physical intervention on Resident A.

INVESTIGATION: On 12/07/2023, I received a BCAL (Bureau of Child and Adult Licensing) online complaint. The complainant reported that on 11/22/2023, Resident A was “having a behavior,” Resident A had a hold of the home manager’s shirt, but the manager was not in any danger of being hurt. The complainant reported direct care staff, Pauleysha Adams came up behind Resident A and put him in a choke hold, and then Ms. Adams attempted to “drag” Resident A outside. The complainant reported that usually, staff re-direct Resident A or have him count to 20 and these strategies work to defuse Resident A’s behaviors. The complainant reported that Ms. Adams has been trained on the proper way to handle Resident A and his behaviors, and this was not warranted. Resident A is unable to provide pertinent information to this investigation due to cognitive deficits.

On 12/07/2023, I interviewed Tyler Mihalatos, Adult Protective Services Worker, Ottawa County Department of Health and Human Services (DHHS) via telephone. Mr. Mihalatos stated the Ottawa County Sheriff’s Department, Detective Dave Dewitt has an open case and is investigating this allegation. Mr. Mihalatos and I discussed a joint investigation and will wait until Det. Dewitt has concluded his interviews.

On 12/11/2023, I interviewed Det. Dave Dewitt via telephone. Det. Dewitt stated he interviewed home manager, Felisha Battice at the facility, Ms. Battice reported that she was interacting face-to-face with Resident A. Resident A had a hold of her shirt but there was no need for direct care worker (DCW) Pauleysha Adams to use any form of physical intervention on Resident A. Despite this, she approached Resident A from behind and used a “chokehold” type hold on Resident A to move him away from her (Ms. Battice). Det. Dewitt stated Ms. Battice reported that Ms. Adams took Resident A to a bean bag chair in the living room and then Ms. Adams attempted to get Resident A to go outside with her, but Resident A did not want to go so Ms. Adams pulled Resident A by the arm to get him to go outside. Det. Dewitt stated Ms. Battice reported that there was no reason for Ms. Adams to use the physical force she used with Resident A. Det. Dewitt stated Ms. Battice reported that Ms. Adams no longer works at the facility. Det. Dewitt stated he has attempted to contact Ms. Adams but has not been able to reach her for an interview.

On 12/12/2023, I interviewed Ms. Battice via telephone. Ms. Battice stated she was interacting with Resident A face-to-face and Resident A was holding onto her shirt. She had control of the situation when Ms. Adams came up behind Resident A and put him in a chokehold. Ms. Battice stated she told Ms. Adams to stop and not to continue to intervene. Ms. Battice stated Ms. Adams let go of the chokehold she had on Resident A and guided him into the living room and sat on a beanbag with him trying to get him to focus on other things. Ms. Battice stated Ms. Adams then attempted to get Resident A to go outside with her, but Resident A refused to go, and Ms. Adams then began to pull Resident A by the arm to get him to go outside the facility with her. Ms. Battice stated she requested that Ms. Adams leave the

facility immediately, which she did, then she sat in her car in the parking lot for approximately 20 minutes before leaving the grounds. Ms. Battice stated Ms. Adams no longer works at the facility and has not returned to the facility since this incident.

On 12/14/2023, I received and reviewed the Ottawa County Sheriff's Office police report. The allegations reported the following: *'On 11/22/2023, (Resident A) was having a behavior and had a hold of the Managers shirt, but the manager was not in any danger of being hurt. Then, Pauleysha Adams (a staff member) came up behind (Resident A) and put him in a choke hold. Then Pauleysha tried to drag (Resident A) outside. Usually, the staff persons will re-direct (Resident A) or have him count to 20. These strategies usually work to defuse (Resident A's) behaviors. Pauleysha has been trained on the proper way to handle (Resident A) and his behaviors.'*

The police report investigation was conducted by Det. Dewitt and documented the following information from an interview with Ms. (Felicia) Battice on 12/07/2023: *'Felisha said that on 11/22/23, (Resident A) was acting out and described how he has tantrums. Felisha's terminology was that (Resident A) was "having behaviors" just before Pauleysha grabbed (Resident A). Felisha said that (Resident A) had Felisha by the shirt, and Pauleysha came up to (Resident A) from behind and grabbed him around the neck with her arm. Pauleysha's other hand was over the top of (Resident A's) head and pulling him back, away from Felisha. Felisha did not hear Pauleysha saying anything during the action. Felisha said that her response was immediate, and that she told Pauleysha, "You can't do that, you have to let him go." Felisha reports that Pauleysha did let (Resident A) go immediately. Felisha did not hear Pauleysha say anything after letting go. After letting (Resident A) go, Pauleysha tried to convince (Resident A) to put shoes on and go outside. (Resident A) was reluctant and passively resistant. Felisha helped (Resident A) get his shoes on, then Pauleysha was trying to get (Resident A) to go outside. (Resident A) was still passively resistant. Pauleysha took (Resident A) by the hands and began to pull him toward to door to go outside. (Resident A) began yelling, while resisting. Felisha assisted Pauleysha by talking with (Resident A) and verbally convincing him to go outside, in the hope that redirection would calm him. Felisha reports that she sat outside with (Resident A) and he became calm, and upon entering the home again, she asked Pauleysha to leave for the day. Felisha described that Pauleysha agreed to leave the home and went to her car at sat in the lot for a while. Felisha noticed that 20 minutes had passed and Pauleysha had not left. Felisha said that Pauleysha did ultimately leave on 11/22/23 and did not return. Pauleysha was terminated by phone and should have no reason to return. Felisha did not see any injury on (Resident A), and (Resident A) did not complain of injury after the incident.'*

Det. Dewitt interviewed Ms. Troulliet and documented the following information: *'Chenan said that she was present when (Resident A) was having behaviors, and Pauleysha grabbed him from behind. Chenan said that (Resident A's) behaviors on 11/22/23 involved (Resident A) hitting and kicking. Chenan said that the staff was working through the behaviors when "he attacked us" and named Felisha as (Resident A's) primary focus. Chenan said that (Resident A's) behaviors have a similar routine, describing that he often starts with slapping himself, then biting*

himself, then going after other people. Chenan explained that when (Resident A) goes after someone, he uses his hands to grab and scratch. Chenan revealed scratches on her chest below the clavicle and described them as "battle scars" from (Resident A's) behaviors. Chenan said that (Resident A) had already been hitting and biting himself, then (Resident A) went towards Felisha with his hands up. Chenan observed as Pauleysha went toward (Resident A) from behind him and used her arm to grab (Resident A) around the neck. Chenan did not hear Pauleysha say anything during that action. Pauleysha let (Resident A) go when asked, and then continued to engage playfully and appropriately with (Resident A) to calm his behaviors. Chenan said that Pauleysha laughed and played with (Resident A), playing tag and "snuggling" him to cheer him up. Later, (Resident A) began displaying behaviors again, and sat down on the floor in disgust. Pauleysha took (Resident A) by the arm and pulled him across the floor in an apparent attempt to get him to come outside. Chenan witnessed Felisha tell Pauleysha to leave and described that Pauleysha complied with the order. Chenan observed Pauleysha go to her car and sat in the parking lot for some time. Chenan said that she was disappointed because Pauleysha should not have done that. Chenan said that it was important to note that Pauleysha did not appear enraged, or out of control when she grabbed (Resident A). Chenan said that the response was an overreaction, and inappropriate for this environment, but not malicious, or intentional to hurt (Resident A). Chenan did not see any injury on (Resident A), and (Resident A) did not complain of pain or injury after the incident.'

Det. Dewitt documented the following: *'I did see the scratches on Chenan's chest that validate her statement that (Resident A) uses his hands to "attack" the staff when he is experiencing tantrum-like behaviors. The explanation made by Chenan makes clear that there was an active incident and that Pauleysha responded inappropriately. Felisha reports that Pauleysha was trained in Crisis Prevention & Intervention (CPI) that offers techniques to restrain adults in a way that reduces the risk of injury. Felisha and Chenan both report that grabbing (Resident A) from behind was not CPI protocol.'*

Det. Dewitt contacted, court appointed legal guardian and conservator for Resident A, Dianne South: *'Dianne said that she has received the AFC Incident report and reviewed the summary of information but does not have any specific details of the incident. Dianne said that she has been guardian for (Resident A) for many years and he has resided in multiple different residential homes and has had several behavioral/incident reports over the years. I explained the information that I obtained through interviews with Felisha and Chenan, and asked if she had an opinion on criminal charges. Dianne responded with high praise of the Beacon home, citing that (Resident A) has done best at this home, and she feels he is safest there. Dianne said that she does have concerns about the response by Pauleysha to (Resident A's) behavior but does not believe Pauleysha's actions were intended to harm (Resident A) or assault him. Dianne said that she suspects that Pauleysha is new to the facility and possibly this field of work and can understand that an instinctive response to a grown man acting out may be intimidating, but surely not appropriate given his cognitive function. Dianne said that she would leave the investigation and*

disposition “to the professionals” and would be satisfied with whatever the outcome might be, but she was not seeking criminal charges based on the information provided.’

Det. Dewitt documented that he attempted to interview Ms. Adams via telephone on 12/09/2023 and left a voicemail message. Det. Dewitt documented that Ms. Adams did not answer the call, nor did she return the call.

On 12/15/2023, Mr. Mihalatos and I conducted an unannounced inspection at the facility and interviewed DCW Katrina Griswold. Ms. Griswold stated she was not present when the incident occurred on 11/22/2023 but during her shift, she did not see any marks or bruises.

On 12/15/2023, Mr. Mihalatos and I attempted to interview Resident A at the facility. Resident A was not able to provide pertinent information to this investigation due to cognitive deficits.

On 12/19/2023, Mr. Mihalatos and I conducted an unannounced inspection at the facility and interviewed DCW Chenan (pronounced Keenan) Troulliet. Ms. Troulliet confirmed that she was working 1st shift on 11/22/2023 with Ms. Battice and Ms. Adams when the incident occurred. Ms. Troulliet stated Resident A was “obsessing over something, kept hitting himself, and he charged” at Ms. Battice. Ms. Troulliet stated Ms. Adams did what she called a “bear hug” to get Resident A away from Ms. Battice. Ms. Troulliet stated it was more like Ms. Adams, while standing behind Resident A grabbed him around his chest with her left arm and had her right arm on Resident A’s head. Ms. Troulliet stated Resident A moved away from Ms. Battice and went to the living room with Ms. Adams. Ms. Troulliet stated Ms. Adams and Resident A were in the living room, Resident A’s mood had changed, and he was laughing. Ms. Troulliet stated Resident A “amped back up and put himself on the floor in the living room.” Ms. Adams tried to get Resident A to go outside with her, but Resident A resisted going outside and that is when Ms. Adams “dragged” Resident A by his arm out the door while Resident A was laying on the floor. Ms. Troulliet stated all staff are trained in CPI (nonviolent crisis intervention) before they work with residents but none of the physical interventions performed on 11/22/2023 by Ms. Adams were CPI trained interventions. Ms. Troulliet stated she has never known Ms. Adams to be violent with residents.

On 12/19/2023, I reviewed the CPI training card for Ms. Adams, the training was complete and issued on 10/12/2023.

On 12/19/2023, I attempted to interview Ms. Adams via telephone. I was unable to make contact with Ms. Adams and left a message on a voice mail. I have not received a return call from Ms. Adams.

On 12/19/2023, I reviewed the CPI training card for Ms. Adams, the training was complete and issued on 10/12/2023.

On 12/19/2023, I reviewed Resident A's assessment plan for AFC residents. The assessment plan documented Resident A does not control aggressive behavior and documented: *'(Resident A) does have history of aggression towards others, staff will verbally redirect and work with (Resident A) on developing some coping skills to use when he becomes upset.'* The assessment plan documents Resident A exhibits self-injurious behavior and documented: *'(Resident A) will engage in biting himself and hitting himself when he becomes upset. Staff will work with (Resident A) daily on developing his coping skills when he becomes upset and redirect as needed.'*

On 12/19/2023, I reviewed Resident A's behavior support plan (BSP) written by Clara Lee, M.Ed. The BSP documented Resident A's behaviors as 'physical aggression, property destruction, self-injurious behavior, and stealing/theft.' The BSP details several techniques such as 'listening to music with headphones (preferred activity), watching a movie (preferred activity), removing himself to a quiet spot-bedroom or sensory corner, utilizing white board or emotion cards, watching tv and deep breath exercises to work through episodes of behaviors.'

On 01/29/2024, I conducted an exit conference with Licensee Designee, Suzy Hunter via telephone. Ms. Hunter stated she agrees with the information, analysis, and conclusion of this applicable rule and will provide an acceptable corrective action plan.

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:	The complainant reported direct care staff, Pauleysha Adams came up behind Resident A and put him in a choke hold, and then Ms. Adams attempted to "drag" Resident A outside. Det. Dewitt stated Ms. Battice and Ms. Troulliet reported Ms. Adams approached Resident A from behind and placed him in a chokehold type hold and then pulled Resident A by the arm to get him to go outside. Det. Dewitt stated Ms. South reported Ms. Adams actions were not intended to harm Resident A or assault him but not appropriate given his cognitive function. Ms. Battice and Ms. Troulliet stated Ms. Adams came up behind Resident A and put him in a chokehold and then began to pull

	Resident A by the arm to get him to go outside the facility with her. Ms. Adams was trained in CPI on 10/12/2023. Resident A's assessment plan documented that Resident A does not control aggressive behavior and has a history of aggression towards others. Staff will verbally redirect and work with (Resident A) on developing some coping skills to use when he becomes upset.' Resident A's behavior plan documented some of Resident A's behaviors as 'physical aggression, property destruction, self-injurious behavior, and stealing/theft.' The behavior plan details several techniques to work through episodes of behaviors that does not include physical intervention. Based on investigative findings, there is a preponderance of evidence to show that Ms. Adams failed to provide Resident A with protection and safety on 11/22/2023 when she used an unnecessary physical intervention on Resident A during an incident at the facility. Therefore, a violation of this applicable rule has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain the same.

02/05/2024

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

02/05/2024

Jerry Hendrick — Date
Area Manager