GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 8, 2024

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

RE: License #: AS370413382
Investigation #: 2024A1029036
Beacon Home At Nottawa

Dear Ms. Goldammer:

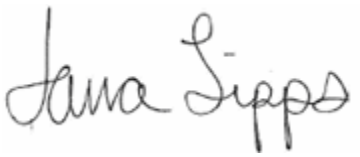
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Jana Lipps, 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 #:	2024A1029036
Complaint Receipt Date:	03/07/2024
Investigation Initiation Date:	03/07/2024
Report Due Date:	05/06/2024
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, Designee
Licensee Designee:	Roxanne Goldammer, Designee
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:	REGULAR
Effective Date:	05/14/2023
Expiration Date:	05/13/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Cynthia Bermudez, told Resident A to “shut the fuck up”, threatened to break his cigarettes, and stood in the doorway of the restroom and did not allow Resident A privacy while attempting to use the restroom. Resident A then urinated on his clothing and Ms. Bermudez called Resident A, a “sick fuck”.	Yes

III. METHODOLOGY

03/07/2024	Special Investigation Intake 2024A1029036
03/07/2024	Special Investigation Initiated – Letter to Angela Wend Office of Recipient Rights.
03/08/2024	APS Referral- APS referral to Centralized Intake
03/08/2024	Contact - Telephone call made to Lauren Lora (# d/c) and Joyce Human.
03/19/2024	Inspection Completed On-site- Interviews conducted with licensee designee, Roxanne Goldammer, home manager/direct care staff, Naomi Voorhees, direct care staff, Lauren Lora, Resident B, and Resident C. Review of Resident A's resident record initiated.
03/22/2024	Contact - Telephone call made- Interview with direct care staff, Ashley Wolfe, via telephone.
03/22/2024	Contact - Document Sent- Email correspondence with Community Mental Health, Central Michigan, Office of Recipient Rights Advisor, Angela Wend.
04/08/2024	Contact – Telephone call made Interview with direct care staff, Cynthia Bermudez/Watson.
04/08/2024	Exit Conference Conducted via telephone with licensee designee, Roxanne Goldammer.

ALLEGATION: Direct care staff, Cynthia Bermudez, told Resident A to "shut the fuck up", threatened to break his cigarettes, and stood in the doorway of the restroom and did not allow Resident A privacy while attempting to use the restroom. Resident A then urinated on his clothing and Ms. Bermudez called Resident A, a "sick fuck."

INVESTIGATION:

On 3/7/24 an online complaint was received regarding the Beacon Home at Nottawa, adult foster care facility (the facility). The complaint alleged that direct care staff, Cynthia Bermudez, told Resident A to "shut the fuck up", threatened to break his cigarettes, and stood in the doorway of the restroom not allowing Resident A privacy while attempting to use the restroom. Resident A then urinated on his clothing and Ms. Bermudez called Resident A, a "sick fuck." On 3/8/24 Adult Foster Care Licensing Consultant, Jennifer Browning, interviewed direct care staff, Joyce Human, via telephone. Ms. Human reported to Ms. Browning that she is currently employed at the facility. She reported to Ms. Browning that she does not have direct knowledge of the allegations but noted Resident A can use the bathroom regularly or sometimes he will urinate off the back porch if he is outside. She further reported that at times Resident A will use a urinal that is provided to him by the hospice program Resident A is enrolled in. Ms. Human reported to Ms. Browning that Resident A can use the restroom on his own and there is no reason why he would not be allowed privacy while in the restroom.

On 3/19/24 I conducted an unannounced, on-site investigation at the facility. I interviewed licensee designee, Roxanne Goldammer. Ms. Goldammer reported that she had received an email about the allegations against Ms. Bermudez, but she has not interviewed Ms. Bermudez as this is a current Community Mental Health, Office of Recipient Rights investigation. Ms. Goldammer was not present on the date of the alleged incident, which was identified as 3/5/24. She reported no direct knowledge of the incident.

During on-site investigation, on 3/19/24, I interviewed direct care staff/home manager, Naomi Voorhees. Ms. Voorhees reported that on the date 3/5/24 at the time of the alleged incident, direct care staff, Ashley Wolfe, Lauren Lora, and Ms. Bermudez, were working. She reported that she was not at the facility and received a telephone call from Ms. Wolfe. Ms. Voorhees reported that Ms. Wolfe had called her to request how to report an event to the Office of Recipient Rights (ORR). She reported that Ms. Wolfe stated she witnessed, firsthand, Ms. Bermudez swearing at Resident A, threatening to break his cigarettes, and not allowing him to close the restroom door to have privacy in the restroom. Ms. Voorhees reported she gave Ms. Wolfe the contact information for ORR and encouraged her to make a complaint. Ms. Voorhees reported that Ms. Wolfe then called Ms. Voorhees back about three hours after the initial telephone call to express that she had made the complaint, but Ms. Bermudez was continuing to swear at Resident A. Ms. Voorhees reported that an email was sent to ORR from Ms. Wolfe and Ms. Lora regarding the allegation that

Ms. Bermudez was swearing at Resident A, threatening to break his cigarettes, and not allowing him to have privacy in the restroom. Ms. Voorhees reported that this email states that two residents were direct witnesses to this incident, Resident B and Resident C. Ms. Voorhees reported Ms. Bermudez has worked at the facility for about three months. She reported having no knowledge of Ms. Bermudez acting in this manner with any other residents. Ms. Voorhees reported that Resident A is difficult to converse with as he has active delusions, due to his mental health diagnosis, and has difficulty focusing on conversations and answering appropriately.

During the on-site investigation on 3/19/24 I interviewed Resident B. Resident B reported that he has no knowledge of Ms. Bermudez swearing at Resident A, threatening to break his cigarettes, or not allowing him privacy in the restroom. Resident B reported that he has no concerns about the direct care staff at the facility.

During the on-site investigation on 3/19/24 I interviewed Resident C. Resident C reported that on 3/5/24 he directly observed Ms. Bermudez state to Resident A to "shut the fuck up!" He further reported that he observed Ms. Bermudez threaten to break Resident A's cigarettes. Resident C reported that on this date he observed Ms. Bermudez yelling and swearing at Resident A. Resident C reported that he did not observe Ms. Bermudez deny Resident A privacy while using the restroom.

During the on-site investigation on 3/19/24 I interviewed Ms. Lora. Ms. Lora reported that she has worked at the facility for about one year. She reported that she was working on 3/5/24 with Ms. Bermudez and Ms. Wolfe. Ms. Lora reported that at the time of the alleged incident she had been sitting on the couch charting in resident records. She reported that Resident A was yelling (confirming this is a normal behavior for Resident A). She reported that Resident A asked for a cigarette and Ms. Bermudez responded, "You just had one". Ms. Lora reported that Resident A then began screaming and yelling in response to Ms. Bermudez's statement and Ms. Bermudez then stated if Resident A did not stop screaming and yelling, she was going to "snap them all in half!", (referring to the cigarettes). Ms. Lora reported that Ms. Bermudez stated to Resident A that it needed to be an hour between his cigarettes, and he had just had one. She reported that Resident A then got up to use the restroom and Ms. Bermudez followed him and stopped the restroom door from closing. Ms. Lora reported that Resident A requires "eyes on supervision" and she had to make sure he was safe in the restroom. Ms. Lora reported that at this time Resident A became upset with this and Ms. Bermudez stated, "I'll stay here until you piss yourself." Ms. Lora reported that Resident A then stated, "Never mind, I'll go back to my wheelchair." Ms. Lora reported that Ms. Bermudez was then sitting on the couch and Resident A went to another restroom and urinated on the floor. Ms. Lora reported that Ms. Bermudez was then in the restroom observing the urine on the floor and Ms. Lora asked what happened. Ms. Lora reported that Ms. Bermudez stated, Resident A had just urinated on the floor. Ms. Lora stated that she asked, "why?" and was told by Ms. Bermudez, "because he's a nasty fuck." Ms. Lora reported that Resident B had been seated at the nearby table and Resident C had

been seated on the couch when these events took place. Ms. Lora reported that she and Ms. Wolfe reported this incident to ORR.

On 3/22/24 I interviewed Ms. Wolfe, via telephone. Ms. Wolfe reported that she had been working on 3/5/24 at the time of the alleged incident. She reported that she did observe Ms. Bermudez become "annoyed" with Resident A because he was asking for a cigarette immediately after having smoked one. She reported that the direct care staff try to keep the residents to one cigarette an hour to make them last longer. Ms. Wolfe reported that Ms. Bermudez became irritated with Resident A and raised her voice at him stating he needed to wait for another cigarette. Ms. Wolfe reported that Ms. Bermudez was standing by the restroom door as Resident A is on hospice and she did not want him to fall while he was in the restroom. Ms. Wolfe reported she observed Ms. Bermudez threaten to break Resident A's cigarettes. Ms. Wolfe denied hearing Ms. Bermudez state, "I'll stay here until you piss yourself." She reported that she did not observe Ms. Bermudez refer to Resident A as a "sick fuck." Ms. Wolfe confirmed she did report these events to ORR and the home manager, Ms. Voorhees. She confirmed she called Ms. Voorhees back to inform her that Ms. Bermudez was continuing to swear at Resident A and told him to "shut the fucking door" as Resident A had left the front door of the facility open. Ms. Wolfe reported that Ms. Lora, Resident B, and Resident C were all present at the time of the incident.

During the on-site investigation on 3/19/24 I reviewed the following documents:

- *Assessment Plan for AFC Residents* form for Resident A, dated, 2/14/24. On page 1, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, it states, *No*, "Per IPOS will need 24hour 1:1 staff supervision in the community." Under subsection, *N. Smokes*, it states, *No*, "History of smoking." On page 2, section, *II. Self Care Skill Assessment*, subsection, *B. Toileting*, it reads, *Yes*, "Wears briefs, needs help at times will have bowel accidents, staff will assist in cleaning up."
- *Beacon IPOS In-service Signature Form* for Resident A. Ms. Bermudez signed this document on 12/28/23.
- *Community Mental Health for Central Michigan, PCP Addendum,* for Resident A, dated 1/3/23. On page 2 of this document, under paragraph 2, it states, "[Resident A] has a behavior treatment plan in place to help with his current behaviors. He is to have line of sight while in the house (with the exception of the bathroom and his bedroom) and in the community. If he needs to use the restroom while in the community, staff are to stay outside when in a single stall bathroom or in the lobby if in a multiple stall bathroom."
- *Behavior Treatment Plan,* for Resident A, dated 3/6/23. On page 10 under the section, *Intensive Supervision*, paragraph 2 and 3, it reads, "[Resident A] does not require line of sight supervision when he is in his bedroom or bathroom in the home. [Resident A] may go into a single stall bathroom in the community on his own while staff wait outside the door. Or if it is a multi-stall bathroom, staff will wait in the common area of the restroom but outside of the stall."

On 4/8/24 I interviewed Ms. Bermudez, via telephone. Ms. Bermudez reported that she has recently changed her name and now would like to be addressed as Cynthia Watson. Ms. Watson stated that she is familiar with Resident A's plan of care and noted that Resident A requires 24 hour one on one direct care staff supervision. She reported that Resident A is allowed to have privacy in his bedroom and in the bathroom areas. She reported that direct care staff will assist Resident A to the bathroom and wait outside the door for him to finish and then will assist with his personal care. Ms. Watson reported that she has never stopped Resident A from having privacy in the bathroom by blocking the doorway so that he could not close the bathroom door. She reported that she has never told Resident A to "shut the fucking door" when he left the front door open. She reported she has never referred to Resident A as a "sick fuck". Ms. Watson reported that she has never threatened to break Resident A's cigarettes. Ms. Watson reported that the Office of Recipient Rights had received a complaint against her for these allegations and she did not do these things. She reported that the management at the facility has removed her from providing one to one care for Resident A at this time and she disagrees with this directive but has been compliant.

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:	Based upon interviews with Ms. Human, Ms. Goldammer, Ms. Voorhees, Ms. Wolfe, Ms. Lora, Resident B, Resident C, and Ms. Watson, as well as review of Resident A's resident record, it can be determined that on the date 3/5/24 there were a reported five individuals present at the facility who directly observed the alleged events. Each of these individuals were interviewed for this investigation. Three of the five interviewed, Ms. Wolfe, Ms. Lora, and Resident C, all confirmed that they observed Ms. Watson threaten to break Resident A's cigarettes, and aggressively direct profanity toward him on this date. Ms. Voorhees also acknowledged that she had received communication from Ms. Wolfe on 3/5/24 with similar allegations regarding Ms. Watson's behaviors on this date. Although, Ms. Watson, denies these allegations, there is a majority consensus that these behaviors were demonstrated by Ms. Watson on 3/5/24, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

4/8/24

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Jana Lipps Date
Licensing Consultant

Approved By:

04/08/2024

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Dawn N. Timm Date
Area Manager