GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 31, 2024

Roxanne Goldammer
The Country House, LLC
890 N. 10th St. Ste 110
Kalamazoo, MI 49009

RE: License #: AM040291143
Investigation #: 2024A0360023
Beacon Home at Ossineke

Dear Roxanne Goldammer:

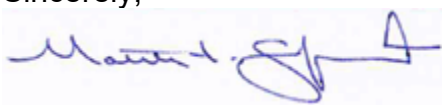
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 241-2758.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
931 S Otsego Ave
Gaylord, MI 49735
(989) 370-8320
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM040291143
Investigation #:	2024A0360023
Complaint Receipt Date:	09/03/2024
Investigation Initiation Date:	09/03/2024
Report Due Date:	11/02/2024
Licensee Name:	The Country House, LLC
Licensee Address:	110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(989) 471-8482
Administrator/Licensee Designee:	Roxanne Goldammer
Name of Facility:	Beacon Home at Ossineke
Facility Address:	10685 Spruce Rd Ossineke, MI 49766
Facility Telephone #:	(989) 471-1192
Original Issuance Date:	12/17/2009
License Status:	REGULAR
Effective Date:	06/12/2024
Expiration Date:	06/11/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was pushed and yelled at by a direct care staff.	Yes

III. METHODOLOGY

09/03/2024	Special Investigation Intake 2024A0360023
09/03/2024	APS Referral assigned to Kayla Kelly
09/03/2024	Special Investigation Initiated - Telephone Kayla Kelly APS
09/05/2024	Inspection Completed On-site DCS supervisor Sarah Patterson, Resident A
09/26/2024	Inspection Completed On-site DCS supervisor Sarah Patterson
10/28/2024	Contact - Telephone call made Resident A
10/28/2024	Contact - Telephone call made DCS Richard Beegan
10/28/2024	Contact - Telephone call made DCS Eric Dubie
10/28/2024	Contact - Document Received Administrator Roxanne Goldammer
10/29/2024	Contact - Document Received Kayla Kelly APS
10/31/2024	Exit Conference

ALLEGATION:

Resident A was pushed and yelled at by a direct care staff.

INVESTIGATION:

On 9/5/24, I conducted an unannounced onsite inspection at the facility. The direct care staff (DCS) supervisor Sarah Patterson stated DCS Richard Beegan was currently on suspension pending a recipient rights investigation regarding an incident on 8/28/24 at 3 a.m. between Mr. Beegan and Resident A. Ms. Patterson provided me with an incident report regarding the complaint. The incident report documented that DCS Eric Dubie and Mr. Beegan were sitting in the living room when Resident A came into the living room and started talking with Mr. Beegan. Mr. Beegan became upset and started a verbal altercation with Resident A. Mr. Beegan then took the glasses off of Resident A's face and pushed him back to his room continuing to yell expletives. The incident report was completed by DCS Eric Dubie.

On 9/5/24, I attempted an interview with Resident A. Resident A stated he was not interested in being interviewed regarding the incident.

On 9/26/24, I conducted another unannounced onsite inspection at the facility. Ms. Patterson stated Resident A was not at the facility as he had been psychiatrically hospitalized. Ms. Patterson stated when he is discharged from the hospital he will be moving to another Beacon facility. Ms. Patterson stated Mr. Beegan remains on suspension pending the recipient rights investigation.

On 10/28/24, I contacted DCS Eric Dubie and interviewed him by telephone. He stated on 8/28/24 he was sitting in the back living room with Mr. Beegan. He stated that Resident A came back into the living room at around 3 a.m. and was antagonizing Mr. Beegan. Mr. Dubie stated that Mr. Beegan became upset, swiped the glasses off of Resident A's face, yelled at him and pushed him back into his bedroom. Mr. Dubie stated that he then completed the incident report and submitted it to recipient rights.

On 10/28/24, I contacted DCS Richard Beegan by telephone. He did not answer but I left a voicemail.

On 10/28/24, I contacted Resident A and interviewed him by telephone. Resident A stated that Mr. Beegan is a bully. He stated Mr. Beegan smacked his glasses off of his face, yelled at him and pushed him back into his bedroom. Resident A then stated he did not want to talk any more and that he wanted to go back to bed.

On 10/28/24, I was contacted by the administrator Roxanne Goldammer. Ms. Goldammer stated Mr. Beegan remains on suspension pending the recipient rights investigation.

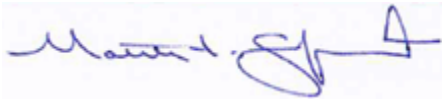
On 10/29/24, I contacted Kayla Kelly with adult protective services (APS). Ms. Kelly stated she did substantiate her APS complaint for physical abuse.

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:	Interviews with Ms. Patterson, Mr. Dubie, Resident A and APS worker Kayla Kelly revealed that Resident A was yelled and pushed by Mr. Beegan and not treated with dignity and his personal needs, including protection and safety, were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/31/2024 I conducted an exit conference with Roxanne Goldammer. Ms. Goldammer concurred with the findings of the investigation.

IV. RECOMMENDATION

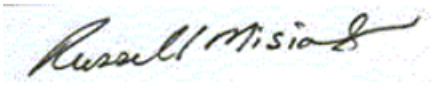
Upon receipt of an acceptable corrective action, I recommend no change in the status of the license.



10/31/24

Matthew Soderquist Date
Licensing Consultant

Approved By:



10/31/24

Russell B. Misiak Date
Area Manager