GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 18, 2024

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

RE: License #: AS800404242
Investigation #: 2025A0790004
Beacon Home at Hartford

Dear Nichole VanNiman:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Rodney Gill, 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 #:	2025A0790004
Complaint Receipt Date:	11/14/2024
Investigation Initiation Date:	11/15/2024
Report Due Date:	01/13/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
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 harassed by Resident B and direct care staff members are not intervening.	No
Additional Findings	Yes

III. METHODOLOGY

11/14/2024	Special Investigation Intake 2025A0790004
11/14/2024	APS Referral is not necessary because the allegations in this special investigation came from a denied Adult Protective Services (APS) referral.
11/15/2024	Special Investigation Initiated – Telephone call to Complainant to confirm the allegations are accurate and comprehensive.
12/03/2024	Inspection Completed On-site Interviewed Resident A and direct care staff members (DCSMs) Kathryn Whitfield who functions as the assistant manager and Aaron King.
12/05/2024	Contact - Telephone call made Interviewed DCSM Katherine Smith.
12/05/2024	Inspection Completed-BCAL Sub. Compliance
12/09/2024	Exit Conference with licensee designee Nichole VanNiman.
12/09/2024	Corrective Action Plan Requested and Due on 12/24/2024.

ALLEGATION:

Resident A was harassed by Resident B and direct care staff members are not intervening.

INVESTIGATION:

On 11/14/24, I reviewed a denied Adult Protective Services (APS) referral dated 11/12/24. The referral indicated Resident A resides at Beacon Home at Hartford. Resident A is diagnosed with bipolar disorder, post-traumatic stress disorder (PTSD), intellectual disability, autism spectrum disorder, alcohol use disorder, cannabis use disorder, tobacco use disorder, obesity, sleep apnea, and hypothyroidism. Resident A has a legal guardian. He can complete his activities of daily living independently with prompting.

The referral indicated Resident A is being antagonized by Resident B who is a new resident in the home. It is believed the Resident B has only been at the residents for two to three weeks. Resident B has been verbally aggressive towards Resident A and has threatened to harm him and his family. Resident B follows Resident A around the home. Resident B has also been banging on Resident A's door and yelling, causing Resident A not to be able to sleep for two weeks.

The referral indicated on 11/12/24, Resident A had an appointment for his behavioral health. Resident B was interfering in Resident A's personal visit by yelling because Resident B believed Resident A was talking about him. Direct care staff members (DCSMs) were informed of the concerns. DCSMs told Resident A and the Behavioral health specialist present to ignore Resident B.

The referral indicated Resident A attempted to ignore Resident B but continued to be antagonized. Resident A has not experienced any physical harm from Resident B. There are concerns DCSMs are aware of the concerns and have not done anything about them. This has caused Resident A not to feel safe in the home. Resident A has had an increase in physical and verbal aggression since the concerns have occurred. He has also destroyed property.

On 11/15/24, I called the complainant to confirm the allegations are accurate and comprehensive.

I completed an unannounced onsite investigation on 12/3/24. I witnessed Resident B pacing back and forth through the facility. Resident B was making nonsensical comments and initiated a conversation with me in an illogical and aggressive manner.

On 12/3/24, I interviewed Resident A in his room. Resident A confirmed Resident B Is manic and has been harassing the other residents and DCSMs. He said Resident B is angry and violent when he smokes marijuana and said Resident B has been smoking it.

Resident A stated he does not believe Resident B is right for this facility. He said Resident B has been bulling him and other residents for quite some time. Resident A could not tell me exactly how long Resident B has been bullying him and the other residents but said it had been "quite a while".

Resident A said he finally had to standup to Resident B and Resident B backed Down. He stated Resident B continues to bully and harass him even after he stood up to him.

Resident A stated Resident B is always talking and saying things that do not make sense.

Resident A said Resident B was taking certain grocery items from him and he finally had to have DCSMs lock his personal grocery items up.

Resident A stated Resident B is always demanding cigarettes from Resident A. Resident A said Resident B forces him to give him cigarettes. Resident A stated he gives Resident B his cigarettes because he fears Resident B. Resident A said Resident B recently forced another resident to give Resident B his whole pack of cigarettes.

Resident A said Resident B calls him names like fat Santa Claus, pedophile, etc. Resident A stated Resident B has been knocking in his and other residents' bedroom doors and that is why many of the doors are broken. He said every time Resident B gets weed in his system this is how he acts.

Resident A said Resident B has the female DCSMs trembling. He said DCSMs appear to not know what to do or how to manage Resident B's behaviors. Resident A stated the only thing DCSMs can do is be nice to Resident B. He said one of the male-DCSMs is an old skinny man and if Resident B hit him, he could die. Resident A said Resident B targets the weak and scared residents and DCSMs.

Resident A stated he knows Resident B is receiving injections to help stabilize his mood every month. Resident A said the injections are not working because Resident B never sleeps, and he is always aggressive.

Resident A said I cannot even go outside to smoke. He then said, "I'm scared." Resident A stated he would like to move back to Jackson, MI. He said he is from Jackson, and it is where his family and friends live.

Resident A said Resident B tried to physically harm him. Resident A stated Resident B previously grabbed him by his coat, swung him around, and banged his head into the wall. He said Resident B also punched him in the ribs. Resident A stated this happened about a week ago and it was the first time Resident B was transported to the hospital for a psychological evaluation and admitted into a psychiatric ward located in Indiana.

Resident A said Resident B subsequently returned to the facility and continues to intimidate, verbally, and physically harass him, other residents, and DCSMs.

On 12/3/24, I interviewed DCSMs Kathryn Whitfield and Aaron King. Mr. King said it was his first day working at the facility. Ms. Whitfield stated she has worked at the facility for two years and she functions as the assistant home manager.

Ms. Whitfield indicated Resident B is currently in a state of psychosis. She said Van Buren Sheriff's deputies came and picked Resident B up while I was interviewing \ Resident A and transported him to Corwell Lakeland Hospital located in St. Joseph, MI for a psychological evaluation.

Ms. Whitfield stated Resident B was admitted to the facility on 7/3/23. She said most of the time Resident B has spent at the facility, he has been quiet, nice to others, willing to share and would often keep to himself.

Ms. Whitfield said Resident B has experienced some traumatic family issues within the past few weeks which have caused a change in his mental state and behavior. She said Resident B had two close relatives pass away recently. Ms. Whitfield said one passed on 10/10/24 and the other on 11/10/24.

Ms. Whitfield stated Relative B1 previously picked up Resident B on a routine basis and would take him to stay with her for three or four days at a time. She said Relative B1 has not done so in the past few weeks. Ms. Whitfield stated Relative B1 promised Resident B she would pick him up and take Resident B to her home recently and never showed up. She said she believes these life events have negatively affected Resident B emotionally and mentally and contributed to his recent behaviors.

Ms. Whitfield said Resident B has been harassing Resident A. She indicated Resident B has verbally and physically assaulted Resident A. Ms. Whitfield said Resident B has called Resident A "demon" and accused him of drinking blood.

Ms. Whitfield stated there was one specific occasion occurring on 11/23/24 when Resident B physically assaulted Resident A by grabbing him and punching him somewhere on his body. Ms. Whitfield said Resident B was subsequently transported to Corwell Lakeland Hospital for a psychological evaluation directly after the altercation occurred. She stated she wrote the request for Resident B to be transported for the psychological evaluation. Ms. Whitfield said she would provide the request documentation.

Ms. Whitfield agreed to provide me with the *AFC Licensing Division – Incident / Accident Report* documenting the physical altercation as well as other requested supporting documentation. Ms. Whitfield said she was not working when the physical altercation occurred but has spoken to the DCSMs that were working at the time and reviewed the incident report. She stated DCSMs were able to de-escalate and defuse the situation through verbal redirection.

Ms. Whitfield stated DCSMs are trained to deescalate verbal and physical

altercations. She said they are trained to first attempt verbal de-escalation but if that is not successful to step in between the residents and continue to de-escalate verbally. Ms. Whitfield stated DCSMs are Crisis Prevention Institute (CPI) trained. She said CPI training teaches skills to recognize, prevent, and respond to crises at the workplace.

Ms. Whitfield said Resident B has been calling DCSMs out saying sexually inappropriate things to and regarding female DCSMs. She stated he has become physically aggressive and hit and slammed doors when the DCSMs have ignored and/or diverted his sexually inappropriate comments. Ms. Whitfield stated Resident B has not attempted to intimidate her or say sexually inappropriate things. She said she has not felt intimidated or afraid because of Resident B's behaviors but is aware of another female DCSM Resident B has targeted attempting to intimidate and saying sexually inappropriate things to and around. Ms. Whitfield stated the DCSM is Katherine Smith and provided me with her cell phone number.

On 12/5/24, I interviewed DCSM Katherine Smith via phone. Ms. Smith said she has been caring for Resident B since his admission. She stated Resident B never displayed any behaviors until approximately 3 weeks ago. Ms. Smith said Resident B was previously quiet, nice to others, willing to share, and kept to himself much of the time.

Ms. Smith said over the course of the past three weeks, Resident B has been Verbally and physically aggressive. She stated Resident B's behaviors are predominately directed towards Resident A. Ms. Smith said at times Resident B intimidates and becomes verbally aggressive with other residents and DCSMs, but his focus is on Resident A.

Ms. Smith said Resident B has experienced some significant traumatic family issues within the past few weeks which appears to have caused a change in his mental state and behavior. She said Resident B had two close relatives pass away and Relative B1 who previous took Resident B to her home for three to four days on a routine basis has indicated she cannot do it anymore because of Resident B's extreme behaviors.

Ms. Smith stated Resident B has been seriously harassing Resident A. She indicated Resident B has verbally and physically assaulted Resident A. Ms. Smith said Resident B has calls Resident A "pedophile" and tells him to "burn in hell". She stated Resident B is always on Resident A's tail picking on him as soon as Resident A will exit his room.

Ms. Smith said she was not working at the time but there has been at least one occasion when Resident B physically assaulted Resident A. She said she spoke with the DCSMs working and reviewed the incident report. Ms. Smith stated Resident B allegedly busted Resident A's bedroom door open, grabbed Resident A, and punched him in his side. She said the DCSM on shift had to lie in between Resident A and

Resident B to stop the physical altercation. Ms. Smith stated Resident B was subsequently transported to Corwell Lakeland Hospital for a psychological evaluation. She said Resident B was transported immediately after the verbal and physical altercation occurred.

Ms. Smith stated DCSMs must remain caring, understanding, and fair when a

Resident is having a behavior. She said she and other DCSMs are trained how to verbally de-escalate situations when residents become verbally and physically aggressive. Ms. Smith stated DCSMs are also CPI trained. She said during the CPS training they are taught how to recognize, prevent, and respond to crises at the workplace. Ms. Smith said as soon as she realizes she is unable to verbally de-escalate a situation, she calls the on-call manager and emergency services.

Ms. Smith admitted she, other DCSMs, and the other residents are all scared of \ Resident B in his current state. She said Resident B has been saying sexually inappropriate things to and around her since becoming psychotic. Ms. Smith stated Resident B has been telling her he is “sexually frustrated” and indicating that is why he has been having behaviors. She said she personally does not feel safe and does not feel it is safe for the other residents to allow Resident B to return to the facility. Ms. Smith said she will no longer work at the facility if Resident B is allowed to return.

Ms. Smith stated Resident B returned to the facility on 12/3/24 after being transported to Corwell Lakeland Hospital located in St. Joseph, MI for a psychological evaluation. She said she was sitting in the medication room and Resident B beat on the door after returning from the hospital. Ms. Smith stated she was afraid but had to disguise her fear while speaking to Resident B. Ms. Smith stated Resident B has beat on all the residents’ doors over the past few weeks.

Ms. Smith said when Resident B smokes marijuana he becomes aggressive. She stated Resident B has admitted to his PCP and other practitioners he smokes marijuana and has been told he should not be doing so. Ms. Smith said DCSMs do not allow Resident B to smoke marijuana while at the facility, but Resident B’s Behavioral Treatment Plan allows Resident B to sign out of the facility up to three times and/or six hours per day. Ms. Smith stated Resident B is allowed to go on independent outings and DCSMs have no control over what Resident B does while in the community. She said Resident B often smokes marijuana while he is on outings. Ms. Smith stated DCSMs can tell when Resident B has smoked marijuana because of his behaviors.

I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 11/23/24. The report indicated Resident B engaged in verbal aggression directed toward Resident A. Resident B was targeting Resident A all day. DCSMs verbally redirected Resident B away from Resident A multiple times successfully. At approximately 7:45 p.m., Resident B broke Resident A’s door and broke some

belongings in Resident A's room. DCSMs immediately redirected Resident B out of

Resident A's room according to the report. DCSMs contacted the Van Buren County Sheriff's Department for assistance as Resident B became more aggressive. Approximately 15 minutes later, Resident B did target Resident A unprovoked. Resident B continued to yell at

Resident A calling Resident A, "Demon" and claiming Resident A "drinks animal blood". DCSMs continued their attempts to verbally redirect Resident B away from Resident A. Resident B suddenly grabbed Resident A by his shirt, backed him towards the door and slammed him against the door. A DCSM managed to get in between Resident B and Resident A, but Resident B reached around the DCSM and punched Resident A in his body once. The DCSM was able to intervene successfully and immediately removed Resident A from the facility for his safety. Resident A remained outside the facility with DCSMs while Resident B continued to yell at Resident A and threatened to attack him. Van Buren County Sheriff's Department arrived at the facility and assisted in deescalating the situation. DCSMs did not observe any marks or bruised on Resident A. Resident A did verbalize he was shaken up but physically alright. DCSMs notified the on-call manager, district director Kim Howard, and clinician Leroy regarding this altercation. DCSMs indicated they would continue to monitor Resident A to ensure his health and safety. Resident B was transported to Corewell Lakeland Hospital for a psychological evaluation. Resident B was later transported to Neuro Psych in Indiana for inpatient treatment. Resident B later returned to the facility and was back at his baseline. The report indicated DCSMs will continue to monitor Resident B for his health and safety.

I reviewed a second *AFC Licensing Division – Incident / Accident Report* dated 11/23/24. The report indicated Resident B has recently experienced two deaths in his family. Resident B has had a difficult time dealing with his grief and has become increasingly agitated. Resident B did wake up after 3:00 p.m. and was immediately agitated towards others. Resident B had been extremely agitated, engaged in verbal aggression towards other residents, and engaged in property destruction the previous night. DCSMs requested and were given permission to give Resident B his injection four days early by Dr. P, and it was injected by nurse Mark at around 4:15 p.m. Resident B continued to engage in verbal aggression towards the other residents and male DCSM today. DCSMs were able to successfully verbally redirect Resident B multiple times throughout the day. At approximately 7:45 p.m., Resident B did target Resident A unprovoked. DCSMs continued their attempts to verbally redirect Resident B away from Resident A. Resident B suddenly grabbed Resident A by his shirt, backed him towards the door and slammed him against the door. A DCSM managed to get in between Resident B and Resident A, but Resident B reached \ around the DCSM and punched Resident A in his body once. The DCSM was able to intervene successfully and immediately removed Resident A from the facility for his safety.

Resident A remained outside the facility with DCSMs while Resident B continued to

yell at Resident A and threatened to attack him. Van Buren County Sheriff's Department arrived at the facility and assisted in deescalating the situation. DCSMs did not observe any marks or bruised on Resident A. Resident A did verbalize he was shaken up but physically alright. DCSMs notified the on-call manager, district director Kim Howard, and clinician Leroy regarding this altercation. DCSMs indicated they would continue to monitor Resident A to ensure his health and safety. Resident B was transported to Corewell Lakeland Hospital for a psychological evaluation.

I reviewed a Petition for Resident B to receive Mental Health Treatment written on 11/23/24 by DCSM Ms. Whitfield indicating Resident B has not slept for several days straight. Resident B is having delusions and delusional thoughts that he will die if he falls asleep. Resident B returned from a recent hospitalization and is not at baseline for day-to-day functioning.

I reviewed several documents in Resident B's *Resident Records.* I reviewed physical examination notes from 9/17/24 authored by Resident B's Physician's Assistant (PA), Tamara N. Gaishin. The notes indicated Resident B admitted to using marijuana about two times a week via inhalation. Resident B suffers from schizophrenia and bipolar disorder.

I reviewed a Petition for Resident B to receive Mental Health Treatment written by DCSM Ms. Whitfield indicating Resident B has not slept for several days straight. Resident B is having delusions and delusional thoughts that he will die if he falls asleep. Resident B returned from a recent hospitalization and is not at baseline for day-to-day functioning.

I reviewed Resident B's *Assessment Plan for AFC Residents* and found Resident B generally, gets along well with others when stable but can become socially intrusive when symptomatic. The assessment indicated Resident B has no issues with controlling aggressive behavior when clinically stable. The assessment further indicated Resident B may require verbal redirection DCSMs to redirect if symptomatic. The assessment indicated Resident B should not have access to drugs or alcohol because of past abuse.

APPLICABLE RULE	
	Resident care; licensee responsibilities.
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with Resident A, DCSMs Ms. Whitfield, Mr. King, and Ms. Smith there was insufficient evidence found indicating direct care staff members did not intervene when Resident B was harassing,

	antagonizing, intimating, and/or verbally/physically assaulting Resident A. There was insufficient evidence found indicating the licensee failed to provide supervision, protection, and personal care as defined in the act and as specified in Resident A's written assessment plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The smell of cigarette smoke was overwhelming while interviewing Resident A in his bedroom. Resident A stated recently he has been smoking in his bedroom to avoid Resident B.

DCSM Ms. Smith stated Resident B is always on Resident A's tail picking on him as soon as Resident A leaves his room and has both verbally and physically assaulted Resident A.

DCSMs Ms. Smith and Ms. Whitfield confirmed DCSMs have been allowing Resident A to smoke cigarettes in his bedroom to avoid confrontation between Resident A and Resident B.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to the following provision: (a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.

ANALYSIS:	Based on the information gathered during this special investigation through interviews with Resident A, DCSMs Ms. Whitfield, Mr. King, and Ms. Smith there was sufficient evidence found indicating direct care staff members have been allowing Resident A to smoke in his bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/9/24, I conducted an exit conference / interview with licensee designee Nichole VanNiman via phone. Ms. VanNiman admitted they have had issues with Resident A smoking in his bedroom and plan to address the concern. Ms. VanNiman did not dispute the findings or recommendations and agreed to complete a Corrective Action Plan (CAP) within the requested timeframe.

IV. RECOMMENDATION

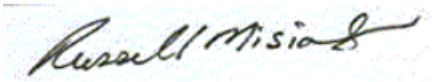
Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

12/9/24

_____

Rodney Gill Date
Licensing Consultant

Approved By:



12/18/24

_____

Russell B. Misiak Date
Area Manager