GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 3, 2025
Nichole VanNiman
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AM800084653
Investigation #: 2025A1030018
Beacon Home at Meadowland

Dear Ms. VanNiman:

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.

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 (616) 356-0183.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, 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 #:** | AM800084653 |
| | |
| **Investigation #:** | 2025A1030018 |
| | |
| **Complaint Receipt Date:** | 01/17/2025 |
| | |
| **Investigation Initiation Date:** | 01/17/2025 |
| | |
| **Report Due Date:** | 03/18/2025 |
| | |
| **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:** | Kim Howard |
| | |
| **Licensee Designee:** | Nichole VanNiman |
| | |
| **Name of Facility:** | Beacon Home at Meadowland |
| | |
| **Facility Address:** | 56844 48th Avenue<br>Lawrence, MI 49064 |
| | |
| **Facility Telephone #:** | (269) 674-7306 |
| | |
| **Original Issuance Date:** | 09/28/1999 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/24/2023 |
| | |
| **Expiration Date:** | 10/23/2025 |
| | |
| **Capacity:** | 12 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED<br>MENTALLY ILL AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff used excessive physical force with Resident A. | Yes |
| Additional Findings | No |

## II. METHODOLOGY

| | |
|---|---|
| 01/17/2025 | Special Investigation Intake<br>2025A1030018 |
| 01/17/2025 | Special Investigation Initiated - Telephone<br>Interview with Danyell Baltazar |
| 01/17/2025 | Contact - Document Received<br>Received and reviewed an incident report |
| 01/17/2025 | APS Referral<br>APS referral made |
| 01/21/2025 | Contact - Telephone call made<br>Interview with Tiffany VanGessel |
| 01/21/2025 | Contact - Face to Face<br>Attempted interview with Resident A |
| 01/22/2025 | Contact - Face to Face<br>Interview with Resident B |
| 01/28/2025 | Contact - Telephone call made<br>Interview with Tobitiara Gains |
| 01/28/2025 | Contact - Face to Face<br>Interview with Tami Branch |
| 01/30/2025 | Exit Conference<br>Exit conference by phone |

**ALLEGATION:**

**Staff used excessive physical force with Resident A.**

**INVESTIGATION:**

On 1/17/25, I interviewed facility supervisor Danyell Baltazar by phone. Ms. Balatazar reported direct care staff member (DCSM) Tiffany VanGessel assaulted Resident A on 1/16/24. Ms. Baltazar reported she received a text message from Resident A's sister and was informed that Resident A was suicidal. Ms. Balatazar reported she called the facility and was informed that there was altercation between Resident A and Ms. VanGessel and that Ms. VanGessel was the aggressor. Ms. Balatazar reported the incident occurred in Resident A's bedroom and was witnessed by Resident B Ms. Balatazar reported there were three other staff members working and provided their names. Ms. Balatazar reported she sent Ms. VanGessel was sent home and was suspended. Ms. Balatazar reported the facility made a referral to Adult Protective Services, Recipient Rights and law enforcement. Ms. Balatazar reported an incident report was completed and several pictures were taken of Resident A's injuries.

On 1/17/25, I received and reviewed an Incident Report (IR) dated 1/16/24 and authored by DCSM Maryah Vasquez. The IR indicated Ms. Vasquez and the other staff working were alerted by a resident that Resident A and Ms. VanGessel were fighting in the basement of the facility. The IR indicated that they ran downstairs and found Ms. VanGessel standing over Resident A with her hand on her back and Resident A on the floor. Ms. VanGessel was then instructed to let go of Resident A and it was noted that Resident A had red marks and scratches on her neck, back and chest while Ms. VanGessel had a long scratch on her left arm and was bleeding from the mouth.

After Resident A and Ms. VanGessel were separated Ms. VanGessel reported she was hit in the mouth by Resident A and had to use CPI. Resident B provided a different account and indicated Resident A pushed past Ms. VanGessel to get into her bedroom and in response Ms. VanGessel grabbed Resident A by the hair and punched her in the head while forcing her to the ground by her neck and back.

On 1/21/24, I interviewed DCSM Tiffany VanGessel by phone. Ms. VanGessel reported she was working on 1/16/24. Ms. VanGessel reported Resident A was having a bad day and it began by asking everyone in the home for their personal food because she was hungry. Ms. VanGessel reported later in the shift she asked one of the other residents to borrow her lighter to go outside to smoke and Ms. VanGessel remined her that she is not allowed to have a lighter and the facility has community lighter outside on the porch that she can use. Ms. VanGessel reported Resident A then started calling her names including a bitch, cunt, whore and continued for several hours.

Ms. VanGessel reported Resident A was in the kitchen at 4:45pm while the staff was preparing dinner, and she asked Resident A to please leave the kitchen as she was

getting in the way. Ms. VanGessel reported Resident A then walked out of the kitchen but stood in the doorway and was then asked to please sit down at the table to wait for dinner. Ms. VanGessel reported after dinner Resident A went downstairs and began "throwing a fit" saying she wanted to kill herself. Ms. VanGessel reported one of the other DCSM spoke with Resident A about her suicidal statements while she prepared banana bread for tomorrow's breakfast. Ms. VanGessel reported she took the banana bread downstairs to lock in the staff office she was called to Resident B's bedroom and was asked about night-time medications. Ms. VanGessel reported Resident A and Resident B share a bedroom and Resident A came downstairs swearing and saying Ms. VanGessel better not be in her bedroom. Ms. VanGessel reported Resident A threatened to "punch her in the mouth" and Ms. VanGessel responded by saying "please do so I can CPI you." Ms. VanGessel reported Resident A faked like she was going to punch her, and Ms. VanGessel told her was not afraid. Ms. VanGessel reported Resident A then pushed her into her bedroom and took a swing at her. Ms. VanGessel reported she grabbed Resident A by the back of her hair and took her to the ground and held her in a CPI hold. Ms. VanGessel reported she let Resident A up and she punched Ms. VanGessel in the lip and then she put Resident A back in a CPI hold and held her down on the floor. Ms. VanGessel reported Resident B then ran upstairs and alerted the other staff about the situation. Ms. VanGessel reported the other staff members came downstairs and had her let Resident A go. Ms. VanGessel reported she then called the on-call supervisor and clinical person and was then sent home by Ms. Baltazar.

On 1/22/24, I attempted to interview Resident A at the facility however she was admitted to a psychiatric hospital yesterday.

On 1/22/24, I interviewed Resident B at the facility. Resident B reported she has lived at the facility since August 2024 and is Resident A's roommate. Resident B reported she witnessed the physical altercation between Resident A and Ms. VanGessel on 1/16/24 and indicated both individuals were "gripping" back and forth all day. Resident B described the gripping as Resident A and Ms. VanGessel were swearing and calling each other names. Resident B reported Resident A pushed Ms. VanGessel and then was standing in the doorway to her bedroom. Resident B reported Resident A then tried to get past Ms. VanGessel and get into their bedroom and Ms. VanGessel tried to prevent her from entering the bedroom. Resident B reported Ms. VanGessel and Resident then began punching each other. Resident B reported Ms. VanGessel grabbed Resident A buy the back of her hair and pulled her to the ground. Resident B reported she went upstairs and told the other staff that Resident A and Ms. VanGessel were fighting downstairs. Resident B reported the other staff came downstairs and deescalated the situation.

On 1/28/25, I interviewed DCSM Tobitiara Gains at the facility. Ms. Gains reported she was working on 1/16/25 and reported Resident A was agitated all day long and had been going at it with Ms. VanGessel. Ms. Gains reported Ms. VanGessel took some items downstairs at about 7:00pm and she tried to engage Resident A in a conversation to prevent her from going downstairs however it did not work and she went downstairs.

Ms. Gains reported she could hear Resident A screaming she “hated this house and wanted to kill herself.” Ms. Gains reported a few minutes later Resident B came upstairs and said that they were fighting. Ms. Gains reported she and the other staff members got downstairs as fast as they could, and she saw Resident lying face down on the ground with Ms. VanGessel standing over her beathing heavy and Ms. Van Gessel had her hand on Resident A’s back. Ms. Gains reported she instructed Ms. VanGessel to move away from Resident A and she helped Resident A off the ground. Ms. Gains reported Ms. VanGessel’s mouth was bleeding, and she had scratches on her arm. Ms. Gains reported Resident A told her that Ms. VanGessel grabbed her by hair and punched her in the face. Ms. Gains reported she does not believe that Ms. VanGessel was using CPI appropriately as she is not supposed to use CPI when she is alone and had the ability to move away from Resident A and go to another part of the facility.

On 1/28/25, I interviewed DCSM Tami Branch at the facility. Ms. Branch reported she was working on 1/16/25 and confirmed that Resident A and Ms. VanGessel had been having verbal conflicts throughout the shift. Ms. Branch reported she and the other DCSM were trying to keep them apart due to the verbal arguments. Ms. Branch reported after dinner Ms. VanGessel went downstairs, and a few minutes Resident A also went downstairs. Ms. Branch reported Resident B came upstairs and told them that Resident A and Ms. VanGessel were fighting, and they all ran downstairs. Ms. Branch reported when she got downstairs, she noted Ms. VanGessel was standing over Resident A with her hand on Resident A’s back. Ms. Branch reported she and the other staff separated them. Ms. Branch reported she spoke with Resident B a little later and she reported that Ms. VanGessel was standing in the doorway to her bedroom and Resident A pushed past her to get into the bedroom and Ms. VanGessel grabbed her by the hair and began punching her.

| **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>**(b) Use any form of physical force other than physical restraint as defined in these rules.** |
| **ANALYSIS:** | It was alleged that staff used excessive physical force with Resident A. Based on interviews and documentation this violation will be established. On 1/16/25, staff member Tiffany VanGessel and Resident A had a physical confrontation at the facility. Ms. VanGessel indicated she had to employ CPI (physical intervention) to restrain Resident A after she was assaulted by Resident A. According to an eyewitness, an |

| | |
|---|---|
| | incident report and two other staff members working at the time, Ms. Vangessel grabbed Resident A by the hair and punched her several times which are not approved CPI techniques. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 1/30/25, I shared the findings of my investigation with administrator, Kim Howard by phone. Ms. Howard acknowledged the findings and agreed to submit a corrective action plan.

## III. RECOMMENDATION

Contingent upon the submission of an acceptable corrective action plan, I recommend no change to the current license status.

Nile Khabeiry, LMSW 2/3/25

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak 2/3/25

Russell B. Misiak Date
Area Manager