



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 3, 2023

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

RE: License #: AS630393369
Investigation #: 2024A0612001
Beacon Home at Clarkston

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.

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 (248) 975-5053.

Sincerely,

A handwritten signature in cursive script that reads "Johnna Cade".

Johnna Cade, Licensing Consultant
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
Phone: 248-302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630393369
Investigation #:	2024A0612001
Complaint Receipt Date:	09/29/2023
Investigation Initiation Date:	10/02/2023
Report Due Date:	11/28/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nicole VanNiman
Licensee Designee:	Nicole VanNiman
Name of Facility:	Beacon Home at Clarkston
Facility Address:	10358 Horseshoe Circle Clarkston, MI 48348
Facility Telephone #:	(248) 933-3133
Original Issuance Date:	10/16/2018
License Status:	REGULAR
Effective Date:	11/24/2021
Expiration Date:	11/23/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct Care Staff, Courtney Nickerson smokes marijuana in the home with Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

09/29/2023	Special Investigation Intake 2024A0612001
10/02/2023	APS Referral Referral received from Adult Protective Services (APS). APS denied referral for investigation.
10/02/2023	Special Investigation Initiated - Letter Referral made to Oakland County Recipient Rights via email. Recipient Rights Specialist advised that the resident is not within their jurisdiction.
10/17/2023	Contact - Telephone call made Telephone interview with Beacon Clinician, Cassidy Jewel.
10/17/2023	Contact - Telephone call made Telephone interview completed with home manager, Quayanna Norris. Telephone call to direct care staff Janiya and Tamerah Stokes. There was no answer.
10/19/2023	Contact - Telephone call made Telephone interview completed with direct care staff, Courtney Nickerson.
10/24/2023	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed Resident A, Resident B, Resident C, Resident D, and direct care staff Tamerah Stokes.
10/24/2023	Contact - Document Received Resident C's Individual Plan of Service.
10/30/2023	Exit Conference I held an exit conference with licensee designee, Nicole VanNiman via telephone.

ALLEGATION:

Direct Care Staff, Courtney Nickerson smokes marijuana in the home with Resident A.

INVESTIGATION:

On 10/02/23, I received a complaint from Adult Protective Services (APS). APS denied the referral. The referral indicated Resident A lives at Beacon Home at Clarkston. Resident A is diagnosed with Reactive Attachment Disorder, Unspecified Personality Disorder, a Mild Intellectual Disability, and Post-Traumatic Stress Disorder. Resident A has a legal guardian. Direct Care Staff, Courtney Nickerson smokes marijuana in the home with Resident A. The most recent incident occurred this week. Resident A's treatment plan does not specify marijuana use for recreational or medicinal purposes. It is unknown how the marijuana use is impacting Resident A however, she has had an increase in self-harming and problematic behaviors. On 10/02/23, I initiated this investigation by making a referral to Oakland Community Health Network (OCHN) – Office of Recipient Rights (ORR) via email. I was informed that Resident A does not receive services from Oakland County and therefore OCHN - ORR will not be investigating.

On 10/17/23, I completed a telephone interview with Beacon Clinician, Cassidy Jewel. Ms. Jewel provides therapy to residents at the Beacon Home at Clarkston. Resident A and Resident B are roommates and close friends. While meeting with Resident B she disclosed to Ms. Jewel that she witnessed Resident A smoking marijuana in the garage at the home with direct care staff, Courtney Nickerson. Ms. Jewel explained, Resident A is only twenty years old and therefore, she is unable to purchase marijuana independently. As such, she suspects that Ms. Nickerson supplied the marijuana to Resident A. Ms. Jewel stated she believes Resident A has a history of marijuana use. However, she did not know that Resident A was actively smoking marijuana. This incident was reported to the home manager, Quayanna Norris and the Beacon human resource department. During a meeting with human resources, Ms. Nickerson chose to terminate her employment with Beacon.

On 10/17/23, I completed a telephone interview with home manager, Quayanna Norris. Ms. Norris stated she was informed of this allegation by Ms. Jewel. Ms. Norris stated she was aware that Resident A had a history of smoking marijuana, but she was not aware Resident A had smoked marijuana while living in this home. Ms. Norris has never witnessed Resident A smoking marijuana with Ms. Nickerson. She has never smelled marijuana in the home or observed Resident A and/ or Ms. Nickerson appearing to be under the influence of marijuana. Ms. Norris explained that she works on the day shift and Ms. Nickerson worked alone on third shift. Therefore, she did not spend a lot of time with Ms. Nickerson. Ms. Norris stated on 10/04/23, human resources held a meeting with Ms. Nickerson regarding this allegation. During the meeting, Ms. Nickerson chose to terminate her employment.

On 10/19/23, I completed a telephone interview with direct care staff, Courtney Nickerson. Ms. Nickerson stated she has had an on and off work history with Beacon for the past two years. In October 2023, Ms. Nickerson chose to terminate her employment. Prior to quitting she worked alone on third shift from 7:00 pm – 7:00 am. Ms. Nickerson stated she is aware that Resident A smokes marijuana, but she told Resident A that she could not bring contraband on Beacon property so as far as she knows Resident A did not have marijuana in the home. Ms. Nickerson stated Resident A has independent community access. Resident A smokes marijuana with her friend when they hang out outside of the home. This usually occurs during the day on first shift and therefore, Ms. Nickerson is not working. Ms. Nickerson stated she has never witnessed Resident A appear to be under the influence of marijuana. Ms. Nickerson denied ever smoking marijuana with Resident A. Ms. Nickerson denied smoking marijuana at the Beacon Home at Clarkson. Ms. Nickerson further denied bring marijuana to work or being under the influence of marijuana while at work.

On 10/24/23, I completed an unscheduled onsite investigation. I interviewed Resident A, Resident B, Resident C, Resident D, and direct care staff Tamerah Stokes.

On 10/24/23, I interviewed Resident A. Resident A stated she smokes marijuana however, she does not smoke it at her home as she knows marijuana is not allowed on Beacon property. Resident A stated per her plan of service, she has independent community access. She regularly goes into the community and hangs out with her friends. If she wants to smoke marijuana, she does it while she is in the community. Resident A stated she has never smoked marijuana with any direct care staff including Ms. Nickerson. Resident A stated she was very closed with Ms. Nickerson; she trusted her, and she told her many things. Resident A stated she has never witnessed Ms. Nickerson smoking marijuana and Ms. Nickerson never appeared to be under the influence of marijuana while at work.

On 10/24/23, I interviewed Resident B. Resident B stated on an unknown date she witnessed Ms. Nickerson smoking marijuana outside standing near her car while she was on shift. Resident B stated on another unknown date she witnessed Resident A smoking marijuana with Ms. Nickerson outside standing near Ms. Nickerson's car.

On 10/24/23, I interviewed Resident C. Resident C stated she has not witnessed Resident A smoking marijuana at the house or with any direct care staff. Resident C stated if Resident A smoked marijuana with any direct care staff she would not tell her because she and Resident A do not always get along. Resident C stated in September 2022 she smoked marijuana outside at her home. She did this alone, and the marijuana was provided to her from a friend that lives in Pontiac, MI. Resident C stated she has not smoked marijuana since then. Resident C stated Resident A has independent community access and goes into the community and hangs out with her friends. There are times that Resident A comes back home and appears to be under the influence of marijuana.

On 10/24/23, I interviewed Resident D. Resident D was observed working on arts and crafts at the kitchen craft. Resident D was minimally engaged with interview questions and provided no information regarding this investigation.

On 10/24/23, I interviewed direct care staff, Tamerah Stokes. Ms. Stokes has worked for this company for one year. Ms. Stokes works first shift stated that she only talks to Ms. Nickerson during shift change as Ms. Nickerson worked on third shift. Ms. Stokes stated Ms. Nickerson never appeared to be under the influence of marijuana. Ms. Stokes has never witnessed Resident A smoking marijuana or appear to be under the influence of marijuana.

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:	Based on the information gathered through my investigation there is insufficient information to conclude that Resident A's personal needs including protection and safety were not attended to. Other than Resident B, there were no reports of direct care staff, Candice Nickerson smoking marijuana in the home with Resident A. Resident A and Ms. Nickerson denied the allegation. Resident C and Resident D denied the allegation. Home manager, Quayanna Norris and direct care staff, Tamerah Stokes consistently stated that they have never observed Ms. Nickerson and/or Resident A smoking marijuana at the home or appearing to be under the influence of marijuana.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

Throughout the course of this investigation, it was reported by Resident A, Resident B, Resident C, home manager Quayanna Norris, and direct care staff Courtney Nickerson that on an unknown date Resident C purchased Cannabidiol (CBD) gummies from Wild Bills Tabaco Shop when she was taken to the store with an unknown direct care staff to purchase vapes. Resident C then gave the CBD gummies to Resident A and Resident B who consumed them.

On 10/24/23, I interviewed Resident A and Resident B. Resident A and Resident B consistently stated a few months ago Resident C went to Wild Bills and purchased CBD gummies. She brought them home and offered to share them. Resident C said they were candy fruit snacks. Resident A and Resident B consistently stated that they ate the gummies and as a result they were “high.”

On 10/24/23, I interviewed Resident C. Resident C stated on an unknown date she went to Wild Bills Tabaco Shop with direct care staff, Rachel, and another staff whose name she cannot recall. While in the store she purchased CBD gummies. Resident C stated she shared the gummies with Resident A and Resident B. Resident C said both Resident A and Resident B knew that they were CBD gummies. Resident C denies telling them that they were candy fruit snacks. Resident C stated staff were not aware that she purchased and/or consumed the gummies.

On 10/19/23, I completed a telephone interview with direct care staff, Courtney Nickerson. Ms. Nickerson stated she heard from Resident A and Resident B that Resident C bought CBD gummies. Resident C told Resident A and Resident B that they were candy and both Resident A and Resident B ate the CBD gummies. Ms. Nickerson stated she was not present when this occurred.

On 10/24/23, I interviewed direct care staff, Tamerah Stokes. Ms. Stokes stated she was not aware that Resident C purchased CBD gummies. However, approximately a week ago (exact date unknown) she and direct care staff, Rachel took Resident C to Wild Bills Tabaco Shop. While in the store, Resident C tried to buy CBD gummies, but she intervened, not allowing her to make the purchase. Ms. Stokes reports she was unaware that Resident C had ever been successful in purchasing any CBD gummies and shared them with housemates.

On 10/24/23, I interviewed home manager, Quayanna Norris. Ms. Norris stated Resident C does not have independent community access and was taken to the tabaco shop by direct care staff. However, staff were not aware that Resident C purchased CBD gummies. Ms. Norris further stated that the home does not keep receipts when Resident C spend her personal funds. Therefore, she cannot provide proof of purchase for the CBD gummies.

I reviewed Resident C’s Easterseals MORC Individual Plan of Service (IPOS). Resident C’s IPOS indicates that she does not have independent community access. Beacon staff must be present at all times while in the community to provide monitoring and support. Resident C has a limited understanding of boundaries, and she has a history of sneaking things into her bedroom such as sugar and electronics.

On 10/30/23, I held an exit conference with licensee designee, Nicole VanNiman via telephone to discuss my findings. Ms. VanNiman acknowledged the findings of this investigation and understands a corrective action plan is required. Ms. VanNiman stated Resident C is not a one on one in the community and therefore she will need to discuss with the team how to prevent a reoccurrence of this problem.

APPLICABLE RULE	
R 400.14303	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:	<p>Based on the information gathered through my investigation there is sufficient information to conclude Resident A, Resident B, and Resident C did not receive supervision, protection, and personal care as identified in their written assessment plan.</p> <p>Resident C's IPOS indicates that she has a history of sneaking things into her bedroom. It further indicates that Beacon staff must be present at all times while in the community to provide monitoring and support. Although Resident C does not have an one-on-one staff while in the community it was reported by direct care staff, Tamerah Stokes that Resident C had recently made an attempt to purchase CBD gummies while at Wild Bills Tabaco Shop and staff had to intervene to prevent the purchase. Therefore, it was known that Resident C was motivated to purchase CBD from Wild Bills. To effectively provide supervision, protection and personal care as defined in Residence C's IPOS direct care staff should maintain some level of general awareness while in the community with Resident C. Moreover, Resident A and Resident B consistently stated that they ate the CBD gummies believing that it was a candy fruit snack. Resident A and Resident B ate these CBD gummies at home while under the supervision and protection of direct care staff. Consuming a substance that contains CBD unknowingly could have placed Resident A and Resident B at risk of harm.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend this investigation be closed with no change to the status of the license.




10/31/2023

Johnna Cade
Licensing Consultant

Date

Approved By:



11/03/2023

Denise Y. Nunn
Area Manager

Date