GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 15, 2023

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

RE: License #: AS630408237
Investigation #: 2023A0991034
Beacon Home at Wolverine Lake

Dear Nichole VanNiman:

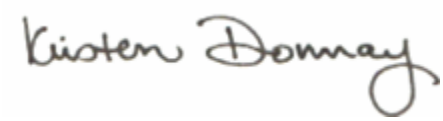
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W Grand Blvd, Suite 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630408237
Investigation #:	2023A0991034
Complaint Receipt Date:	09/28/2023
Investigation Initiation Date:	09/28/2023
Report Due Date:	11/27/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St. Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Wolverine Lake
Facility Address:	1615 Glengary Rd Wolverine Lake, MI 48390
Facility Telephone #:	(734) 992-6011
Original Issuance Date:	12/17/2021
License Status:	REGULAR
Effective Date:	06/17/2022
Expiration Date:	06/16/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 9/6/23, staff, Devonisha Fance and Alicia Williams, forced all the residents to go on an "emergency" outing to Walmart to buy cupcakes. There were eight people in the van, which seats seven people. Staff left the residents alone in the van for 40 minutes while they went into Chipotle to get food for themselves. Upon arriving home, the food in the crockpot was inedible and the residents did not eat dinner.	Yes

III. METHODOLOGY

09/28/2023	Special Investigation Intake 2023A0991034
09/28/2023	Special Investigation Initiated - Telephone Call to Office of Recipient Rights (ORR) worker, Dawn O'Connor
09/28/2023	Referral - Recipient Rights Received from Recipient Rights
09/28/2023	APS Referral Received additional information from Adult Protective Services (APS) - APS denied complaint for investigation
10/05/2023	Inspection Completed On-site Unannounced onsite inspection
10/05/2023	Contact - Document Received Copy of incident report
11/14/2023	Contact - Telephone call made Interviewed direct care worker, Devonisha Fance
11/14/2023	Contact - Telephone call made Interviewed direct care worker, Alicia Williams
11/14/2023	Contact - Telephone call made To ORR worker, Dawn O'Connor
11/14/2023	Contact - Document Received Individual plans of service and crisis plans

11/14/2023	Contact - Telephone call made Left message for home manager
11/14/2023	Exit Conference Via telephone with licensee designee, Nichole VanNiman
11/15/20203	Contact - Telephone call received Return phone call from home manager, Matthew Abdilla
11/15/2023	Exit Conference Conducted follow-up exit conference with licensee designee, Nichole VanNiman regarding additional rule citation.

ALLEGATION:

On 9/6/23, staff, Devonisha Fance and Alicia Williams, forced all the residents to go on an "emergency" outing to Walmart to buy cupcakes. There were eight people in the van, which seats seven people. Staff left the residents alone in the van for 40 minutes while they went into Chipotle to get food for themselves. Upon arriving home, the food in the crockpot was inedible and the residents did not eat dinner.

INVESTIGATION:

On 09/28/23, I received a complaint alleging that on 09/06/23, direct care workers, Devonisha Fance and Alicia Williams, forced all the residents to go on an "emergency" outing to Walmart to buy cupcakes. The van only has a capacity for seven people, and they had eight individuals in the van. At least one individual had to share a seat with the staff. After Walmart, the staff went to Chipotle and left the six residents alone in a hot van with the windows up for 40 minutes while they got themselves food. During the outing, staff made a U-turn and almost got into an accident. Upon arrival to the home, dinner was ruined in the crockpot and no alternative was offered. Staff served the overcooked food to the residents, and they did not eat dinner.

The complaint was referred to Adult Protective Services, but it was denied for investigation. I initiated my investigation on 09/28/23, by contacting the assigned Office of Recipient Rights (ORR) worker, Dawn O'Connor.

On 10/05/23, I conducted an unannounced onsite inspection at Beacon Home at Wolverine Lake. I interviewed direct care workers, Michael Pytel and Mariah Harris. Mr. Pytel and Ms. Harris stated that they were not working on 09/28/23, but they heard about the incident. They stated that the two staff who were working, Devonisha Fance and Alicia Williams, do not typically work in the home, but were covering a shift that day. Mr. Pytel and Ms. Harris confirmed that the van is a minivan that only has room for seven passengers. There are two seats in front for the driver and passenger, two seats

in the middle, and three seats in the back row. Resident A told them that Ms. Williams was sharing a seat with Resident B and then moved to the floor in the van. They do not typically take all six residents on an outing at once. Resident A told staff that Ms. Fance and Ms. Williams took them to Walmart and then went to Chipotle to get food. They left the residents in the van with the windows up when it was 85°- 87°F outside. The van was not running. Resident B got out of the van and was talking to girls and then started cussing them out. Resident C was smoking a cigarette outside of the van. Mr. Pytel and Ms. Harris stated that none of the residents are supposed to have community access and they should all be within eyesight. They stated that Ms. Williams no longer works for Beacon and Ms. Vance works at another Beacon Home.

On 10/05/23, I interviewed Resident A. Resident A stated that he has lived in the home for about a year and a half. Resident A stated that he recalled the incident that occurred on 09/06/23. Staff, Devonisha (Fance) and Alicia (Williams), were filling in at the home. They stated that there was an emergency and all the residents needed to go on an outing. They did not give anyone an option to stay home. Resident A stated that the emergency was that they were hungry. Resident A was previously told that he never has to go on an outing and that he has a right to stay home if he does not want to go, but on this occasion, everybody was forced to go out. Usually, Resident A and Resident C stay home when the rest of the residents go on outings. Resident A stated that the home uses a minivan for transportation, which only seats seven people. It has two seats in the front, two seats in the middle, and three in the very back. When they were all forced to go on the outing, there were eight people in the van. Ms. Fance was driving, and Resident C was sitting in the front passenger seat. Ms. Williams was sharing a middle seat with Resident B. They first stopped at Walmart. Two of the residents went into the store with Ms. Williams and the rest of the residents stayed in the van with Ms. Fance. They got cupcakes for someone’s birthday. Next, they went to Chipotle. Ms. Vance and Ms. Williams both went into the restaurant and left the six residents in the van. Resident B got out of the van and was talking to strangers who were trying to eat. The staff did not come back out for 30-40 minutes.

Resident A stated that he is not allowed to be in the community unsupervised, and he is supposed to have staff with him at all times. The staff told the residents to “wait here” and then took the keys and went inside. The van was not running or locked. The windows were up, and it was hot in the van. Resident A stated that he also had concerns with how Ms. Fance was driving. As they were leaving Walmart, she made a U-turn on a four-lane road. She wasn’t looking and almost got T-boned by another car. On another occasion, Ms. Fance was talking on the phone while driving. She was not paying attention to the road and almost got hit. Resident A had to yell at her so that she would avoid getting into an accident. He stated that staff do not typically talk on the phone while driving. Resident A stated that when they finally got home, dinner was ruined, because they left it in the crockpot for too long. The food was inedible, so he did not eat. He was not offered another option.

On 10/05/23, I interviewed Resident B. Resident B stated that he has lived at Beacon Home at Wolverine Lake for over a year. He recalled the incident when Devonisha

(Fance) and Alicia (Williams) left the residents in the car for 40 minutes without air conditioning or the windows rolled down. He stated that they went into Chipotle and there was a long line. The staff could not see the residents from where they were standing inside the restaurant. Resident B stated that he got out of the van and was smoking cigarettes, but everybody else stayed in the van. He had community access at that time, but it was taken away for other reasons after this happened. Nobody else in the home has community access. Resident B stated that the staff forced everyone to go out with them and did not give anybody an option to stay home. Resident A does not like going places, so he usually chooses to stay home. There is not enough room in the van for everybody to go on an outing at the same time. The van only seats seven people.

Resident B stated that he was in the middle row and Ms. Williams was sharing a seat with him. He could not put on a seatbelt because of how they were sharing the seat. He stated that he was pushed against the door. Resident B stated that he did not eat dinner that night, because the food was cooked all day and they could not eat it when they got home. He stated that none of the residents ate dinner that night. Normally they get three meals a day, as well as an afternoon and nighttime snack. Resident B stated that while they were driving, Ms. Fance did a U-turn in the middle of a main road. She went to turn and almost got hit. He stated that they had to yell “car” at her, or she would have been T-boned. Resident B stated that Ms. Williams has worked one night shift at the home since this incident. Ms. Fance works at a different home, but he stated she had her driving suspended by Beacon.

On 10/05/23, I interviewed Resident C. Resident C stated that he has lived at Beacon for three years. He stated that he did not think the incident on 09/06/23 was that big of a deal. He stated that staff did not force everyone to go with them and did not give any commands, they were just begging the residents to go because they both wanted to go out. Resident C stated that they were not “locked in the van” at Chipotle, but staff did leave them in the van alone. He and Resident B both got out of the van, and he was smoking outside. The staff went into Chipotle and got food and then brought it home. Resident C did not remember what he ate for dinner that day. He stated that he thought he ate dinner before they left for Chipotle. Resident C stated that he did not remember almost getting into a car accident. He stated that they all had seatbelts except for Ms. Williams. Resident C stated that it was not that big of a deal. The staff are very responsible, and things are all good.

On 10/05/23, I interviewed Resident D. Resident D stated that he has lived in the home for two years. He recalled the time when staff forced all of the residents to go to the store. He stated that there was one staff driving and the other staff person sat in the middle with him and Resident B. There were not enough seats for everyone in the van, and Resident B was not buckled with a seatbelt because he was sharing a seat with the staff person. They went to Walmart to buy cupcakes and then they went to a restaurant. The staff went inside the restaurant for 45 minutes and left everybody else in the van. He stated that it was hot in the van. He stated that when they got back home, he did not eat dinner because the food was terrible. He had one bite and then skipped dinner

because the food was cold and not good. Nobody ate dinner and staff did not offer them any other options. Resident D stated that the staff's driving was horrible. She turned the wrong way out of Walmart and almost hit another car. He stated that he thinks she was talking on the phone while driving and was using the map on her phone. Resident D stated the staff have not been back since this incident.

On 10/05/23, I interviewed Resident E. Resident E stated that he has lived in the home for about a year. He stated that on the day of the incident staff told all the residents to get in the van. They said everybody had to go, but usually staff do not force people to go on outings. There were too many people in the van. They went to Walmart and Chipotle. At Walmart, half of the residents went in, and half stayed in the van. When they were leaving Walmart, there were two lanes of traffic each way. The staff went to do a U-turn and pulled out in front of oncoming traffic, almost getting hit. Resident E stated that they were at Chipotle for 45 minutes to an hour. Staff ordered food and did not get anything for the residents. They left everybody in the van. Resident B got out and was talking to people on the patio. Resident E stated that he does not have community access. He has to be with family or staff if he leaves the home. Resident B is the only one who had community access. Resident E stated that when they got back to the home, dinner was still cooking in the crockpot. It was overcooked and was not good. He only ate about half of a bowl. Resident E stated that the staff are not coming back to the home, and he is glad that they are not driving anymore. He stated that there was another time when Ms. Fance was driving and almost got into an accident when they were leaving the corner store, because she was talking on her phone while driving. Resident E stated that he does not have any other issues with the home.

On 10/05/23, I attempted to interview Resident F. He stated that he did not recall what happened and could not provide any additional information regarding the incident.

On 11/14/23, I interviewed direct care worker, Devonisha Fance, via telephone. Ms. Fance stated that she was covering a shift at Beacon Home at Wolverine Lake with Alicia Williams. They took the residents to Walmart and Chipotle. She stated that they took everybody with them, and she was not aware of how many seats were in the van or who was sitting where because she was driving. She did not know if everyone had a seatbelt. Ms. Fance stated that one of the residents was mad because they could not stay behind, but another resident wanted to go exchange their vape, so everybody had to go, or they would have been out of compliance with the staff to resident ratio. She stated that there were two staff on shift, and they need to have one staff per three residents. Ms. Fance denied leaving the residents in the van alone. She stated that she stayed in the van with them while they were at Walmart. When they got to Chipotle, she stood outside of the van. She stated that she and the other staff took turns going into Chipotle. She stated that two of the residents, Resident B and someone else, got out of the van to smoke. She could see the residents the whole time. Ms. Fance denied almost getting into a car accident. She stated that she was not talking on the phone and that they are allowed to use their GPS for navigation. Ms. Fance stated that she does not typically work at the Wolverine Lake home. In the home where she usually works, all the

residents enjoy going out. She stated that nobody gave them any information about the residents at Wolverine Lake before they covered the shift.

On 11/14/23, I interviewed direct care worker, Alicia Williams. Ms. Williams stated that she has covered shifts at Beacon Home at Wolverine Lake on two or three occasions. She stated that she was covering a shift with Devonisha Fance, and they took the residents to Walmart and Chipotle. She stated that they asked the residents if they wanted to go, and Resident A stated that he did not want to go. She stated that if he did not go with them, then they could not take five residents and leave one person behind, so she convinced him to come along. She did not force him, but she told him it would be fun to get out of the house and he agreed to go on the outing. Ms. Williams stated that there were not enough seats in the van for everybody. She shared a seat with one of the residents. She could not recall who she was sharing a seat with, but she stated that the resident was buckled in with a seatbelt. She was the only person not using a seatbelt. Ms. Williams stated that when they went to Walmart, she went into the store with two of the residents. The other four residents stayed in the van with Ms. Fance. When they were turning out of Walmart, they missed a turn and had to pull in somewhere to turn around. She stated that they were kind of making a U-turn and a car was coming fast, so they had to stop quickly to avoid being hit. Ms. Williams stated that they then went to Chipotle. She stated that everyone was outside of the van, except for Resident A who wanted to stay in the van. She stated that she and Ms. Fance went into Chipotle, but they took turns. Ms. Fance went in as she was coming out. Some of the residents were outside smoking. The door to the van was open. She stated that it is 100% false that they left the residents in the van for almost an hour while they got Chipotle. She stated that they were only at the restaurant for fifteen minutes. She stated that they stopped at the smoke shop on their way home, as one of the residents needed to exchange a vape that they had purchased. The residents had a chicken crockpot dish and sweet potatoes when they got home. Everybody ate dinner. She stated that Resident A might have complained about it and ate something else, but he said he rarely eats what is prepared because he does not like the food. Ms. Willimas stated that the staff at Wolverine Lake are not very helpful about providing information to new staff or staff who are covering shifts. She stated that they read the residents' plans when they cover a shift, but they do not receive any other information, so they just figure it out on their own.

I reviewed a copy of an incident report completed by the home manager, Matthew Abdilla, on 09/07/23. The incident report notes that Mr. Abdilla was contacted by a resident from the Wolverine Lake Home who informed him that yesterday staff told him and his housemates that there needed to be an emergency trip to Walmart and that everybody needed to go. The residents stated that one staff went into Walmart and returned a few moments later with a package of cupcakes. He then stated that staff, Devonisha Fance, was on her phone when pulling out of the Walmart parking lot and nearly got hit by another car. The staff then arrived at Chipotle 10 minutes later. Both staff went inside, leaving the windows to the van open, but did not leave the air conditioning on in the van. The resident and his housemates were alone in the vehicle for approximately 40 minutes before staff returned to the van with only food for

themselves. The incident report notes that the corrective measures taken to remedy and prevent recurrence of the incident is that they will continue to monitor the residents and ensure that staff are following all of company policies and procedures, as well as recipient rights policies. They will follow the recommendations set by the Office of Recipient Rights.

I reviewed the individual plans of service and crisis plans for the residents in the home. Resident B's plan states that he has current restrictions in his behavior treatment plan that include restricted access to the community, with independence to be introduced gradually. His plan notes that he will not wander away from home staff while in the community, unless utilizing independent community access; however, staff need to be notified that he will be using community time. None of the other plans address residents having independent access in the community. Resident A's crisis plan notes that he has a history of homicidal actions, elopement, and non-compliance. His individual plan of service states that 24-hour specialized AFC home staff provide CLS (community living services) and FTF (face to face) in the community.

On 11/14/23, I left a message for the home manager, Matthew Abdilla. I received a return phone call on 11/15/23. Mr. Abdilla stated that the staff who were involved in the incident were filling in from different homes due to the home being short staffed. He stated that staff who are covering a shift at the home are responsible for reading the residents' plans of service. They receive a tour of the home and staff also fill them in on the needs of the residents. Mr. Abdilla stated that Ms. Fance and Ms. Williams had both worked a few shifts in the home prior to this occasion. Mr. Abdilla stated that the home does not have a van that can accommodate all the residents at once, so they do not take all of the residents on outings at the same time. He stated that following the incident, the residents reported to him that they were left in the van while staff went into Chipotle. Resident B is the only resident who had access to the community at that time.

On 11/14/23, I conducted an exit conference via telephone with the licensee designee, Nichole VanNiman. Ms. VanNiman did not have any additional information regarding the investigation. She agreed to submit a corrective action plan to address the violations.

On 11/15/23, I conducted a follow-up exit conference with the licensee designee, Nichole VanNiman to inform her of an additional citation regarding staff suitability.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff, Devonisha Fance and Alicia Williams, did not act in a manner that was suitable to meet the needs of the residents. The staff used poor reasoning when they took all six residents on an outing, despite the van not having room to accommodate all of the residents and two staff. They also used poor judgment when they left the residents unattended to go into Chipotle to purchase food for themselves. The staff did not accept responsibility, as their account of the incident did not align with the information gathered from the residents in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 sufficient information to conclude that staff, Devonisha Fance and Alicia Williams, did not ensure the safety and protection of the residents on 09/06/23. The staff transported six residents and two staff in a minivan that only has room for seven people. Ms. Williams shared a seat with Resident B, and Resident B stated that he was unable to buckle his seatbelt due to the way they were sitting. Several residents reported that Ms. Vance nearly got into an accident by making a U-turn in front of another car. Although Ms. Vance and Ms. Williams denied leaving the residents unattended, all of the residents who were interviewed reported that both staff went into Chipotle and left the residents in the van without supervision for nearly 40 minutes while they got food for themselves. Resident B is the only resident who had independent access to the community. Both Ms. Vance and Ms. Williams reported that they did not receive much information about the residents prior to covering a shift at the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the residents did not receive a meal of proper form, consistency, and temperature on 09/06/23. Resident A, Resident B, Resident D, and Resident E stated that they could not eat dinner when they returned from being out in the community, because the meal had been cooked all day in the crockpot and was overcooked and inedible. They stated that an alternate meal was not offered or provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

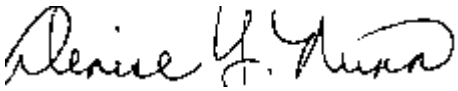
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

11/15/2023

_____

Kristen Donnay Date
Licensing Consultant

Approved By:



11/15/2023

_____

Denise Y. Nunn Date
Area Manager