GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 8, 2023

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

RE: License #: AS390406167
Investigation #: 2023A1024055
Beacon Home at Interlochen

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 note that violations of any licensing rules are also violations of the MSA and your contract.

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,

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406167
Investigation #:	2023A1024055
Complaint Receipt Date:	09/13/2023
Investigation Initiation Date:	09/13/2023
Report Due Date:	11/12/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Kimberly Howard
Name of Facility:	Beacon Home at Interlochen
Facility Address:	8038 Interlochen St. Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-6941
Original Issuance Date:	06/21/2021
License Status:	REGULAR
Effective Date:	12/21/2021
Expiration Date:	12/20/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A bottle of Ativan medication came up missing during the overnight shift.	Yes
The facility is not kept clean due to feces and urine constantly being on the floor.	Yes

III. METHODOLOGY

09/13/2023	Special Investigation Intake 2023A1024055
09/13/2023	Special Investigation Initiated – Telephone with Officer of Recipient Rights (ORR) Suzie Suchyta
09/15/2023	Contact - Document Received additional allegations from Intake #197643 regarding Resident B
09/16/2023	Contact - Document Received-Police report regarding missing medications.
09/19/2023	Inspection Completed On-site with direct care staff member Rachel Carter
09/22/2023	Contact - Telephone call made with Adult Protective Services (APS) Jessica Muellen
09/22/2023	Contact-Telephone call-with direct care staff members Sandy Lago, Dajion Sortor, Resident A
9/22/2023	Contact-Document Received-Pictures sent via text by Sandy Lago of facility conditions.
09/25/2023	Inspection Completed On-site with direct care staff members Rachel Carter,Patrice McCall, Kennedy VanNiman, Abby Vanderoust, Hospice worker Kristen Boyd, Residents B, C, D
11/01/2023	APS Referral-already invovled
11/01/2023	Contact - Face to Face-with licensee designee Nichole VanNiman
11/01/2023	Exit Conference with Nichole VanNiman

ALLEGATION: A bottle of Ativan medication came up missing during the overnight shift.

INVESTIGATION:

On 9/13/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged a bottle of Ativan medication came up missing during the overnight shift.

On 9/13/2023, I conducted an interview with ORR Suzie Suchyta who stated that she will be substantiating for neglect regarding this allegation as it is believed direct care staff member Steven Morale stole Resident B's prescription medication Ativan out of the medication room. Suzie Suchyta stated direct care staff member Rachel Carter counted the medication before she left her evening shift on 8/21/2023 and the next morning discovered that some medications were missing. A police report was made by the facility direct care staff members. However direct care staff member Steven Morale denied that he took the medication although he was the only staff member working during the night of 8/21/2023 and the only staff member with a key to access the medication room.

On 9/16/2023, I reviewed *Police Report* #2023-00028406 from the Kalamazoo County's Sheriff's Office. According to this report, on 8//22/2023, a nurse from Beacon Specialized Services reported that a 60-count bottle of Ativan was stolen from the facility and the last count of the medications was made on the evening of 8/21/2023.

On 9/19/2023, I conducted an onsite investigation at the facility with direct care staff member Rachel Carter who stated that on the morning of 8/22/2023 she arrived on shift and when she unlocked the medication room she discovered Resident B's medication pill packs, Gapapentin and Lomictal, were left out on the counter and not locked in a drawer as usual. Rachel Carter stated these specific pill packs were adequately accounted for however just not stored properly and locked in the drawer as required. Rachel Carter stated she then counted Resident B's narcotic medication and discovered a 60-count bottle of Ativan was missing. Rachel Carter stated Resident B receives extra narcotic medication from Hospice due to pain and usually has two 60-count bottles of Ativan. Rachel Carter further stated her last count of his Ativan medication was 208 total pills which is what she counted the night before leaving her shift and the next morning was at 148 pills. Rachel Carter stated she immediately called the assisted manager Abby Vanderoust who immediately came to the home along with their nurse Mark Oyster to assist her in searching for the missing Ativan medication. Rachel Carter stated nurse Mark Oyster eventually made a police report for the missing medication. Rachel Carter stated Steven Morale was not able to be contacted until the following day when he came in to work a morning shift at which time she asked Steven Morale about the missing medication and he denied taking them. Rachel Carter stated Nichole VanNiman and Mark Oyster also came to the facility the following morning to interview

Steven Morale regarding the missing medication at which time he was suspended pending further investigation. Rachel Carter stated after Steven Morale was sent home, he returned to the facility a couple hours later to ask her questions about her interview with Nichole VanNiman and became hostile towards her because she would not tell him what she stated in her interview. Rachel Carter stated Steven Morale then attempted to try to open the medication room door however the door was locked therefore he stormed out of the facility. Rachel Carter stated she immediately called Nichole VanNiman and reported this incident to her.

While at the facility, I reviewed the facility's *Daily Controlled Medication Chart* for Resident B which showed from for the month of August 2023 until 8/22/2023 Resident A had 208 pills of his Lorazepam 1mg (Ativan) medication which should be given as needed.

I also observed Resident B's Lorazepam 1mg medication packaged in 2 pill packs totally 60 and in a bottle in the amount of 88 counted by Rachel Carter.

On 9/25/2023, I conducted an onsite investigation at the facility with direct care staff members Kennedy VanNiman, and Abby Vanderoust. Kennedy VanNiman stated that she was aware Resident B was missing medications. Kennedy VanNiman stated that all the medications were passed when Steven Morale arrived to work on 8/21/2023 and residents typically do not ask for any medications during the overnight shift therefore, there was no reason for Steven Morale to be in the medication room. Kennedy VanNiman stated she also counted Resident B's medication with Rachel Carter before leaving on the evening of 8/21/2023 at which time he had 208 pills of Lorazepam (Ativan) 1mg.

Direct care staff member Abby Vanderoust stated on the morning of 8/22/2023 she was contacted by Rachel Carter saying that Resident B was missing 60 of his Ativan medication. Abby Vanderoust stated she immediately came to the facility and searched the medication room for the missing medications and could not find them. Abby Vanderoust stated their nurse also came to the facility to search and contacted law enforcement to make a police report. Abby Vanderoust stated the medications were counted the night before by Rachel Carter therefore she believes the medications were taken during the overnight shift. Abby Vanderoust stated Steven Morale was the only staff member working after Rachel Carter left her shift on the evening of 8/21/2023. Abby Vanderoust stated calls were made to Steven Morale to ask about the medications however he did not return anyone's phone calls on 8/22/2023 and has stopped answering any phone calls made from Beacon Specialized Services after he was interviewed on 8/23/2023.

On 11/01/2023, I conducted an interview with licensee designee Nichole VanNiman who stated that she was notified on 8/22/2023 by Rachel Carter that Resident B's narcotic medication count was off by 60 pills from her last count on 8/21/2023. Nichole VanNiman stated she was also notified when Rachel Carter arrived to work on 8/21/2023 she discovered two of Resident B's prescription medication were left out on

the counter and not locked in the drawer like they were when she left her shift the night before on 8/21/2023. Nichole VanNiman stated Steven Morale was the only staff member who was working with access to the medication room after Rachel Carter left her shift on the evening of 8/21/2023. Nichole VanNiman stated she interviewed Steven Morale on 08/23/2023 but he denied taking them. Nichole VanNiman stated after she interviewed Steven Morale, she received a phone call from Rachel Carter a couple hours later stating that Steven Morale came back to the facility and attempted to gain access to the medication room. Nichole VanNiman stated she believes Steven Morale may have been attempting to put the Ativan medication back in the medication room.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my investigation which included interviews with ORR Suzie Suchyta, direct care staff members Rachel Carter Kennedy VanNiman, Abby Vanderoust, licensee designee Nichole VanNiman along with my review of the facility's *Daily Controlled Medication Chart,* Resident B's Lorazepam (Ativan) 1mg medication, and police report there is evidence to support a bottle of Ativan medication came up missing during the overnight shift on 08/21/2023. According to the police report, on 8/22/2023, a nurse from Beacon Specialized Services reported that a 60-count bottle of Ativan was missing and assumed stolen from the facility with the last medication count occurring on the evening of 8/21/2023. Rachel Carter stated she counted Resident B's medication on the evening of 8/21/2023 and discovered missing medications on the following morning after observing medications in the medication room not locked in the cabinet as usual. Kennedy VanNiman stated she also counted Resident B's medication with Rachel Carter before leaving on the evening of 8/21/2023 at which time Resident B had 208 pills of his Lorazepam (Ativan) 1mg medication. The facility's *Daily Controlled Medication Chart* also showed that Resident B had 208 pills of Larazepam (Ativan) on 8/21/2023. Abby Vanderoust, Nichole VanNiman and Rachel Carter all stated that they searched Resident B's medications on the morning of 8/22/2023 and discovered 60 pills of Resident B's Larazepam (Ativan) missing. Consequently, reasonable precautions were not taken after Resident B's Ativan medication was determined missing on the morning of 08/22/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility is not kept clean due to feces and urine constantly on the floor.

INVESTIGATION:

On 9/15/2023, I received additional allegations through the BCHS online complaint system alleging the facility floor is not kept clean due to feces and urine constantly being on the floor.

On 9/22/2023, I conducted an interview with APS Specialist Jessica Muellen who stated that she is also investigating this allegation.

On 9/22/2023, I conducted interviews with direct care staff members Sandy Lago, Dajion Sortor and Resident A. Sandy Lago stated that recently Resident B had an accident and defecated on himself which caused feces to be on the living room floor and direct care staff member Rachel Carter refused to clean the feces off the floor as she wanted to wait until the next staff member on shift arrived which was hours later. Sandy Lago stated when she came in the following day, she was informed that Resident B had an accident on the floor therefore she cleaned the feces off the floor. Sandy Lago stated she also found feces on Resident B's toilet and bedroom floor that she had to clean up which was there since the previous day. Sandy Lago stated she has watched Rachel Carter refuse to clean up behind Resident B so other staff members will have to do it. Sandy Lago stated today she found feces on Resident B's toilet seat in his bedroom which is shared with Resident C who has complained about having feces found on the toilet in the past. Sandy Lago stated Resident A also has complained about Rachel Lago refusing to clean up after Resident B when he has accidents on the floor. Sandy Lago stated she is planning on cleaning Resident B's and C's toilet however has not been able to get to this task yet. Sandy Lago stated she is frustrated because overnight direct care staff should have checked Resident B's and Resident C's toilet to ensure it was clean but neglected to do so as well.

Dajion Sorter stated he normally assist with cleaning Resident B when he has toileting accidents and has no knowledge of Rachel Carter refusing to assist with cleaning Resident B or the facility after Resident B had a bowel accident. Dajion Sorter stated sometimes Resident C does not like for staff members to enter his bedroom therefore he has no knowledge of Resident B's and Resident C's bathroom being dirty or any other area of the facility.

Resident A stated Resident B recently "pooped on himself and had poop everywhere" and Rachel Carter refused to clean the poop off the floor. Resident A stated Rachel Carter waited until direct care staff for the next shift to arrive to clean the poop off the floor which was hours later. Resident A stated he has observed staff members clean up after Resident B however Rachel Carter is the only staff member that refuses to clean up "poop" off the floor.

On 9/22/2023, I reviewed pictures of Resident B and Resident C bathroom toilet. I observed feces on the toilet seat and variety of other areas of the toilet. It was not known from the pictures how long the fecal material had been on the toilet.

On 9/25/2023, I conducted an onsite investigation at the facility with direct care staff members Rachel Carter, Patrice McCall, Kennedy VanNiman, Abby Vanderoust, hospice nurse Kristen Boyd, and Residents B, C, D. Rachel Carter stated she does not refuse to clean up after Resident B. Rachel Carter stated last week Resident A thought he saw feces on the floor after Resident B had an accident however there was no feces on the floor. Rachel Carter stated she did not check to see if there was feces in Resident B's and C's bedroom or bathroom therefore, she does not know if feces was found in those areas. Rachel Carter stated Resident B has a catheter bag monitored by hospice and it sometimes leaks urine on the floor when Resident B rips the bag therefore during this time, staff members are constantly cleaning urine off the floor while waiting for Resident B's hospice worker to come out to repair the bag. Rachel Carter stated she has cleaned up after Resident B on numerous occasions and has never left the conditions of the facility intentionally unkept. Rachel Carter stated hospice workers are out to the home weekly and they have called hospice on-call staff when Resident B has an accident to assist with cleaning and when he rips his catheter bag.

Patrice McCall stated direct care staff members are constantly cleaning the home and she has not seen any feces or urine on the floor.

Kennedy VanNiman stated direct care staff members are usually good about cleaning up after Resident B however she has seen Rachel Carter perform other duties and responsibilities around the facility to avoid cleaning up after Resident B leaving other staff members to clean up when Resident B has accidents of defecating on himself. Kennedy VanNiman stated she has not seen urine or feces left on the floors or anywhere in the facility. Kennedy VanNiman stated there are times she has tried to enter Resident B's and C's bedroom to clean their bathroom but has been turned away by Resident C when he does not want anyone in his bedroom. Kennedy VanNiman stated Resident B has hospice involved to assist with his care needs which helps when Resident B has accidents however when immediate assistance is needed due to Resident B' ripping his catheter bag, it may take hospice staff hours to respond to the facility which causes staff members to have to continuously clean up after Resident B until hospice arrives.

Abby Vanderoust stated direct care staff members do a good job cleaning up after Resident B after he has a bowel or urinary accident on the floor. Abby Vanderoust further stated staff members also call hospice staff right away when there are issues with Resident B's catheter bag which is probably about once a week. Abby Vanderoust stated she has not witnessed or heard of any staff members refusing to clean up after Resident B however there have been times it may take up to 20 minutes to clean after a bowel accident if staff members are performing other duties and responsibilities. Abby Vanderoust further stated there also have been times she has attempted to clean Resident B's bedroom who he shares with Resident C however has been denied entry

by Resident C when he does not want staff members to bother him. Abby Vanderoust stated when this situation occurs, she or another staff member will make an attempt later in the day when Resident C is in a different mood to clean his bedroom and bathroom.

Kristen Boyd stated she comes out to the home weekly and direct care staff will call her for emergency purposes such as when Resident B rips his catheter bag. Kristen Boyd stated Resident B was having improvement in his health conditions however as of recent, his health conditions have been declining as he is not eating as much. Kristen Boyd stated she has had to come out to the home to assist staff members with cleaning Resident B after he has had a bowel movement and would not let staff members help him. Kristen Boyd stated currently she is responsible for monitoring and changing Resident B's catheter as the staff members are not able to perform this task and she is on-call to assist staff members as needed. Kristen Boyd stated she has not seen the home conditions unclean.

Resident B was observed sitting on the couch meeting with his hospice worker. He was observed to be clean. Resident B is nonverbal and was not able to be interviewed.

Resident C stated Resident B has bowel accidents leaving feces on the floor accidentally however staff members are usually good about cleaning up after Resident B. Resident C stated last week Resident B "had poop on the floor in the living room" and staff waited hours to clean it up because they were busy doing other things. Resident C further stated Resident B will sometime break his catheter bag open causing urine to leak on the floor however staff members will clean the urine off the floor until the bag is repaired which is on the same day.

Resident D stated he has not seen urine and feces left on the floor. Resident D stated when Resident B has accidents, direct care staff members clean up after Resident B right away. Resident D stated he believes the facility is kept clean.

While at the facility, I observed the facility to be clean with no odors or other concerns, including feces on the resident toilets.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	Based on my investigation which included interviews with direct care staff members Rachel Carter, Kennedy VanNiman, Abby Vanderoust, Sandy Lago, Dajion Sortor, Patrice McCall, hospice worker Kristen Boyd, Residents A, B, C, D, and a review of the facility's home conditions there is enough evidence the facility is not kept clean due to residents being exposed to fecal and urine matter on a regular basis. This occurs because direct care staff members do not prioritize cleaning fecal matter timely and Resident B's catheter bag leaks at times. Although the facility was clean at the time of my unannounced onsite investigation, direct care staff members and residents interviewed reported delays, which at times are significant, after a resident experiences a toileting accident in shared living spaces. The staff members have not arranged and maintained the maintenance of the premises that adequately provides for the health and safety of the residents by not immediately addressing and cleaning feces and urine off the floor.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/1/2023, I conducted an exit conference with licensee designee Nichole VanNiman. I informed Nichole VanNiman of my findings and allowed her an opportunity to ask questions or make comments.

IV. RECOMMENDATION

Upon an acceptable corrective action plan, I recommend the current license status remain unchanged.

Ondrea Johnson 11/3/2023

Ondrea Johnson Date
Licensing Consultant

Approved By:

Dawn Timm 11/08/2023

Dawn N. Timm Date
Area Manager