GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 30, 2024

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

RE: License #: AM800299049
Investigation #: 2024A1030031
Beacon Home at Woodland

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 #:	AM800299049
Investigation #:	2024A1030031
Complaint Receipt Date:	05/02/2024
Investigation Initiation Date:	05/02/2024
Report Due Date:	07/01/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kim Howard
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Woodland
Facility Address:	56832 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	09/12/2016
License Status:	REGULAR
Effective Date:	03/12/2023
Expiration Date:	03/11/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided protection from Resident B.	No
Resident A was not administered her prescription medication.	No
Additional Findings	Yes

III. METHODOLOGY

05/02/2024	Special Investigation Intake 2024A1030031
05/02/2024	Special Investigation Initiated - Telephone Interview with Kim Howard
05/02/2024	APS Referral Received denied APS referral
05/02/2024	Contact - Face to Face Interview with Danyell Beltazar
05/02/2024	Contact - Face to Face Interview with Resident B
05/02/2024	Contact - Face to Face Interview with Resident C
05/02/2024	Contact - Document Received Received and reviewed Incident Reports
05/02/2024	Contact - Document Received Reviewed Resident A's EMAR
05/14/2024	Contact - Telephone call made Interview with Danyell Baltazar
05/29/2024	Contact - Telephone call made Interview with Angelina Lewis
05/29/2024	Contact - Document Received Received and review an incident report
05/29/2024	Exit Conference Exit conference by phone

ALLEGATION:

Resident A was not provided protection from Resident B.

INVESTIGATION:

On 5/2/24, I interviewed home manger Danyell Baltazar at the home. Ms. Baltazar reported Resident A was admitted to the home on 4/28/24 and was picked up at the Kent County Jail and was brought to the home by staff. Ms. Baltazar reported the first day went well but Resident A quickly decompensated as she was not given her mental health medications while in jail. Ms. Baltazar reported Resident A and her roommate began having conflicts and Resident A accused Resident B of punching her in the hip although there was no evidence. Ms. Baltazar reported Resident A became a one-to-one supervision on 4/30/24 as her behaviors continued to escalate as she and several other residents were having verbal conflicts.

Ms. Baltazar reported they moved Resident A to another bedroom as she and Resident B continued to have verbal conflicts. Ms. Baltazar reported on 5/1/24 Resident A and Resident B have a physical altercation although there were no injuries and no medical attention was needed. Ms. Baltazar reported Resident A also assaulted Resident C on 5/1/24. Ms. Baltazar reported they contacted Resident A's Community Mental Health case manager and they decided to complete a mental health petition and she was taken to the hospital for a psychiatric evaluation and inpatient treatment.

On 5/2/24 I received and reviewed seven Incident Reports (IR) regarding Resident A. Five of the seven IR's documented behavioral issues and conflicts Resident A was having with the DCSM and other residents.

On 5/2/24, I interviewed Resident B at the home. Resident B acknowledge that she and Resident A were at odds while she was in the home but denied being the aggressor. Resident B reported she tried to get along with her. Resident B denied punching her on the hip but did admit pushing her to the ground after Resident A hit her on the shoulder. Resident B reported the staff were very supportive and tried to redirect Resident A as well as intervened when they had a physical conflict.

On 5/2/24, I interviewed Resident C at the home. Resident C reported Resident A assaulted her and had a small bruise on her right forearm. Resident C denied retaliating and informed staff that she was assaulted by Resident A. Resident C reported she did file a police report.

On 5/29/24, I interviewed District Director Kim Howard by phone. Ms. Howard acknowledged the investigation and indicated Resident A was still psychiatrically

hospitalized and the home will not be taking her back as they are unable to meet her needs.

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:	It was alleged that the home did not provide Resident A from Resident B. Based on interviews and review of several incident reports this violation will not be established. According to all accounts Resident A's mental health had decompensated shortly after admission to the home and she instigated several conflicts with Resident B and Resident C. The staff members acted appropriately by increasing supervision, moving Resident A to a different bedroom and contacting her Community Mental Health case manager.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not administered her prescription medication.

INVESTIGATION:

I interviewed district director, Kim Howard by phone. Ms. Howard reported the staff do not pass medications unless the specific medication is documented on the Electronic Medication Administration Record (E-MAR) and medications get added to the MAR as they are prescribed by the resident's physician. Ms. Howard if a medication is delivered late in the afternoon it may not get added to the MAR until the next day and direct care staff members (DSCM) are not allowed to add medication to the MAR. Ms. Howard reported a supervisor, nurse or the medical director will add medications to the MAR.

Ms. Baltazar reported Resident A complained of having a urinary tract infection and was taken to Corwell Health Urgent Care on 4/29/24. Ms. Baltazar reported Resident A was prescribed Amoxicillin and the pharmacy delivered the medication to the home at 7:00pm. Ms. Baltazar reported she was not working at that time but was contacted by

staff at 10;00pm and informed that the medication had been delivered. Ms. Baltazar reported she added it to Resident A's E-MAR on 5/1/24 and it was administered to her that morning. Ms. Baltazar reported the DCSM working second shift are not authorized to add medications to the E-MAR and therefore would not administer the medication if it was not on the E-MAR.

I received and reviewed an IR dated 4/29/24 and indicated Resident A asked for the anti-biotic prescribed earlier that day. The DCSM located the medication and contacted Ms. Baltazar however was not able to pass the medication because it had not been added to the E-MAR. The IR dated 5/1/24 8:00am documented Resident A refusing take any of her medications.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**
ANALYSIS:	It was alleged that Resident A was not administered her prescription medication. Based on interviews and review of incident reports this violation will not be established. Resident A was prescribed an anti-biotic on 4/29/24 which the home received at 7:00pm. Per policy, the home does not administer medications until they are added to the Electronic Medication Administration Record to ensure accuracy. The home manager was informed of the medication delivery, added it the E-MAR on 4/30/24 and it was administered to Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

On 5/14/24, I received additional allegations that were added to the current investigation. Most allegations are identical to the current investigation. However, there was one new allegation regarding Resident A being accused of stealing medication.

On 5/14/24, I interviewed home manager Danyell Baltazar by phone. Ms. Baltazar reported Resident A admitted to stealing medication from DCSM #1 purse. Ms.

Baltazar reported DCSM #1 was outside with several residents smoking and left her purse on the dining room table which contained a personal prescription for Xanax. Ms. Baltazar reported Resident A asked DCSM #1 if “she was missing anything from her purse” and then discovered her medication was missing. Ms. Baltazar reported Resident A indicated she put the prescription bottle in her dresser drawer however they did not find it there after doing a search of her bedroom. Ms. Baltazar reported they searched the entire home and did not find the medication. Ms. Baltazar reported DCSM #1 was suspended for seven days and written up for the incident.

On 5/29/24, I interviewed DCSM #1 by phone. DCSM #1 acknowledged she had a bottle of prescription anxiety medication in her purse and left her purse in the dining room on 5/1/24 when she went outside. DCSM #1 reported being away from her purse for about five minutes and when she came back into the home Resident A said “I hope no one stole anything from your purse.” DCSM #1 reported that she agreed with Resident A but did not check her purse. DCSM #1 reported that when she came back to work later that day she was informed by another DCSM that some of the residents indicated that a bottle of medication was taken from her purse and they called law enforcement and did a home search. DCSM #1 reported that she checked her purse and found that her bottle of medication was missing. DCSM #1 acknowledged that she should not have left her purse in a common area of the home.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(2) 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:	On 5/1/24 DCSM #1 left her purse unattended in a common area of the home which allowed Resident A to take a bottle of narcotic prescription from her purse. The home took appropriate action by contacting the agency nurse, law enforcement and conducting a search of the home. Ms. Lewis acknowledged her error.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/29/24, I shared the findings of my investigation with administrator, Kim Howard by phone. Ms. Howard agreed with the findings and to submit a corrective action plan.

IV. RECOMMENDATION

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

Nile Khabeiry, LMSW 6/4/24

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak 6/5/24

Russell B. Misiak Date
Area Manager