GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2024

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

RE: License #:	AS250395771
Investigation #:	2024A0872043
	Beacon Home at Linden

Dear Nicole 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 (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250395771
Investigation #:	2024A0872043
Complaint Receipt Date:	06/12/2024
Investigation Initiation Date:	06/12/2024
Report Due Date:	08/11/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Linden
Facility Address:	14180 N. Hogan Road Linden, MI 48451
Facility Telephone #:	(248) 286-6900
Original Issuance Date:	10/09/2018
License Status:	REGULAR
Effective Date:	04/09/2023
Expiration Date:	04/08/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 6/10/24, Residents A and B were allowed to come into the GHS building alone to use the restroom, while the AFC staff person responsible for monitoring remained in the van. Neither of these individuals should be in the community unattended.	No
Additional Findings	Yes

III. METHODOLOGY

06/12/2024	Special Investigation Intake 2024A0872043
06/12/2024	Special Investigation Initiated - Letter I contacted RRO Matthew Potts regarding this complaint
06/25/2024	Inspection Completed On-site Unannounced
07/08/2024	APS Referral I made an APS complaint via email
07/08/2024	Contact - Document Sent I emailed the licensee designee requesting information related to this complaint
07/10/2024	Inspection Completed On-site Unannounced
07/15/2024	Contact - Document Received I received AFC documentation related to this complaint
07/29/2024	Contact - Telephone call made I interviewed staff Tahjah Dixon
07/29/2024	Contact - Telephone call made I interviewed staff Shateiya Williams
07/29/2024	Exit Conference I conducted an exit conference with the licensee designee, Nichole VanNiman

07/29/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 6/10/24, Residents A and B were allowed to come into the GHS building alone to use the restroom, while the AFC staff person responsible for monitoring remained in the van. Neither of these individuals should be in the community unattended.

INVESTIGATION: On 06/25/24, I conducted an unannounced onsite inspection of Beacon Home at Linden Adult Foster Care facility. I interviewed the acting home manager (AHM), Jordan Eldridge. AHM Eldridge said that she is aware that a complaint was made regarding Residents A and B entering the Genesee County community mental health building (GHS) without staff supervision. AHM Eldridge said that to her knowledge, Resident B has unsupervised community access, but she does not know if Resident A has unsupervised community access. None of the residents were home at the time of my inspection so I was not able to interview any of them.

On 07/10/24, I conducted another unannounced onsite inspection of Beacon Home at Linden AFC. I interviewed Resident A and Resident B. Resident A said that he has lived at this facility since March 2024. Resident A said that on 06/10/24, he and some of the other residents were transported to GHS by staff because one of the residents had an appointment. Resident A told me that after his appointment, Resident A and Resident B went back to the facility van where they waited with two staff. Resident B needed to use the bathroom so Resident A volunteered to take him. Resident A said that he took Resident B inside the building, Resident B used the bathroom, and they returned to the facility van without incident. Resident A said that he did not feel uncomfortable taking Resident B to the bathroom and “nothing happened” while they were in the building. I asked Resident A if he has unsupervised community access and he said no.

Resident B said that he has lived at this facility for “a little while” and said that he does not know if he has unsupervised community access. I asked Resident B about the incident from 06/10/24 and he said that he does not remember using the bathroom at GHS without staff supervision. Resident B said that he does have trouble remembering things because he has a traumatic brain injury (TBI), and he gets confused sometimes. Resident B told me that staff does not leave him alone and they normally accompany him when he is in the community.

On 07/15/24, I received AFC documents related to this complaint from Jacqueline Wilson, East Region Executive Director of Operations (EDO.)

Resident A was admitted to this facility on 03/20/24. Resident A is diagnosed with schizoaffective disorder, bipolar type, bipolar I disorder, cocaine use disorder, and cannabis use disorder. Resident A has a significant substance abuse history, a long history of hospitalizations, and he is on NGRI status due to a crime he committed in 2014.

According to Resident A's individualized plan of service (IPOS) dated 03/06/24, he has several risk mitigation strategies, and he requires staff supervision while in the community. "Due to safety concerns related to the symptoms of (his) diagnoses and the team wanting a successful transition from a secured hospital setting to a community specialized AFC setting (he) will initially have supervised community access upon admission to the home." According to his Assessment Plan dated 02/27/24, he needs staff supervision while in the community.

Resident B was admitted to this facility on 09/29/22. Resident B is diagnosed with bipolar disorder and depressive disorder. According to Resident B's GHS IPOS dated 10/11/23, due to traumatic brain injuries, he has poor short-term memory. His IPOS does not specify what type of community access he receives. According to his Assessment Plan dated 10/05/22, he is allowed to move independently in the community.

On 07/29/24, I interviewed staff Tahjah Dixon via telephone. Staff Dixon confirmed that she and staff Shateiya Williams were working on 06/10/24. Staff Dixon said that Resident C had an appointment at GHS, so Staff Williams transported him and Residents A and B while she remained at the AFC facility with the other residents. Staff Dixon told me that she is aware that a complaint was made alleging that Staff Williams allowed the residents to use the bathroom without staff supervision, but Staff Williams told her that she was in the building while the residents were using the bathroom.

On 07/29/24, I interviewed staff Shateiya Williams via telephone. Staff Williams confirmed that on 06/10/24, she transported Residents A, B, and C to GHS because Resident C had a medication review appointment. According to Staff Williams, she and the residents went into GHS together and while Resident C was having his med review, she and Residents A and B stayed in the common area of GHS. Residents A and B said that they needed to use the bathroom, so they used the public restroom while she waited in the common area. Staff Williams said that at no time did she leave the residents unattended and said that they were never in the GHS building without her. Staff Williams stated that she has only worked at this facility since May 2024, and she believes that perhaps the person making this complaint was not aware that she was staff. Staff Williams said that neither Resident A nor Resident B had appointments at GHS that day, but they wanted to ride along with her and Resident C which is why they were with her.

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:	According to Resident A, on 06/10/24 he took Resident B into the GHS building to use the bathroom. He said that two staff waited in the van while they were in the building. Resident B said that he does not remember using the bathroom at GHS unattended by staff. Staff Tahjah Dixon and Shateiya Williams said that they were the only staff working on 06/10/24. Staff Williams took Residents A-C to GHS while Staff Dixon remained at the AFC facility with the other residents. Staff Williams said that she accompanied all three residents into the GHS building where they waited for Resident C to finish his medication review appointment. Staff Williams said that Residents A and B used the bathroom at GHS, but she was in the building with them and could see the bathroom from where she was sitting in the waiting room. Staff Williams said that at no time were the residents left in the building without her supervision. Staff Dixon said that Staff Williams told her that she did not leave the residents unattended while at GHS. I conclude that there is insufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During my investigation, I noted that Resident B's Assessment Plan was dated 09/29/22. According to Jacqueline Wilson, East Region Executive Director of Operations (EDO), due to staffing issues at the facility, an updated Assessment Plan was not completed for him.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of

	the resident's written assessment plan on file in the home.
ANALYSIS:	During my investigation, I noted that Resident B's Assessment Plan was dated 09/29/22. According to Jacqueline Wilson, East Region Executive Director of Operations (EDO), due to staffing issues at the facility, an updated Assessment Plan was not completed for him. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/29/24, I conducted an exit conference with the licensee designee, Nichole VanNiman. I told her I have concluded my investigation and explained which rule violation I am substantiating. I asked her to complete and submit a corrective action plan upon the receipt of my investigation report.

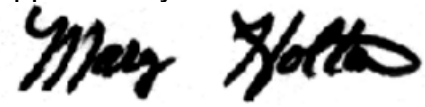
IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

July 30, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:



July 30, 2024

Mary E. Holton Area Manager	Date