GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 25, 2024

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

RE: License #: AS800404242
Investigation #: 2025A1030011
Beacon Home at Hartford

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 #:	AS800404242
Investigation #:	2025A1030011
Complaint Receipt Date:	11/19/2024
Investigation Initiation Date:	11/19/2024
Report Due Date:	01/18/2025
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 Hartford
Facility Address:	68134 CR 372 Hartford, MI 49057
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/27/2020
License Status:	REGULAR
Effective Date:	02/27/2023
Expiration Date:	02/26/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not appropriately supervised by a staff member.	Yes
Additional Findings	No

III. METHODOLOGY

11/19/2024	Special Investigation Intake 2025A1030011
11/19/2024	Special Investigation Initiated - Telephone Interview with Referral Source
11/20/2024	Contact - Telephone call made Interview with Bradly Cooper
11/21/2024	Contact - Face to Face Interview with Resident A
11/21/2024	Contact - Face to Face Interview with Crystal Jennings
11/21/2024	Contact - Document Received Received and reviewed Incident Report
11/21/2024	Contact - Document Received Received and reviewed Resident A's Behavior Treatment Plan
11/22/2024	Exit Conference Exit Conference by phone

ALLEGATION:

Resident A was not appropriately supervised by a staff member.

INVESTIGATION:

On 11/19/24, I interviewed the Referral Source (RS) by phone. The RS reported Resident A has a history of elopement and is a "line of sight" supervision requirement. The RS reported she interviewed direct care staff member (DCSM) Bradley Cooper, and he admitted to not supervising Resident A while they were at McDonalds.

On 11/20/24, I interviewed DCSM Bradley Copper by phone. Mr. Copper reported he took Resident A to his court mandated drug screen on 11/4/24. Mr. Cooper reported they were both hungry after he Resident A took his drug screen and went to McDonald's on Sprinkle Road in Kalamazoo. Mr. Cooper reported they went inside to eat their meals, and he had to use the bathroom. Mr. Cooper reported he informed Resident A and Resident A indicated he had to use the bathroom as well and would follow him into the bathroom. Mr. Copper reported he was unable to wait to use the bathroom as he has intestinal problems and did not know that Resident A did not follow him into the bathroom or had eloped from McDonald's. Mr. Copper reported he realized Resident A had eloped after he walked out of the bathroom and contacted the police, his supervisor and the clinical on-call staff person. Mr. Copper reported he drove around for 30 minutes looking for Resident A but could not find him and drove back to the facility. Mr. Copper reported he knew that Resident A had a history of eloping and is supposed to be in his direct line of sight while in the community.

On 11/21/24, I interviewed Resident A at the facility. Resident A acknowledged that he took off from McDonald's on 11/4/24. Resident A reported DCSM Bradly Cooper was in the bathroom when he left the restaurant. Resident A reported he and Mr. Cooper went to McDonald's after his drug screen because Mr. Cooper was hungry and wanted to stop. Resident A reported he did not have any money and had to sit and watch Mr. Cooper eat his meal before he had to use the bathroom. Resident A reported he was aware that Mr. Cooper was not supposed to leave him unsupervised.

On 11/21/24. I interviewed home manager, Crystal Jennings at the home. Ms. Jennings reported she is aware of the situation and acknowledged that Mr. Cooper should not have left Resident A unsupervised. Ms. Jennings reported Mr. Copper is allowed to stop at any location in the community with Resident A but should always keep him in his line of sight due to Resident A having a history of elopement.

On 11/21/24, I received a reviewed an Incident Report (IR) authored by DCSM Brandly Cooper. The IR indicated Resident A wanted to stop at McDonald's after his scheduled appointment to drug screen and eloped from the restaurant when Mr. Cooper went to the bathroom.

On 11/21/24, I received and reviewed Resident A's Behavior Treatment Plan (BTP.) Resident A's BTP indicated he needs staff "supervision at all times" while in the community due to a history of elopement.

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:	It was alleged that Resident A was not appropriately supervised by a staff member. Based on interviews and review of documentation this violation will be established. On 11/4/24 staff member Bradly Cooper took Resident A into the community and left him unsupervised at McDonalds when he went into the bathroom. Resident A eloped when Mr. Copper was in the bathroom and was eventually found and returned to the facility four days later.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 11/22/24, I shared the findings of my investigation with licensee designee Nichole VanNiman by phone. Ms. VanNiman acknowledged the findings and agreed to submit a corrective action plan.

IV. RECOMMENDATION

Contingent upon the submission of an acceptable corrective action plan, I recommend no change in the current license.

Nile Khabeiry, LMSW

11/27/24

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Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

11/27/24

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Russell B. Misiak Date
Area Manager