GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 12, 2024

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

RE: License #: AS630408237
Investigation #: 2024A0602036
Beacon Home at Wolverine Lake

Dear Ms. VanNiman:

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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630408237
Investigation #:	2024A0602036
Complaint Receipt Date:	08/05/2024
Investigation Initiation Date:	08/06/2024
Report Due Date:	10/04/2024
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 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:	06/17/2024
Expiration Date:	06/16/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On July 1st, staff member Jada left the residents unattended for the night.	Yes
Staff member, Michael Pytel takes medication out of the medication room.	No

III. METHODOLOGY

08/05/2024	Special Investigation Intake 2024A0602036
08/06/2024	Special Investigation Initiated - Telephone Call made to complainant – message left.
11/04/2024	Inspection completed on-site Interview staff members, Michael Pytel, Precious Porter, and Resident A, Resident B, Resident C, and Resident D.
11/06/2024	Contact – Telephone call made Call made to the previous home manager, Maliah Spencer – unable to leave a message.
11/06/2024	Contact – Telephone call made Call made to the current home manager, Patricia Lewis
12/03/2024	Exit Conference Message left for the licensee designee Nichole VanNiman.

ALLEGATION:

- **On July 1st, staff member Jada left the residents unattended for the night.**
- **Staff member, Michael Pytel takes medication out of the medication room.**

INVESTIGATION:

On 8/05/2024, a complaint was received and assigned for investigation alleging that on July 1st staff member Jada left the residents unattended for the night and staff member Michael Pytel take medication out of the medication room.

On 11/04/2024, I conducted an unannounced on-site investigation at which time I interviewed staff members Michael Pytel and Precious Porter. Mr. Pytel stated there was a lot going on at the home in July 2024. He said he was very frustrated with the company because there were issues between staff members, and he felt as if nothing was being done. Mr. Pytel admitted that he quit during a meeting with management due to his frustration but decided to come back. He stated that staff member Jada no longer works for the company, but she did leave the residents unattended for about 10 minutes (exact date unknown).

Mr. Pytel said the only time he removed medication from the medication room was to administer it to Resident B. Resident B stays in his room most of the time so he would take his medication to him and administer it in his bedroom. Mr. Pytel stated he was instructed by management to pass medication in the medication room and not in resident rooms.

Ms. Porter stated she began working for the company in June 2024 as a direct care worker on the day shift between the hours of 8 am – 8:30 pm. Ms. Porter said she does not have any firsthand knowledge of Jada leaving the residents unattended, but she heard about an incident where Jada left the residents unattended for an unknown amount of time. She went on to state that she had no knowledge of Mr. Pytel taking medication out of the medication room.

On 11/04/2024, I also interviewed Resident A, Resident B, Resident C and Resident D during the unannounced on-site investigation.

Resident A stated staff member Jada had an argument with her boyfriend over the phone and left her shift early leaving the residents alone. Resident A did not recall the date the incident occurred or how long they were left without staffing. Resident A went on to state that Resident B sleeps a lot and Mr. Pytel would administer his medication to him in his room. This is all the information Resident A had regarding Mr. Pytel removing any medication from the medication room.

Resident B stated he stays in his room most of the time and has no knowledge of any staff member leaving the residents unattended. He is usually asleep by 8 pm and does not know what goes on after that. Resident B went on to state that there were times when Mr. Pytel would administer his medication to him in his bedroom because he likes to stay in his room most of the time. However, he was informed that he must go to the medication room to receive his medication.

Resident C stated staff member Jada was in her car on her phone arguing during the nightshift (exact date unknown) when she left the residents along for a very long time. Resident C had no knowledge of Mr. Pytel taking medication out of the medication room.

Resident D stated he recalls an incident when he was looking for staff member Jada to ask for a snack, but she had left the home. He said this occurred during a midnight shift, but he could not recall the exact date.

On 11/04/2024, I observed the resident medication logs dated 9/2024 and 10/2024 as well as resident medications for the month of 11/2024. I did not observe anything usual with the medication or medication logs.

On 12/03/2024, I attempted to conduct an exit conference with the licensee designee, Nichole VanNiman by telephone, but she was unable. I left message for Ms. VanNiman requesting a return call to discuss the investigative findings and recommendation documented in this report. As of this date, 12/12/2024 I have not received a response.

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 obtained from Mr. Pytel, Resident A, Resident C and Resident D, there is sufficient information to determine that staff member Jada did leave the residents alone for an unknown amount of time. Both Resident A and Resident C stated staff member Jada (last name unknown) was involved in an argument over the phone with her boyfriend and left the residents unattended. Resident D also stated that staff member Jada (last name unknown) was not in the home during a midnight shift (date unknown).
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medication.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of

	the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the information obtained from Mr. Pytel, Resident A, Resident B, and Resident C, there is insufficient information to determine that Mr. Pytel removes residents' medication from the medication room for anything other than to administer it to Resident B when he is in his bedroom. However, Mr. Pytel stated he no longer administers Resident B his medication in his bedroom. Resident B now receives his medication in the medication room. Both Resident A and Resident B stated Mr. Pytel takes medication from the medication room only to administer it to Resident B when he is in his bedroom. Resident C had no knowledge of Mr. Pytel taking any medication out of the medication room.
CONCLUSION:	VIOLATION NOT ESTABLISHED

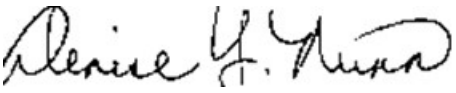
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remain unchanged.

12/12/2024

Cindy Berry Date
Licensing Consultant

Approved By:



12/12/2024

Denise Y. Nunn Date
Area Manager