GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 30, 2025

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

RE: License #: AS130411523
Investigation #: 2025A0790007
Beacon Home At East Ave South

Dear Ms. 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 review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Rodney Gill, 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 #:	AS130411523
Investigation #:	2025A0790007
Complaint Receipt Date:	12/17/2024
Investigation Initiation Date:	12/18/2024
Report Due Date:	02/15/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At East Ave South
Facility Address:	20271 East Ave N Battle Creek, MI 49017
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	04/13/2022
License Status:	REGULAR
Effective Date:	12/12/2024
Expiration Date:	12/11/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff members did not follow Resident A's Behavioral Treatment Plan.	Yes

III. METHODOLOGY

12/17/2024	Special Investigation Intake 2025A0790007
12/18/2024	Special Investigation Initiated - Letter Email received from licensing consultant Nile Khabeiry.
12/18/2024	APS Referral not necessary because this special investigation was initiated from a denied Adult Protective Services (APS) referral.
01/08/2025	Inspection Completed On-site Interviewed direct care staff member (DCSM) Heather Martinez who functions as the home manager and Resident A.
01/30/2025	Inspection Completed-BCAL Sub. Compliance
01/30/2025	Exit Conference with licensee designee Nichole VanNiman .
01/30/2025	Corrective Action Plan Requested and Due on 02/14/2025.

ALLEGATION:

Direct care staff members (DCSMs) did not follow Resident A's Behavioral Treatment Plan.

INVESTIGATION:

On 12/18/24, I reviewed a denied Adult Protective Services (APS) referral dated 12/17/24. The referral indicated Resident A lives with other residents at Beacon Home at East Ave South. Resident A is diagnosed with schizoaffective disorder bipolar type, alcohol and tobacco use disorders, emphysema, osteo arthritis degenerative disks, and migraine headaches.

The referral indicated Resident A has no legal guardian or power of attorney. Resident A has a Behavioral Plan that has a freedom of movement restriction. The

Behavioral Plan is contingent on her progress with refraining from eloping and determines whether Resident A gets community access. Resident A has a long history of elopement, psychiatric hospitalizations, a history of alcohol seeking, and not adhering to her medication regiment. Resident A is currently in a locked and gated facility.

The referral indicated over Thanksgiving, Resident A took a leave of absence (LOA) with friends for four days and three nights. DCSM Heather Martinez who functions as the home manager was aware of Resident A's freedom of movement restriction but allowed Resident A to take the LOA anyway.

DCSMs allowed Resident A to leave and sent her off with her medications, which she did take as prescribed.

The referral indicated for Resident A to leave, DCSMs must first request and receive approval from a behavior treatment committee (BTC) according to Resident A's Behavioral Plan. No one was made aware that Resident A was allowed to take a leave of absence over Thanksgiving until last week.

The referral indicated Resident A is not oriented to reality. Resident A's diagnosis of schizoaffective disorder bipolar type makes her extremely vulnerable and at risk. Resident A does not use a walker, cane, or wheelchair for assistance.

On 12/18/24, I reviewed a Michigan Licensing and Regulatory Affairs (LARA) Bureau of Community and Health Systems (BCHS) online complaint form. The complaint indicated that on 12/11/24, it was discovered Resident A took a leave of absence (LOA) for 4 days and 3 nights over Thanksgiving. The LOA was approved by DCSM Heather Martinez who functions as the home manager.

The complaint indicated Resident A is a vulnerable adult who currently lives in a locked and gated facility with a freedom of movement restriction. The complaint indicated Resident A is working on transitioning to more independent time in the community. At the time of this incident, however, Resident A was only safely at level 3, which is 15 minutes of unsupervised time in the community.

The complaint further indicated Ms. Martinez was aware Resident A could not go on a LOA without BTC approval. Ms. Martinez reported that Resident A was sent with all her medications and administered them as prescribed.

On 12/18/24, I received an email from licensing consultant Nile Khabeiry indicating he has interviewed Resident A many times. Mr. Khabeiry disclosed Resident A is delusional at baseline and has a history of making false allegations of being mistreated which he has investigated with no violations established.

I conducted an announced onsite investigation on 1/8/25.

On 1/8/25, I interviewed DCSM Heather Martinez. Ms. Martinez admitted she was one of many DCSMs who received in-service training instructing her how to follow Resident A's Behavior Support Plan.

Ms. Martinez admitted over Thanksgiving, from 11/23/24 to 12/1/24, she allowed Resident A to take a LOA with a friend without DCSM supervision. Ms. Martinez indicated she was not sure about Resident A's freedom of movement restriction found in her Behavior Support Plan. Ms. Martinez indicated she thought Resident A could access the community without DCSM supervision if Resident A was with a friend or family member and failed to review Resident A's Behavior Support Plan prior to allowing Resident A to take the LOA. Ms. Martinez stated Resident A had no known issues while unsupervised in the community and administered her medications as prescribed according to Resident A and Friend A1.

Ms. Martinez said she has subsequently spoken with Resident A's case managers, Valerie Story and Amanda Stone, from Integrated Services of Kalamazoo (ISK) and was informed Resident A must follow her titration schedule before gaining community access without DCSM supervision.

Ms. Martinez said Resident A has continued to request community access without DCSM supervision but has not been allowed because of her freedom of movement restriction found in her Behavior Support Plan. Ms. Martinez stated Resident A is upset with DCSMs because of this.

On 1/8/25, I interviewed Resident A. Resident A said she was allowed a LOA over Thanksgiving without DCSM supervision. Resident A stated she cannot remember the date she left or returned to the facility. She said she stayed with Friend A1 while on the LOA. Resident A said she had no issues while on the LOA and administered her medications as prescribed. She stated she does not understand why she is not allowed to take another LOA since everything went well and there were no issues during her last one.

On 1/8/25, I reviewed Resident A's Behavior Support Plan dated 1/3/23. I found under Restrictive Strategies: Freedom of Movement that [Resident A] will have a restriction placed on her community access such that whenever [Resident A] goes into the community, she will be accompanied by a DCSM or authorized personnel. The plan indicated currently authorized personnel can be a DCSM or Resident A's case manager. The plan stated other authorized personal must be determined by [Resident A]'s treatment team.

On 1/8/25, I reviewed an Individual Plan of Service (IPOS) In-Service Form from Integrated Services of Kalamazoo dated 5/23/24. The IPOS In-Service Form had DCSM Heather Martinez's name and signature dated 5/23/24 indicating Ms. Martinez and five additional DCSMs received in-service training instructing them how to follow Resident A's Behavior Support Plan.

I reviewed Resident A's *Assessment Plan for AFC Residents.* Under Moves Independently in the Community, the assessment plan indicated Resident A will reside in a fenced in setting / secure home and will have 1:1 supervision in the community. This is addressed in Resident A's Behavioral Support Plan.

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:	Based on the information gathered during this special investigation through review of documentation and interviews with DCSM Ms. Martinez and Resident A there was sufficient evidence found indicating DCSMs did not follow Resident A's Behavioral Support Plan and *Assessment Plan for AFC Residents.*
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/30/25, I conducted an exit conference / interview with licensee designee Nichole VanNiman via phone. Ms. VanNiman did not dispute the findings or recommendations and agreed to complete a Corrective Action Plan (CAP) within the requested timeframe.

IV. RECOMMENDATION

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

1/30/25

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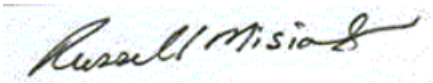
Rodney Gill Date
Licensing Consultant

Approved By:



2/3/25

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Russell B. Misiak Date
Area Manager