GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 28, 2025

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

RE: License #: AS390396198
Investigation #: 2025A1024011
Beacon Home At Augusta

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 was required. On February 26, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390396198
Investigation #:	2025A1024011
Complaint Receipt Date:	01/08/2025
Investigation Initiation Date:	01/10/2025
Report Due Date:	03/09/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At Augusta
Facility Address:	817 Webster St. Augusta, MI 49012
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/29/2018
License **Status:**	REGULAR
Effective Date:	04/03/2023
Expiration Date:	04/02/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 1/1/25 direct care staff member Kenya March left the facility leaving direct care staff member Katrina Burr unable to carry out her staff duties for two residents who both required 1:1 staff supervision.	Yes

III. METHODOLOGY

01/08/2025	Special Investigation Intake 2025A1024011
01/08/2025	APS Referral-not warranted
01/10/2025	Special Investigation Initiated – Telephone with Office of Recipient Rights (ORR) Michele Schiebel
01/14/2025	Contact - Document Received-Resident A's and Resident B's Behavior Treatment Plan (BTP)
01/17/2025	Contact - Telephone call made with direct care member Katrina Burr
01/17/2025	Contact - Telephone call made with direct care staff member Kelly Fox
01/22/2025	Contact - Telephone call made with direct care staff member Tenesha Starling
01/29/2025	Inspection Completed On-site with direct care staff member Rhia Durr
02/18/2025	Contact - Telephone call made with administrator Aubry Napier
02/24/2025	Inspection Completed-BCAL Sub. Compliance
02/24/2025	Exit Conference with licensee designee Nichole VanNiman
02/27/2025	Corrective Action Plan Requested and Due on 02/24/2025
02/26/2025	Corrective Action Plan Received
02/26/2025	Corrective Action Plan Approved

ALLEGATION: On 1/1/25 direct care staff member Kenya March left the facility leaving direct care staff member Katrina Burr unable to carry out her staff duties for two residents who both required 1:1 staff supervision.

INVESTIGATION:

On 1/8/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged on 1/1/25 direct care staff member Kenya March left the facility leaving direct care staff member Katrina Burr unable to carry out her staff duties for two residents who both required 1:1 staff supervision.

On 1/10/2025, I conducted an interview with Office of Recipient Rights Officer (ORR) Michele Schiebel who stated that she is also investigating this allegation, and it was reported to her that there were two residents in the home with one staff member because two staff members had an argument resulting in one of the staff members leaving the facility.

On 1/14/2025, I reviewed Resident A's *Behavior Treatment Plan* (BTP) dated 6/10/24 which stated that Resident A is required to have 1:1 staff supervision at which time the staff should engage in activities of his choice during the awake hours to deter him from having behaviors.

I also reviewed Resident B's BTP dated 11/1/2023 which stated that Resident B is required to have 1:1 staff supervision as monitored by his treatment team and his staff member should stay within 10 feet Resident B and keep Resident B in eyesight. The 1:1 staff person should provide Resident B with access to attention and activities throughout the day.

On 1/17/2025, I conducted an interview with direct care staff member Katrina Burr who stated on 1/1/2025 Kenya March left the facility leaving her with Resident A and Resident B who both require 1:1 staff supervision. Katrina Burr stated she does not know why Kenya March left however when Kenya March returned to the facility after 40 minutes, she continued to argue with her and made rude comments to her. Katrina Burr also stated while she was working alone with the two residents, Resident B started to demonstrate aggressive behaviors which made her uncomfortable as she did not feel equipped to handle these behaviors independently while also tending to Resident A. Katrina Burr stated she called 911 to seek additional assistance after she could not reach the home manager of the facility. Katrina Burr stated she also contacted two other home managers from other facilities owned by the licensee to get assistance and guidance.

On 1/17/2025, I conducted an interview with direct care staff member Kelly Fox who stated that she was contacted on her day off and informed that Katrina Burr was working alone with Resident A and Resident B who both require 1:1 staff supervision. Kelly Fox stated the other scheduled staff member Kenya March was not able to be found. Kelly Fox stated she later found out that Katrina Burr became afraid while

working alone with the two residents due to Resident B demonstrating aggressive behaviors therefore, she called 911 who came out to the home. Kelly Fox stated by the time the police arrived at the home, Kenya March also returned to the facility at which time Katrina Burr and Kenya March became argumentative with each other in front of the police. Kelly Fox stated she arrived at the facility and Aubry Napier asked Kenya March to leave the facility since the two staff members were not able to refrain from arguing with one another. Kelly Fox stated both Resident A and Resident B were calmly sitting on the couch when she arrived and Resident B de-escalated on his own by the time police arrived at facility. Kelly Fox believes Katrina Burr was left alone with Resident A and Resident B who both required 1:1 supervision for about 30 minutes.

On 1/22/2025, I conducted an interview with direct care staff member Tenesha Starling who stated that she is a home manager for another facility owned by the licensee and received a phone call on 1/1/2025 from Katrina Burr stating that she was uncomfortable because she was working alone with two residents who required 1:1 staff supervision and one of these residents were demonstrating aggressive behaviors. Tenesha Starling stated Katrina Burr was calling her because she was not able to get in touch with the home manager of the facility and needed guidance on how to deal with the situation. Tenesha Starling stated while talking on the phone with Katrina Burr, Kenya March along with the police, arrived at the facility as she could hear them talking in the background. Tenesha Starling stated she overheard Kenya March and Katrina Burr both arguing with each other while police were there at which time the phone was disconnected and she never heard back from Katrina Burr.

On 1/29/2025, I conducted an onsite investigation at the facility with direct care staff member Rhia Durr who stated that she works regularly in the facility with Resident A and Resident B and has no knowledge of these two residents being left without proper supervision. It should be noted that Resident A was observed sitting on the couch and was not able to be interviewed due to his cognitive impairment. In addition, Resident B was not interviewed because he was at school however he is also cognitively delayed and unable to be interviewed.

On 2/18/2025, I conducted an interview with administrator Aubry Napier who stated that it was reported to her that Kenya March left the facility and sat in her car leaving Katrina Burr in the facility with Resident A and Resident B who both requires 1:1 staff supervision. Aubry Napier stated Katrina Burr called the police because Resident B started to demonstrate aggressive behaviors but by the time police arrived at the facility Kenya March had already made it back inside the facility. Aubry Napier stated she does not know how long Katrina Burr was left in the facility with the two residents however believes police had to de-escalate the two staff members from arguing with one another when they arrived at the facility. Aubry Napier stated both Katrina Burr and Kenya March no longer work at the facility.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation which included interviews with ORR Officer Michele Schiebel, direct care staff members Katrina Burr, Rhia Durr, Kelly Fox Tenesha Starling, administrator Aubry Napier and review of Resident A's and Resident B's BTP there is evidence to support the allegation on 1/1/25 direct care staff member Kenya March left the facility leaving direct care staff member Katrina Burr to supervise Resident A and Resident B along even though both required 1:1 staff supervision. I reviewed Resident A's and Resident B's BTP which stated that both Resident A and Resident B require enhanced 1:1 staff supervision due to their target behaviors. According to Katrina Burr on 1/1/25, Kenya March left the facility for no apparent reason leaving her alone with Resident A and Resident B for about 40 minutes. Kenya March stated she became uncomfortable as she did not feel equipped to handle resident behaviors therefore Katrina Burr called 911 to seek additional assistance. Kelly Fox and Tenesha Starling also stated they were contacted on 1/1/2025 by Katrina Burr who reported to them that she was working alone with two residents who required enhanced specialized supervision. Consequently, the licensee did not have sufficient direct care staff on duty to provide supervision and protection to the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/24/2025, I conducted an exit conference with licensee designee Nicole VanNiman. I informed Nichole VanNiman of my findings and allowed her an opportunity to ask question and make comments.

On 2/26/2025, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action was received; therefore, I recommend the current license status remain unchanged.

2/27/2025

Ondrea Johnson
Licensing Consultant

Date

Approved By:

02/28/2025

Dawn N. Timm
Area Manager

Date