GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 26, 2025

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

RE: License #: AS390396198
Investigation #: 2025A0581033
Beacon Home At Augusta

Dear 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390396198
Investigation #:	2025A0581033
Complaint Receipt Date:	05/16/2025
Investigation Initiation Date:	05/21/2025
Report Due Date:	07/15/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	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:	04/03/2025
Expiration Date:	04/02/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATIONS

	Violation Established?
The facility's direct care staff have not sought medical treatment for Resident A's significant weight loss, which has been 30% of his body weight in the last 10 months.	No
Direct care staff did not follow Resident A's Medical Nutrition Therapy directives.	Yes

III. METHODOLOGY

05/16/2025	Special Investigation Intake - 2025A0581033
05/20/2025	APS Referral - APS received the allegations. No referral necessary.
05/21/2025	Special Investigation Initiated – Telephone - Interview with APS specialist, Amber Price -Johnson
05/23/2025	Contact - Document Received - Email from Amber Price-Johnson
05/28/2025	Inspection Completed On-site - Interview with staff. Resident A was incarcerated at time of inspection.
06/04/2025	Contact – Document Received – Email from Annalise Murray.
06/24/2025	Contact – Document Sent – Email to Annalise Murray.
06/24/2025	Contact – Telephone call made – Attempted contact with Integrated Services of Kalamazoo case manager, Karon Keri DeLancey.
06/24/2025	Contact – Telephone call made – Attempted contact with Relative A1.
06/24/2025	Contact – Document sent – Email to direct care staff, Kelly Fox.
06/24/2025	Contact – Document Received – Email from Kelly Fox.
06/26/2025	Exit conference with the licensee designee, Nichole VanNiman.

ALLEGATION:

- **The facility's direct care staff have not sought medical treatment for Resident A's significant weight loss, which has been 30% of his body weight in the last 10 months.**

- **Direct care staff did not follow Resident A's Medical Nutrition Therapy directives.**

INVESTIGATION: On 05/16/2025, I received the complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged Resident A unintentionally lost 30% of his total body weight in 10 months and medical conditions were being ruled out. The complaint alleged the facility's direct care staff reported Resident A is eating enough; however, staff did not provide two weeks' worth of food diaries for Resident A's doctor appointment. The complaint alleged Resident A must not be eating enough because in order for him to lose so much weight he would have to be in a calorie deficit. The complaint alleged Resident A's case worker through Integrated Services of Kalamazoo (ISK) was aware of Resident A losing weight, but his case manager was not concerned.

On 05/21/2025, I interviewed Adult Protective Services specialist, Amber Price-Johnson. She stated Resident A visited numerous doctors over the course of his weight loss; therefore, she believed Resident A's physicians were aware of his weight loss. She stated it appeared to her Resident A's various physicians were not coordinating Resident A's care or talking amongst one another. She stated facility staff reported to her Resident A had been on medications in the fall that caused him to be "comatose" and induced vomiting, but once these medications were stopped he became more active and continued losing weight. Amber Price-Johnson stated she did not find any of the facility's direct care staff to be negligent of Resident A's care.

On 05/23/2025, Amber Price-Johnson forwarded me a copy of the licensee's document titled, "Provider Contact Sheet" for Resident A, which documented Resident A was seen on 04/29/2025 by Dr. Bolton for "unintentional weight loss". The provider contact sheet documented the following:

> "[Resident A] has lost 30% of body weight since July 24. 29.5% of body weight since October 24 – this is not intentional. he[*sic*] has lost 16 lbs since April 6 25- 16 lbs in 23 days. Please document [and] log all food [and] caloric drinks pt consumes for the next 2 weeks."

On 05/28/2025, I conducted an unannounced inspection at the facility with ISK Recipient Rights Officer (RRO), Annalise Murray. I interviewed direct care staff, Kelly Fox, who is also identified herself as the facility's home manager. Kelly Fox stated Resident A went through a significant medication change approximately October

2024 whereas he was taken off medications “cold turkey”, including Clozaril and Depakote, at the instruction of his physician and psychiatrist. She stated while he was on these medications he was inactive, sleeping a lot and sick. She stated due to Resident A being taken off these medications so suddenly, he became sick, unable to eat and vomited for approximately one month; however, since the medication changes, Resident A has been more active – often playing sports and being outside – and not sleeping as often.

Kelly Fox stated Resident A did not lose more than 10 pounds in a month except she recalled one month during Fall 2024. She stated Resident A’s doctors were always aware of Resident A’s weight loss because he regularly attended doctor appointments. Kelly Fox stated Resident A’s relative and guardian, Relative A1, attends all Resident A’s doctor appointments. She stated staff complete a Provider Contact Sheet prior to Resident A’s doctor appointments, give it to Relative A1 for Resident A’s physician to complete and then Relative A1 returns the Provider Contact Sheet to the facility. Kelly Fox stated she and staff informed Relative A1 of Resident A’s weight loss, but it was Relative A1’s responsibility to contact and report this information to Resident A’s physician. She stated Relative A1 coordinates and relays all information between the facility’s staff and Resident A’s physicians. Kelly Fox stated Resident A attended multiple doctor appointments since Fall 2024 and completed testing in order to determine the cause of his weight loss; however, a specific cause was not determined.

Kelly Fox provided 11 Provider Contact Sheets documenting Resident A’s medical appointments since October 2024, which included the following dates and reasons for these appointments:

10/24 – vomiting for five days in a row since being take off Depakote
10/25 – recurring nausea and suspected medication issues
10/31 – sleep study results
11/06 – medication review
11/27 – outpatient EEG
02/13 – Fluoro study
03/05 – NM gastric emptying
03/26 – med review
04/28 – Early satiety and Abdominal pain
04/29 – unintentional weight loss
05/15 – weight loss

According to my review of these Provider Contact Sheets, weight loss was not specified as a reason for any of the physician appointments until 04/29 when Resident A was seen by his primary care physician, Dr. Katherine Bolton.

I reviewed Resident A’s *Resident Weight Record*, which documented Resident A’s weight in pounds since July 2024 and included the corresponding comments:

Date	Weight	Comments
07/2024	262.5	2.5 pound decrease
08/2024	262	
09/2025	265	
10/2025	257	
11/2025	241	15 pound decrease
12/2025	235	6 pound decrease
01/2025	215	20 pound decrease
02/2025	210	5 pound decrease
03/2025	205	5 pound decrease
04/2025	196	9 pound decrease
05/2025	194.7	2 pound decrease

I reviewed Resident A's *Health Care Appraisal* (HCA), dated 06/27/2024, completed by Katherine Bolton, DO. The HCA documented Resident A as 5'7", weighing 262 pounds with an ideal weight of 180 pounds. The HCA documented "see attached medical nutrition therapy plan of care" under the HCA's section of "Special Dietary Instructions and Recommended Caloric Intake".

I reviewed the licensee's document titled "Diet Order" for Resident A, dated 06/27/2024, which was signed by Resident A's physician albeit the signature was illegible. The diet order documented Resident A's diet as "2000 or 2200 calories/day" with the instruction of "please see medical nutrition therapy attached".

Attached to the diet order was a document titled "Medical Nutrition Therapy" created by a registered dietician (RD) through Bronson Outpatient Nutrition Services. According to the diet order, RD received a message from Relative A1 regarding Resident A's nutrition plan reporting the facility needed more specific meal plan recommendations before the facility could make any dietary changes. The nutrition interventions were identified as "Recommend weighing patient once weekly – please contact RD if patient is losing >2 lb per week" and "Informed [Relative A1] of my upcoming resignation and provided her with alternative contact information for scheduling nutrition follows[*sic*] up or to ask questions as needed". Included in this document were food group items and the daily amount of food from each group (e.g. vegetables, fruits, protein, dairy, legumes, etc.) Resident A would need each day to meet his caloric intake of either 2000 or 2200 calories.

I reviewed the licensee's document titled, "Consumption Monitoring Chart" for Resident A from 05/01 – 05/16, which documented Resident A consumed 100% of his breakfast, lunch, dinner and snack except when it was documented Resident A was on a Leave of Absence (LOA) from the facility.

I reviewed the facility's menus from 05/05-05/16, which identified a 2200 calorie diet was provided to Resident A. The items on the menu corresponded to a nutritious and balanced diet and included portion sizes to ensure Resident A was receiving the correct calories.

I did not interview or observe Resident A during the inspection as he was incarcerated.

I reviewed Resident A's ISK's Annual Assessment plan, dated 07/27/2024, which documented Resident A gaining significant weight and there being concern for his weight gain in the last several years. The assessment plan did not identify any concerns or issues with Resident A losing weight.

On 06/04/2025, Annalise Murray emailed a copy of ISK's progress note for Resident A, dated 04/29/2025, which documented Resident A's ISK case manager, Karon Keri DeLancey, attended Resident A's primary care physician (PCP) appointment with Resident A and Relative A1. According to the progress note, Resident A's PCP, Dr. Bolton, was very concerned with Resident A's weight loss and reported she thought Resident A had cancer. Karon Keri DeLancey documented in her progress note that she asked Dr. Bolton if there was "…anything in the results of [Resident A's] recent blood tests, CT scan and gastric emptying study that would indicate [Resident A] has cancer and she reported that there was not, but she seemed to take offense to [her] question". Karon Keri DeLancey documented Dr. Bolton ordered Resident A another CT scan and requested the facility to log Resident A's calorie intake and daily activity. Additionally, Karon Keri DeLancey documented she discussed with Relative A1 that Resident A's test results had been normal, he was eating and feeling energetic.

Annalise Murray also forwarded a copy of ISK's Medical Note, dated 04/30/2025, which was completed by Resident A's psychiatrist, Jennifer Richardson. According to this note, Jennifer Richardson documented Resident A's PCP had concerns for Resident A's weight loss. Jennifer Richardson documented "….that a portion/unknown percentage, of weight loss, could be related to change in medication/dietary changes/increasing activity level and decrease in side effects". Jennifer Richardson documented Karon Keri DeLancey reported Resident A had contact with a gastroenterologist and medical testing completed.

On 06/24/2025, Kelly Fox forwarded additional documentation related to Resident A. She forwarded emails, Nextstep electronic charting notes, and discharge paperwork confirming Resident A's medication changes, decrease in appetite, and vomiting in Fall 2024. She forwarded two Provider Contact Sheets, dated 06/16 and 06/20, confirming Resident A was seen by a physician for weight loss and a scheduled CT scan, respectively.

Kelly Fox also provided two *AFC Licensing Division – Incident / Accident Reports* (IR). The IR, dated 11/04/2024, documented Resident A was not feeling well and weighed 241 pounds, which was 15 pounds less than the previous month. The IR documented staff reported the weight loss to the facility's manager and the licensee's nurse. The corrective measure was to continue monitoring Resident A for "health and safety". The IR, dated 01/02/2025, documented Resident A was taken to

the Emergency Room (ER) for not feeling well and vomiting. The IR documented Resident A had lost 20 pounds since the previous month and he was awaiting an appointment with Bronson's Gastroenterology. The corrective measure was to continue monitoring Resident A's health and safety, cooperate with the doctors and follow their recommendations. Both IRs documented Resident A's ISK case manager and Relative A1 were both notified of the incidences.

Kelly Fox also forwarded Resident A's updated HCA, dated 06/20/2025, which documented Resident A as 5'6" and weighing 186 pounds. The HCA documented Resident A was on a "Regular 2400 Cal" diet.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Resident A's *Health Care Appraisal*, dated 06/27/2024, included a diet order and Medical Nutrition Therapy instructions from a registered dietician, which were all approved by Resident A's physician. The Medical Nutrition Therapy document recommended Resident A be weighed weekly along with the instructions to contact the registered dietician if Resident A lost more than two pounds per week. The facility's staff were unable to provide any documentation they were weighing Resident A weekly or contacted his physician or registered dietician when his weight loss was more than two pounds per week. Resident A's monthly weight chart confirmed he lost more than two pounds per week in 11/2024, 01/2025, and 03/2025, when it was documented he lost 20,15, and 9 pounds, respectively. Consequently, the facility's direct care staff did not follow Resident A's Medical Nutrition Therapy recommendations by contacting his registered dietician upon determining Resident A lost more than two pounds in 11/2024, 01/2025 and 03/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on my investigation, Resident A is a an approximately 5'6" or 5'7" tall male whose ideal weight is 180 pounds based on his 06/27/2024 *Health Care Appraisal*, which was completed by his primary care physician. Though Resident A lost approximately 76 pounds during a 10 month timeframe the weight loss resulted in him being near his ideal weight, as documented by his primary care physician. Additionally, throughout the 10 month time frame Resident A was seen by multiple medical professionals and physicians and received testing to determine the reason for his weight loss. Subsequently, the licensee sought medical treatment for Resident A's weight loss.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 06/26/2025, I conducted the exit conference with Nichole VanNiman, via telephone, whereas I informed her of my findings.

IV. RECOMMENDATION

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

Cathy Cushman

06/25/2025

Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm 06/26/2025

Dawn N. Timm Date
Area Manager