GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 2, 2025

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

RE: License #: AM110413530
Investigation #: 2025A0790043
Beacon Home at Eau Claire

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.

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) 356-0100.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
gillr@michigan.gov
(517)980-1433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM110413530
Investigation #:	2025A0790043
Complaint Receipt Date:	08/14/2025
Investigation Initiation Date:	08/20/2025
Report Due Date:	10/13/2025
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 Eau Claire
Facility Address:	7014 Clawson Rd. Eau Claire, MI 49111
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/10/2022
License Status:	REGULAR
Effective Date:	02/10/2025
Expiration Date:	02/09/2027
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff members did not administer medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/14/2025	Special Investigation Intake 2025A0790043
08/15/2025	APS Referral is not necessary because the allegation does not meet assignment criteria for Adult Protective Services (APS). The allegation involves an alleged licensing rule violation and not abuse or neglect.
08/19/2025	Contact - Telephone call made I called the Complainant and left a voicemail message requesting a return call.
08/20/2025	Special Investigation Initiated - Telephone I interviewed the Complainant to ensure the allegations were accurate and comprehensive.
08/20/2025	Contact - Telephone call received I interviewed recipient rights officer Suzie Suchyta.
08/28/2025	Inspection Completed On-site I observed and spoke to Resident A. I interviewed direct care staff member Carin Caldwell who functions as the care team manager.
08/28/2025	Contact - Telephone call received I interviewed Heartland program director Kimberly McCarthy via phone.
09/02/2025	Inspection Completed-BCAL Sub. Non-Compliance

09/02/2025	Exit Conference / interview with licensee designee Nichole VanNiman.
09/02/2025	Corrective Action Plan Requested and Due on 09/17/2025

ALLEGATION:

Direct care staff members did not administer medication as prescribed.

INVESTIGATION:

On 8/15/25, I reviewed a Michigan Department of Licensing and Regulatory Affairs – Bureau of Community and Health Systems Complaint Form dated 8/14/25. The complaint indicated that on 8/8/25, Resident A's blood sugar was high and required insulin. An *AFC Licensing Division – Incident / Accident Report* documented that Resident A did not receive any insulin because there was none at the facility. The report was reviewed by a medical consultant who determined that Resident A was at risk of physical harm because he did not receive his prescribed insulin. When the incident was reviewed, it was discovered that the wrong medication was listed on Resident A's *Medication Administration Record (MAR).* The *MAR* was not updated. Humalog was not prescribed. Novolog was delivered but was not on Resident A's *MAR.*

On 8/20/25, I interviewed the Complainant via phone. I confirmed the allegations to be accurate and comprehensive.

On 8/20/25, I interviewed recipient rights officer Suzie Suchyta via phone. Ms. Suchyta stated she is currently investigating the allegation that direct care staff members (DCSMs) did not administer medication as prescribed. She said she is specifically investigating Resident A not receiving his prescribed medication Humalog on 8/8/25 after it was discovered his blood sugar was high at 182. Ms. Suchyta stated it appears Resident A did not receive his blood sugar medication as it appears he was prescribed NovoLog for high blood sugar diabetic coma and at the time there was no NovoLog available for Resident A at the facility.

Ms. Suchyta stated Resident A suffers from memory loss and is diagnosed with Alzheimer's disease and/or severe dementia. Ms. Suchyta stated Resident A is not mentally competent. Resident A is unable to process information, reason logically, and communicate effectively. Ms. Suchyta stated Resident A will not be able to provide information regarding what medications he was administered on 8/8/25

because of his severe memory loss. Ms. Suchyta indicated Resident A wanders and previously lived in a locked facility for his protection.

Ms. Suchyta stated she interviewed DCSM Shanida Johnson who functions as a lead staff member. Ms. Suchyta stated Ms. Johnson helps with training other DCSMs and works directly with the residents. She said Ms. Johnson indicated it is no longer her responsibility to order the residents' medications, keep track of their medication, or count medication. Ms. Johnson stated it is currently the responsibility of DCSM Carin Caldwell who functions as the care team manager.

Ms. Suchyta stated she reviewed the facility's job descriptions and confirmed that it is the care team manager's responsibility to order the residents' medications, keep track of their medication, and count medication.

Ms. Suchyta stated she interviewed DCSM Carin Caldwell who functions as the care team manager. She said Ms. Caldwell denied it currently being her responsibility to order the residents' medications, keep track of their medication, and count medication.

Ms. Suchyta stated she was informed by a medical consultant that if a resident does not receive their prescribed insulin as ordered when their blood sugar is found to be high, the resident could be at risk of suffering kidney disease / failure, damage to their eyes, and/or diabetic coma. She said the medical consultant stated diabetic coma is a life-threatening disorder.

Ms. Suchyta explained it appears Resident A's Humalog prescription may have been discontinued on 7/15/25 because of insurance issues and a new prescription of NovoLog ordered. Ms. Suchyta said it appears DCSMs continued to give Resident A Humalog until it ran out because the new prescription for NovoLog was not present at the facility. Ms. Suchyta stated she was unable to locate a discontinue note for Humalog or a new prescription for NovoLog at the facility. She said she did receive the prescription to discontinue the Humalog and the new prescription for NovoLog for Resident A from the pharmacy.

I conducted an unannounced onsite investigation on 8/28/25. I observed Resident A sitting on the couch watching television and I spoke to him. Resident A appeared calm, content, well kempt, and wearing clean and appropriate clothing. I was unable to interview Resident A because he is unable to process information, reason logically, or communicate effectively because of significant cognitive decline the result of Alzheimer's disease and/or severe dementia.

On 8/8/25, I interviewed DCSM Carin Caldwell who functions as the home manager. Ms. Caldwell admitted that on 8/8/25, Resident A did not receive his prescribed antidiabetic drug after a DCSM administered a blood sugar test and found Resident A's blood sugar elevated at 182. Ms. Caldwell admitted the prescribed antidiabetic drug was not administered because the medication was not available in the facility at

the time.

Ms. Caldwell stated she and Heartland program director Kimberly McCarthy facility have been investigating why the medication was not available at the time. Ms. Caldwell said they have not been able to definitively determine why the incident occurred.

Ms. Caldwell stated she recently accepted the position of care team manager and is not fully trained. She said DCSM Shanida Johnson who functions as a lead staff member had been responsible for ordering, keeping track of, and counting the residents' medications. Ms. Caldwell stated they have not been able to determine if Ms. Johnson did not request the antidiabetic drug from the pharmacy, Resident A's Primary Care Physician (PCP) did not send the new prescription to the pharmacy, or if the pharmacy did not deliver the medication timely.

Ms. Caldwell informed me that Ms. Johnson is currently on leave of absence (LOA).

Ms. Caldwell stated that going forward it will be her responsibility to order, keep track of, and count the residents' medications.

On 8/28/25, I interviewed Heartland program director Kimberly McCarthy via phone. Ms. McCarthy corroborated the information provided by Ms. Caldwell. She informed me that Ms. Johnson is currently on LOA.

Ms. McCarthy stated Resident A did not receive his prescribed antidiabetic drug on 8/8/25 after a DCSM administered a blood sugar test and found Resident A's blood sugar elevated at 182. Ms. Caldwell admitted the prescribed antidiabetic drug was not administered because the medication was not available in the facility at the time. Ms. McCarthy said they have not been able to definitively determine why the incident occurred.

Ms. McCarthy said they have not been able to definitively determine why the incident occurred. Ms. McCarthy stated Ms. Caldwell recently accepted the position of care team manager and is not fully trained.

Ms. McCarthy said DCSM Shanida Johnson who functions as a lead staff member had been responsible for ordering, keeping track of, and counting the residents' medications. Ms. McCarthy stated they have not been able to determine if Ms. Johnson did not request the antidiabetic drug from the pharmacy, Resident A's Primary Care Physician (PCP) did not send the new prescription to the pharmacy, or if the pharmacy did not deliver the medication timely.

Ms. McCarthy confirmed that Ms. Johnson is currently out on LOA.

Ms. McCarthy indicated that going forward it will be her, and Ms. Caldwell's responsibility to order, keep track of, and count the residents' medications.

On 9/2/25, I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 8/8/25. I found the following information: Staff administered a blood sugar test for Resident A. The test read 182 for Resident A's blood sugar which meant Resident A required insulin. Staff had insulin in stock, but it was not registered for Resident A. Staff are not allowed to administer medication to a resident if the medication is not prescribed to that specific resident. Therefore, staff was not able to administer the insulin in stock to Resident A.

The report indicated staff attempted to contact the head nurse, but they did not respond to emails or texts. Staff then called the head nurse multiple times and tried to contact the pharmacy as well to put the insulin available in Resident A's medication plan. The report indicated staff continued to monitor Resident A to make sure, he is okay and is reactive to contact medical emergency if it becomes serious.

The report indicated that staff can only tell management to correct the technical errors and contact the pharmacy to get available nurse to respond when contacted to assist when these issues occur, specifically when staff are not able to provide insulin in a way that is not against the facility's policy and procedure and/or illegal for the staff to administer the insulin.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on the information gathered during this special investigation through personal observation, review of documentation, and interviews with the Complainant, Ms. Suchyta, Ms. Caldwell, and Ms. McCarthy there was sufficient evidence found indicating that direct care staff members did not administer medication as prescribed. Specifically, Resident A did not receive his prescribed diabetic drug on 8/8/25.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 9/2/25, I reviewed several *AFC Licensing Division – Incident / Accident Reports* dated 8/11/25, 8/22/25, and 8/27/25. I found that DCSMs did not contact the appropriate health care professional when Resident A refused to take his prescribed medication(s).

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation there was sufficient evidence found indicating that DCSMs did not contact the appropriate health care professional when Resident A refused to take his prescribed medication(s) on 8/11/25, 8/22/25, and 8/27/25.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/2/25, I conducted an exit conference / interview with licensee designee Nichole VanNiman via phone. Ms. VanNiman had no information to add to this special investigation. Ms. VanNiman did not dispute the findings or recommendations and agreed to complete a Corrective Action Plan (CAP) within the requested timeframe.

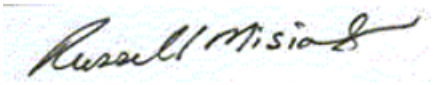
IV. RECOMMENDATION

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

9/2/25

Rodney Gill Date
Licensing Consultant

Approved By:



9/2/25

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Russell B. Misiak Date
Area Manager