



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 2, 2025

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

RE: License #: AS390396198
Investigation #: 2025A0581043
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,

A handwritten signature in black ink that reads "Cathy Cushman". The signature is written in a cursive, flowing style.

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 #:	2025A0581043
Complaint Receipt Date:	08/14/2025
Investigation Initiation Date:	08/15/2025
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:	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. ALLEGATION

	Violation Established?
Resident A did not receive approximately three doses of his required seizure medication in August 2025.	Yes

III. METHODOLOGY

08/14/2025	Special Investigation Intake - 2025A0581043
08/15/2025	Referral - Recipient Rights - ISK received and are investigating.
08/15/2025	APS Referral - No referral necessary. No abuse or neglect. Resident currently has medication. Did not suffer any side effects of not receiving medication.
08/15/2025	Special Investigation Initiated – Telephone - Interview with ISK ORR, Suzie Suchyta
08/15/2025	Contact - Document Received - Received Incident Report from rights and contacts.
08/21/2025	Contact - Telephone call made - Interview with Suzie Suchyta, ISK Rights Officer, and the facility's interim home manager, Erin Gudakunst
08/21/2025	Contact - Document Received - Email from Suzie Suchyta requesting documentation from Erin.
08/22/2025	Inspection Completed On-site - Interview with staff and observed resident.
09/22/2025	Inspection Completed-BCAL Sub. Compliance
09/22/2025	Contact – Document Sent – Email to Suzie Suchyta.
09/22/2025	Contact – Document Received – Email from Suzie Suchyta.
09/24/2025	Contact – Document Sent – Email to Administrator, Aubry Napier.
09/25/2025	Contact – Document Received – Email from Aubry Napier.
10/01/2025	Exit conference with the licensee designee, Nichole VanNiman.
10/01/2025	Contact – Telephone call made – Aubry Napier.

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ALLEGATION: Resident A did not receive approximately three doses of his required seizure medication in August 2025.

INVESTIGATION: On 08/14/2025, I received this complaint through the Bureau of Community Health Systems (BCHS) on-line complaint system. The complaint alleged on or around 08/08/2025, the facility's direct care staff could not administer approximately three doses of Resident A's seizure medication because the facility did not have enough of the medication. The complaint alleged a refill request was not submitted to the pharmacy in time to prevent the medication from running out.

On 08/15/2025, I confirmed with Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Suzie Suchyta, that she also received the allegations and was investigating. Suzie Suchyta stated she interviewed direct care staff and the facility's identified "Care Team Manager", Erin Gudakunst, on 08/11/2025 because the facility's assigned home manager, Kelly Fox, was on an extended leave of absence. Suzie Suchyta stated Erin Gudakunst reported to her Resident A's seizure medication did not get refilled because staff did not report to her the medication was out until Friday after 5 pm and the pharmacy was already closed. Erin Gudakunst reported to Suzie Suchyta that she did not realize the pharmacy had a 24 hour hotline that she could have called to request an immediate refill. Suzie Suchyta stated she also communicated with Aubry Napier, the facility's Administrator, who confirmed Erin Gudakunst would have been the person responsible for ordering Resident A's refill of the medication. Suzie Suchyta stated Resident A currently had the medication in the facility.

Suzie Suchyta forwarded me her notes from her interview with Erin Gudakunst. According to my review of her notes, Erin Gudakunst reported to Suzie Suchyta that she emailed the pharmacy, Kalamazoo Long Term Care (KLTC), that Friday, which would have been 08/08/2025, but she did not receive a response from them because they were closed. Erin Gudakunst reported to Suzie Suchyta that she emailed KLTC again on Monday and the medication was delivered that morning. Suzie Suchyta stated Erin Gudakunst reported to her that Resident A missed doses of his seizure medication the evening of 08/09 and both the morning and evening of 08/10.

Suzie Suchyta documented she interviewed ISK's physician who reported to her a "Precipitous withdrawal of an antiseizure medication can result in an onset of a seizure episode."

Suzie Suchyta forwarded me the *AFC Licensing Division – Incident / Accident Report (IR)* for Resident A pertaining to staff not administering his medication. According to my review of the IR, which was completed on 08/10/2025 by direct care staff, Roderick Sheerin, Resident A did not receive his 8 pm Lacosamide 100 mg

tablet on 08/10 because it was not in the facility. The IR documented the facility's home manager "...reportedly previously contacted the pharmacy multiple times for an order and the home is currently awaiting delivery." The IR documented, "Staff wrote a report, completed all necessary documentation and contacted management." Additionally, the IR documented staff would continue monitoring Resident A for health and safety and inform the facility's home manager when medications are "...down to 10 pills so that Manager can reorder".

On 08/21/2025, in conjunction with Suzie Suchyta, we interviewed Erin Gudakunst via MiTeams. Erin Gudakunst's statement to us was consistent with her interview with Suzie Suchyta. She identified Resident A's missed medication as Lacosamide, which she identified as a seizure medication. Erin Gudakunst stated resident medications are counted every Monday. She stated medication counts are sent to her "boss" who she identified as Devonte Taylor, one of the licensee's nurses, and the pharmacy. She stated she expected one of these individuals to contact the pharmacy about the medication getting low.

Erin Gudakunst stated she instructed her staff to contact her if any of the medications were down to only three or four tablets or pills remaining. Erin Gudakunst stated staff contacted her at approximately 5:30 pm on 08/09 informing her Resident A's medication was low and needed to be refilled. She stated she attempted to contact the pharmacy; however, they were already closed for the night. Erin Gudakunst stated she was not aware of the pharmacy's after hours emergency number until Monday morning. Erin Gudakunst stated she believed Resident A received his last dose of Lacosamide medication the morning of 08/09. She stated the pharmacy delivered the Lacosamide medication on Monday morning (08/11) at approximately 9 am.

Erin Gudakunst stated Resident A did not experience any seizures at any time between 08/09 and 08/11. She also stated he did not display or demonstrate any concerning or troubling behaviors during that time.

Erin Gudakunst stated she has requested staff now contact her via telephone to report if a resident's medication has a 10 day supply left.

On 08/22/2025, I conducted an unannounced inspection. I attempted to interview Resident A; however, due to his cognitive impairments and developmental delays I was unable.

I interviewed direct care staff, Allison Haines, who stated she has worked in the facility for approximately two years. She stated she is not aware of Resident A experiencing any seizures since working in the facility. Allison Haines stated staff do not track Resident A's seizures because Resident A has not had any seizures in two years.

I reviewed the “New Prescription Summary” for Resident A’s missed medication. According to this prescription, Resident A was prescribed Lacosamide 100 mg tablets with the instruction of “Take 1 tablet (100 mg total) by mouth 2 (two) times daily” with an effective date of 04/23/2025. The diagnosis code on the prescription was identified at “R569 – (ICD-10)” which corresponds to “Unspecified convulsions”.

I also reviewed the licensee’s document titled “Daily Controlled Medication Chart” for Resident A’s Lacosamide medication. According to my review of this document, Resident A was administered his last Lacosamide tablet the evening of 08/09/2025 at 8 pm. The daily controlled medication chart documented Resident A was not administered the Lacosamide the morning of 08/10 or the evening of 08/10, as required. The medication chart documented Resident A was administered the Lacosamide the evening of 08/11 at 8 pm.

Despite requesting Resident A’s August Medication Administration Record (MAR) from the licensee, I received and reviewed the licensee’s document titled “Med Pass History for [Resident A]” dated 08/01/2025 through 08/31/2025. According to this medication pass history, Resident A was not administered his Lacosamide Tab 100 mg the morning of 08/10, the evening of 08/10 or the morning of 08/11 because it was not available or in the facility.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation, Resident A did not receive his Lacosamide 100 mg tablet the morning of 08/10, the evening of 08/10 or the morning of 08/11, which is twice a day, as prescribed, because the medication was not in the facility.
CONCLUSION:	VIOLATION ESTABLISHED

On 10/01/2025, I attempted to conduct an exit conference with the licensee designee, Nichole VanNiman; however, after not being able to reach her I contacted the Administrator, Aubry Napier. Aubry Napier acknowledged the findings. She stated she planned an upcoming manager’s meeting where she would stress the importance of communicating to management and facility staff when help is needed with ordering medication refills.

