GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 17, 2021

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

RE: License #: AS130405804
Investigation #: 2022A0462007
Beacon Home At Battle Creek

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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Michele Streeter, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-9037

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS130405804
Investigation #:	2022A0462007
Complaint Receipt Date:	10/28/2021
Investigation Initiation Date:	10/29/2021
Report Due Date:	12/27/2021
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 Battle Creek
Facility Address:	5555 Bauman Rd. Battle Creek, MI 49017
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	01/08/2021
License Status:	REGULAR
Effective Date:	07/08/2021
Expiration Date:	07/07/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Facility staff members are selling drugs from the facility.	No
Additional findings.	Yes

III. METHODOLOGY

10/28/2021	Special Investigation Intake 2022A0462007
10/29/2021	Special Investigation Initiated – Email to Calhoun County Recipient Rights Advisor Tara McKerran.
11/03/2021	Unannounced investigation onsite. Face-to-face interviews with home manager Diante Taylor, Residents A, B, and C, and DCWs Brittany Robinson and Catharine Miller. Contact- Requested and received documentation.
11/04/2021	Contact- Received documentation.
12/16/2021	Contact- Requested documentation. Exit conference with licensee designee Nichole VanNiman, via telephone.

ALLEGATION: Facility staff members are selling drugs from the facility.

INVESTIGATION: On 10/28 the Calhoun County Office of Recipient Rights (CCORR) forwarded this allegation, via a written complaint, to the Bureau of Community and Health Systems (BCHS).

On 10/29, via email, I informed Calhoun County Recipient Rights Advisor Tara McKerran I was assigned to investigation this allegation.

On 11/03 I conducted an unannounced investigation at the facility and interviewed Resident A, who denied the allegation. Resident A stated, “I was hoping you’d come so I could clear things up.” Resident A expressed his frustration with the CCORR. Resident A stated staff members at the CCORR “reversed what I reported because they want to get staff in trouble.” According to Resident A, on 10/26 he called the CCORR to report Resident B was smoking marijuana in the facility. According to Resident A, he believed Resident B obtained marijuana from his family members

and/or friends. Resident A stated that when facility staff members were able to catch Resident B using marijuana in the facility, they did address it. However, Resident B continued to obtain marijuana and bring it into the facility without facility staff members' knowledge. Resident A reiterated that no facility staff members were selling drugs from the facility.

I conducted separate face-to-face interviews with direct care staff member Diante Taylor whose role is home manager and facility staff members Brittany Robinson and Catherine Miller, who all denied the allegation and confirmed Resident A's statements.

Mr. Taylor stated Resident B moved into the facility approximately 3 months ago and had a history of similar behavior in his previous AFC home. According to Mr. Taylor, he expressed his concerns to Resident B on a few occasions and at one point, Resident B gave Mr. Taylor his cannabis vape pens to dispose of and reported no longer wanting to use marijuana. According to Mr. Taylor, even though Resident B was supervised by facility staff members while in the community, it was suspected Resident B's family members and/or friends were still somehow providing Resident B with the drugs. Mr. Taylor stated facility staff members believed Resident B was receiving the drug via personal mail delivered to him at the facility. Mr. Taylor stated that while facility staff members suspected Resident B was using marijuana due to his behaviors, "catching" Resident B using it in the facility was sometimes challenging. Mr. Taylor stated that when marijuana was smoked via a vape pen, facility staff members could not smell it. According to Mr. Taylor, although facility staff members could conduct room searches, as well as searches of Resident B's personal belongings, they were not allowed to conduct a physical search of Resident B to determine if he had marijuana on him.

Ms. Robinson and Ms. Miller's statements were consistent the statements Mr. Taylor provided to me.

I conducted separate face-to-face interviews with Residents B and C. Resident B denied having any knowledge about facility staff members selling drugs from the facility. Resident B had a difficult time conducting an interview, as evidenced by his erratic patterns of thought, and switching from one topic to another in mid-sentence. Initially, Resident B was very friendly. However, when questioned about his marijuana use, Resident B became agitated and defensive. Resident B stated, "we are not little kids." Resident B initially reported that while he occasionally used marijuana, he never used it while at the facility. Resident B then stated that when he first moved in, he found a "joint" and smoked it in the facility. According to Resident B, Mr. Taylor found out and informed Resident B he was not allowed to use marijuana in the facility. Subsequently, Resident B stated he never used the drug in the facility following that incident.

Resident C also denied having any knowledge of facility staff members selling drugs from the facility. Resident C confirmed Resident B somehow obtained marijuana

without facility staff members' knowledge and smoked it while in the facility. According to Resident C, on a few occasions Resident B offered him marijuana and he voluntarily smoked it as well, via a vape pen. Resident C stated that at the time, facility staff members were unaware this occurred. According to Resident C, due to an adverse reaction to smoking marijuana provided to him by Resident B approximately one month ago, he hadn't used it since.

I reviewed a copy of the facility's Use of Alcohol and Drugs Policy, which read;

"Policy: The organization shall not allow possession of illegal drugs, prescription drugs not prescribed to the individual or alcohol on its premises.

Procedure:
1. The Organization does not allow the use or possession of alcohol, illegal drugs, or medications not prescribed to the individual possessing them on its premises. This includes any illegal or controlled drug or other substance which 1) is not legally obtainable, or 2) which is legally obtainable but has not been legally obtained. The term includes prescription drugs which have not been properly prescribed by a licensed physician or are not being used for prescribed purposes or in a prescribed manner. It also includes marijuana, even if the individual has a valid medical marijuana registry card.
2. The Organization reserves the right to refer any individual for evaluation/testing if the use of alcohol, illegal drugs, or medications not prescribed to the individual is suspected.
3. Individuals over the age of 21 are allowed to consume alcohol during community inclusion activities if they may do so in moderate and safe amounts that do not interfere with use of their psychotropic medications. Should an individual not be able to consume alcohol at this level, a behavior plan will be sought to address the behavior so that individual may safety take prescribed medications without fear of cross-sensitivity or interaction with prescribed medications.
4. The use of alcohol, illegal drugs, or medications not prescribed to the individual may be grounds for discharge and/or termination."

I reviewed a copy of Resident B's *Assessment Plan for AFC Residents* (assessment plan), Community Mental Health (CMH) Behavioral Assessment (BA), and CMH Personal Care Plan (PCP). Documentation on Resident B's assessment plan confirmed Resident B was to be supervised while in the community.

According to documentation on Resident B's BA, which was updated on 07/06/2021, Resident B had a history of frequent heroin, fentanyl, and other illicit substance use. Documentation on Resident B's BA confirmed that while in his previous AFC home, Resident B frequently attempted to obtain illicit substances and was found to be in the possession of marijuana, as well as other substances, on multiple occasions. Resident B's BA indicated Resident B received daily methadone treatment. It was suspected Resident B may have obtained substances when visiting the Methadone clinic, as COVID-19 restrictions did not allow for a facility staff members to

accompany him inside of the clinic. According to Resident B's BA, while in his previous AFC home, Resident B began to share substances with other residents in the home, which further compromised their health and well-being. Documentation on Resident B's BA confirmed that on 7/6/2021, due to frequent incidents where Resident B obtained marijuana, and at times used it in the home, his previous AFC home was no longer able to maintain his placement. Subsequently, Resident B was referred to a more secure setting. According to Resident B's BA, should facility staff members identify any illicit substances (alcohol, marijuana, or other drugs) during searches of Resident B's bedroom or personal belongings, they were to remove the items from his access and store them in a safe, secure location until able to be properly disposed of those drugs.

Documentation on Resident B's PCP, which was created on 09/16/2021, indicated Resident B was to stay drug and alcohol free, including marijuana. Facility staff members were to document any time Resident B was in procession of marijuana and refused to "turn it over" to facility staff members.

I reviewed the facility's electronic case notes for Resident B for the months of July 2021 to present.

A case note written by facility staff member Kaylee Daly on 08/04 read;

"[Resident B] brought up to staff today that, "The backyard should be cement because it would make it easier to get over the fence,". On the way to take [Resident B] to the store he asked Staff, "How far away is Kalamazoo?", "How long would it take to get to Kalamazoo?", he also stated that he wanted to know where the house was in relation to Kalamazoo. [Resident B] has been observed by staff speaking in slurred and incoherent rambling speech patterns throughout the day. [Resident B] has been unable to answer direct yes or no questions without losing focus or nodding off. [Resident B] was observed by staff nodding off during mealtime and spilling his food. Later in the evening after dinner Staff saw [Resident B] digging through the trash. Upon being asked what he was looking for he replied, "I'm looking for the ball," Staff then inquired, "What little ball?" [Resident B] lifted his hand and made a small circle with his thumb and pointer finger and replied, "The little ball like this my friend sent me in the mail." Staff then inquired if [Resident B] would elaborate and he replied, "It's fine, it's okay, I'll be fine,".

A case note written by Ms. Daly on 09/02 read;

"The phone was ringing and while Staff was on the way to ask the last resident who'd had it if they still had the phone; Staff overheard [Resident B] in another resident's room saying to another resident, "I lost my THC pen but I can't act pissed. I am not really that pissed though because [resident] is on his way to get one right now. You should get one too [resident]. I don't know who has my weed pen but I am going to find it. You should get one too [resident], they [the thc vape] are only

twenty-one ninety-nine." [Resident B] and the resident he was talking to stopped talking when they heard Staff knock on the resident's door who'd had the phone."

A case note written by Ms. Robinson on 09/14 read;

"Around noon, [Resident B] asked for staff to help open his package he had received in the mail. When staff opened the package, they had come to find a vape pen. Staff could not take the pen away from [Resident B] due to him not offering to give the pen up."

A case note written by facility staff member Tiffany Ablin on 09/16 read;

"Staff went to prompt residents for 2pm medications. Staff walked outside and walked around to the side of the backyard where [Resident B] and another resident was. [Resident B] was sitting on the wooden part in the side yard when staff prompted [Resident B] to come take 2pm medications. Staff noticed a THC pen in [Resident B's] hand. [Resident B] quickly tried to hide the pen but staff had already seen it. This all happened after [Resident B] handed home manager a bunch of empty cartridges and a couple other thc pens."

A case note written by Ms. Daly on 10/01 read;

"While still in the van outside [Resident B's] methadone clinic, [Resident B] asked Staff, "Would you have to follow me if I ran over to the [marijuana] dispensary next to this place? You wouldn't be able to stop me, right? Because you guys can't tell us what we can and can't buy, like, you can't walk up to the clerk and say 'you can't sell that to my resident,' right?" Staff informed [Resident B] that Staff could not follow him into a [marijuana] dispensary but Staff would need to immediately call the home manager and further actions will be taken from there. [Resident B] then stated, "Oh, it's not worth it then, right?" Staff replied, "I would think not," and redirected [Resident B] by reminding him of his care plan and future goals. No further comments were made by [Resident B] about the [marijuana] dispensary."

A case note written by Ms. Robinson on 10/06 read;

"[Resident B] spent time out in the yard during this shift, he also spent time at the library with staff. [Resident B] did reach out to staff and have conversations when he felt like he needed someone to talk to. He did mention to staff how he wanted to smoke marijuana again but he isn't going to risk it. Staff told him to think about his decisions and also to work on becoming happy without the dependency of the drug."

A case note written by Ms. Daly on 10/22 read;

"Staff had noticed [Resident B] being a bit abrasive about interacting with other residents and Staff during this shift. During the afternoon Staff offered to take [Resident B] and a few other residents on a walk after dinner, [Resident B] and other

residents wanted to go on the walk. Just before making dinner Staff had a thc pen that was under the couch pointed out to them by another resident. Staff confiscated the pen from under the couch and contacted the home manager about what to do with the pen. Staff put the pen into the locked medicine cabinet in the medical room as the home manager requested. While making dinner Staff was cutting potatoes when [Resident B] came up to Staff and stated, "I'm calling the police. My non-thc vape is missing and I know somebody stole it from me. I dropped all my stuff out of my bag earlier and I know somebody took it," Staff informed [Resident B] he can call the police if he feels he needs to. [Resident B] said, "Okay, I think I need to." [Resident B] then called a non-emergency police line and informed the officer he was speaking to that his pen was stolen from him. Staff did not interfere with [Resident B's] phone call and finished dinner. When dinner was done Staff was prompting residents for dinner when Staff overheard [Resident B] questioning two other residents about if they had seen his thc pen. After dinner Staff, [Resident B], and other residents went on the walk. After Staff, [Resident B], and other residents returned from their walk [Resident B] went out with Staff to smoke a cigarette. While outside [Resident B] apologized for calling the police and stated, "I'm just really stressed I need my pen. I know somebody took it and I'm about to go crazy on whoever did because I dropped all my stuff in [another resident's] room and [resident] was helping me pick things up to put back in my bag and I know [resident] took it. This place is bullshit and I'm not going to be here for much longer anyway. I'm getting out the right way or the wrong way. I'd be much happier in a tent on my own. I'm going to get guardianship back from my mom just watch. I have friends who will come and get me right now, I'm choosing to stay in this place. I know somebody stole my pen and the officer told me that even though I live in a group home, or even if it [the pen] was thc nobody is allowed to steal from me," Staff redirected [Resident B] by having him talk about his favorite authors and music. [Resident B] calmed down after talking with Staff for a bit longer and appeared to be in a better mood by the time Staff left their shift."

A case note written by Ms. Miller on 10/23 read;

"[Resident B] traveled with staff to the Methadone Clinic on day shift. [Resident B] requested to go to McDonalds on the way back from the clinic. [Resident B] attempted to persuade staff that he could go alone into a cannabis dispensary without staff in attendance to purchase cigarettes."

A case note written by facility staff member Matthew Crumley on 10/27 read;

"Staff witnessed [Resident B] outside smoking weed vape pen. staff asked for the vape pen due to he has been explained he can't have it due to hes [sic] been sharing [sic] it with other clients getting other clients high. [Resident B] was asked by staff if he can give staff the pen. [Resident B] said no he wasn't giving staff the vape pen. [Resident B] told staff hes gonna keep doing it and keep getting the poens [sic] regardless what staff says. [Resident B] also told staff "hes not gonna stop sharing

the pen either if other clients want it he's gonna share it they were full grown adults they can make there own choices [sic]"

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	Resident A denied ever making the allegation facility staff members sold drugs from the facility. According to Resident A, his complaint was that Resident B was smoking marijuana in the facility. Based upon my investigation, there is enough evidence to confirm Resident A's allegation that Resident B smoked marijuana in the facility. Documentation on Resident B's electronic case notes from July 2021 to present confirmed facility staff members attempted to remove marijuana from Resident B and store it in a safe, secure location until it was able to be properly disposed of and documented the times Resident B was in procession of marijuana and refused to "turn it over" to facility staff members, per the directives indicated in his BA and PCP. There is no evidence to substantiate the allegation facility staff members ever sold drugs from the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: During my interview with Resident A on 11/03, Resident A stated Resident C was hospitalized after having a bed reaction to marijuana given to him by Resident B.

During my interview with Resident C on 11/03, Resident C confirmed that approximately one month ago, he had an adverse reaction to smoking marijuana Resident B gave him. Resident C stated that at the time, facility staff members were unaware this occurred. Subsequently, Resident C stated he hadn't used marijuana since.

During my interview with Mr. Taylor on 11/03, Mr. Taylor confirmed that sometime in early September, Resident C was observed not "acting himself". Subsequently, Resident C was transported to Bronson Battle Creek emergency room (ER) for an evaluation. According to Mr. Taylor, Resident C was discharged back to the facility that same day. Mr. Taylor stated that the following day, Resident C physically

assaulted a facility staff member, was transported back to the ER for further evaluation, and was eventually admitted into the hospital for a few days. Mr. Taylor stated it was determined Resident C, who takes several prescription medications, had an adverse reaction to marijuana believed to be given to him by Resident B.

I reviewed an *AFC Licensing Division-Incident/Accident Report* (IR), dated 09/03, which was previously submitted to the department. Documentation on this IR confirmed Mr. Taylor's statements that on 09/03 Resident C was transported to Bronson Battle Creek ER when it appeared Resident C was "high".

I reviewed a copy of Resident C's hospital discharge paperwork from his visit to Bronson Battle Creek ER on 09/03, which confirmed he was discharged back to the facility that same day. Documentation on Resident C's ER discharge paperwork indicated that while at the ER on 09/03, Resident C was diagnosed with transient alteration of awareness and mild tetrahydrocannabinol (TCH) abuse.

I requested and reviewed a copy of the IR regarding the incident that led Resident C to return to Bronson Battle Creek ER on 09/04, which was not previously submitted to the department within 48 hours. Documentation on this IR confirmed Mr. Taylor's statements that on 09/04, Resident C was transported back to Bronson Battle Creek ER after physically assaulting a facility staff member.

According to the facility's electronic case notes for Resident C, following his second visit to the ER on 09/04, Resident C was hospitalized on 09/04 and discharged back to the facility on 09/06.

On 12/16, via email, I requested from Mr. Taylor a copy of Resident C's 09/06 hospital discharge paperwork. According to Mr. Taylor, he was unable to locate this documentation.

APPLICABLE RULE	
400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible **agency, and the adult foster care licensing division within 48 hours of any of the following:** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.**

ANALYSIS:	It has been established the facility did not submit to the department a written report regarding Resident C's display of serious hostility and subsequent hospitalization on 09/04 to 09/06, 48 hours after the incident occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(iv) A record of physician contacts.**
ANALYSIS:	It has been established the facility did not have on record in the facility a copy of Resident C's discharge paperwork from his hospitalization on 09/04 to 09/06.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/16 I conducted an exit conference with licensee designee Nichole VanNiman via telephone and shared with her the findings of this investigation. I suggested that Ms. VanNiman, with the approval of Resident B's legally appointed guardian and responsible agency, consider submitting a request for a variance to AFC administrative licensing rule 400.14304(1)(d), as it was evident Resident B was receiving TCH vape pens via mail delivered to the facility. I suggested to Ms. VanNiman that in the event Resident B continued to obtain marijuana, bring it into the facility, and offer it to other residents, the facility consider issuing Resident B an emergency discharge notice, as it is clear the facility is unable to meet Resident B's needs, as indicated in his BA and PCP, and also assure the safety and well-being of other vulnerable residents in the facility.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

12/16/2021

Michele Streeter — Date
Licensing Consultant

Approved By:

12/17/2021

Dawn N. Timm — Date
Area Manager