GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 21, 2022

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

RE: License #: AS390405404
Investigation #: 2022A0581046
Beacon Home at Schoolcraft North

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

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 #:	AS390405404
Investigation #:	2022A0581046
Complaint Receipt Date:	08/22/2022
Investigation Initiation Date:	08/23/2022
Report Due Date:	10/21/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Howard
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Schoolcraft North
Facility Address:	10713 S. 12th Street Portage, MI 49087
Facility Telephone #:	(269) 372-4820
Original Issuance Date:	09/01/2021
License Status:	REGULAR
Effective Date:	03/01/2022
Expiration Date:	02/29/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Alyssa Buchanan, smokes marijuana in her car when she's working.	No
Direct care staff, Alyssa Buchanan, sleeps during the overnight shift.	No
Direct care staff, Alyssa Buchanan, threated Resident A, yelled at him, and called him a child.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/22/2022	Special Investigation Intake 2022A0581046
08/22/2022	Referral - Recipient Rights ISK is already investigating; no referral is necessary.
08/23/2022	Special Investigation Initiated - Telephone Interview with ISK, Suzie Suchyta.
08/23/2022	APS referral Confirmed with Ms. Suchyta a referral to APS was made.
08/25/2022	Inspection Completed On-site Interviewed staff and residents.
08/25/2022	Inspection Completed-BCAL Sub. Compliance
08/30/2022	Contact – Telephone call made Left voicemail message with direct care staff, Heather Bond-Davidson.
09/01/2022	Contact – Telephone call made Interview with direct care staff, Robert Derushia.
09/01/2022	Contact – Telephone call made Interview with direct care staff, Adam Tissue.
09/02/2022	Exit conference with Nichole VanNiman, via telephone.

ALLEGATION:

- **Direct care staff, Alyssa Buchanan, smokes marijuana in her car when she's working.**

- **Direct care staff, Alyssa Buchanan, sleeps during the overnight shift.**

INVESTIGATION:

On 08/22/2022, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged direct care staff, Alyssa Buchanan, smokes marijuana in her car during both overnight and day shifts and sleeps during the overnight shift.

On 08/23/2022, I interviewed Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Suzie Suchyta, via telephone. Ms. Suchyta stated she received the referral as well and confirmed a referral had been made to Adult Protective Services (APS). Ms. Suchyta stated she had already gone to the facility and interviewed direct care staff, Adam Tissue, and Resident A. She stated Mr. Tissue stated to her he had observed Ms. Buchanan using a "vape" and/or "dap" pen with marijuana in it. He also reported to Ms. Suchyta that Ms. Buchanan dropped a "roach" (i.e., the remains of a marijuana joint or blunt) in the facility gravel driveway and asked Mr. Tissue to help find it. Mr. Tissue also reported to Ms. Suchyta that he had come in for a day shift and discovered Ms. Buchanan, who had worked the overnight shift, "pretending to fold towels" on the facility couch but reported to Ms. Suchyta he believed Ms. Buchanan was actually sleeping because he had to "shake" her awake.

On 08/25/2022, I conducted an unannounced onsite inspection at the facility, in conjunction with Ms. Suchyta.

I interviewed direct care staff, Andrea Reese. She denied having concerns Ms. Buchanan was smoking marijuana while working or having any knowledge of Ms. Buchanan smoking marijuana while working. She stated if she had any concerns, she would report them to management. Ms. Reese stated she had no concerns Ms. Buchanan was sleeping during the overnight shifts or any other shift. She denied ever coming into a day shift and discovering Ms. Buchanan sleeping on the facility couch.

I interviewed Ms. Buchanan. Ms. Buchanan denied smoking marijuana at work or in her vehicle while she was working. Ms. Buchanan stated only one direct care staff works during the overnight shift. She denied sleeping during the overnight shift. She acknowledged there had been times when she would sit on the facility couch and cover herself in a blanket or towel to stay warm but denied ever sleeping. While

interviewing Ms. Buchanan I did not observe any signs or symptoms indicating she was under the influence of marijuana. Additionally, I did not smell marijuana on her.

I interviewed Resident A and Resident B. Resident A stated he did not want to answer any questions relating to the allegations; therefore, I was unable to interview him. Resident B stated he had no concerns relating to how Ms. Buchanan treats him or any of the other residents. He denied observing her sleeping during the overnight shift or witnessing her smoke marijuana.

I was unable to interview Resident C or Resident D as they were both sleeping. I was unable to interview Resident E as he was nonverbal, which was confirmed by Ms. Suchyta and facility staff.

I interviewed the facility's assistant home manager, Luann Scott, who was working at a neighboring facility. Ms. Scott had no personal knowledge of witnessing Ms. Buchanan smoke marijuana at the facility or sleep during her shift. She stated Ms. Buchanan has smelled of marijuana and when this has been reported to her by other direct care staff, Ms. Scott stated she has gone to the facility, but has never observed Ms. Buchanan smoking marijuana while working. Ms. Scott stated she has not observed Ms. Buchanan under the influence of marijuana while working. Ms. Scott stated she has observed Ms. Buchanan under a blanket on the facility couch in the dark; however, upon walking into the facility room, she stated Ms. Buchanan spoke to her first and she did not sound like she had just woken up. She stated Ms. Buchanan had been sitting upright on the couch rather than lying down.

On 08/30/2022, I interviewed direct care staff, Heather Bond-Davidson, via telephone. She stated she could not recall specific dates, but indicated it was almost every shift where she observed Ms. Buchanan smoking marijuana while working. She stated Ms. Buchanan would use a "dap pen" or a would smoke a marijuana joint. She also indicated Ms. Buchanan would go to her car while working and smoke marijuana. She stated she addressed it with Ms. Buchanan but indicated Ms. Buchanan dismissed her by telling her no one was working at the facility. Ms. Buchanan's statement to me regarding Ms. Buchanan sleeping was consistent with the allegations. She stated she believed Ms. Buchanan had been sleeping as her voice sounded tired and her hair would be "messy". Ms. Bond-Davidson stated none of the residents reported any concerns to her about Ms. Buchanan smoking marijuana in the facility. She stated Resident B reported to her he had found Ms. Buchanan sleeping; however, Ms. Bond-Davidson could not recall a specific day and time when Resident B made this statement to her.

On 09/01/2022, I interviewed with direct care staff, Adam Tissue. Mr. Tissue stated he has worked at the facility for eight months and primarily works the day shift. He indicated there had been instances where he worked the overnight shift. He stated he was unable to recall specific dates but indicated there had been multiple instances when Ms. Buchanan went to her vehicle during the day shift and smoked marijuana. He stated he observed her using a marijuana pipe and smoking joints. He

stated the amount of time she was in her car ranged from 20 minutes to a couple hours, but it depended on what was happening in the facility. He indicated there was always a staff inside the facility to address the residents' needs or provide them with care. Mr. Tissue denied ever observing her under the influence to the point she was not caring for the residents' needs.

Mr. Tissue stated he was also unable to recall specific dates, but stated he observed Ms. Buchanan sleeping on the facility couch when he came in to relieve her at the end of her overnight shift. He stated he had to "nudge" her awake and it would take him "3-4 nudges" before she would awaken. He stated he was unable to recall if any other staff or residents were present when he discovered Ms. Buchanan sleeping.

On 09/01/2022, I interviewed direct care staff, Robert Derushia, via telephone. Mr. Derushia stated he had no knowledge of Ms. Buchanan smoking marijuana in the facility or being under the influence of marijuana while working. He stated he only had contact with her during shift changes. He stated he did not have any concerns of marijuana use during these shift changes. He stated he also had no knowledge of Ms. Buchanan sleeping during her shifts.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on my investigation, there is not enough concrete evidence direct care staff, Alyssa Buchanan, was smoking marijuana in the facility or in her car, or was under the influence of substance while she was working at the facility; therefore, there is no evidence indicating Ms. Buchanan is not meeting the physical, emotional, intellectual or social needs of the residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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:	There are conflicting accounts amongst direct care staff and no evidence indicating direct care staff, Alyssa Buchanan, was found sleeping during any overnight shifts at the facility. Though Ms. Buchanan stated she had sat in an upright position on the couch under a blanket during overnight shifts she denied ever falling asleep. Subsequently, there is no evidence indicating the facility has been insufficiently staffed during overnight shifts when Ms. Buchanan was working.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Direct care staff, Alyssa Buchanan, threated Resident A, yelled at him, and called him a child.

INVESTIGATION:

The complaint alleged direct care staff, Alyssa Buchanan, threatened to "lay hands" on Resident A when he asked for milk in his oatmeal. It was alleged Ms. Buchanan yelled at him and called him a child.

Ms. Reese stated she had no concerns with how Ms. Buchanan treated any of the residents, including Resident A. Ms. Reese stated she had not observed or witnessed Ms. Buchanan threatening, being rude, or treating any of the residents disrespectfully. She denied having any personal knowledge of the allegations.

Ms. Buchanan acknowledged an incident on or around June 2022 involving Resident A being verbally aggressive towards her. She stated she was the only direct care staff working in the morning and tried administering resident medications; however, Resident A became impatient and verbally aggressive toward her. She stated she told Resident A to “stop acting like a child”, as well as something similar to “you’re throwing a temper tantrum.” Ms. Buchanan indicated she responded to Resident A in that manner because she was overwhelmed being the only staff working and had been working double shifts.

I was unable to interview Resident A regarding the allegations as he stated he did not want to answer my questions. Resident B stated he had never witnessed or observed Ms. Buchanan being rude, disrespectful, or threatening to Resident A. He stated he had no concerns with how Ms. Buchanan treated him or any of the other residents. He stated he felt safe at the facility.

Ms. Scott stated the allegations were only reported to her; therefore, she had no direct knowledge of the allegations. Her statement of what was reported to her was consistent with the allegations.

Ms. Bond-Davidson described an incident where she observed and heard Ms. Buchanan telling Resident A he was “acting like a child” because he was telling her his oatmeal was hot. Ms. Bond-Davidson stated she could not recall the date of the incident, but indicated it occurred when she was relieving Ms. Buchanan from her overnight shift. She stated Resident A had not been displaying any inappropriate behaviors at the time of the incident, but he did raise his voice. Ms. Bond-Davidson stated there were no other staff or residents around when the incident occurred.

Both Mr. Tissue and Mr. Derushia denied ever hearing Ms. Buchanan threaten or yell at any residents, including Resident A. They both denied ever hearing her call Resident A “a child”. Mr. Tissue stated there were incidences where he heard Ms. Buchana raise her voice, but indicated it was not inappropriate.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.**
ANALYSIS:	Based on my interview with direct care staff, Alyssa Buchanan, she made insulting, demeaning, and/or derogatory remarks to Resident A by telling him he needed to “stop acting like a child” and told him he was throwing a tantrum.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When I arrived at the facility for my unannounced on-site inspection, I observed the facility’s garage door opened. In the garage on a shelf within my reach, I observed a 64-ounce container of outdoor multi surface cleaner wash for the house and deck.

The back of the container indicated the ingredients of the surface cleaner contained the following:

Sodium Hypochlorite (bleach) Commercial Grade, highly stable,
70% less NaCl(salts)…8%
Proprietary Ingredients…6%
Inert Ingredients…86%

During the course of my on-site inspection, Ms. Suchyta and I interviewed residents in the facility's garage. All the residents indicated they smoke cigarettes on the facility's front porch area, which is accessible to the facility's open garage door. Additionally, my interviews with direct care staff, Ms. Buchanan and Ms. Reese, indicated staff smoke cigarettes in the garage.

Ms. Bond-Davidson stated she could not recall if there was cleaner in the facility garage that was not being safeguarded. She also stated residents go into the facility garage. She indicated chemicals and caustics are kept locked in either a hallway closet, under the kitchen sink, or in a cabinet near the medication room.

Mr. Tissue checked the garage while I interviewed him via telephone and also found the multi surface cleaner in the garage. He stated the cleaner had been in the garage since he started working at the facility. He stated he would take the cleaner in the facility and move it.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(6) Poisons, caustics, and other dangerous materials shall be stored and safeguarded in nonresident areas and in non-food preparation storage areas.
ANALYSIS:	Based on my own observation, a 64-ounce container of outdoor multi surface cleaner wash for the house and deck was on a shelf in the facility garage accessible to residents. This cleaner contained the ingredient, Sodium Hypochlorite (bleach). Subsequently, the cleaner was not being safeguarded by facility staff, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/02/2022, I conducted the exit conference with the licensee designee, Nichole VanNiman, via telephone. Ms. VanNiman acknowledged my findings and stated the violations would be addressed.

IV. RECOMMENDATION

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

09/02/2022

Cathy Cushman Date
Licensing Consultant

Approved By:

09/21/2022

Dawn N. Timm Date
Area Manager