



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

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

December 20, 2022

RE: License #: AM800084653  
Investigation #: 2023A1030012  
Beacon Home at Meadowland

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.

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 (616) 356-0183.

Sincerely,

Nile Khabeiry, Licensing Consultant  
Bureau of Community and Health Systems  
Unit 13, 7th Floor  
350 Ottawa, N.W.  
Grand Rapids, MI 49503

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AM800084653
<b>Investigation #:</b>	2023A1030012
<b>Complaint Receipt Date:</b>	12/07/2022
<b>Investigation Initiation Date:</b>	12/08/2022
<b>Report Due Date:</b>	02/05/2023
<b>Licensee Name:</b>	Beacon Specialized Living Services, Inc.
<b>Licensee Address:</b>	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
<b>Licensee Telephone #:</b>	(269) 427-8400
<b>Administrator:</b>	Kimberly Howard
<b>Licensee Designee:</b>	Nichole VanNiman
<b>Name of Facility:</b>	Beacon Home at Meadowland
<b>Facility Address:</b>	56844 48th Avenue Lawrence, MI 49064
<b>Facility Telephone #:</b>	(269) 674-7306
<b>Original Issuance Date:</b>	09/28/1999
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	10/24/2021
<b>Expiration Date:</b>	10/23/2023
<b>Capacity:</b>	12
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A ran out of three of her medications.	Yes
Additional Findings	No

## III. METHODOLOGY

12/07/2022	Special Investigation Intake 2023A1030012
12/08/2022	Special Investigation Initiated - On Site Interview with Resident A
12/08/2022	Contact - Face to Face Interview with Danyell Baltazar
12/08/2022	Contact - Document Received Documents received
12/09/2022	Contact - Telephone call made Interview with Kim Howard
12/20/2022	Exit Conference Exit conference by phone

### **ALLEGATION:**

**Resident A ran out of three of her medications.**

### **INVESTIGATION:**

On 12/8/22, I interviewed Resident A at the home. Resident A reported she went on a home visit on 11/20/22 and returned on 12/3/22. Resident A reported she was given her medications to take home and ran out of some of her medications but is unsure the names of the medications. Resident A reported the home is responsible for ordering her medications from the pharmacy. Resident A reported she was taken to the emergency department at Lakeland Hospital on 12/6/22 and had her prescriptions refilled.

On 12/8/22, I interviewed home manager, Danyell Baltazar at the home. Ms. Baltazar reported she is filling in at this home as the home manager is on medical leave. Ms. Baltazar acknowledged Resident A's medications have been "messed up" and she is working to get everything organized. Ms. Baltazar reported she knows Resident A should not be without her seizure medication as well as her other medications.

On 12/8/22, I reviewed a Release of Responsibility for Medications (RRM) document for Resident A and an After Visit Summary (AVS) dated 12/6/22. The RRM indicated Resident A's mother received her prescriptions and instructions for dispensing her medications. According to the RRM Resident A's Depakote 250mg, Depakote 500mg, Linzess 72mg and Neurontin 300mg ran out while Resident A was visiting her family during the Thanksgiving Holiday. According to the AVS those medications were refilled on 12/6/22.

On 12/9/22, I interviewed district director Kim Howard by phone. Ms. Howard reported Resident A is one of the few residents that go home for extended periods of time and her mother gets her medications to dispense at home. Informed Ms. Howard that according to the RRM there was not enough medication sent home with Resident A therefore the home is not acquiring the medications from the pharmacy when needed. Ms. Howard acknowledged, agreed, and indicated they are developing a new process to avoid any future problems.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.</b>
<b>ANALYSIS:</b>	It was alleged that Resident A was without three of her prescribed medications including her seizure medication for four days. Based on interviews and review of two documents pertaining to Resident A's medication, this violation will be established. The home did not anticipate Resident A running out of her medications while on a home visit during the Thanksgiving Holiday.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 12/20/22, I shared the findings of my investigation with licensee designee, Nichole VanNiman. Ms. VanNiman acknowledged and agreed with the findings. Ms. VanNiman agreed to submit a corrective action plan within 15 days of receiving the report.

**IV. RECOMMENDATION**

Contingent upon an acceptable corrective action plan, I recommend no change in the current license status.

*Nile Khabeiry, LMSW*

12/21/22

---

Nile Khabeiry  
Licensing Consultant

Date

Approved By:

*Russell Misiak*

12/22/22

---

Russell B. Misiak  
Area Manager

Date