GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 9, 2023

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

RE: License #: AM800267885
Investigation #: 2023A1031041
Beacon Home at Anchor Point 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.
- 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 (616) 356-0183.

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

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

I. IDENTIFYING INFORMATION

License #:	AM800267885
Investigation #:	2023A1031041
Complaint Receipt Date:	05/16/2023
Investigation Initiation Date:	05/16/2023
Report Due Date:	07/15/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Israel Baker
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Anchor Point North
Facility Address:	28720 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/03/2005
License Status:	REGULAR
Effective Date:	04/24/2022
Expiration Date:	04/23/2024
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff were not aware that Resident A eloped from the home.	Yes
Additional Findings	No

III. METHODOLOGY

05/16/2023	Special Investigation Intake 2023A1031041
05/16/2023	Special Investigation Initiated – Telephone Interview held with Israel Baker.
05/24/2023	Inspection Completed On-site
05/24/2023	Contact - Face to Face Interviews held with Israel Baker and Resident A.
05/24/2023	Contact - Document Received
06/06/2023	Contact - Telephone Interviews held with Jessie Ballard, Thomas Schneider, and Robert McCabe.
06/06/2023	Contact - Telephone Interview with Israel Baker.
06/09/2023	Exit Conference held with Licensee Designee Nichole VanNiman.

ALLEGATION:

Staff were not aware that Resident A eloped from the home.

INVESTIGATION:

On 5/16/23, I reviewed an incident report received from the home dated 5/14/23. The incident report stated that a 4:45am staff received a telephone call from South Haven Hospital that Resident A had eloped from the home and got a ride to the hospital. The report indicates staff had made regular bed checks prior to the event. Staff drove to the hospital to get Resident A and bring him back to the home. Staff observed Resident A to ensure safety and further elopements.

On 5/16/23, I interviewed administrator Israel Baker via telephone. Mr. Baker reported he does not believe staff completed bed checks as required. Mr. Baker

reported Resident A must have been gone for an extended period to end up at the hospital.

On 5/24/23, I interview Mr. Baker at the home. Mr. Baker reported the policy in the home is to conduct bed checks every hour. Mr. Baker reported staff are always reminded to conduct these checks due to residents having elopement behaviors.

On 5/24/23, I interviewed Resident A in the home. Resident A reported he eloped from the home due to “radioactive activity”. Resident A reported the only way to stop the radioactive activity was to leave the home. Resident A reported he climbed the fence and left the property. Resident A reported he got “stuck in South Haven” and was walking around and then went to the hospital. Resident A reported staff did not check on him before he left the home.

On 6/6/23, I interviewed direct care worker (DCW) Jessie Ballard via telephone. Mr. Ballard reported he was a 2:1 staff for another resident in the home. Mr. Ballard reported bed checks are supposed to be done every half hour to an hour by the staff that are not 1:1 staff. Mr. Ballard reported DCW Thomas Schneider and lead worker (LW) Robert McCabe were both working that shift and responsible for bed checks.

On 6/6/23, I interviewed DCW Thomas Schneider via telephone. Mr. Schneider reported the lead staff Mr. McCabe received a telephone call from the hospital stating Resident A was there and needed to be picked up. Mr. Schneider reported he conducted 15–30-minute checks throughout the night and Resident A was in the home. Mr. Schneider reported he did not notice Resident A was gone from the home until the call was received by the hospital. Mr. Schneider was not able to explain how Resident A’s whereabouts were unnoticed when he conducted the bed checks. Mr. Schneider reported he went to the hospital to pick up Resident A who was waiting in the lobby. Mr. Schneider reported Resident A informed him he left the home and got a ride from someone to go to the hospital.

On 6/6/23, I interviewed LW Robert McCabe via telephone. Mr. McCabe reported he was in the main office completing paperwork when he received a telephone call from the hospital. Mr. McCabe reported he was informed that Resident A was at the hospital and needed to be picked up. Mr. McCabe reported he went to the main living area to inform staff that Resident A had eloped and was at the hospital. Mr. McCabe reported he observed Mr. Schneider to be sleeping when he went to inform him about Resident A. Mr. McCabe reported he does not believe Mr. Schneider was completing bed checks due to the length of time Resident A was away from the home and observing Mr. Schneider to be sleeping. Mr. McCabe reported he did not inform management that Mr. Schneider was found to be sleeping on shift.

On 6/6/23, I interviewed Mr. Baker via telephone. Mr. Baker reported he was never informed that Mr. Schneider was sleeping on shift. Mr. Baker reported there have never been any reported issues of Mr. Schneider sleeping on shift.

On 6/9/23, I reviewed Resident A's *Assessment Plan for AFC Residents* and Beacon's Bed Check Policy. The AFC Assessment read that Resident A needs to be accompanied by staff in the community and has a history of elopement. Beacon's bed check policy states that staff are to complete bed checks every hour between the hours of 9pm to 6am every day of the week. Bed checks are defined as physically and visually verifying that the resident is present in their bed.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on interviews and supporting documentation, staff did not provide appropriate supervision or protection as required in Resident A's assessment plan and home policy. Resident A eloped form the home and was located at South Haven Hospital. Staff were not aware of his absence until they were notified by the hospital. Staff responsible for doing bed checks was sleeping and not providing appropriate supervision.
CONCLUSION:	**VIOLATION ESTABLISHED**

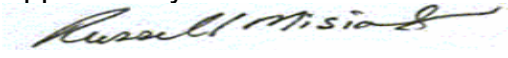
IV. RECOMMENDATION

Upon receipt of an acceptable corrective plan, it is recommended that the status of the license remain unchanged.

6/9/23

Kristy Duda Date
Licensing Consultant

Approved By:



6/9/23

Russell B. Misiak Date
Area Manager