GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 29, 2023

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

RE: License #: AS390406167
Investigation #: 2024A0581003
Beacon Home at Interlochen

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) 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 #:	AS390406167
Investigation #:	2024A0581003
Complaint Receipt Date:	10/12/2023
Investigation Initiation Date:	10/13/2023
Report Due Date:	12/11/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kim Howard
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Interlochen
Facility Address:	8038 Interlochen St. Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-6941
Original Issuance Date:	06/21/2021
License Status:	REGULAR
Effective Date:	12/21/2021
Expiration Date:	12/20/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION

	Violation Established?
Direct care staff stole approximately $800 worth of Resident A's personal belongings.	No
Additional Findings	Yes

III. METHODOLOGY

10/12/2023	Special Investigation Intake 2024A0581003
10/13/2023	Contact - Telephone call made Left voicemail with Complainant.
10/13/2023	Special Investigation Initiated - On Site Interview with residents and staff.
10/13/2023	Contact - Telephone call made Interview with direct care staff/home manager, Kristina Garcia.
10/13/2023	Contact - Telephone call made Interview with Relative A1
10/13/2023	Contact - Telephone call made Interview with Relative A2
10/13/2023	Contact - Face to Face Interview with Resident A
10/17/2023	Contact - Telephone call made Interview with facility's Administrator, Kim Howard.
10/17/2023	Contact - Document Sent Email to Ms. Howard.
10/17/2023	Contact - Telephone call made Left voicemail with Guardian A1
10/18/2023	Contact - Telephone call received Interview with Guardian A1
10/30/2023	Contact - Document Sent Email to Ms. Howard and licensee designee, Nichole VanNiman.

10/30/2023	Contact - Document Received Email from Ms. Howard and Ms. VanNiman.
11/03/2023	Contact - Telephone call made Interview with licensee designee, Ms. VanNiman.
11/03/2023	Exit Conference with licensee designee, Nichole VanNiman, via telephone.
11/03/2023	Inspection Completed-BCAL Sub. Compliance
11/03/2023	APS referral An APS referral for this investigation was not made due to APS not investigating Resident A's alleged stolen belongings in SIR 2023A1034043.
11/03/2023	Referral – Law Enforcement Made LE referral to Kalamazoo County Sheriff's Office regarding alleged stolen items. Case # 23-37552.

ALLEGATION:

Direct care staff stole approximately $800 worth of Resident A's personal belongings.

INVESTIGATION:

On 10/12/2023, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on or around 04/20/2023, Resident A, who was residing in the facility, fell and broke her arm. The complaint alleged on 04/28/2023, Resident A's family went to the facility to pick up Resident A's makeup and other unidentified personal belongings, but discovered these items were missing from the facility. The complaint further alleged in June 2023, Resident A was told she was unable to return to the facility, but the licensee had arranged to hold onto her personal belongings. The complaint then alleged in October 2023, after Resident A's relatives went to retrieve her coat from the facility, it was then discovered her laptop, a TV, and jewelry were also missing despite them being stored at the facility. The complaint alleged it was believed a direct care staff with a key to her bedroom had stolen approximately $800 worth of Resident A's personal belongings.

On 10/13/2023, I conducted an unannounced inspection at the facility. I interviewed direct care staff, Sandy Lago, who stated she's worked in the facility since May

2023. Ms. Lago stated she was not familiar with Resident A since Resident A had not been residing in the facility since approximately the end of April. Ms. Lago stated Resident A's personal belongings were still being stored in Resident A's bedroom, which was kept always locked. Ms. Lago stated she had no knowledge as to why Resident A's personal belongings were still being stored in the facility despite Resident A not residing in the facility since April 2023. Ms. Lago stated residents didn't have access to Resident A's bedroom or her belongings because they didn't have a key; however, she stated all staff are able to access her room because they have keys. Ms. Lago stated she had not observed or heard of any staff entering Resident A's bedroom. She stated the door is always shut and locked. Ms. Lago stated she recalled making an inventory of Resident A's belongings at the time Resident A was discharged; however, she was unable to locate or access Resident A's inventory during my inspection.

I also interviewed direct care staff, Dajion Sowtor, who stated he's worked in the facility for approximately one month. He also denied observing or hearing any residents or staff entering Resident A's bedroom. He confirmed he was working on or around 10/05/2023 when Resident A's relatives came to the facility and retrieved some of Resident A's personal belongings.

I interviewed Resident B who stated Residents A's bedroom has been and is always locked. He stated he's never observed or heard of any staff or residents going into Resident A's bedroom. He stated the only time he's ever seen anyone in Resident A's bedroom was when her family came to the facility and took belongings out of her room. Resident B stated staff had instructed him and the other residents to stay out of one another bedrooms, including Resident A's room.

During the inspection, Ms. Lago unlocked Resident A's bedroom allowing me inside. I observed numerous boxes in Resident A's bedroom; however, I did not go through any belongings or any boxes during the investigation due to Resident A or Guardian A1 not being present. Without going through boxes or bags, I did not see a TV or computer present in Resident A's bedroom.

On 10/13/2023, I contacted direct care staff, Kristina Garcia, who also identified herself as the facility's home manager. Ms. Garcia stated Resident A's belongings had been stored at the facility for months. She stated she recalled an inventory being completed of Resident A's belongings at time of discharge. Ms. Garcia stated since Resident A's belongings had been stored at the facility, Resident A's family members had come and retrieved some of Resident A's belongings or personal property on a couple of occasions with the most recent visit being on or around 10/05/2023.

Ms. Garcia stated she hadn't been in Resident A's bedroom or observed any other staff in her room. She denied being aware of anyone taking anything from Resident A's bedroom besides Resident A's family members. Ms. Garcia stated she had been on medical leave when staff packed up Resident A's belongings back in June 2023.

On 10/13/2023, I interviewed Complainant via telephone. Complainant's statement to me were consistent with the allegations.

On 10/13/2023, I interviewed Relative A1 via telephone. Relative A1's statement to me was consistent with the allegations, as well. Relative A1 stated the licensee agreed to store Resident A's items while she was admitted to a rehabilitative facility because neither Relative A1 nor Relative A2 were able to store all Resident A's belongings.

On 10/13/2203, I interviewed Resident A at the nursing home and rehabilitation center in Kalamazoo. Resident A stated she recalled only being at the facility (Beacon Home at Interlochen) for approximately one week before she fell and broke her shoulder. She stated when she moved into the facility she had a laptop, a small television, makeup, and jewelry; however, these items were now missing from her bedroom after she and/or Relative A2 went to retrieve these items on various occasions since April 2023.

Resident A provided me with a list of items she believed to have been stolen from her bedroom, which totaled over $800 and included the following:

- pink stone square ring – valued at $22
- red heart ring – valued at $25
- pink heart ring - valued at $25
- rhinestone necklace - valued at $24
- small box of earrings/assortment – valued at $100
- portable TV/DVD player - valued at $250
- gold pink computer - valued at $250
- two black computer bags with pink flowers – valued at $35
- makeup from Avon - valued at $75-$100
- Alexa – valued at $50

Resident A stated she last observed these items in her bedroom at the facility in April 2023 prior to being sent to the ER for her injury. Resident A stated the facility staff did not complete an inventory of her belongings at the time she was admitted to the facility; however, she believed an inventory may have been completed at the time she was discharged from her previous facility, which was also one of the licensee's facilities.

Resident A stated her relatives had been to the facility several times to pick up her belongings, but they were unable to find the items she requested. Resident A stated she did not have receipts for any of the missing items or pictures of what was missing.

On 10/13/2023, I interviewed Relative A2, via telephone. Her statement to me was consistent with Relative A1's statement to me. She stated she visited the facility on

or around 04/28/23 to retrieve Resident A's mascara and some clothing items; however, when she returned to the facility a few weeks later, on or around 05/20/2023, about half of Resident A's makeup was gone. She stated when she visited the facility on 05/20/2023, Resident A's belongings had not been packed up yet, but shortly after that visit she was told by Relative A1 and Guardian A1 facility staff packed up Resident A's belongings and her items were going to continue being stored there.

Relative A2 stated she recalled seeing Resident A's computer at the facility but was unable to recall if it was during the 04/28 or 05/20 visit. She stated she could not recall seeing Resident A's TV, but she stated Resident A expressed being upset about it being gone.

Relative A2 stated she went back to the facility on or around 10/05/2023 with Resident A to retrieve Resident A's warmer clothing. She stated at that time, Resident A's belongings were packed up in boxes. Relative A1 stated Resident A felt the soft bags and went through the boxes during the 10/05 visit and was unable to find her computer or TV.

On 10/17/2023, I interviewed the facility's Administrator, Kim Howard. Ms. Howard stated Resident A only resided at the facility approximately one week prior to sustaining an injury on or around 04/18/2023, requiring emergency treatment, and then needing rehabilitation. She stated Resident A was issued a discharge once it was determined she would need rehabilitation for several months. Ms. Howard stated Resident A's belongings were packed up in her room and her room was locked. Ms. Howard stated Resident A's bedroom had been locked since she'd been in the hospital and rehabilitation. She stated Resident A's room was packed up at the time Resident A was issued her discharge. Ms. Howard believed an inventory had been completed at the time of Resident A's admission and discharge from the facility. I requested Ms. Howard provide me with these inventories.

Ms. Howard stated it had been the intention to move Resident A's belongings and property to the facility's basement; however, a new resident was never admitted so her belongings and property stayed locked within Resident A's bedroom. Ms. Howard stated that normally, resident belongings are moved quickly out of the home; however, in this case the licensee agreed to store Resident A's belongings in the home with the possible intention of moving Resident A to another one of the licensee's facilities.

On 10/18/2023, I interviewed Guardian A1. Guardian A1's statement to me was consistent with Ms. Howard's statement to me; however, Guardian A1 stated she never received an inventory list of Resident A's belongings and property after Resident A was issued a discharge from the facility. Guardian A1 stated she was not aware of Resident A having a computer or TV.

On 10/19/2023, Guardian A1 emailed me a copy of Resident A's discharge notice, dated 06/08/2023. According to the discharge notice, as of 06/08/2023 Resident A had been out of the facility for 48 days. The discharge documented Resident A required a nursing home placement and rehabilitation and consequently her needs were beyond the scope of the licensee. The discharge documented that once Resident A was ready for discharge, the licensee would assess for possible placement at another one of the licensee's facilities.

On 11/03/2023, I interviewed the facility's licensee designee, Nichole VanNiman, via telephone. Ms. VanNiman stated there hadn't been inventory of Resident A's belongings and property due to how quickly Resident A was in the home and then sent out for medical treatment. Ms. VanNiman stated she will remind and refresh staff on completing inventories of resident belongings and property at time of admittance and discharge to ensure resident property is being tracked appropriately.

On 11/03/2023, I interviewed Deputy Stark with Kalamazoo County Sheriff's Department. Deputy Stark stated he went to the facility and confirmed with facility staff Guardian A1 picked up most of Resident A's belongings and property that day. Deputy Stark stated he reviewed an inventory list of Resident A's belongings from when she was admitted to the facility; however, he stated there were only clothing type items listed on the inventory.

Deputy Stark stated he followed up with Guardian A1 after visiting the facility confirming she retrieved Resident A's belongings. Deputy Stark stated Guardian A1 reported to him she never received an inventory of Resident A's belongings and property; therefore, she had no way to compare what Resident A came into the facility with and what was inventoried at the time she was issued a discharge. Deputy Stark stated Guardian A1 reported to him she had no way to confirm what belongings, if any, were missing from Resident A's personal property. Deputy Stark stated Guardian A1 reported to him that she would be purchasing Resident A a new computer. He stated facility staff provided him with an inventory for Resident A at the time she was admitted to the facility, but he stated it only had clothing type items on it. Deputy Stark stated that based on his investigation, he was unable to prove Resident A's belongings and personal property had been stolen by any direct care staff. Subsequently, he stated he would be closing his investigation.

On 10/17/2023 and 10/30/2023, I emailed Ms. Howard requesting an inventory of Resident A's belongings when she was admitted to Beacon Home at Interlochen, an inventory at the time she was discharged from her placement, and an inventory of her belongings at the time she was discharged from Beacon Home at Interlochen; however, these inventories were never provided.

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(10) A licensee, administrator, direct care staff, other employees, volunteers under the direction of the licensee, and members of their families shall not accept, take, or borrow money or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Based on my investigation, which included interviews with direct care staff, Sandy Lago, Dajion Sowtor, Kristina Garcia, Administrator, Kim Howard, Licensee Designee, Nichole VanNiman, Complainant, Relative A1, Relative A2, Resident A, Resident B, Guardian A1, and Kalamazoo County Sheriff's Department Deputy Stark, there was is no evidence supporting direct care staff took Resident A's belongings and valuables while these items were being stored at the facility after Resident A's discharge on 06/08/2023.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14315	**Handling of resident funds and valuables.**
	(16) Personal property and belongings that are left at the home after discharge shall be inventoried and stored by the licensee. The resident and designated representative shall be notified by the licensee, by registered mail, of the existence of property and belongings. Personal property and belongings that remain unclaimed, or for which arrangements have not been made, may be disposed of by the licensee after 30 days from the date that written notification is sent to the resident and the designated representative.

ANALYSIS:	Based on my investigation, the licensee agreed to store Resident A's personal property and belongings while Resident A was receiving rehabilitation after suffering an injury on or around 04/18/2023. Despite storing Resident A's property and belongings in Resident A's bedroom, with the door locked, the licensee failed to provide an inventory of Resident A's property and belongings at the time she was discharged on 06/08/2023, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/03/2023, I conducted my exit conference with the Licensee Designee, Nichole VanNiman, via telephone. Ms. VanNiman acknowledged my findings and stated she would refresh staff on completing inventories of resident belongings and property at time of discharge.

IV. RECOMMENDATION

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

11/28/2023

Cathy Cushman — Date
Licensing Consultant

Approved By:

11/29/2023

Dawn N. Timm — Date
Area Manager