GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 13, 2023

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

RE: License #:	AS250413017
Investigation #:	2024A0872004
	Beacon Home At Lennon

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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250413017
Investigation #:	2024A0872004
Complaint Receipt Date:	10/24/2023
Investigation Initiation Date:	10/24/2023
Report Due Date:	12/23/2023
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At Lennon
Facility Address:	5328 Lennon Rd Swartz Creek, MI 48473
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/29/2022
License Status:	REGULAR
Effective Date:	05/29/2023
Expiration Date:	05/28/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 10/22/23, Resident A left the facility to meet a man she met online. Resident A was physically and sexually assaulted and was transported to the hospital. Staff did not know Resident A's whereabouts.	Yes

III. METHODOLOGY

10/24/2023	Special Investigation Intake 2024A0872004
10/24/2023	Special Investigation Initiated - Letter I made an APS referral via email
10/24/2023	APS Referral
10/31/2023	Inspection Completed On-site Unannounced
11/09/2023	Contact - Document Sent I emailed the licensee designee requesting information related to this complaint
11/09/2023	Contact - Document Sent I emailed the Flint Township Police Department requesting a copy of the police report
11/14/2023	Contact - Document Received I received a copy of the police report
11/21/2023	Contact - Document Received I received AFC documentation related to this complaint
11/22/2023	Contact - Telephone call made I left a message for Flint Township Police Detective, Chris Weber
11/22/2023	Contact - Telephone call made I spoke to Resident A
12/13/2023	Contact - Telephone call made I interviewed staff Jaushea Jones

12/13/2023	Contact - Telephone call made I interviewed staff ShaNareyha Johnson
12/13/2023	Inspection Completed-BCAL Sub. Compliance
12/13/2023	Exit Conference I conducted an exit conference with the licensee designee, Nichole VanNiman

ALLEGATION: On 10/22/23, Resident A left the facility to meet a man she met online. Resident A was physically and sexually assaulted and was transported to the hospital. Staff did not know Resident A's whereabouts.

INVESTIGATION: On 10/31/23, I conducted an unannounced onsite inspection of Beacon Home at Lennon Adult Foster Care facility and interviewed Resident A. Resident A said that she has lived at this facility since February 2023. Resident A said that she has full community access. When Resident A leaves the facility, Resident A signs out, telling staff where she is going and whether she is going to be home in time for medications. Resident A said that she has a job, she goes to college, and she typically leaves the facility on a regular basis.

Resident A told me that on 10/22/23, just after 7pm she took her medications and signed out of the facility. Resident A told staff that she was going to a bible study, and she would be gone approximately two hours. Resident A said that she rode her bike to a local church where she met up with a man that she met online. According to Resident A, she thought she could trust this man even though looking back she realized she should have never trusted him. Resident A stated that after meeting the man in the parking lot, he sexually assaulted her and then he drove away, telling her not to tell anyone what had happened. Resident A told me that after he left, she rode her bike to the nearby Urgent Care and told the receptionist what had happened. Urgent Care staff called the police and told her she had to go to the hospital. Flint Township police officers met Resident A at Urgent Care and an ambulance transported Resident A to the hospital where she had a rape kit.

Resident A said that she got to Urgent Care just after 8pm but she does not know what time she arrived at the hospital. Resident A said that she told hospital staff where she lived, and a victim advocate stayed with her during the exam. Resident A was discharged at approximately 8am the next morning, and staff Jackie came and picked her up, taking her back home. Resident A told me that she does not know what time hospital staff notified the AFC facility about her whereabouts and said that none of the AFC staff called her on her cell phone while she was at Urgent Care or the hospital. Resident A was very tearful and upset during this interview and said that she is working with the police to press charges against this man.

On 11/15/23, I obtained a copy of the Flint Township police report completed by Officer Gaven Ackerman and Detective Weber. According to this report, on 10/22/23, Flint Township Police Officers were contacted regarding a complaint involving a sexual assault. Officers responded to Genesee Urgent Care and met with Resident A. Officers followed Resident A to Hurley Medical Center and gathered evidence. They obtained a full statement from Resident A and searched for the vehicle Resident A's assailant was driving, but they were unsuccessful. The report noted that in addition to being sexually assaulted, Resident A was also physically assaulted by her assailant. As of this date, the investigation is ongoing.

On 12/11/23, I reviewed AFC documentation related to Resident A. According to her Health Care Appraisal, she is diagnosed with syncope, bipolar disorder, borderline personality disorder, posttraumatic stress disorder, and reactive attachment disorder. I reviewed Resident A's Monroe County Community Mental Health individualized plan of service (IPOS) dated 10/12/21. According to that report, Resident A requires "eye-on level of supervision while in the community." She also has phone restrictions and will adhere to the following: "1. Not possess any electronic that has internet abilities or phone capabilities. 2. Have group home staff dial out her phone calls. 3. (She) is not to have a cell phone that makes calls or can access the internet. (She) is not to have any device that can make calls or can access the internet. (She) must have house staff dial her out going phone calls."

According to Resident A's Assessment Plan dated 01/24/23, she is not allowed to move independently in the community. She "Has BTP restricting community access, can have approved overnights with family."

I reviewed an Incident/Accident Report (IR) dated 10/22/23 completed by Jaushea Jones. According to this report, "Around 12:46am the Flint Township police department came to the home and notified staff that (Resident A) was currently in the hospital due to accusations of sexual assault. They stated that they are waiting on test to be done and that she is expected to return back to the home and that she would need a ride back to the home upon her release. (She) signed herself out at 7:13pm."

I reviewed a face sheet for Resident A dated 11/09/23. She was admitted to Beacon Home at Lennon AFC on 02/20/23. I reviewed the staff schedule for this facility and noted that staff Alessandra Wiggins, ArNita Mae Mance, and ShaNareyha Johnson worked on 10/22/23 from 7am-7:30pm and staff Jaushea Jones worked on 10/22/23 from 7pm-7:30am.

On 12/13/23, I interviewed staff Jaushea Jones via telephone. Staff Jones said that on 10/22/23, she arrived to work at approximately 10:30pm and relieved staff ShaNareyha Johnson and ArNita Mance. At approximately 11:30pm, the police came to the door and told her that Resident A had been sexually assaulted and was at the hospital. Police told Staff Jones that the hospital would contact the facility when Resident A was ready to be discharged. I asked Staff Jones if she knew that Resident A was not home. She said that Staff Johnson and Staff Mance did not tell her that Resident A was not home,

so she assumed Resident A was in her room. When the police got there, Staff Jones checked the sign in/sign out sheet and saw that Resident A had signed out of the facility at around 7pm and she never signed back in.

I asked Staff Jones what restrictions Resident A had regarding community access. Staff Jones told me that it was her understanding that Resident A was allowed full community access. Resident A was allowed to sign herself out of the facility, stating where she was going, and it was not staff's responsibility to check on her while she was out in the community. I asked if there was a protocol to follow if Resident A had not returned by bedtime and she said no.

On 12/13/23, I interviewed staff ShaNareyha Johnson via telephone. Staff Johnson confirmed that she and Staff Mance worked on 10/22/23. She said that at approximately 7:14pm, Resident A signed herself out of the facility, saying that she was going up the street to the church. Resident A said that she would be gone for approximately 2.5 hours. At approximately 10:30pm, Staff Jones got to the facility to relieve Staff Johnson and Staff Mance. I asked Staff Johnson if she told Staff Jones that Resident A was not home yet, and she said no. She said that she forgot to pass this information on to Staff Jones.

I asked Staff Johnson what type of community access Resident A is allowed and she said that to her knowledge, at the time of the incident, Resident A was allowed full community access. She said that originally when Resident A was placed at Beacon Home at Lennon, she had limited community access and had to be home by dusk. Approximately 5+ months ago, the then-home-manager, (HM) Denise Funderburg told staff that Resident A's community access restrictions had been lifted and she was allowed to come and go from the facility if she signed out and told staff where she was going. Staff Johnson said that HM Funderburg was working on getting an updated IPOS for Resident A reflecting her new community access guidelines but at the time of the incident, she and the rest of the staff only had verbal instructions.

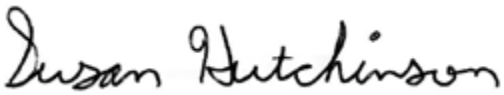
I asked Staff Johnson what staff's responsibilities were if Resident A did not come home when she was supposed to. Staff Johnson said that when residents are home, staff are to conduct 30-minute room checks and if residents are in the community, staff are to conduct 2-hour checks but the instructions on how to conduct these checks was never made clear. Staff Johnson said that to her knowledge, the new home manager (HM) Megan Smithingell has been in contact with Resident A's case manager to get a written updated IPOS.

On 12/13/23, I conducted an exit conference with the licensee designee (LD), Nichole VanNiman. I discussed the results of my investigation and explained which rule violation I am substantiating. LD VanNiman agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

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:	On 10/22/23, Resident A signed herself out of the facility at approximately 7:13pm, telling staff that she would be home in approximately 2.5 hours. On 10/22/23 at approximately 11pm, the police went to the AFC facility and told staff Jaushea Jones that Resident A had been physically and sexually assaulted and she was currently in the hospital. According to Resident A's Assessment Plan dated 01/24/23, she "has BTP restricting community access, can have approved overnights with family." According to her IPOS dated 10/12/21, Resident A requires "eye-on level of supervision while in the community." I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

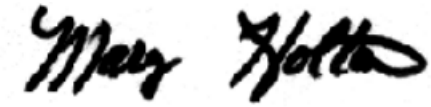
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



December 13, 2023

Susan Hutchinson Licensing Consultant	Date

Approved By:



December 13, 2023

Mary E. Holton Area Manager	Date