GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

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

February 7, 2024

RE: License #: AM800267886
Investigation #: 2024A1030013
Beacon Home at Anchor Point South

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,

Nile Khabeiry, LMSW

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

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AM800267886 |
| | |
| **Investigation #:** | 2024A1030013 |
| | |
| **Complaint Receipt Date:** | 01/15/2024 |
| | |
| **Investigation Initiation Date:** | 01/16/2024 |
| | |
| **Report Due Date:** | 03/15/2024 |
| | |
| **Licensee Name:** | Beacon Specialized Living Services, Inc. |
| | |
| **Licensee Address:** | Suite 110<br>890 N. 10th St.<br>Kalamazoo, MI 49009 |
| **Licensee Telephone #:** | (269) 427-8400 |
| | |
| **Administrator/ Licensee Designee:** | Nichole VanNiman |
| | |
| **Name of Facility:** | Beacon Home at Anchor Point South |
| | |
| **Facility Address:** | 28720 63rd Street<br>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:** | PHYSICALLYHANDICAPPED<br>DEVELOPMENTALLY DISABLEDMENTALLY ILLAGED TRAUMATICALLY BRAIN INJURED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| The home did not provide appropriate supervision. | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 01/15/2024 | Special Investigation Intake<br>2024A1030013 |
| 01/16/2024 | Special Investigation Initiated - Telephone<br>Interview with Israel by phone |
| 01/18/2024 | Contact - Face to Face<br>Interview with Resident A |
| 01/18/2024 | Contact - Face to Face<br>Interview with Resident B |
| 01/18/2024 | Contact - Face to Face<br>Interview with Linda Graham |
| 01/18/2024 | Contact - Document Received<br>Documents received and reviewed |
| 01/29/2024 | Contact - Telephone call made<br>Interview with Demetrius Jones |
| 01/29/2024 | Contact - Telephone call made<br>Interview with Rudy Serratos |
| 01/29/2024 | Contact - Document Received<br>Document received and reviewed |
| 01/31/2024 | Contact - Telephone call made<br>Interview with Buffie Delong |
| 02/01/2024 | Exit Conference<br>Exit conference by phone |

**ALLEGATION:**

**The home did not provide appropriate supervision.**

**INVESTIGATION:**

On 1/16/24, I interviewed home supervisor Israel Baker by phone. Mr. Baker provided the names of the residents that eloped as well as the staff members working at the home. Mr. Baker reported the two residents have a history of leaving the facility without permission. Mr. Baker reported the residents do not have community access, but the home is not a "secured facility" which means there are no fences preventing the residents from leaving the property if they chose to leave. Mr. Baker reported Resident A is a 24 hour one to one and direct care staff member (DCSM) Demetrius Jones was assigned to provide supervision during the shift. Mr. Baker reported Mr. Smith became aware that the two residents left the home around 1:00am but did not report it to anyone "for a while" and was unsure why he did not inform the lead worker the residents left the home. Mr. Baker reported he was informed about the residents and called in additional staff to locate them. Me. Baker reported the residents were found about one and a half miles away from the home.

On 1/18/24, I interviewed Resident A at the home. Resident A confirmed that he and Resident B left the home but was unsure what time they left. Resident A reported he is on a one to one and DCSM Demtrius Jones was his assigned staff on 1/14/24. Resident A reported they went out the back door. At this point in the interview Resident A got up and left the room thereby ending the interview.

On 1/18/24, I interviewed Resident B at the home. Resident B reported he and Resident A wanted to "get out of this place" and have some "freedom." Resident B reported he and Resident A did not plan to elope until just before they left the home. Resident B reported Mr. Jones was not watching Resident A and was "lying on the couch" when they left the home. Resident B reported they left the home about midnight and walked a "mile or so" from the home and went to someone's home and asked to use their lighter to light a cigarette. Resident B reported the police eventually found them and contacted the home. Resident B reported he was transported home and Resident A went to jail because he broke a window at the home and tried to fight the police.

On 1/18/24, I interviewed assistant home manager Linda Graham at the home. Ms. Graham confirmed she was working 1/14/24 and was the "lead staff." Ms. Graham reported Demetrius Jones was on a "one on one" with Resident A. Ms. Graham reported she was dealing with another resident who was having a behavior problem when Resident A and Resident B left the home. Ms. Graham reported she thinks they left about 12:45am but is unsure of the exact time. Ms. Graham reported she thought

Resident A was in his bedroom as the last time she saw him he was wearing shorts and a t-shirt and seemed to be getting ready to go to sleep. Ms. Graham reported she noted Resident B's bedroom door was open and asked Mr. Jones about his whereabouts and was told "he is outside smoking." Ms. Graham reported she asked Mr. Jones to go outside to check on Resident B and was told he was not outside so they began looking for him in the home. Ms. Graham reported that while she and the other two DCSM searched for Resident B they discovered that Resident A was also not in the home. Ms. Graham reported she called the other homes in the area to look for Resident A and Resident B and she called her supervisor and law enforcement. Ms. Graham reported the residents were found a mile or so away from the home by the police. Ms. Graham was unable to provide a reason why Mr. Jones was not supervising Resident A as being a one on one means he should have Resident A in his "line of sight" or within arm's reach.

On 1/18/24, I received and reviewed Resident A's Assessment Plan for AFC Residents (AP) dated 12/29/22 and Resident A's Riverwood CMH Treatment Plan (CMHTP) dated 11/27/23. Resident A's AP indicated he receives "24 hours of enhanced staffing daily." Resident A's CMHTP indicated Resident A "requires 1:1 staffing 24/7 for his and others health and safety."

On 1/29/24, I interviewed DCSM Demetrious Jones by phone. Mr. Jones confirmed that he was working on 1/14/24 and was assigned to Resident A as a "one on one." Mr. Jones reported he checked on Resident A at midnight and 1:00am and noted that Resident A was in his bedroom. Mr. Jones reported he had to use the bathroom "real bad" and tried to find someone to cover for him but no one was available so he went to the bathroom. Mr. Jones reported he was gone for "five minutes" and then came back to check on Resident A and found him to be missing from his bedroom. Mr. Jones reported he informed the lead staff, Ms. Graham, and they began to search for Resident A. Mr. Jones reported another resident was found to have eloped as well and they searched for Resident A and Resident B on the property, but they could not be located. Mr. Jones reported he remained at the home while several DCSM went driving around looking for the residents who were eventually found.

Mr. Jones reported he thinks they left the home "about 1:15am" and Resident B was brought back to the home at 3:00am. Mr. Jones reported Resident A was taken to jail due to assaulting police officers. Mr. Jones reported he was supposed to always have Resident A in his direct line of sight and admitted to not providing supervision while he was using the bathroom.

On 1/29/24, I interviewed DCSM Rudy Serratos by phone. Mr. Serratos confirmed he was working as a float staff on 1/14/24. Mr. Serratos reported he received a call from Ms. Graham that Resident A and Resident B were not able to be located and began searching for them. Mr. Serratos reported he and other DCSM were looking on the property along with searching other homes on the property. Mr. Serratos reported the police were called about an hour after the residents eloped. Mr. Serratos reported the residents were found on 66th Street by another DCSM who was also searching for them.

Mr. Serratos reported he drove the house van to location and was able to get Resident B into the van. Mr. Serratos reported Resident A began swearing at him and refused to get onto the van. Mr. Serratos reported Resident A "took off running" and he followed in the van until Resident A stopped at a home on 66th Street. Mr. Serratos reported he again tried to get Resident A into the van, and he picked up an object and threw it through a window at the home. Mr. Serratos reported he was then able to get Resident A into the van. Mr. Serratos reported Resident A then began threatening him and trying to assault him. Mr. Serratos reported the police arrived and tried to get Resident A to "calm down" however Resident A got angry at the officers and began "fighting with the police" and was eventually put in handcuffs and taken to jail.

On 1/29/24, I received and reviewed Resident A's Behavior Treatment Plan (BTP) dated 2/21/23. Resident A's BTP was competed to address several problematic behaviors including "elopement, verbal aggression, physical aggression and property destruction." The BTP provided the specific "reaction strategy" for elopement by "blocking opportunities for elopement" however that strategy could not be utilized due to the lack of supervision.

On 1/31/24, I interviewed Resident A's CMH case manager, Buffie Delong by phone. Ms. Delong reported that she was aware of the Resident A's elopement and the subsequent investigation. Ms. Delong agreed that the home did not provide appropriate supervision as specified in his CMHTP and BTP. Ms. Delong reported the home is aware of their responsibility to provided one on one staffing as she recently asked the home if it was possible to reduce his hours of one-on-one supervision from 24/7 to 18/7 and they refused due to Resident A's need for the highest level of supervision possible.

| **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.** |

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|---|---|
| **ANALYSIS:** | It was alleged the home did not provide appropriate supervision. Based on interviews and review of Resident A's Assessment Plan this violation will be established. I reviewed several documents relating to Resident A's care and supervision including his Assessment Plan, CMH Treatment Plan and Behavior Treatment Plan and all three documents indicated that Resident A needs one-on-one supervision due to behavioral problems and safety concerns. Resident A eloped from the home on 1/12/24 without being seen by Demetrius Jones who was assigned to provided one-on-one supervision. Mr. Jones admitted to leaving him unsupervised. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 2/1/24, I shared the findings of my investigation with licensee, Nichole VanNiman. Ms. VanNiman acknowledged and agreed to submit a corrective action plan.

## IV. RECOMMENDATION

Based on the submission of an acceptable corrective action plan, I recommend no change to the current license status.

Nile Khabeiry, LMSW

2/8/24

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Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

2/8/24

_____

Russell B. Misiak Date
Area Manager