GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 26, 2024
Nichole VanNiman
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AM800084653
Investigation #: 2024A1030046
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.

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
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

License #:	AM800084653
Investigation #:	2024A1030046
Complaint Receipt Date:	08/05/2024
Investigation Initiation Date:	08/06/2024
Report Due Date:	10/04/2024
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 Meadowland
Facility Address:	56844 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 674-7306
Original Issuance Date:	09/28/1999
License Status:	REGULAR
Effective Date:	10/24/2023
Expiration Date:	10/23/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II ALLEGATION(S)

	Violation Established?
Resident A was allowed to sleep in the facility's van.	No
Staff threatened to throw water on Resident A.	No
Staff refused to pass Resident A her medication.	No
Additional Findings	Yes

II. METHODOLOGY

08/05/2024	Special Investigation Intake 2024A1030046
08/06/2024	APS Referral Received and reviewed APS referral
08/06/2024	Special Investigation Initiated - Telephone Interview with referral source
08/08/2024	Contact - Face to Face Interview with Resident A
08/08/2024	Contact - Face to Face Interview with Resident B
08/08/2024	Contact - Face to Face Interview with Resident C
08/08/2024	Contact - Face to Face Interview with Resident D
08/08/2024	Contact – Face to Face Interview with Veronica Vance
08/09/2024	Contact - Document Received Received and reviewed Resident A's MAR
08/15/2024	Contact - Telephone call made Interview with Kristin McHenry
08/15/2024	Contact - Telephone call made Interview with Dayzhanique Crowley

08/16/2024	Exit conference – Exit conference by phone

ALLEGATION:

Resident A was allowed to sleep in the facility's van.

INVESTIGATION:

On 8/6/24, I interviewed the referral source (RS) by phone. The RS reported he interviewed Resident A and the direct care staff members who were working on 7/26/24 and did not find any evidence Resident A being mistreated.

On 8/8/24, I interviewed Resident A at the facility. Resident A reported she ran away on 7/26/24 and was brought back by the police. Resident A reported she got into the facility's minivan to sleep as she was angry with the facility. Resident A reported she was not allowed to sleep in the van and went into the facility to sleep.

On 8/8/24, I interviewed home assistant manager Veronica Vance at the home. Ms. Vance reported she was not working on 7/26/24 but was told that Resident A was not allowed to sleep in the van when she came in the next day.

On 8/15/24, I interviewed Dayzhanique Crowley by phone. Ms. Crowley reported Resident A was upset on 7/26/24 and got into the house van because she wanted to sleep in the van instead of her bedroom. Ms. Crowley reported she informed Resident A that she is not allowed to sleep in the van and needed to exit the van. Ms. Crowley reported Resident A then got out of the van and walked to another facility on the property.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged that Resident A was allowed to sleep in the facility's van. Based on interviews this violation will not be established. Although Resident A was able to get into the facility's van she was not allowed to sleep in the van and eventually exited the van.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff threatened to throw water on Resident A.

INVESTIGATION:

Resident A reported direct care staff member Dayzhanique Crowley threatened to throw water on her when she refused to get out of the facility's van. Resident A denied Ms. Crowley had water in her hand when the threat was made or threw water on her.

Ms. Crowley denied threatening to throw water on Resident A and indicated Resident A misunderstood her as she was talking about a time when she worked at a different facility. Ms. Crowley reported she knows that threatening the residents in any way is wrong. Ms. Crowley reported Resident A got out of the van after she was informed that she is not allowed to sleep in the van.

Ms. Vance reported she was told that Ms. Crowley threatened Resident A but does not believe that Ms. Crowley would threaten to throw water on Resident A.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	It was alleged that staff threatened to throw water on Resident A. Based on interviews this violation will not be established. Although Resident A indicated she was threatened by Ms. Crowley there is no indication that Ms. Crowley made any threatening statements to Resident A and did not have any water in her possession when she was alleged to have threatened Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff refused to pass Resident A her medication.

INVESTIGATION:

Resident A reported she usually takes her medications but refused to take them on 7/26/24 because she was angry with the staff. Resident A reported she took her night medications later in the evening.

On 8/9/24, I received and reviewed Resident A's Medication Administration Record (MAR) and noted Resident A received her medications late on 7/26/24. I also noted several days in July that she refused to take her medications.

Ms. Crowley reported Resident A initially refused to take her night medications because she was having behaviors. Ms. Crowley Resident A was able to calm down and when she returned to the facility she took her medication. Ms. Crowley denied ever refusing to pass Resident A's medications to her.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(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 S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was alleged that staff refused to pass Resident A's medication. Based on interviews and review of Resident A's MAR, this violation will not be established. According to the all the information obtained Resident A initially refused to take her evening medications but agreed to take them later in the evening.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 8/8/24, I interviewed Resident A, B, C, D at the home. All four residents reported observing Ms. Crowley sleeping multiple times during her shifts.

Ms. Crowley reported she has been caught “dozing off” while working. Ms. Crowley reported she is pregnant and prescribed B-6 vitamin with a sleep aid. Ms. Crowley reported she knows she is not supposed to be sleeping during her shift.

On 8/15/24, I interviewed Clinical Director for the facility, Kristin McHenry by phone. Ms. McHenry reported she did a “pop in” at the facility on 8/4/24. Ms. McHenry reported she noted Ms. Crowley sitting on the couch, talking on cell phone with her sweatshirt hood pulled up over her head. Ms. McHenry reported she assumed Ms. Crowley was a resident based on her behavior. Ms. McHenry reported Ms. Crowley continued to talk on the phone and eventually went outside to continue the conversation. Ms. McHenry reported she left the facility and went to visit two other facilities on the campus and returned about 30-45 minutes later and Ms. Crowley was still talking on the phone. Ms. McHenry reported Ms. Crowley was on her phone for a least an hour and did not provide any supervision to the residents during that time. Ms. McHenry reported she prompted Ms. Crowley to end her conversation which she reluctantly did but then began texting and indicated she was dealing with a personal problem. Ms. McHenry reported Ms. McHenry was sent home due to Ms. Crowley not performing her work duties.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	During the course the investigation it was alleged by several residents that Ms. Crowley had been sleeping while she was working. When questioned, Ms. Crowley admitted to dosing off several times at work. In addition, Ms. Crowley was sent home for being on her cell phone for at least an hour while working. Both situations clearly demonstrate that Ms. Crowley was unable to properly supervise the 12 residents who have significant behavioral and mental health problems at the specialized residential facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A reported part of what upset her about Ms. Crowley on 7/27/24 was her sharing personal information about her being abused while she was on the telephone. Resident A reported she believes Ms. Crowley was talking with her husband.

Resident B reported she is also concerned with Ms. Crowley violating HIPPA as she speaks to her husband on the phone about the residents at the facility. Resident B reported Ms. Crowley informed her that it's not a violation because her husband is a law enforcement officer. Resident B reported she overheard Ms. Crowley say that Resident A had been sexually assaulted and knew Ms. Crowley was referring to Resident A because she used her initials.

Resident C reported she has overheard Ms. Crowley talking on her cell phone to her husband about the residents. Resident C reported that another resident indicated Ms. Crowley called them "retards." Resident C reported she has asked Ms. Crowley to be respectful to the residents but Ms. Crowley responded by saying that she can do whatever she wants.

On 8/8/24, I interviewed Resident D at the facility. Resident D reported Ms. Crowley called her a "retard."

Ms. Crowley reported she did not disclose confidential resident information to her husband and indicted the residents overheard her talking to her brother and she was criticizing her brother's parole officer and not one of the residents.

Ms. McHenry reported while she was at facility several residents expressed concern about Ms. Crowley as she disclosed personal information about her being sexually assaulted to someone on her cell phone, called one of the residents a "retard." Ms.

McHenry reported she knows the residents very well and believes there was validity to the allegations as they were clearing angry with Ms. Crowley.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**
ANALYSIS:	During the course of the investigation several residents reported Ms. Crowley had been disclosing personal information over the phone and was calling the residents derogatory names. In addition, the residents reported identical information to the clinical director and appeared to be sincere in their feelings about the situations. Although Ms. Crowley denies the allegations there is significant credible evidence that Ms. Crowley violated the residents right to privacy and personal dignity.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/16/24, I shared the findings of my investigation with district director, Kim Howard. Ms. Howard acknowledged the findings and agreed to submit a corrective action plan.

III. RECOMMENDATION

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

Nile Khabeiry, LMSW

8/26/24

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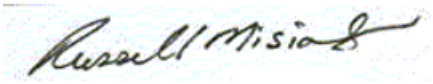
Nile Khabeiry Date
Licensing Consultant

Approved By:



8/27/24

Russell B. Misiak Date
Area Manager