GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 2, 2024

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

RE: License #: AS800343665
Investigation #: 2024A1031046
Beacon Home at Bayview

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS800343665
Investigation #:	2024A1031046
Complaint Receipt Date:	07/12/2024
Investigation Initiation Date:	07/15/2024
Report Due Date:	09/10/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Licensee Designee/Administrator:	Nichole VanNiman
Name of Facility:	Beacon Home at Bayview
Facility Address:	29320 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-0288
Original Issuance Date:	10/07/2013
License Status:	REGULAR
Effective Date:	04/04/2024
Expiration Date:	04/03/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A assaulted Resident B.	No
Staff provided the wrong medication to Resident C's family following discharge.	Yes

III. METHODOLOGY

07/12/2024	Special Investigation Intake 2024A1031046
07/15/2024	Special Investigation Initiated - Letter Email sent to Mike Hartman.
07/25/2024	Contact - Telephone call made Interview with Israel Baker.
07/25/2024	Contact - Document Sent Documents Requested and Received.
08/08/2024	Inspection Completed On-site
09/04/2024	Contact - Document Received Email Exchange with Mike Hartman.
09/04/2024	Inspection Completed-BCAL Sub. Compliance
09/182024	Contact – Document Requested and Received.
09/27/2024	Contact – Telephone Interview with Jermaine Burrell and Sallena Pritchard.
09/30/2024	Exit Conference held with Nichole VanNiman.

ALLEGATION:

Resident A assaulted Resident B.

INVESTIGATION:

On 7/25/24, I interviewed the district manager Israel Baker via telephone. Mr. Baker reported Resident A did assault Resident B. Mr. Baker reported Resident B was sent

to the hospital to treat his injuries and Resident A was admitted to the psychiatric unit for evaluation.

On 7/25/24, I requested police reports from Van Buren County Sherrif. The police report read that Resident A admitted to assaulting Resident B because he was having a bad day. Resident B reported that Resident A did hit him in the face because he was upset.

On 8/8/24, I attempted to interview Resident B in the facility. Resident B did not engage in the interview process.

On 8/8/24, I interviewed direct care worker (DCW) Gloria Braswell in the facility. Ms. Braswell reported that she was not working when the alleged incident occurred and could not provide any information.

On 8/8/24, I interviewed the home manager Teresa Merritt. Ms. Merritt reported that due to Resident A's aggressive behaviors he was currently receiving psychiatric treatment and would not be returning to the facility.

On 8/16/24, I exchanged emails with Mr. Baker. Mr. Baker reported Resident A will not be returning to the facility due to his assaultive behaviors. Mr. Baker reported Resident A's treatment team through community mental health is looking for an alternative place for him to reside.

On 9/4/24, I exchanged emails with adult protective services worker Mike Hartman. Mr. Hartman reported he had concluded his investigation, and he did not find any evidence to support that staff were neglectful of Resident B. Mr. Hartman found that Resident B was abused by Resident A.

On 9/18/24, I requested, received and reviewed Resident A's assessment plan. The assessment plan dated 3/21/24 read that Resident A does not require additional staffing beyond the minimum staff to resident ratio due to behaviors and is able to participate in social activities with others.

On 9/27/24, I interviewed direct care workers Jermain Burrell and Sallena Pritchard via telephone. They were both consistent in reporting they were the only staff working during that shift. They reported Resident A started arguing with Resident A over pop bottles and then Resident A assaulted Resident B. They intervened by redirecting Resident A out of the home and Resident B was redirected to another area of the home. The police were contacted, and Resident A was taken to the hospital for a psychiatric review.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria;**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(c) The resident appears to be compatible with other residents and members of the household.**
ANALYSIS:	Interviews and the review of documentation revealed that Resident A did assault Resident B. However, the home took appropriate measures to address this incident by ensuring that Resident A received psychiatric treatment and will not be returning to the home as they are not compatible with other residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff provided the wrong medication to Resident C's family following discharge.

INVESTIGATION:

Mr. Baker reported staff did mail the wrong medication to Resident C's family. Mr. Baker reported Resident C moved from the facility and the family requested that his medication be mailed due to him residing in a different state. Mr. Baker reported staff mailed another residents medication on accident.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The facility admitted to mailing the wrong medication to Resident C's family following discharge from the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

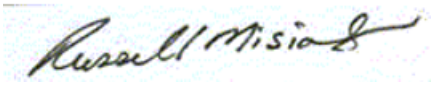
IV. RECOMMENDATION

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

9/27/24

Kristy Duda — Date
Licensing Consultant

Approved By:



10/1/24

Russell B. Misiak — Date
Area Manager