GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 15, 2024

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

RE: License #: AS230404895
Investigation #: 2024A0007031
Beacon Home at Arlene

Dear Nicole 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) 284-9720.

Sincerely,

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604
Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230404895
Investigation #:	2024A0007031
Complaint Receipt Date:	05/20/2024
Investigation Initiation Date:	05/21/2024
Report Due Date:	07/19/2024
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kim Rawlings
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Arlene
Facility Address:	4219 Arlene Drive Lansing, MI 48917
Facility Telephone #:	(517) 253-7112
Original Issuance Date:	10/02/2020
License Status:	REGULAR
Effective Date:	03/29/2023
Expiration Date:	03/28/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff sleeping during shift.	Yes

III. METHODOLOGY

05/20/2024	Special Investigation Intake - 2024A0007031
05/21/2024	Special Investigation Initiated – Letter - Email to and from the complainant. Additional information gathered.
06/04/2024	Inspection Completed On-site - Unannounced - Face to face contact with Employee #1, DCW, Vernon Hill, DCW, Resident A, and Resident B.
07/11/2024	Contact - Document Received from Kristina Potesta, Recipient Rights Officer, Gogebic County Community Mental Health. Copy of report.
07/12/2024	Contact - Telephone call made to Employee #1, DCW. No answer.
07/12/2024	Contact - Telephone call made to Alexandria Pugh. Interview.
07/12/2024	Contact - Telephone call received from Alexandria Pugh.
07/12/2024	Contact - Telephone call received from Alexandria Pugh x3.
07/12/2024	Contact - Telephone call received from Alexandria Pugh. Discussion.
07/12/2024	Contact - Telephone call made to Shelly Keinath, Administrative Staff. Documents requested.
07/12/2024	Contact - Document Received - Incident Report and BTP.
07/12/2024	Contact - Telephone call made to the facility. Interview with Michele Hitsman.
07/12/2024	Contact - Document Received - Individual Plan of Service for Resident A.
07/15/2024	Exit Conference conducted with Shelly Keinath, Administrative Staff. I also requested updated information regarding the licensee designee and administrator designations.

ALLEGATION: Staff sleeping during shift.

INVESTIGATION:

As a part of this investigation, I reviewed the complaint, and the following additional information was noted: On May 11, 2024, Alexandria Pugh, direct care worker (DCW), was sleeping during her shift. Alexandria Pugh was interviewed by ORR, and she admitted to "dozing off" and stated, “people doze off sometimes, that’s what they do, I don’t understand the big deal.”

On June 5, 2024, I conducted an unannounced on-site investigation and made face to face contact with Employee #1, DCW, Vernon Hill, DCW, Resident A, and Resident B. Vernon Hill was cooperative with the investigation. Vernon Hill, DCW informed me that Michele Hitsman, who has the role of home manager, was not at the facility at that time. Employee #1, DCW, was on a conference call.

At the time of arrival, Vernon Hill reported that Resident A was asleep, but he awoke while I was at the facility. I attempted to interview Resident A; however, he paced and kept walking away when I tried to speak with him.

I interviewed Vernon Hill and inquired about staff sleeping while on duty. Vernon Hill reported to be aware of an ORR investigation regarding the allegations of staff sleeping on shift. He stated that he has not observed Alexandria Pugh sleeping on the job. Vernon Hill reported that he does not sleep on the job, and staff are required to be awake during their shift.

While at the facility, I reviewed Resident A’s file. On the *Assessment Plan for AFC Residents*, it noted that Resident A required supervision while in the community “due to safety and cognition.”

As a part of this investigation, I reviewed the *Incident Report* and *Individual Plan of Service* for Resident A. The Incident Report was authored by Employee #1, DCW. It was noted that on May 11, 2024, at 10:45 a.m., Resident A was in his room playing a game, while Employee #1 was outside with others. Employee #1 heard loud knocking, so she came in to see what was going on. When she came in, she found Alexandria Pugh asleep. All the lights were off, the shades were pulled, and the front door was locked. Family members for another resident were knocking at the door to be let into the facility.

It was noted in the *Individual Plan of Service* for Resident A that due to his intellectual disability; cognition is limited, and that he (Resident A) requires supervision, due to the disability.

I also reviewed the *Office of Recipient Rights Summary* report, authored by Kristina Potesta, Recipient Rights Officer. It was noted that Alexandria Pugh was interviewed and she “stated she was not awake for a minimum of 5-10 minutes and stated that

she wasn't "full on sleeping" just "dozing off" and "people doze off sometimes, that's what they do, I don't understand the big deal." It was also noted that the recipient [Resident A] "requires 24/7 monitoring and supervision per his treatment plan." The report documented that there was a "preponderance of the evidence that Alexandria Pugh was asleep while working in the Beacon Home at Arlene on 5/11/24…" The allegations were substantiated for Neglect Class III.

On July 12, 2024, I attempted to interview Alexandria Pugh, (previous direct care worker). Alexandria Pugh stated that she no longer worked for the facility and did not know why I was contacting her. I explained to her that licensing has the regulatory authority to investigate potential rule violations, we received a complaint, and I was attempting to gather her story. Alexandria Pugh appeared to be agitated, she was not cooperative with the interview, and when I tried to ask questions, she stated "Why does it matter?" During the interview, Alexandria Pugh stated that she has some health problems, which cause her to be tired. When asked if she slept while on duty, Alexandria Pugh replied "Everyone in there sleeps!" Alexandria Pugh then started to list her complaints against the facility, and I told her she could file a complaint if she had concerns. The interview was concluded. Alexandria Pugh then immediately called me back and asked some additional questions; including if this would be on her record or if potential employers would be able to have access to this information. I informed her that if there was a preponderance of evidence, the report would be on our website, available for the public to review, for at least two years. She ended the call. Alexandria Pugh called back again, with additional questions, I answered her questions, and she was provided with the AFC Licensing website.

On July 12, 2024, I interviewed Michele Hitsman, who has the role of home manager. She reported to have experience in the field and has managed this home for three years. I inquired if there had been any issues in the facility with staff sleeping while on duty, and she stated that there had not been any since she took over the home three years ago. Michele Hitsman reported to become aware of the situation when it was brought to her attention by staff, Employee #1. Michele Hitsman informed me that ORR investigated, the allegations were substantiated, and Alexandria Pugh no longer works for Beacon Specialized Living Services.

On July 15, 2024, I conducted the exit conference with Shelly Keinath, Administrative Staff, who confirmed that all staff are to be awake while on duty. We discussed the investigation, my findings, and recommendations. She agreed to submit a written corrective action plan to address the established violation.

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:	According to the *Individual Plan of Service* for Resident A, he has an intellectual disability, which requires him to be supervised. Based on the information documented in the *Incident Report*, on May 11, 2024, Employee #1 observed Alexandria Pugh to be asleep in the facility. During my interview with Alexandria Pugh, she stated that she has some health problems, which cause her to be tired. When asked if she slept while on duty, Alexandria Pugh replied "Everyone in there sleeps!" The Office of Recipient Rights Summary report documented that there was a "preponderance of the evidence that Alexandria Pugh was asleep while working in the Beacon Home at Arlene on 5/11/24…" The allegations were substantiated for Neglect Class III. Based on the information gathered during this investigation and provided above, it's concluded that Resident A was not provided with the required level of staff supervision, as identified in his *Individual Plan of Service.*
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, it's recommended that the status of the license remains unchanged.

Mahtina Rubritius

07/15/2024

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

Dawn Timm

07/15/2024

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Dawn N. Timm Date
Area Manager