GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 8, 2024
Nichole VanNiman
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS800242668
Investigation #: 2024A1030054
Beacon Home at Highland

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 #:	AS800242668
Investigation #:	2024A1030054
Complaint Receipt Date:	09/18/2024
Investigation Initiation Date:	09/19/2024
Report Due Date:	11/17/2024
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 Highland
Facility Address:	56838 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	01/22/2002
License Status:	REGULAR
Effective Date:	07/08/2023
Expiration Date:	07/07/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGEDALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not appropriately supervised.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/18/2024	Special Investigation Intake 2024A1030054
09/19/2024	Special Investigation Initiated - Telephone Interview with referral source
09/26/2024	Contact - Face to Face Interview with Resident A
09/26/2024	Contact - Face to Face Interview with Veronica Vance
09/26/2024	Contact - Face to Face Interview with Adrienne Jones
09/26/2024	Contact - Face to Face Interview with Danyell Baltazar
09/26/2024	Contact - Document Received Received and reviewed Resident A's Behavior Support Plan
09/27/2024	Exit Conference by phone

ALLEGATION:

Resident A was not appropriately supervised.

INVESTIGATION:

On 9/18/24, I interviewed the referral source (RS) by phone. The RS reported Resident A has a behavior management plan that mandates she is in line of site at all times due to her being a vulnerable adult. The RS reported she was human trafficked for 3 weeks in January 2024. The RS reported direct care staff member Adrian Jones was asked to transport her to a therapy appointment by home manager Veronica Vance and when Resident A was taken to the appointment she was dropped off at the front door of the building and Ms. Jones drove across the street to a gas station to purchase a cup of coffee. Resident was informed by the receptionist that she was a day early for her therapy appointment and went back outside and could not find Ms. Jones. The RS reported she interviewed Ms. Jones who was unaware that Resident A had a behavior plan that mandated line of site supervision as she works at a different facility and that Ms. Vance told her it was ok to just drop her off at the front door. Ms. Vance denied ever telling Ms. Jones that she could drop her off however home manager Danyell Baltazar confirmed that Ms. Vance did not provide proper instructions to Ms. Jones.

On 9/26/24, I interviewed Resident A at the home. Resident A reported the staff is supposed to watch her and dropped her off at a therapy appointment on 8/29/24 without supervising her. Resident A reported she was driven by a staff member and dropped off at the front door and went inside to check in and was informed that she was a day early for her appointment. Resident A reported she went back outside and did not see the staff member in the parking lot. Resident A reported she went back inside and had the receptionist call the facility to inform them she needed to be picked up. Resident A reported the staff member returned and drove her back to the facility.

On 9/26/24, I interviewed home manager, Veronica Vance at the home. Ms. Vance reported she was working on 8/29/24 and asked Adrian Jones, who works at another facility, to drive her because they were short staffed. Ms. Vance reported Ms. Jones was not familiar with Resident A or her behavior plan. Ms. Vance reported Ms. Jones went to the gas station next door to get gas after she dropped Resident A off and was unaware of the scheduling problem. Ms. Vance reported Ms. Jones was within eyesight of building but was not within eyesight of Resident A.

On 9/26/24, I interviewed DCSM Adrian Jones at the facility. Ms. Jones reported she was working on 8/29/24 and agreed to do a favor for Ms. Vance and transport Resident A to her therapy appointment. Ms. Jones reported Ms. Vance told her she could drop Resident A off and the front door and never told her that she was supposed to walk Resident A into the building. Ms. Jones reported she went next door to the gas station to purchase some coffee and was called by another DCSM that Resident A's appointment was on a different and she had to pick her up. Ms. Jones reported she

drove right back to the office building and picked Resident A up and took her back to the facility.

On 9/26/24, I interviewed Danyell Baltazar at the home. Ms. Baltazar reported she and Ms. Vance co-manage the facility. Ms. Baltazar reported she is aware of the situation and acknowledged that Ms. Jones did not follow Resident A's BMP, however she was unaware of the BMP as Ms. Jones works at a different facility on the campus. Ms. Baltazar reported that Ms. Jones should have been informed that Resident A needs to be in her line of sight when she was asked to provide transportation to her therapy appointment.

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:	It was alleged Resident A was not appropriately supervised. Based on interviews and review of documentation this violation will be established. According to Resident A's behavior management plan, she needs to be in in the line of sight when in the community due to safety concerns. On 8/29/24, Resident A was transported to a therapy appointment and was dropped off at the front door while the staff member drove to the gas station to purchase gas and coffee thereby making it impossible to have her in direct line of sight.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/27/24, I shared the findings of my investigation with licensee Nichole VanNiman. Ms. VanNiman acknowledged the findings and agreed to submit a corrective action plan.

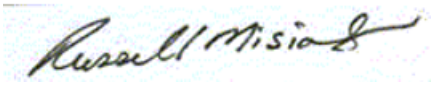
IV. RECOMMENDATION

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

10/8/24

Nile Khabeiry Date
Licensing Consultant

Approved By:



10/10/24

Russell B. Misiak Date
Area Manager