GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 12, 2024

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

RE: License #: AS390403202
Investigation #: 2024A0578057
Beacon Home at Kal-Haven

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) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390403202
Investigation #:	2024A0578057
Complaint Receipt Date:	09/19/2024
Investigation Initiation Date:	09/20/2024
Report Due Date:	11/18/2024
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 Kal-Haven
Facility Address:	5359 N. 8th Street Kalamazoo, MI 49009
Facility Telephone #:	(269) 214-4341
Original Issuance Date:	05/05/2020
License Status:	REGULAR
Effective Date:	11/05/2022
Expiration Date:	11/04/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the Kalamazoo County Justice Complex after being left unattended by direct care staff.	Yes
Resident A missed his injection appointment on 08/27/2024 and his drug test on 08/26/2024.	Yes

III. METHODOLOGY

09/19/2024	Special Investigation Intake 2024A0578057
09/19/2004	Contact-Document Reviewed- Integrated Services of Kalamazoo *Incident Report* related to the allegations and dated 06/07/2024.
09/20/2024	Special Investigation Initiated - On Site
09/20/2024	APS Referral
09/20/2024	Special Investigation Completed On-Site- Interview with direct care staff Andrea Jackson and direct care staff Thressa Carpenter.
09/20/2024	Contact-Document Reviewed- *Interim Behavior Support Plan* for Resident A, dated 05/03/2024.
09/20/2024	Contact-Document Reviewed- *Health Care Appraisal* for Resident A, dated 12/27/2024.
09/20/2024	Contact-Document Reviewed- *Assessment Plan for AFC Residents* for Resident A, dated 04/23/2024.
09/20/2024	Contact-Document Reviewed- Integrated Services of Kalamazoo *Incident Report*, dated 06/07/2024.
09/20/2024	Contact-Document Reviewed- *Continuing Order for Mental Health Treatment* for Resident A dated 11/09/2024.
11/04/2024	Contact-Telephone- Interview with Bridgeways case manager Zach Mousseau, unsuccessful.
11/04/2024	Interview with direct care staff Zach Lacey.
11/07/2024	Exit Conference- Message left for licensee designee Nichole VanNiman.

ALLEGATION: Resident A eloped from the Kalamazoo County Justice Complex after being left unattended by direct care staff.

INVESTIGATION:

On 09/19/2024, I received this complaint through the BCHS On-line Complaint System. Complainant alleged on 06/07/2024, Resident A eloped after being transported to the Kalamazoo County Justice Complex and being left unattended by direct care staff. Complainant reported there was no communication between direct care staff and the case manager for Resident A that Resident A would not be supervised by direct care staff when attending Resident A's court ordered appearance. Complainant reported Resident A was returned to this facility later the same day.

On 09/19/2024, I reviewed an Integrated Services of Kalamazoo *Incident Report* related to the allegations and dated 06/07/2024.This Integrated Services of Kalamazoo *Incident Report* was completed by case manager Sydney Morris. The Integrated Services of Kalamazoo *Incident Report* documented that Sydney Morris was informed by Resident A's case manager that direct care staff at this facility were running late with bringing Resident A to the Kalamazoo Mental Health Recovery Court. The Integrated Services of Kalamazoo *Incident Report* documented that Sydney Morris informed Resident A's case manager that she had another appointment to attend and was leaving the courthouse. The Integrated Services of Kalamazoo *Incident Report* documented that Sydney Morris saw Resident A outside of the courthouse with no direct care staff present and had no communication with any direct care staff regarding direct care staff not attending Resident A's court hearing or that direct care staff were only transporting Resident A. The Integrated Services of Kalamazoo *Incident Report* documented that Sydney Morris asked Resident A if direct care staff had dropped him off to park the vehicle and Resident A responded with 'yes they did" and watched as Resident A entered the building. The Integrated Services of Kalamazoo *Incident Report* documented that case management was later notified that Resident A was reported missing at 2PM by the direct care staff at this facility.

The Integrated Services of Kalamazoo *Incident Report* documented that Resident A was returned to the facility by Sydney Morris after being spotted by Sydney Morris in the community. The Integrated Services of Kalamazoo *Incident Report* documented that Sydney Morris was informed by the management of this facility the direct care staff that had transported Resident A to court was unaware of Resident A's *Interim Behavior Support Plan* and Resident A's need for supervision while in the community.

On 09/20/2024, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Andrea Jackson regarding the allegations. Andrea Jackson confirmed the allegations and reported that she had scheduled direct care staff Mikayla Langford to transport and supervise Resident A at his scheduled court

appearance at the Kalamazoo Mental Health Recovery Court. Andrea Jackson reported that in order to meet the staffing ratio for this appointment, she had arranged for direct care staff Zach Lacey to work at this facility while Mikayla Langford attended the appointment with Resident A. Andrea Jackson reported that instead of attending this appointment as instructed, Mikayla Langford instructed Zach Lacey to transport Resident A to his appointment instead. Andrea Jackson reported Zach Lacey was a new staff and was not completely trained. Andrea Jackson reported she could not facilitate this appointment as she was working at another facility. Andrea Jackson acknowledged that direct care staff should have been present for Resident A's court appearance as identified in Resident A's behavior plan.

On 09/20/2024, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 04/23/2024. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A does not move independently in the community, and identifies that Resident A has a *Behavior Plan* with a "freedom of movement" restriction.

On 09/20/2024, I reviewed the *Health Care Appraisal* for Resident A, dated 12/27/2024. The *Health Care Appraisal* for Resident A documented Resident A is diagnosed with Chronic Inflammatory Demyelinating Polyradiculoneuropathy, Schizophrenia and Hepatitis C.

On 09/20/2024, I reviewed the *Interim Behavior Support Plan* for Resident A, dated 05/03/2024. The *Interim Behavior Support Plan* for Resident A documented Resident A's target behaviors as substance use behavior, ADL non-compliance, and elopement, which the *Interim Behavior Support Plan* for Resident A identifies as leaving the AFC property without staff or other authorized supervision. The *Interim Behavior Support Plan* for Resident A identifies authorized supervision as leaving this facility with direct care staff, Integrated Services of Kalamazoo, or Bridgeways staff. The *Interim Behavior Support Plan* for Resident A identifies that Resident A is working with Mental Health Recovery Court to avoid felony convictions that could result in long-term incarceration. The *Interim Behavior Support Plan* for Resident A identifies that direct care staff should have a general knowledge of Resident A's whereabouts in the facility and should be able to see Resident A when he is outside of this facility, but preferably go outside with Resident A when he is outdoors. The *Interim Behavior Support Plan* for Resident A documented that during community outings, direct care staff will accompany Resident A to provide verbal redirection as needed. The *Interim Behavior Support Plan* for Resident A documented that Resident A does not require "line of sight" supervision at all times and may be unsupervised briefly during outings, such as for using the bathroom. The *Interim Behavior Support Plan* for Resident A documented that should Resident A elope from staff supervision, or direct care staff cannot locate where Resident A is, the missing person procedures should be followed.

On 11/04/2024, I interviewed direct care staff Zachary Lacey regarding the allegations. Zachary Lacey acknowledged the allegations and recalled transporting Resident A to his court appointment without accompanying Resident A while Resident A entered the building alone. Zachary Lacey acknowledged not being familiar with Resident A's behavior plan and not being aware of Resident A's supervision requirements while in the community. Zach Lacey acknowledged that Resident A did not return from this court appearance and was considered missing but was returned to this facility later in the day. Zach Lacey clarified he was a new employee at the time of the allegations, and this was the first shift he had ever worked for Beacon, and was simply told that all he would have to do is "hang out" at this facility before he was instructed by Mikayla Langford to provide transportation for Resident A.

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(1) Staffing levels shall be sufficient to implement the individual plans of service and plans of service shall be implemented for individuals residing in the facility. **(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas:** **(a) An introduction to community residential services and the role of direct care staff.** **(b) An introduction to the special needs of clients who have developmental disabilities or have been diagnosed as having a mental illness. Training shall be specific to the needs of clients to be served by the home.**

ANALYSIS:	Based upon my investigation, which consisted of interviews with direct care staff Andrea Jackson and direct care staff Zachary Lacey, as well as a review of pertinent documentation relevant to this investigation, Zachary Lacey was not provided with training specific to the special needs of Resident A, and the *Interim Behavior Support Plan* for Resident A was not implemented for Resident A while Resident A was left unattended by direct care staff in the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Based upon my investigation, which consisted of interviews with direct care staff Andrea Jackson and direct care staff Zachary Lacey, as well as a review of pertinent documentation relevant to this investigation, Resident A's personal needs, protection and safety were not attended to at all times when Resident A was transported to Kalamazoo Mental Health Recovery Court by direct care staff and left unattended resulting in an elopement.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A missed his injection appointment on 08/27/2024 and his drug test on 08/26/2024.

INVESTIGATION:

On 09/20/2024, I interviewed direct care staff Thressa Carpenter regarding the allegations. Thressa Carpenter reported she did not know why Resident A missed these medical appointments, but reported she could provide documentation of completed injections for Resident A. While at this facility, I reviewed the Medical Appointment Records for Resident A. I could not locate Resident A's *Medical Appointment Record* for 08/27/2024. I reviewed the available *Medical Appointment Records* for Resident A with Thressa Carpenter. Thressa Carpenter was unable to find *Medical Appointment Records* for Resident A documenting that Resident A completed his Invega Sustena 234MG injection on 08/27/2024.

On 09/20/2024, I interviewed direct care staff Andrea Jackson regarding the allegations. Andrea Jackson reported that she did not know why Resident A missed

his injection appointment or his drug test. Andrea Jackson reported both appointments are standing appointments in order to comply with Kalamazoo Mental Health Recovery Court.

ON 11/06/2024, I reviewed the details of the allegations with Integrated Services of Kalamazoo recipient rights officer Kate Koyak. Kate Koyak reported Resident A's injection and drug test appointment occurred while Andrea Jackson, the home manager for this facility, was on unexpected medical leave. Kate Koyak reported that Andrea Jackson did not record any kind of medical appointments in the facility, and as a result, the assistant home manager, Darnice Haskell, was unaware of Resident A's upcoming injection and drug test appointments. Kate Koyak reported that as soon as Darnice Haskell was informed of Resident A missing his injection and drug test appointment, she was able to correct this and resume Resident A's regularly scheduled drug tests and injection appointments.

On 09/20/2024, I reviewed the *Continuing Order for Mental Health Treatment* for Resident A provided by the State of Michigan Probate Court of Kalamazoo County on 11/09/2024. The *Continuing Order for Mental Health Treatment* for Resident A documented that Resident A is ordered to comply with the following assisted outpatient services: case management plan, case management services, all services recommended by the treatment provider and all medications including injectables, medications, blood or urinalysis tests to determine compliance with or effectiveness of prescribed medication, individual and group therapy, day programs, partial day programs, educational training, vocational training, supervised living, assertive community treatment team services, substance use disorder treatment, substance use disorder testing for individuals with a history of alcohol or substance abuse, and "any other services prescribed to treat the individual's mental illness and either to assist in the individual in living and functioning in the community or to help prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization."

On 09/20/2024, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 04/23/2024. The *Assessment Plan for AFC Residents* for Resident A documented that direct care staff will administer all Resident A's medications with the exception of his Invega Sustena 234MG injection, which will be done at Integrated Services of Kalamazoo.

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:	Based upon my investigation, which consisted of interviews with direct care staff Andrea Jackson, direct care staff Thressa Carpenter, and Integrated Services of Kalamazoo rights officer Kate Koyak well as observations made during an unannounced investigation on-site and a review of pertinent documentation relevant to this investigation, Resident A was not provided with the supervision, protection, and personal care to consistently maintain Resident A's court ordered Invega Sustena 234MG injection or routing drug screenings.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

11/07/2024

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Eli DeLeon Date
Licensing Consultant

Approved By:

11/12/2024

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Dawn N. Timm Date
Area Manager