GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 18, 2024
Nichole VanNiman
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AS800242668
Investigation #: 2025A1030006
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 #:	2025A1030006
Complaint Receipt Date:	10/21/2024
Investigation Initiation Date:	10/21/2024
Report Due Date:	12/20/2024
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 Howard
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 AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility did not obtain appropriate medical care for Resident A.	Yes
Additional Findings	

III. METHODOLOGY

10/21/2024	Special Investigation Intake 2025A1030006
10/21/2024	Special Investigation Initiated - Telephone Interview with referral source
10/21/2024	APS Referral APS referral made
10/23/2024	Contact – Face to face Interview with Resident A
10/23/2024	Contact – Face to Face Interview with Kalya Cummins
10/23/2024	Contact – Document received Received and reviewed Incident Report and Misc. Note
10/28/2024	Contact- Phone call made Interview with Mickie Tingley
10/30/2024	Contact – Phone call made Interview with Irma Solis
11/18/2024	Exit Conference Exit conference by phone

ALLEGATION:

The facility did not obtain appropriate medical care for Resident A.

INVESTIGATION:

On 10/21/24, I interviewed the referral source (RS) by phone. The RS reported Resident A swallowed some vape liquid in a suicide attempt. The RS reported direct care staff member (DCSM) Irma Solis contacted assistant home manger Kalya Cummins who instructed her to contact poison control who advised her to take Resident A to the hospital for evaluation for suicidality. The RS reported Ms. Solis documented the recommendation in miscellaneous note (MN). The RS reported Ms. Solis reported she called assistant home manager Kayla Cummins who was on call and was advised not to contact the clinical staff member or take Resident A to the hospital. The RS reported Ms. Cummins denied ever telling Ms. Solis not to call the facilities clinical staff member or take her to the hospital despite Ms. Solis documenting both conversations with poison control and Ms. Cummins.

On 10/23/24, I attempted to interview Resident A at the home, however she declined to be interviewed.

On 10/23/24, I interviewed assistant home manager Kayla Cummins at the facility. Ms. Cummins reported she was on-call on 9/24/24. Ms. Cummins reported she received a call from DCSM Irma Solis and was informed that Resident A drank vape liquid. Ms. Cummins reported she instructed Ms. Solis to contact the on-call medical staff, poison control and the on-call clinical person. Ms. Cummins reported Ms. Solis called her back and indicated that Resident A would be fine. Ms. Cummins reported she was never informed that poison control indicated Resident A should be taken to the hospital. Ms. Cummins also reported she was having difficulty remembering all the details of the situation.

On 10/23/24, I received and reviewed an incident report (IR) and a miscellaneous note (MN) authored by Irma Solis dated 9/24/24. The IR indicated Resident A consumed vape juice and was feeling suicidal and the on-call supervisor, Kalya Cummins was contacted. The IR further indicated Ms. Cummings instructed Ms. Solis to contact the facilities medical on-call staff member who instructed her to call poison control and was instructed by poison control that if Resident A was suicidal she was to be taken to the hospital for medical clearance. The IR also indicated that Ms. Solis was instructed not to contact the facility's on-call clinical person about the situation.

The MN documented similar information to the IR however the MN indicated Ms. Solis informed Ms. Cummins that poison control instructed her to take Resident A to the hospital to be medically cleared due to suicidality. The MN further documented that Ms. Solis was instructed by Ms. Cummins to review Resident A's behavior treatment plan

and that the clinical on-call person did not need to be called because Resident was feeling better and socializing and laughing.

On 10/28/24, I interviewed Mickie Tingley RN by phone. Ms. Tingley reported she was on-call for the facility on 9/24/24 and spoke with Ms. Solis about Resident A drinking vaping liquid. Ms. Tingley reported she told Ms. Solis to contact Poison Control and follow their instructions. Ms. Tingley reported she also Ms. Solis to complete an IR and an MN and to call her back if she needed any other assistance.

On 10/30/24, I interviewed Irma Solis by phone. Ms. Solis reported she was working on 9/24/24 and noted Resident A appeared to be anxious when she got to work at 8:30pm. Ms. Solis reported Resident A came to her and informed her about drinking the vape liquid and feeling suicidal. Ms. Solis reported she called the on-call supervisor Ms. Cummins who instructed her to call the on-call medical person. Ms. Solis reported she called the facilities medical on-call person who instructed her to call Poison Control. Ms. Solis reported Poison Control recommend Resident A be taken to the hospital if she was suicidal. Ms. Solis reported she called Ms. Cummins back and told her Poison Control recommended Resident A be taken to the hospital and asked if she should call the on-call clinical staff member. Ms. Solis reported Ms. Cummins instructed her not to call the clinical person and instead review her behavior plan and talk to her.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an incident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	It was alleged the facility did not obtain appropriate medical care for Resident A. Based on interviews and review of documentation this violation will be established. On 9/24/24 Resident A informed Ms. Solis that she drank vape liquid and was feeling suicidal. Ms. Solis contacted her supervisor, the on call medical person and Poison Control about Resident A and was instructed to take her to the hospital for medical clearance for being suicidal. There was a discrepancy between Ms. Solis and Ms. Cummins' version of events after Ms. Solis was instructed to take Resident A to the hospital, however Resident A was not taken to the hospital for a medical evaluation per the recommendation made by Poison Control authorities.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/18/24, I shared the findings of my investigation with licensee designee, Nichole VanNiman by phone. Ms. VanNiman acknowledged the findings and agreed to submit a corrective action plan.

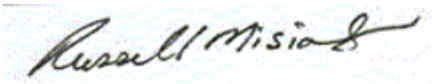
IV. RECOMMENDATION

Contingent upon the submission of an acceptable corrective action plan, I recommend no changes to the current license status.

11/18/24

Nile Khabeiry Date
Licensing Consultant

Approved By:



11/19/24

Russell B. Misiak Date
Area Manager