GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 10, 2025
Nichole VanNiman
Beacon Specialized Living Services, Inc.
890 N. 10th St. Suite 110
Kalamazoo, MI 49009

RE: License #: AM800084653
Investigation #: 2025A1030023
Beacon Home at Meadowland

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 #:	AM800084653
Investigation #:	2025A1030023
Complaint Receipt Date:	02/13/2025
Investigation Initiation Date:	02/13/2025
Report Due Date:	04/14/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimbery Howard
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Meadowland
Facility Address:	56844 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 674-7306
Original Issuance Date:	09/28/1999
License **Status:**	REGULAR
Effective Date:	10/24/2023
Expiration Date:	10/23/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff physical and verbally abused Resident A.	Yes
Staff refused to give Resident B her prescription medication.	No
Additional Findings	No

II. METHODOLOGY

02/13/2025	Special Investigation Intake 2025A1030023
02/13/2025	Special Investigation Initiated - On Site Interview with Resident A
02/13/2025	APS Referral Received and reviewed APS referral
02/13/2025	Contact - Face to Face Interview with Danyell Baltazar
02/13/2025	Contact - Document Received Received and reviewed four incident reports
02/13/2025	Contact - Document Received Received and reviewed After Visit Summary
02/13/2025	Contact - Face to Face Interview with Tobitiara Gains
02/13/2025	Contact - Face to Face Interview with Tammy Branch
02/13/2025	Contact - Telephone call made Interview with referral source
02/14/2025	Contact - Telephone call made Interview with Kristen McHenry
02/20/2025	Contact - Face to Face Interview with Resident B

02/20/2025	Contact - Face to Face Interview with Hanna Duban-Barns
02/20/2025	Contact - Document Received Received and reviewed Resident B's MAR
02/20/2025	Contact - Face to Face Interview with Veronica Vance
03/10/2025	Exit Conference Exit conference by phone

ALLEGATION:

Staff physical and verbally abused Resident A.

INVESTIGATION:

On 2/13/25, I interviewed Resident A at the facility. Resident A reported direct care staff member Kayla Cummings put her hands on her and pushed her into her bedroom. Resident denied knowing the date but believed it was two or three weeks ago. Resident A reported she yelled at Ms. Cummings and refused to go into her bedroom. Resident A reported this was the only time something like this happened. Resident A reported Ms. Cummins told her she was acting like a baby and to shut up.

On 2/13/25, I interviewed home manager, Danyell Baltazar at the facility. Ms. Baltazar reported the incident happened sometime in January however this just came out in the last week. Ms. Baltazar reported Resident A was taken to the hospital and had her evaluated for any injuries as she complained of having bruises and having other issues because of the assault. Ms. Baltazar provided the names of the two other DCSM who were present. Ms. Baltazar reported Ms. Cummings was suspended pending the investigation. Ms. Baltazar reported Resident A was recently psychiatrically hospitalized and was taken off several of her medications which has resulted in her being more dysregulated. Ms. Baltazar reported Resident A has been having lots of behaviors and been much more aggressive towards residents and staff.

On 2/13/25, I received and reviewed four incident reports (IR) regarding Resident A's behaviors on 1/21/25, 1/22/25, 1/29/25 and 2/2/25. The IR documented Resident A being verbally and physically aggressive with staff and residents, destroying property and making suicidal statements. The IR also indicated the staff members contacted the clinical staff about Resident A's behaviors.

On 2/13/25, I received and reviewed an after-visit summary (AVS) for Resident A dated 2/7/25. The AVS indicated Resident A was seen for bicep strain, acute pain of the left shoulder and strain of the left rotator cuff. The AVS recommended Resident A take Motrin and Tylenol for pain and apply ice twenty minutes per hour to decrease pain and swelling.

On 2/13/25, I interviewed DCSM Tobitiara Gains. Ms. Gains reported she was working when the incident occurred. Ms. Gains reported Resident A was threatening residents and staff as well and destroying property. Ms. Gains attempted to verbally redirect Resident A several times however it did not work. Ms. Gains reported assistant home manager Kayla Cummings was also working and tried to get Resident A to go into her bedroom to keep everyone safe and to calm Resident A down. Ms. Gains reported that Ms. Cummings put her hand on Resident A's back to try and guide her into her bedroom however Resident A refused to go into her bedroom and instead went and sat on the couch in the common area of the facility. Ms. Gains denied Ms. Cummings ever grabbed Resident A by her arms or pushed her aggressively pushed Resident A into her bedroom

On 2/13/25, I interviewed DCSM Tammy Branch at the facility. Ms. Branch reported she was also working when the incident with Resident A occurred. Ms. Branch reported Resident A was having behaviors and they tried to calm her down verbally. Ms. Branch reported Ms. Cummins tried to get Resident A to go into her bedroom to calm down but did not physically force her into her bedroom. Ms. Branch denied ever seeing Ms. Cummins being physical with any of the residents, however, has witnessed Ms. Cummins being verbally disrespectful to Resident A as well as other residents. Ms. Branch reported Ms. Cummins tells residents to "shut up and to spoke acting like a fucking child."

On 2/13/25, I interviewed Kayla Cummings by phone. Ms. Cummings denied being too physical with Resident A and tried to guide her into her bedroom as the other residents were in the common area of the home and she was concerned about their safety. Ms. Cummings reported she put her hand on Resident A's back and never grabbed or pushed her into her bedroom. Ms. Cummins denied being verbally abusive to any of the residents.

On 2/13/24, I interviewed the referral source (RS.) The RS reported he has not found any evidence that Ms. Cummings grabbed or pushed Resident A into her bedroom.

On 2/14/25, I interviewed the facilities clinical director Kristen McHenry by phone. Ms. McHenry reported she was contacted by the staff when Resident A was having behavior problems and met with her in the facility. Ms. McHenry reported Resident A reported Ms. Cummings told her that residents cannot be in each other's bedrooms or be relationships with each other which is a violation of their rights. Ms. McHenry reported that Ms. Cummings encouraged other staff members to ignore her. Ms. McHenry reported Ms. Cummings made other inappropriate statements to other residents and

called Resident B “lazy” and that she was going to take her funds when they came to the facility because Resident B keyed her car.

On 2/20/25, I interviewed DCSM Hanna Duban-Barns at the facility. Ms. Duban-Barns reported she has worked with Kayla Cummings and has some concerns about the way Ms. Cummings interacts with the residents. Ms. Duban-Barns reported she has witnessed Ms. Cummings yell and scream at Resident A and tell her “She was acting like a child.”

On 2/20/25, I interviewed home manager Veronica Vance. Ms. Vance reported she is aware of the situation between Ms. Cummings and Resident A even though she was at the facility when it occurred. Ms. Vance reported she has never witnessed Ms. Cummins being physical with any of the residents but has noted her being verbally abusive as he has yelled at residents and told them to shut up. Ms. Vance reported having a conversation with her about tone and conversations with the residents.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	It was alleged that a staff member physically and verbally abused Resident A. Based on interviews and review of documentation this violation will be established regarding Resident A being verbally abused, however there was no evidence that Resident A was physically abused. According to all of the individuals who witnessed this interaction between Kayla Cummins and Resident A there was no physical force used on Resident A however Ms. Cummins was rude and disrespectful and used profanity and told Resident A that she was acting like a child.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff refused to give Resident B her prescription medication.

INVESTIGATION:

On 2/14/24, I received additional allegations regarding Resident B. The allegations indicated that the staff members would not give Resident B her prescription pain medication.

On 2/20/25, I interviewed Resident B at the facility. Resident B reported she fell and broke her shoulder last week. Resident B reported she was in pain and asked for her pain medication, but the staff refused to give it to her. Resident B denied knowing the specific schedule for administering her pain medications.

Ms. Duban-Barns reported she passes medications and was working when Resident B complained about not getting her pain medication. Ms. Duban-Barns reported she and the other staff members pass medications according to the prescriptions and the Medication Administration Record (MAR.) Ms. Duban-Barns reported Resident B broke her shoulder and was prescribed Oxycodone for pain. Ms. Duban-Barns reported Resident B can take over the counter pain reliever which was offered to her in between Oxycodone however she refused to take anything but the Oxycodone.

On 2/20/25, I received and reviewed Resident B's MAR. The MAR indicated Resident B was prescribed Oxycodone on 2/14/25 and was supposed to take one tablet by mouth twice daily for pain as needed.

Ms. Vance reported they are very attentive to the need to administer medications correctly. Ms. Vance reported the staff administered Resident B's medication as prescribed and she wanted additional Oxycodone, but they did not give it to her.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan

	Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was alleged that staff refused to give Resident B her prescription medication. Based on interviews and review of documentation this violation will not be established. According to Resident B's MAR she was prescribed Oxycodone for pain twice per day as needed and was administered the proper medication. The staff offered Resident B OTC pain medication in between doses of Oxycodone however she refused to take anything but the narcotic pain medication.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 3/10/25, I shared the findings of my investigation with program administrator, Kimberl Howard. Ms. Howard acknowledged the findings and agreed to submit a corrective action plan.

III. RECOMMENDATION

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

Nile Khabeiry, LMSW

3/11/25

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Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

3/12/25

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Russell B. Misiak Date
Area Manager