GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 20, 2025

Roxanne Goldammer
Gonyer Home Adult Foster Care LLC
Suite 110
890 North 10th Street
Kalamazoo, MI 49009

RE: License #: AM400310461
Investigation #: 2025A0009018
Beacon Home at Fife Lake

Dear Ms. Goldammer:

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 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 (616) 356-0100.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM400310461
Investigation #:	2025A0009018
Complaint Receipt Date:	05/05/2025
Investigation Initiation Date:	05/06/2025
Report Due Date:	06/04/2025
Licensee Name:	Gonyer Home Adult Foster Care LLC
Licensee Address:	5568 Gonyer Road Fife Lake, MI 49633
Licensee Telephone #:	(231) 879-4190
Administrator:	Roxanne Goldammer
Licensee Designee:	Roxanne Goldammer, Designee
Name of Facility:	Beacon Home at Fife Lake
Facility Address:	5568 Gonyer Road Fife Lake, MI 49633
Facility Telephone #:	(231) 879-7606
License Status:	REGULAR
Effective Date:	07/05/2024
Expiration Date:	07/04/2026
Capacity:	8
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On May 1, 2025, at approximately 12:15 p.m., direct care worker Lauren Shupiery was observed walking out of the home with a resident's prescribed medication.	Yes

III. METHODOLOGY

05/05/2025	Special Investigation Intake 2025A0009018
05/06/2025	Special Investigation Initiated – Telephone call made to Complainant
05/07/2025	Inspection Completed On-site Interviews with licensee designee Roxanne Goldammer, home manager Vera Cousino, direct care worker Candy Birgy and direct care worker Lauren Shupiery
05/08/2025	Contact – Telephone call made to licensee designee Roxanne Goldammer
05/08/2025	Contact – Telephone call made to Kalkaska County Central Dispatch
05/08/2025	Contact – Telephone call received from Trooper Kyleigh Huttenga with the Michigan State Police
05/08/2025	Contact – Document (email with attachment) sent to Trooper Kyleigh Huttenga with the Michigan State Police
05/20/2025	Exit conference with licensee designee Roxanne Goldammer

ALLEGATION: On May 1, 2025, at approximately 12:15 p.m., direct care worker Lauren Shupiery was observed walking out of the home with a resident's prescribed medication.

INVESTIGATION: I spoke with the complainant by telephone on May 6, 2025. They reported that they were at the Beacon Fife Lake adult foster care home on May 1, 2025. They stated that they were sitting at the dining room table at around 12:15 p.m. and observed direct care worker Lauren Shupiery walk out of the home with a resident's prescribed medication in her hands. When she walked back in, she did not have the medication. The complainant knew that this was suspicious. I asked

the complainant if they knew what medication was taken. They said that it was two boxes of Resident A's Trulicity insulin pens. They did not know if the home manager, Vera Cousino, was aware of it or not but she was in the front office at the time. The complainant said that they are unaware of anything like this happening previously.

I spoke with licensee designee Roxanne Goldammer by telephone on May 7, 2025. I told her that I planned on doing a site visit at the Beacon Home at Fife Lake that day and that she was welcome to meet me there if she chose. I had known Ms. Goldammer to be helpful during a previous investigation at another location.

I then conducted an on-site visit at the Beacon Home at Fife Lake on May 7, 2025. Licensee designee Roxanne Goldammer was present at that time and met with me in the front office of the facility. I told her of the complaint and what I was investigating. Ms. Goldammer reported that there is video footage available for the medication room. She suggested we start there. We reviewed the date and time of the alleged incident but did not see direct care worker Lauren Shupiery in the video footage of the medication room at that time. We also reviewed other days at around that time and other times in case the complainant was mistaken about the day and/or time of the incident. We did observe direct care worker Lauren Shupiery enter the medication room at what we believed to be 9:35 a.m. on May 2, 2025. She grabbed a resident's medication folder at that time and left the medication room. Ms. Goldammer explained that a resident was likely being transported to a medical appointment and needed their medication folder with them. We also observed Ms. Shupiery walk into the medication room at a different time and grab something off a shelf and leave. We could not see what she took but did not believe it was medication since this was away from where resident medication is located. We did observe other staff conducting medication tasks in the medication room. They all seemed to be doing routine and appropriate medication duties while in the room.

We spoke with home manager Vera Cousino about Resident A's Trulicity insulin pens. She said that Resident A does take Trulicity. Her prescription for Trulicity had recently changed. Resident A received the new Trulicity pens of a different dosage on May 1, 2025. The records showed that Resident A would still have had some left-over, unused insulin pens of the previous prescription when the new ones arrived at the home. We checked in the medication room and did not locate the left-over, unused medication. Ms. Goldammer and Ms. Cousino stated that they maintain a log of destroyed medication. I asked to view that log which was located in the medication room. The last record of a medication being destroyed was on March 12, 2025 after a Vitamin D supplement had been found on the floor. There was no record of any medications being destroyed since that time. Ms. Cousino stated that was the only place where the destruction of a medication should have been recorded. She said that if Resident A's insulin had been destroyed, it should have been logged there. I asked if there was any other explanation for the missing medication and there being no log of it having been destroyed. Ms. Cousino did not

have an explanation and said that she had always known staff to document the destruction of medication properly.

Ms. Goldammer and I returned to the video footage of the medication room. Ms. Cousino came over at one point, looking over our shoulders. She pointed out that she believed the time posted in the footage was one hour off, possibly because of it not updating with daylight saving time. Ms. Goldammer and I made this correction and went back to May 1, 2025 at what we now knew to be 12:00 p.m. We observed direct care worker Candy Birgy logging in resident medication that had arrived to the home that day. We observed her logging in new insulin pens and placing them in the medication room refrigerator. She took out two boxes of insulin pens from the refrigerator which we supposed to be the left-over, unused prescription for Resident A. At about 12:13 p.m. on that day, we observed Ms. Birgy leave the room with the boxes and is then out of the range of the video footage at that point. Ms. Goldammer and I note that this is very close to the complainant information which is that the two boxes were taken out of the home on that date at almost exactly that time.

Home manager Ms. Cousino denied that she remembered the two boxes of left-over, unused medication coming into the office at that time. She said that she does have the medication technician bring her outdated medication so she can log it out and log in the new medication. She likes to have the actual medication sitting in front of her so she can verify that everything is correct. We talked about what would have been happening on May 1, 2025 at that time. Ms. Goldammer stated that she recalled that she conducted a video meeting with home managers on that day and time. She said that Ms. Cousino would have been at her computer during the meeting. We also determined that Ms. Shupiery was at the other desk in the office at that time. She was performing duties which necessitated her being at the other computer. One desk is not necessarily in the field of vision of the other desk as they face adjoining walls.

I asked to speak with direct care worker Candy Birgy who was the last known person to handle Resident A's left-over, unused medication. She was not at work at that time but we called her personal phone. Ms. Birgy spoke with us at that time. She did recall that Resident A's Trulicity insulin prescription had changed recently. Ms. Birgy recalled that there was left-over, unused medication. She said that she did remember taking the medication out of the medication room over to the front office. Ms. Birgy denied remembering who exactly was in the office at the time. She said that she placed the medication on one of the desks or possibly on the printer by Ms. Cousino's desk. Ms. Birgy denied that she handled the medication after that. She denied that she was involved in the destruction of the medication. She was unaware what happened to it after that point.

Ms. Goldammer and I then spoke with direct care worker Lauren Shupiery. I told her that two boxes of Resident A's left-over, unused insulin was missing and asked if she knew what had happened to it. Ms. Shupiery replied, "To tell you the truth, it is

sitting in my fridge." I asked if she meant her refrigerator at home. She said, "yes". I asked her why she took it. Ms. Shupiery replied, "To be honest, because I have to lose weight." She denied that she had used any of it yet. I asked if she knew what was supposed to happen to outdated medication. She said that she knew that it is supposed to be disposed of properly. I asked Ms. Shupiery if she would write a statement of what she had done. She agreed and wrote, "On May 1st, I took home medication that was discontinued (Trulicity)" and signed the page. Ms. Goldammer told Ms. Shupiery to go home, retrieve the medication and bring it back to the facility. Ms. Shupiery agreed and left at that time.

Ms. Goldammer and I then spoke with home manager Vera Cousino. She said that she denied remembering Ms. Shupiery grabbing the medication. Ms. Goldammer said that Ms. Shupiery would have been sitting at the other desk and it gave her the opportunity to take the medication at that time. Ms. Goldammer stated that she would wait until Ms. Shupiery returned and handle the situation from there.

I spoke with licensee designee Roxanne Goldammer by telephone on May 8, 2025. She stated that Ms. Shupiery had returned to the facility with Resident A's medication the day before. She and Ms. Cousino verified that all the medication was accounted for. Ms. Shupiery's employment was terminated at that time. Ms. Goldammer reported that they would be looking closely at their medication procedures, including the disposing of medications. She believed they would initiate a procedure which would have staff disposing of medication in the medication room.

I made a law enforcement referral to Trooper Kyleigh Huttenga with the Michigan State Police on May 8, 2025. I gave her the information I had regarding Ms. Shupiery taking a resident's medication from the home. She requested the statement that Ms. Shupiery had written and the statute and rules which covered resident medication in a State of Michigan, licensed adult foster care home which I provided to her.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It was alleged that on May 1, 2025, direct care worker Lauren Shupiery took Resident A's medication from the facility to use herself. It was confirmed through this investigation that the licensee did not take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	It was confirmed through this investigation that Resident A's prescription medication was not disposed of properly after it was no longer required.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee Roxanne Goldammer by telephone on May 20, 2025. I told her of the findings of the investigation and gave her the opportunity to ask questions.

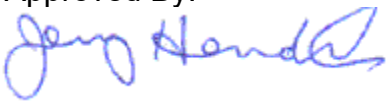
IV. RECOMMENDATION

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

05/20/2025

Adam Robarge Date
Licensing Consultant

Approved By:



05/20/2025

Jerry Hendrick Date
Area Manager