GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 1, 2025

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

RE: License #: AM800267886
Investigation #: 2025A1031017
Beacon Home at Anchor Point South

Dear Licensee Designee:

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 (616) 356-0183.

Sincerely,

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
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 #:	AM800267886
Investigation #:	2025A1031017
Complaint Receipt Date:	01/08/2025
Investigation Initiation Date:	01/09/2025
Report Due Date:	03/09/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator/Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Anchor Point South
Facility Address:	28720 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/03/2005
License Status:	REGULAR
Effective Date:	04/24/2024
Expiration Date:	04/23/2026
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff did not provide appropriate supervision for Resident A and B.	Yes

III. METHODOLOGY

01/08/2025	Special Investigation Intake 2025A1031017
01/08/2025	APS Referral
01/08/2025	Special Investigation Initiated - Inspection Completed On-site
01/08/2025	Contact - Face to Face Interview Resident A and Israel Baker.
01/09/2025	Contact - Email Exchange with Kristina Potesta.
1/16/2025	Contact - Document Requested and Received.
01/23/2025	Contact - Face to Face Interview with Isreal Baker.
01/30/2025	Contact - Telephone Interview with Linda Graham.
01/30/2025	Contact - Voicemail left with Jerome White and Jessie Ballard.
02/18/2025	Contact - Face to Face Interview with Resident A and Israel Baker.
03/04/2025	Contact - Email exchange with Kristina Potesta.
03/18/2025	Contact - Face to Face Interview with Johnny Jackson, Joseph Waller, and Theodore Nicolet.
04/01/2025	Contact – Email Exchange with Lindsey Taylor.
04/29/2025	Exit Conference held with Nichole VanNiman.

ALLEGATION:

Staff did not provide appropriate supervision for Resident A and B.

INVESTIGATION:

On 1/8/25, I interviewed district manager Israel Baker at the facility. Mr. Baker reported Resident A did leave the facility and was located at the neighboring facility. Mr. Baker reported Resident A had not required 1:1 supervision after 9pm.

On 1/8/25, Resident A was not available to be interviewed as he was on an outing.

On 1/9/25, I sent an email to recipient rights officer Kristina Potesta. Ms. Potesta reported she received an incident report about Resident A leaving the facility. Ms. Potesta included the incident report as in attachment within the email.

On 1/9/25, I reviewed the incident report dated 1/3/25. The report read that direct care worker Jerome White conducted bed checks at 9:05pm and Resident A was in his bedroom. Bed checks were completed again and Mr. White noticed Resident A was not in their bedroom and checked other resident's bedrooms and bathrooms. Staff notified the lead worker that Resident A was missing. Staff located Resident A and Resident A returned to the home at 9:45pm. Resident A was located walking between the facilities on campus. Actions taken by staff included increasing safety checks due to him leaving the facility.

On 1/16/25, I received and reviewed Resident A's *Assessment Plan for AFC Residents* dated 1/9/24 and *Individual Plan of Service (IPOS)* dated 3/13/24. The assessment read that Resident A required 12 hours of enhanced supervision due to health and safety needs for himself and others. The IPOS read that Resident A had aggressive behaviors and a history of property destruction that required him to be monitored by staff at all times. Resident A has enhanced 1:1 staffing for 12 hours daily during 9am to 9pm.

On 1/23/25, I attempted to interview Resident A, and he did not want to engage in the interview process.

On 1/23/25, I interviewed Mr. Baker at the facility. Mr. Baker informed me of an incident that occurred at an attached but separately licensed AFC facility. Mr. Baker reported DCW Jessie Ballard was assigned to Anchor Point South facility and left to provide assistance at Anchor Point North where he was not scheduled. Mr. Baker reported Mr. Ballard was assigned to Resident B who resides in Anchor Point South that required 1:1 staffing.

On 1/30/25, I interviewed DCW Linda Graham via telephone. Ms. Graham reported she was responsible for supervising two residents in Anchor Point South. Ms. Graham admitted to leaving the individuals unsupervised while she managed an incident occurring in Anchor Point North facility.

On 1/30/25, I left a voicemail with DCW Jerome White. As of the writing of this report, Mr. White did not respond to my request to interview.

On 2/18/25, I interviewed Mr. Baker at the Anchor Point South facility. Mr. Baker was consistent in reporting that Resident A walked to a neighboring facility. Mr. Baker reported Resident A of Anchor Point South facility has a friend at Wavecrest facility where he liked to get soda pop from. Mr. Baker again reported that Resident A does not require a 1:1 staff after 9pm and bed checks were completed every hour or less per policy. Mr. Baker reported Resident B of Anchor Point South facility does require 1:1 supervision and Mr. Ballard left him alone when he went to the Anchor Point North facility.

On 3/4/25, I received an email from Ms. Potesta that read she substantiated for Neglect Class III through recipient rights. Ms. Potesta reported Resident A requires 24/7 supervision and monitoring per his treatment plan. Ms. Potesta reported "note that 24/7 monitoring and supervision is knowing the general whereabouts of the recipient, whereas 1:1 staffing is usually within arm's reach or in sight. While his enhanced staffing ended at 9pm, staff were still responsible for knowing his general whereabouts, which they did not. Staff were unaware of his whereabouts for approximately 45 minutes." Ms. Potesta reported that it was unclear whether Resident A eloped prior to his enhanced staffing or after.

On 3/18/25, I interviewed DCW Johnny Jackson, Joseph Waller, and Theodore Nicolet.

Mr. Jackson reported there are two licensed facilities located in one building which is referred to as "North" and "South". Mr. Jackson reported on 1/19/25 he was scheduled to work at the North facility. Mr. Jackson reported Mr. Ballard was scheduled as a 1:1 staff at the South facility but came over to the North facility. Mr. Ballard did not have Resident B with him. Mr. Jackson reported Mr. Ballard then asked him to go locate Resident B as he had left him alone. Mr. Jackson reported he then went to search for Resident B at the South facility and he was found to be unattended.

Mr. Waller and Mr. Nicolet both reported that Mr. Ballard was not scheduled to work at the North facility. They both reported Mr. Ballard was assigned Resident B and he did not have Resident B with him. They both reported they heard Mr. Ballard ask other staff to go locate Resident B as he was assigned to him.

On 4/1/25, I reviewed Resident B's *Assessment Plan for AFC Residents* dated 6/27/24. The assessment read that Resident B requires 24 hour 1:1 supervision until 3/11/25 due to a court order. It further read that Resident B had a history of elopement.

On 4/1/25, I exchanged emails with adult protective services worker Lindsey Taylor. Ms. Taylor reported she did conduct an investigation and did not find any evidence to support that Resident A was neglected or abused.

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.
ANALYSIS:	Based on interviews with staff and the review of documentation, it has been determined that Resident A and Resident B were not provided with appropriate supervision as required by their individual plans of service. Staff did not notice Resident A had left the facility and subsequently his whereabouts were unknown until he was located at the neighboring facility. Mr. Ballard was assigned to Resident B for 1:1 staffing and left Resident B unattended. Staff reported Mr. Ballard was aware that he had left Resident B unattended as he requested for another staff to help locate him. Ms. Graham admitted to leaving the individuals unsupervised while she managed an incident occurring in the other licensed facility from which she was not assigned.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was held with Ms. VanNiman on 4/29/25. Ms. VanNiman reported she was aware of the alleged incident and the facility will complete a corrective action plan as soon as possible.

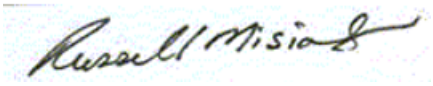
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

4/1/25

Kristy Duda Date
Licensing Consultant

Approved By:



4/24/25

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Russell B. Misiak Date
Area Manager