GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 12, 2021

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

RE: License #: AS630387840
Investigation #: 2021A0602029
Beacon Home at Lake Orion

Dear Mr. Kalinowski:

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 (248) 975-5053.

Sincerely,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630387840
Investigation #:	2021A0602029
Complaint Receipt Date:	07/19/2021
Investigation Initiation Date:	07/20/2021
Report Due Date:	09/17/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St., Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kevin Kalinowski
Licensee Designee:	Kevin Kalinowski
Name of Facility:	Beacon Home at Lake Orion
Facility Address:	175 E. Silverbell Rd. Lake Orion, MI 48360
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/10/2017
License Status:	REGULAR
Effective Date:	08/08/2020
Expiration Date:	08/07/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 07/16/21, Resident A fell in the bathroom, cut his arm, and caused damage to the bathroom wall. Staff member, Michael Weatherby, did not respond appropriately and failed to obtain needed care immediately.	Yes

III. METHODOLOGY

07/19/2021	Special Investigation Intake 2021A0602029
07/20/2021	Special Investigation Initiated - Telephone Call made to the complainant.
08/04/2021	Inspection completed On-site Interviewed staff member the home manager Jana Goss, Resident A and Resident B.
08/26/2021	Contact – Document received Received requested documents from the home manager, Jana Goss.
08/26/2021	Contact – Telephone call made Message left for staff member Diamond Crowfield.
09/07/2021	Contact – Telephone call received Spoke with staff member Diamond Crowfield.
10/01/2021	Exit Conference Message left for the licensee designee, Kevin Kalinowski.

ALLEGATION:

On 07/16/21, Resident A fell in the bathroom, cut his arm, and caused damage to the bathroom wall. Staff member, Michael Weatherby, did not respond appropriately and failed to obtain needed care immediately.

INVESTIGATION:

On 7/19/2021 a complaint was received and assigned for investigation alleging that on 07/16/21, Resident A fell in the bathroom, cut his arm, and caused damage to the bathroom wall. Staff member, Michael Weatherby, did not respond appropriately and failed to obtain needed care immediately. Mr. Weatherby did not call 911, contact the home manager, or complete an incident report. Resident A was taken to the hospital after the next staff person arrived on shift.

On 7/20/2021 I conducted an unannounced on-site investigation at which time I interviewed the home manger, Jana Goss, Resident A and Resident B. Ms. Goss stated on 7/16/2021 she received a call from the home around 7:45 am but she missed the call. She then received a picture from staff member, Diamond Crowfield of a hole in the bathroom wall. Ms. Crowfield stated she was doing rounds when she initially started her shift when she observed a hole in the bathroom wall. She asked staff member, Michael Weatherby what happened, and he asked for the first aid kit because Resident A had hurt himself. Mr. Weatherby did not state what happened and left the home. Ms. Goss stated she arrived at the home shortly after and found that Mr. Weatherby had left the home without completing an incident report or obtaining medical treatment for Resident A. She observed a mop bucket that contained water in the hallway outside of the bathroom where Resident A had fallen. Staff member, Diamond Crowfield transported Resident A to the hospital. Ms. Goss called Mr. Weatherby but he did not answer. Mr. Weatherby returned Ms. Goss call about two hours later. He said he forgot to call and report the incident to her and did not complete an incident report because there was an emergency at his second job, and he had to leave. On 7/16/2021 Mr. Weatherby was suspended and on 7/17/2021 he resigned from his position.

On 7/20/2021, I interviewed Resident A at the facility. Resident A stated the bathroom is across the hall from his bedroom. On 7/16/2021 (exact time unknown) he was leaving his bedroom and headed into the bathroom when he realized the bathroom floor was slippery with water or soap. Resident A said he had his tennis shoes on but slipped and fell and was unable to stop. He fell near the toilet and hit the wall causing a hole. Resident A said he injured his right arm and noticed that there was a skid mark on his arm that was bleeding. He called out for help and Mr. Weatherby came in, assisted him up from the floor and instructed him to go to his room. Resident A stated he did not receive any treatment for his injury until the next staff arrived for their shift.

On 7/20/2021, I interviewed Resident B at the facility. Resident B stated his bedroom is the room next to the bathroom. He heard Resident A’s walker hit the floor and Resident A fall immediately following (exact date and time unknown). He also heard what sounded like Resident A hitting the wall or floor 4-5 times before Mr. Weatherby went into the bathroom to assist him. Resident A remained on the floor for about 3½ - 4 minutes. Mr. Weatherby assisted Resident A up from the floor and instructed him to go to his room and lay down. Resident B said he yelled out from his room not to let

Resident A lay down because he could have a concussion, but Mr. Weatherby did not respond. This is all the information Resident B had regarding the incident.

On 8/26/2021, I received and reviewed Resident A's Individual Plan of Service (IPOS) dated 7/2/2021, hospital discharge paperwork dated 7/16/2021 and pictures of the hole in the bathroom wall. According to Resident A's IPOS, Resident A suffers from Schizophrenia paranoid type, hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, hypothyroidism, left foot drop and utilizes a walker. As documented in the plan, Resident A has a history of medication non-compliance and delusional thoughts. The discharge paperwork documents that Resident A was seen and treated at Ascension Providence Rochester Hospital on 7/16/2021. Resident A was treated for an acute cervical sprain, blunt head trauma, hydronephrosis of right kidney and multiple contusions.

On 9/07/2021, I interviewed staff member, Diamond Crowfield by telephone. Ms. Crowfield stated on 7/16/2021 she arrived for her shift (day shift) sometime between 7 am and 7:30 am and was informed by Mr. Weatherby (who had worked the midnight shift) that Resident A had fallen. Ms. Crowfield told Mr. Weatherby that Resident A needed to go to the hospital and the police needed to be contacted. Mr. Weatherby rushed out of the home and did not provide any details regarding what occurred during his shift. Ms. Crowfield observed the mop bucket sitting in the hallway outside of the bathroom and a hole in the bathroom wall near the toilet. Resident A stated the bathroom floor was wet causing him to slip and fall. Resident A initially refused to go to the hospital but finally agreed. An incident report was written, and Ms. Crowfield transported Resident A to Ascension Providence Hospital in Rochester.

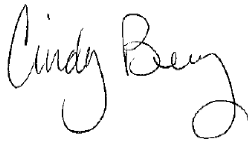
On 10/01/2021, I left a message for the licensee designee, Kevin Kalinowski informing him of the investigative findings and recommendation documented in this report.

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 on the information obtained from Ms. Goss, Resident A, Resident B and Ms. Crowfield, on 7/16/2021 Resident A's personal needs were not met. Resident A fell while in the bathroom, injured himself and Mr. Weatherby left the home before seeking medical treatment or notifying the home manager.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the information obtained from Ms. Goss, Resident A, Resident B and Ms. Crowfield, on 7/16/2021 Resident A fell while in the bathroom and injured himself. Mr. Weatherby left the home before seeking medical treatment or notifying the home manager.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.



10/01/2021

Cindy Berry — Date
Licensing Consultant

Approved By:

10/12/2021

Denise Y. Nunn — Date
Area Manager