GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 21, 2020

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

RE: License #:	AM610088673
Investigation #:	2020A0356012
	Beacon Home at Morton Terrace

Dear Mr. Kalinowski:

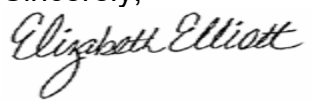
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM610088673
Investigation #:	2020A0356012
Complaint Receipt Date:	11/19/2019
Investigation Initiation Date:	11/19/2019
Report Due Date:	01/18/2020
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110, 890 N. 10th St., Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kevin Kalinowski
Licensee Designee:	Kevin Kalinowski
Name of Facility:	Beacon Home at Morton Terrace
Facility Address:	3929 Hess Street, Norton Shores, MI 49444
Facility Telephone #:	(231) 733-2751
Original Issuance Date:	02/01/2000
License **Status:**	REGULAR
Effective Date:	08/01/2018
Expiration Date:	07/31/2020
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A died unexpectedly at the facility.	Yes

III. METHODOLOGY

11/19/2019	Special Investigation Intake 2020A0356012
11/19/2019	APS Referral
11/19/2019	Special Investigation Initiated - Telephone Suzy Hunter, Program Director called to inform me of Resident A's death and the events preceding his death.
11/19/2019	Contact - Document Received APS denial of this complaint.
11/19/2019	Contact-Document Received Incident Report
01/06/2020	Contact - Face to Face Staff interviews, Benjamin Moye, Talia Churchwell, Andre Banks, La'Toya Hendricks, Suzy Hunter, Jenny Bishop.
01/06/2020	Contact - Document Received Facility documents for Resident A.
01/07/2020	Contact - Document Sent Request for police report.
01/07/2020	Contact - Telephone call made Staff, Mary Johnson.
01/08/2020	Contact - Document Received Muskegon Police Report.
01/14/2020	Contact - Telephone call made Staff, Mary Johnson. Benjamin Moye and Suzy Hunter, Program Manager Aaron Westbrook, Medical Examiner.
01/15/2020	Contact-Telephone call received Talia Churchwell.

01/17/2020	Contact-Telephone call made Relative #1 and DCW Mary Johnson.
01/17/2020	Exit Conference Licensee Designee, Kevin Kalinowski

ALLEGATION: Resident A died unexpectedly at the facility.

INVESTIGATION: On 11/19/2019, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint forwarded to the department from Centralized Intake, Adult Protective Services (APS). The complainant reported on 11/18/2019, Resident A was eating lunch and began to choke. Resident A went into cardiac arrest, staff performed CPR and the Heimlich Maneuver. EMS and police were contacted immediately. The complainant reported Resident A had a faint pulse and was transported to Mercy hospital where he died at 3:00PM. APS denied this complaint for investigation.

On 11/19/2019, I received and reviewed an Incident Report (IR) written by Home Manager, Benjamin Moye on 11/18/2019 and signed by Licensee Designee, Kevin Kalinowski on 11/19/2019. The IR documented the following information, *'Date of Incident, 11/18/2019, 12:30PM, name of employee assigned to resident, Talia Churchwell. (Resident A) was sitting at the dining room table eating lunch. (Resident A) appeared to make an attempt to stand while clutching his neck. (Resident A) was administered the Heimlich by staff until he appeared to slump over. (Resident A) was administered CPR by staff and was continued by EMS when they arrived. (Resident A) was transported to Mercy Hospital by ambulance. (Resident A) was pronounced dead at Mercy Hospital. Staff observed (Resident A) attempting to stand up from the dining room table holding his neck. Staff encouraged (Resident A) to cough as he seemed to be choking. Staff contacted 911 and began stomach/chest thrusts and managed to dislodge some of the food. Home Manager began stomach/chest thrust and assisted (Resident A) to the floor when he became unresponsive to begin CPR. Staff began CPR and continued to monitor the area of safety of other clients. Staff continued CPR until the paramedics arrived to relieve staff and continue emergency medical attention.'*

On 01/06/2020, I interviewed Direct Care Worker (DCW) Talia Churchwell at the facility. Ms. Churchwell stated Resident A was sitting at the table in the dining room and DCW Mary Johnson noticed Resident A was eating really fast. Ms. Churchwell stated Resident A is a slow eater, "he is first to the table and last to leave, he eats his food piece by piece, one chip at a time" so eating fast was very unusual for Resident A. Ms. Churchwell stated she has never seen Resident A eat fast like he was on this day nor does Resident A have issues with choking or swallowing his food. Ms. Churchwell stated she was in the kitchen and Ms. Johnson told her that Resident A was choking. Ms. Churchwell stated she ran to the dining room and did the Heimlich on Resident A and was able to get some food out. Ms. Churchwell stated Home Managers, Benjamin Moye and La'Toya Hendricks came out to assist

and DCW Andre Banks immediately called 911. Ms. Churchwell stated she performed CPR with help from DCW Sequoia Johnson until EMS arrived and took over Resident A's care. Ms. Churchwell stated EMS transported Resident A to Mercy Hospital where he went into cardiac arrest and died. Ms. Churchwell stated Resident A was acting normal and nothing was out of the ordinary with Resident A prior to this event. Ms. Churchwell stated Resident A does not have a special diet nor does he have restrictions with what he can eat.

On 01/06/2020, I interviewed Home Managers, Benjamin Moye and La'Toya Hendricks at the facility. Mr. Moye and Ms. Hendricks concurred with Ms. Churchwell's statement about the events that occurred on 11/18/2019. Mr. Moye and Ms. Hendricks stated Resident A was eating a ham sandwich, cottage cheese and a fruit cup with peaches. Mr. Moye and Ms. Hendricks stated there were no big chunks that came out when the Heimlich was performed but EMS did notice a white substance that was cottage cheese. Mr. Moye stated Resident A did not have any teeth, but he was on a regular diet. Mr. Moye stated Resident A's sandwich was made with shaved ham and his food was cut up for him. Mr. Moye and Ms. Hendricks stated Resident A does not have a history of choking or issues with food or swallowing food. Ms. Hendricks stated Resident A was sitting at the table talking to another resident about his feelings and that was unusual for Resident A, normally he would answer questions but did not engage in conversation much. This was the only out of the ordinary thing Ms. Hendricks stated she noticed about Resident A prior to his death. Mr. Moye stated Resident A was acting as he normally did prior to the choking event and there was nothing that seemed wrong or out of the ordinary with Resident A.

On 01/06/2020, I interviewed DCW Andre Banks at the facility. Mr. Banks stated he was in the kitchen and Ms. Johnson was in the dining room when he heard her say, "he's choking." Mr. Banks stated Ms. Churchwell went out to help and performed the Heimlich on Resident A. Mr. Banks stated CPR was started immediately after and he (Mr. Banks) called 911, the response was quick, and help arrived right away. Mr. Banks stated he noticed Resident A was eating quicker than normal on this day. Mr. Banks stated Resident A is a slow, "organized" eater, eating one thing at a time until it's gone and then moving on to the next food item on his plate. Mr. Banks stated Resident A is usually the last person at the table during meals and has had no issues with eating or swallowing his food. Mr. Banks stated Resident A did not complain of any aches or pains prior to his death and everything seemed normal prior to this meal. Mr. Banks stated Resident A was not on a special diet and his food did not need to be chopped or pureed.

On 01/06/2020, I received and reviewed Resident A's Assessment Plan for AFC Residents dated 03/12/2019 and signed by Resident A, Licensee Designee, Kevin Kalinowski and Shannon Woodwyk, Responsible Agency/HealthWest case manager. The assessment plan documents that Resident A has a special diet and describes the following; "(Resident A) is prescribed a CC 3-4 diet. Staff will encourage (Resident A) to follow his diet plan."

On 01/06/2020, I received and reviewed Resident A's Healthcare Appraisal dated 08/06/2019 and signed by Karel Schram, PA-C, Integrated Health. The healthcare appraisal documents Resident A is 67 years of age and his special dietary instructions as a "mechanical soft diet." Resident A's healthcare appraisal documents Resident A's diagnosis as "Alzheimer's dementia, Atherosclerosis, Diabetes Type 2, Schizoaffective Schizophrenia."
On 01/07/2020, I left a voicemail message for DCW Mary Johnson at the telephone number provided by Mr. Moye with no return call.

On 01/08/2020, I received and reviewed the Norton Shores Police Department Incident/Investigation Report dated 11/18/2019 at 12:27PM and written by Officer K.A. Neher. The police report documented the following information; '*We were dispatched to assist medical at Morton Terrace with a male who was choking and went unconscious. We arrived and ProMed and NSFD (*Norton Shores Fire Department*) were already on scene providing medical attention. We made contact with house manager, Benjamin Moye who stated (*Resident A*) is a 67-year-old resident of Morton Terrace. Benjamin was contacted by his employees who stated that (*Resident A*) was choking on a sandwich and they were doing CPR. We spoke with Mary (*Johnson*) inside. Mary advised that (*Resident A*) was eating a ham sandwich at the kitchen table. She saw him in distress and went out to help him and saw he was choking. Mary called Talia over and Talia performed the Heimlich maneuver. This dislodged a portion of the sandwich, but (*Resident A*) went blue and went unconscious. Mary called 911 and Talia started CPR as instructed by dispatch until medical arrived. We spoke with Talia outside. Talia advised that she was notified by Mary that (*Resident A*) was choking. She performed the Heimlich maneuver and dislodged some of the ham sandwich, but he turned blue and went unconscious. She continued CPR as instructed by dispatch until medical arrived. ProMed transported (*Resident A*) to Mercy Hospital. He was still unresponsive when transported.'*

On 01/14/2020, I interviewed Valorie Stein, RN at Integrated Health Clinic (Integrated Health Clinic). Ms. Stein stated IHC began seeing Resident A as a new patient on 06/13/2019 and Resident A was prescribed a mechanical soft diet prior to becoming a patient at IHC. Ms. Stein stated Resident A would have been seen by a speech pathologist for testing if IHC had prescribed the mechanical soft diet and assumes that staff from the facility told IHC that Resident A was on a mechanical soft diet and that was then included on the healthcare appraisal. Ms. Stein stated she does not know what a CC 3-4 diet is as documented on Resident A's assessment plan under special diet. Ms. Stein stated Resident A did not have teeth, his teeth were removed and so he should have soft foods to reduce the need to physically chew food up. Ms. Stein stated a regular ham sandwich would not be on a mechanical soft diet unless it was chopped up.

On 01/14/2020, I interviewed Mr. Moye via telephone. Mr. Moye stated a CC 3-4 (Carb count 3-4) diet is a carbohydrate-controlled diet because Resident A had

diabetes, so this is a diabetic diet. Mr. Moye explained that Resident A could not have whole, tough foods but his diet was not blended or pureed. Mr. Moye confirmed that Resident A did not have teeth and ate egg salad, tuna salad sandwiches and ham sandwiches which he never had any issues with before. Mr. Moye stated the ham was very thin sliced and describes it as “chipped” or shaved thin. Mr. Moye stated the sandwich was cut into ¼ or ½ size.

On 01/14/2020, I left a voicemail message for DCW Mary Johnson at the telephone number provided by Mr. Moye with no return call.

On 01/14/2020, I received and reviewed Resident A’s Medication Administration Records (MARs) for the months of October and November 2019. The MARs do not document any type of special diet, diabetic or mechanical soft.

On 01/14/2019, I interviewed Suzy Hunter via telephone, and she concurred with Mr. Moye that a CC 3-4 diet is the calorie/carbohydrate portion size due to Resident A’s diabetes. Ms. Hunter stated most of the residents’ sandwiches are cut into smaller pieces including Resident A’s. Ms. Hunter stated the ham is typically shaved into thin slices. Ms. Hunter reviewed the menus with me and stated the meal for this date consisted of ham sandwich, cottage cheese and a fruit cup. A mechanical soft diet is food cut up; shredded meat made into small chewable pieces. Ms. Hunter stated Ms. Churchwell made up the plates on 11/18/2019.

On 01/14/2020, I interviewed Aaron Westbrook, Medical Examiner via telephone. Mr. Westbrook stated EMS reported pieces of bread and shaved ham were removed from Resident A’s mouth after the Heimlich was done by staff and EMS removed more shaved ham and bread once they began their medical care of Resident A. Mr. Westbrook stated he interviewed Resident A’s next of kin, Relative #1 who reported to Mr. Westbrook that Resident A did not have any problems with food consumption or swallowing. Mr. Westbrook stated staff at the facility told him Resident A was eating unusually fast on 11/18/2019 which was out of the ordinary for him. Mr. Westbrook stated Dr. DeYoung from the Medical Examiner’s Office completed the death certificate on 11/18/2019 and documented the cause of death as “Asphyxia due to choking on food bolus,” manner of death as “accident” and explanation, “choked while eating bread and ham.”

On 01/15/2020, I again interviewed Ms. Churchwell via telephone. Ms. Churchwell acknowledged that she prepared Resident A’s lunch on 11/18/2019 and his sandwich had thinly sliced ham with two pieces of bread, the ham was chopped up real fine like a “potted meat” and cut into pieces, lunch included cottage cheese and a fruit cup with small pieces of fruit. Ms. Churchwell added Resident A was on a “mechanical soft diet” and when asked if she knew Resident A’s special diet on 11/18/2019, Ms. Churchwell stated she did know it that day.

On 01/17/2020, I interviewed Relative #1 via telephone. Relative #1 stated she was Resident A’s legal guardian and that she did not know anything about a special diet

that had been prescribed for Resident A. Relative #1 stated staff at the facility did not tell her he was on a special diet or give any special instructions regarding his diet. Relative #1 stated she took Resident A out on a weekly basis and they would always go out to eat. Relative #1 stated Resident A ate hamburgers, French fries, chicken sandwiches and Subway subs and he never had any difficulty eating those food items. Relative #1 stated Resident A loved to eat and was a very slow and methodical eater, eating one food item at a time until it was gone and then would move onto the next food item. Relative #1 stated Resident A would take an inordinate amount of time eating and was a very careful eater. Relative #1 stated Resident A had very few teeth but always did well with whatever he was eating and was not prone to choking on food. Relative #1 stated after calling 911 for medical assistance, staff at the facility called her (Relative #1) immediately so she was able to get to the facility prior to Resident A being taken to the hospital. Relative #1 stated the staff at the facility took good care of Resident A and she felt he was safe in this facility.

On 01/17/2020, I interviewed DCW Mary Johnson via telephone. Ms. Johnson stated Resident A got his lunch on 11/18/2019 and immediately began to “shovel” it in, he was eating really fast, which was unusual for him. Ms. Johnson stated Resident A did not have a history of choking or being unable to swallow his food. Ms. Johnson stated she saw Resident A grabbing his throat and shaking his head, so she yelled to Ms. Churchwell in the kitchen that Resident A was choking. Ms. Johnson stated Ms. Churchwell came out and performed the Heimlich maneuver and was not able to dislodge the food. Ms. Johnson stated 911 was called immediately and CPR was performed until EMS arrived. Ms. Johnson stated the only thing Resident A had eaten at lunch that day was the ham sandwich. He had not yet eaten any of his other food. Ms. Johnson stated Resident A’s sandwich was shaved lunchmeat ham, a slice of cheese on two pieces of bread and the sandwich was cut into small pieces. Ms. Johnson stated the ham was shaved, not chopped but not big chunks. Ms. Johnson stated Resident A was on no dietary restrictions, no special diet and no blended/pureed type foods that she had been made aware of by other staff or managers. Ms. Johnson stated she was not aware that Resident A was on a soft mechanical diet. Ms. Johnson stated other residents in the facility are on soft mechanical diets, so she is knowledgeable about what foods are on a soft mechanical diet. Ms. Johnson stated the ham on the sandwich was thinly sliced and the sandwich was cut into smaller pieces so even though she did not know Resident A had a special diet, the sandwich met the soft mechanical diet specifications.

On 01/17/2020, I conducted an Exit Conference with Licensee Designee, Kevin Kalinowski via telephone. Mr. Kalinowski stated an acceptable corrective action plan will be submitted.

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:	On 11/18/2019 at approximately 12:30PM, as documented on the IR, Resident A choked on a ham sandwich while eating lunch at the facility. Ms. Churchwell, Mr. Banks and Ms. Johnson stated they acted immediately by performing the Heimlich maneuver, CPR and calling 911. Mr. Moye and Ms. Hendricks concurred that staff acted immediately by performing the Heimlich, CPR and calling 911 to obtain needed care for Resident A immediately. The Norton Shores Police report documents a dispatch time of 12:27PM on 11/18/2019 and upon arrival, EMS and the Norton Shores Fire Department were already on scene providing emergency medical assistance to Resident A. Relative #1 stated she was immediately notified by staff of the incident with Resident A and upon arrival at the facility, EMS was still at the facility. Based on interviews, investigative findings, and a review of the IR and police report, it is apparent that staff obtained necessary care for Resident A in a timely manner. Therefore; a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	Resident health care. (1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (b) Special diets.

ANALYSIS:	The complainant reported that on 11/18/2019, Resident A was eating lunch and began to choke. Staff performed CPR and the Heimlich Maneuver and EMS and police were contacted immediately. Resident A died at Mercy Hospital on 11/18/2019. The IR dated 11/18/2019 documented that Resident A choked while eating lunch at the facility. Ms. Churchwell, Mr. Banks and Ms. Johnson stated Resident A was eating a ham sandwich on 11/18/2019 when he began to choke on his food. Ms. Churchwell, Mr. Banks and Ms. Johnson stated Resident A is not on a special diet, has no restrictions, does not need his food pureed and has had no issues with eating or choking in the past. In a later interview with Ms. Churchwell, she stated she knew Resident A was on a mechanical soft diet on 11/18/2019 and that the ham was chopped up into fine pieces. Mr. Moye and Ms. Hendricks stated Resident A did not have any teeth, was on a regular diet and did not have a history of choking or swallowing issues. Mr. Moye and Ms. Hendricks stated Resident A's sandwich was made with shaved ham and his food was cut up for him. Resident A's assessment plan documents that Resident A has a CC 3-4 special diet which is a diabetic diet according to Mr. Moye and Ms. Hunter. Resident A's healthcare assessment signed by Karel Schram, PA-C documents that Resident A has a special diet and describes it as a mechanical soft diet. The Norton Shores Police Department Incident/Investigation Report documents they were called to the scene for a medical due to Resident A choking on a ham sandwich. Ms. Stein stated Resident A did not have teeth and was on a mechanical soft diet, so he should have soft foods to reduce the need to physically chew food up. Ms. Stein stated a regular ham sandwich would not be included in a mechanical soft diet unless it was chopped up. Mr. Moye and Ms. Hunter stated a CC 3-4 (Carb count 3-4) diet is a carbohydrate-controlled diabetic diet. Mr. Moye stated Resident A's diet did not require his food to be blended or

	pureed. Mr. Moye stated the ham was very thin sliced and described it as “chipped” or shaved thin. Mr. Moye stated the sandwich was cut into ¼ or ½ size. A review of Resident A’s MARs does not document any type of special diet. Mr. Westbrook stated EMS reported pieces of bread and shaved ham were removed from Resident A’s mouth after the Heimlich was done by staff and EMS removed more shaved ham and bread once they began their medical care of Resident A. Mr. Westbrook stated Resident A’s cause of death was asphyxia due to choking on food bolus, the manner of death is an accident and the explanation is that Resident A choked while eating bread and ham. Relative #1 stated she was not aware that Resident A was prescribed a mechanical soft diet and that she took him out to eat all the time with no issues with swallowing or choking on food. Based on information gathered from staff interviews, Resident A’s ham sandwich had shaved ham on it and was cut into smaller pieces; however, the resident assessment plan documented that Resident A had a diabetic diet while the healthcare appraisal documented that Resident A had a mechanical soft diet. Staff reported Resident A was on a regular diet with no special instructions. There is a preponderance of evidence to show that staff were not aware of Resident A’s special diet as documented on his healthcare appraisal and did not follow that special diet. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

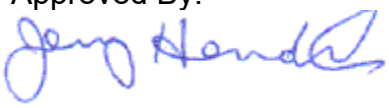
Upon receipt of an acceptable corrective action plan, I recommend the current status of the license remain unchanged.

Elizabeth Elliott

01/17/2020

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



01/21/2020

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Jerry Hendrick Date
Area Manager