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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 14, 2021

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

RE: License #: AS500390453
Investigation #: 2021A0465016
Beacon Home At New Haven

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,

A handwritten signature in cursive script that reads "Stephanie Gonzalez".

Stephanie Gonzalez, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(517) 243-6063

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
 BUREAU OF COMMUNITY AND HEALTH SYSTEMS
 SPECIAL INVESTIGATION REPORT
 THIS REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

License #:	AS500390453
Investigation #:	2021A0465016
Complaint Receipt Date:	04/28/2021
Investigation Initiation Date:	04/30/2021
Report Due Date:	06/27/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Matthew Owens
Licensee Designee:	Kevin Kalinowski
Name of Facility:	Beacon Home At New Haven
Facility Address:	36790 28 Mile Road Lenox Township, MI 48048
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	03/13/2018
License Status:	REGULAR
Effective Date:	09/18/2020
Expiration Date:	09/17/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Karen Koffman, has treated Resident A in a disrespectful manner.	No
Resident A's bedroom has a bad odor.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/28/2021	Special Investigation Intake 2021A0465016
04/30/2021	Special Investigation Initiated - Telephone Spoke to Complainant
05/27/2021	Inspection Completed On-site I conducted a walk-through of the facility, observed Resident A's bedroom area and reviewed Resident A's record
06/17/2021	Contact - Telephone call made Conducted interviews with direct care staff, Barb Bayhan and Kennedy Campbell
06/28/2021	Exit Conference Held with Mr. Kalinowski

ALLEGATION:

Direct care staff, Karen Koffman, has treated Resident A in a disrespectful manner.

INVESTIGATION:

On 4/28/2021, a complaint was received, alleging that direct care staff, Karen Koffman, has treated Resident A in a disrespectful manner. The complaint indicated that on 4/20/2021, Ms. Koffman called Resident A "a fat bitch." On this same day, Ms. Koffman refused to speak to Resident A and on an unknown date, Ms. Koffman did not appropriately handle Resident A's concern of being bullied by an unknown resident.

On 4/30/2021, I spoke to Complainant, who confirmed that the information contained in the complaint is accurate.

On 5/27/2021, I conducted an onsite investigation at the facility. I reviewed Resident A's record. The *Face Sheet* indicated that Resident A was admitted to the facility on 5/27/2020 and has a legal guardian, Guardian A1. The *Health Care Appraisal* indicated that Resident A's medical diagnoses are Major Depressive Disorder, Anti-Social Personality Disorder, Borderline Personality Disorder, Borderline Intellectual Functioning and Anxiety Disorder. The *Assessment Plan for AFC Residents* read indicated that Resident A requires supervision in the community, has a history of self-harm behavior, is incontinent and requires staff prompting to shower, and does not require use of assistive devices.

I interviewed direct care staff, Kennedy Campbell, who stated that she has worked at the facility for five months. Ms. Campbell stated that she is familiar with Resident A and has provided direct care to her during the time that she has worked at the facility. Ms. Campbell stated, "{Resident A} can be verbally aggressive. She has a history of yelling and swearing at others. I have never observed a direct care staff yell at, or swear at, {Resident A}. {Resident A} has never told me that she has been bullied by other residents." Ms. Campbell denied any knowledge of the allegation being true.

I interviewed direct care staff, Barbara Bayhan, who stated that she has worked at the facility for one year. Ms. Bayhan stated, "I have never observed any staff be rude to {Resident A} and I never observed Ms. Koffman treat any resident rudely, including {Resident A}. {Resident A} has a temper and often will yell and swear at others when she gets upset. I am not aware of any time when {Resident A} was bullied by another resident." Ms. Bayhan denied any knowledge of this allegation being true.

I interviewed Guardian A1, who stated, "{Resident A} has never reported any concerns to me regarding staff treating her in a disrespectful manner and I have never observed this type of incident. {Resident A} has never told me that she has been bullied or her privacy has been violated by anyone at the facility. {Resident A} has a history of verbal aggression and sometimes will yell at staff. I have never observed any staff treat {Resident A} in a disrespectful manner and I can't confirm or deny if this allegation is true because I did not witness it." Guardian A1 believes the facility is treating Resident A with dignity and respect. Guardian A1 did not vocalize any concerns related to resident rights.

Due to Resident A's medical diagnoses, she was not interviewed as part of this investigation.

I attempted to contact Ms. Koffman, ex-direct care staff, to conduct an interview and have not received a return call as of the date of this report.

APPLICABLE RULE	
R 400.14304	Resident rights; licensee responsibilities.
	<p>(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:</p> <p style="padding-left: 40px;">(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.</p>
ANALYSIS:	<p>Resident A was admitted to the facility on 5/27/2020 and has a legal guardian, Guardian A1. The <i>Health Care Appraisal</i> indicated that Resident A's medical diagnoses are Major Depressive Disorder, Anti-Social Personality Disorder, Borderline Personality Disorder, Borderline Intellectual Functioning and Anxiety Disorder.</p> <p>According to Ms. Campbell and Ms. Bayhan, they have never treated Resident A in a disrespectful manner and have never observed any other direct care staff, including Ms. Koffman, treat Resident A in a disrespectful manner.</p> <p>Resident A has never reported to Guardian A1 any concerns related to being treated in a disrespectful manner. Guardian A1 believes the facility is treating Resident A with dignity and respect. Based on the information above, including interviews with two direct care staff and Guardian A1, the direct care staff are treating Resident A with dignity and respect.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A's bedroom has a bad odor.

INVESTIGATION:

On 4/28/2021, a complaint was received, alleging that Resident A's bedroom has a bad odor.

On 4/30/2021, I spoke to Complainant, who confirmed that the information contained in the complaint is accurate.

On 5/27/2021, I conducted an onsite investigation at the facility. I conducted a walk-through of Resident A's bedroom, which had an extremely strong smell of urine, both in the hallway and inside her bedroom. I did not observe any clutter or wet urine or feces on the floor inside Resident A's bedroom.

I interviewed Ms. Campbell, who stated, "{Resident A} is incontinent and has a lot of accidents on her bed and in her room. We try to clean as much as we can, but the odor is hard to get rid of. Her mattress and flooring have been heavily soaked in urine on a repeated basis." Ms. Campbell acknowledged that Resident A's bedroom does have a strong urine odor both inside her room and the hallway area.

I interviewed Ms. Bayhan, who stated, "Resident A is incontinent and frequently urinates on her mattress and in her bedroom area. We try to clean the room and mattress, but the odor lingers. The odor lingers into the hallways and the other residents' bedrooms. One resident has begun placing a towel under her door to try and keep the odor out of her room. We also have one resident that has requested to move to another facility due to the strong urine odor throughout the facility."

APPLICABLE RULE	
R 400.14403	Maintenance of premises.
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On 5/27/2021, I observed Resident A's bedroom. There was a strong odor of urine both in the hallway and inside of Resident A's bedroom. Ms. Campbell and Ms. Bayhan acknowledged that Resident A's bedroom has a strong urine smell that lingers into the hallway and other resident bedrooms, negatively impacting other residents in the home. Based on the information above, the facility is not maintaining Resident A's bedroom in a manner that provides adequately for the health, safety, and well-being of all residents, including Resident A.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/27/2021, I conducted an onsite investigation at the facility. I interviewed Ms. Campbell, who stated, "Resident A is incontinent and has a lot of accidents and will pee on herself. Resident A refuses to shower or bathe for long periods of time. Resident A

also refuses to wear Depends. Resident A’s body has an extremely strong odor of urine and body odor. We encourage her to shower, but she refuses.”

I interviewed Ms. Bayhan, who stated, “Resident A is incontinent and frequently urinates on herself. She refuses to shower weekly and refuses to allow staff to help her shower or bathe. She will urinate on herself and then refuse to change out of the soiled clothing for long periods of time. We try to encourage her to take showers and bathe but a lot of times she refuses no matter what we do.”

APPLICABLE RULE	
R 400.14314	Resident hygiene.
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	According to Ms. Campbell and Ms. Bayhan, Resident A refuses to complete daily bathing and personal hygiene tasks on a consistent basis. Ms. Campbell and Ms. Bayhan stated that Resident A refuses to bath at least weekly and also refuses to bathe after having urinary incontinence occurrences. Based on the information above, the facility is not ensuring that Resident A bathes at least weekly and more often if necessary.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On 5/27/2021, I conducted an onsite investigation at the facility. I observed Resident A’s mattress with a protective cover and an extremely strong urine odor coming from the mattress area.

I interviewed Ms. Campbell, who stated, “{Resident A} is incontinent and has a lot of accidents and will pee on herself. {Resident A} also refuses to wear Depends. {Resident A’s} mattress has been heavily soiled in urine over a long period of time, and we can’t get the odor out of the mattress. We have replaced the mattress cover several times, but the mattress still smells like urine.” Ms. Campbell stated that all attempts to clean the mattress with cleaning supplies has not assisted in getting rid of the urine odor.

On 6/28/2021, I conducted an exit conference with Mr. Kalinowski. Mr. Kalinowski stated that he is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14410	Bedroom furnishings.
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a waterbed is not prohibited by this rule.
ANALYSIS:	On 5/27/2021, I conducted an onsite investigation at the facility. I observed Resident A's mattress with a protective cover and an extremely strong urine odor coming from the mattress area. Ms. Campbell stated that Resident A's mattress has been heavily soiled in urine on a repeated basis and attempts to clean the mattress have not been successful in removing the urine odor. Based on the information above, the facility is not providing Resident A with a mattress that is clean, in good condition and well protected.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

Stephanie Gonzalez

07/06/2021

Stephanie Gonzalez
Licensing Consultant

Date

Approved By:

Denise Y. Nunn

07/14/2021

Denise Y. Nunn
Area Manager

Date