GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 15, 2021

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

RE: License #: AS810393269
Investigation #: 2021A0122020
Beacon Home At Ypsilanti

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 (517) 284-9720.

Sincerely,

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810393269
Investigation #:	2021A0122020
Complaint Receipt Date:	06/24/2021
Investigation Initiation Date:	06/25/2021
Report Due Date:	08/23/2021
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kevin Kalinowski
Licensee Designee:	Kevin Kalinowski
Name of Facility:	Beacon Home At Ypsilanti
Facility Address:	7862 Tuttle Hill Road Ypsilanti, MI 48197
Facility Telephone #:	(734) 221-5424
Original Issuance Date:	05/24/2018
License Status:	REGULAR
Effective Date:	11/24/2020
Expiration Date:	11/23/2022
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 06/22/2021, staff member, Keisha Woodyard, left two residents alone at the facility.	Yes

III. METHODOLOGY

06/24/2021	Special Investigation Intake 2021A0122020 APS Denied Referral
06/25/2021	Special Investigation Initiated - Telephone Interview completed with Trena Phenix, Home Manager.
06/30/2021	Contact - Document Received Resident information picked up from the facility.
07//2021	Exit Conference Discussed findings with Kevin Kalowinski.

ALLEGATION: On 06/22/2021, staff member, Keisha Woodyard, left two residents alone at the facility.

INVESTIGATION: Trena Phoenix, Home Manager, reported on 06/22/2011 staff member, Keisha Woodyard, left Residents A and B home alone unsupervised. Neither resident were injured while left alone.

On 06/25/2021, Ms. Phoenix confirmed the above. She stated the incident happened later in the afternoon when she decided to stop by the facility after working her shift. Ms. Phoenix observed “two residents in the home alone. Ms. Woodyard was the assigned staff on shift, and she had taken 3 of the residents with her to the store but left the other 2. Residents A and B were unharmed.

Ms. Phoenix further reported that there were contractors working outside of the home that day. The contractors reported that the residents were left alone for approximately 20 minutes. After Ms. Phoenix made certain the residents were fine, she reported the incidents to her supervisor and the Office of Recipient Rights (ORR).

Resident A's Individual Plan of Service dated 07/23/2020 states that he is diagnosed with Other Schizoaffective Disorder, Bipolar disorder, Cannabis Use Disorder, and other secondary diagnoses. His plan states that he resides in a specialized adult foster care facility where foster care services are needed, including but not limited to 24-hour supervision. Resident A also has a Crisis Plan which states he has elopement issues.

Resident B's Individual Plan of Service dated 09/16/2020 recommends adult foster care placement which provides 24/hour staffing. Resident B has the following "Supervision Requirements: …does not need eyes-on supervision while in his house. However, once he walks out of his home he is considered to be in the community and MUST HAVE EYES-ON SUPERVISION at ALL TIMES. There is a risk of others health and safety in the community if he is not strictly monitored." He is diagnosed with Unspecified disruptive, impulse-control and conduct disorder, Pervasive Developmental Disorder, and Unspecified Bipolar and related disorder.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	On 06/22/2021, staff member, Keisha Woodyard, left Residents A and B alone and unsupervised. On 06/23/2021, Home Manager, Trena Phoenix, confirmed that she observed Residents A and B alone in the facility on 06/22/2021. Both Residents A and B have personalized plans which stated they are in need of 24-hour supervision and protection. Based upon my investigation I find there is evidence to support that the licensee, Beacon Specialized Living Services, Inc. did not provide supervision and protection to Residents A and B on 06/22/2021 as staff member, Keisha Woodyard left them alone and unsupervised.
CONCLUSION:	**VIOLATION ESTABLISHED**

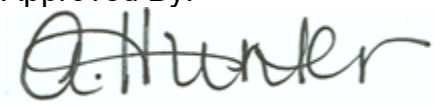
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 06/22/2021, staff member, Keisha Woodyard, left Residents A and B alone. On 06/23/2021, Trena Phoenix reported she observed that Residents A and B were alone in the facility. Both Residents A and B have personalized plans which stated they are in need of 24-hour supervision and protection. Based upon my investigation I find there is evidence to support that neither Residents A nor B's protection and safety were attended to on 06/22/2021 as staff member, Keisha Woodyard left them alone and unsupervised.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon submission and approval of a corrective action plan I recommend no change in the status of the license.

Vanita C. Bouldin
Licensing Consultant
Date: 07/07/2021

Approved By:



Ardra Hunter
Area Manager
Date: 07/15/2021