GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 18, 2021

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

RE: License #:	AS410397920
Investigation #:	2021A0356025
	Beacon Home At Walker

Dear Mr. Kalinowski:

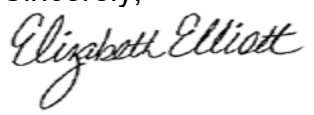
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS410397920
Investigation #:	2021A0356025
Complaint Receipt Date:	04/05/2021
Investigation Initiation Date:	04/05/2021
Report Due Date:	06/04/2021
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 Walker
Facility Address:	1706 Wilson Ave. Walker, MI 49534
Facility Telephone #:	(616) 591-3834
Original Issuance Date:	04/04/2019
License Status:	REGULAR
Effective Date:	10/04/2019
Expiration Date:	10/03/2021
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident B is not being properly supervised.	Yes

III. METHODOLOGY

04/05/2021	Special Investigation Intake 2021A0356025
04/05/2021	APS Referral
04/05/2021	Special Investigation Initiated - Telephone Rodney Allen, APS, Kent Co. DHHS.
04/09/2021	Contact - Document Sent Emily Fairris and Jessica Kibiloski, home managers.
04/16/2021	Inspection Completed On-site
04/16/2021	Contact - Face to Face Interviewed Resident A, Resident B, staff Johnny Blakely, Jessica Kibiloski, home manager and staff Nokoia Ward.
04/16/2021	Contact - Document Received Facility documents for Residents A&B received and reviewed.
05/12/2021	Contact-Document Received Facility documents for Resident B received and reviewed.
05/12/2021	Contact-Telephone call made. Molly Chase, legal guardian for Resident B.
05/14/2021	Contact-Telephone call made & received. Ms. Kibiloski.
05/14/2021	Contact-Documents received. Updated PCP.
05/18/2021	Exit Conference-Licensee Designee, Kevin Kalinowski.

ALLEGATION: Resident B is not being properly supervised.

INVESTIGATION: On 04/05/2021, I received an Adult Protective Services (APS) referral forwarded to me from APS worker, Rodney Allen, Kent County DHHS (Department of Health and Human Services). Mr. Allen stated he has an open APS

case for Resident A and this information came to him as additional information regarding this resident. Mr. Allen stated on 03/31/2021, Resident A disclosed that he and Resident B “smoked a little weed” and Resident A was “stoned” at the facility. Resident A further reported that he also drank alcohol and got drunk at the facility, the police were never called, staff never found out about he and Resident B drinking or smoking at the facility and he is not going to stop doing it.

On 04/16/2021, I conducted an inspection at the facility and interviewed Resident A. Resident A stated he did smoke marijuana and drank alcohol with Resident B “down the street” from the facility. Resident A then stated he smoked marijuana and drank alcohol with Resident B “on the side of the house” down near the road. Resident A stated they did not smoke or drink in the facility but outside on the grounds of the facility. Resident A stated he did not remember what date or when it was that he smoked marijuana and drank alcohol with Resident B outside of the facility but stated it did happen. Resident A stated Resident B provided the marijuana and alcohol that he had obtained while away from the facility on one of his outings.

On 04/16/2021, I interviewed Direct Care Worker (DCW), Johnny Blakely at the facility. Mr. Blakely stated Resident A told him the same thing, that he and Resident B smoked marijuana and drank alcohol at some time in January or February 2021. Mr. Blakely stated Resident A reported to him that they did this “down the road.” Mr. Blakely stated he has never seen Resident A or B under the influence in the facility, nor has he seen Resident A or B smoke marijuana or drink alcohol in the facility.

On 04/16/2021, I interviewed DCW Nokoia Ward at the facility. Ms. Ward stated Resident A told her that he drank alcohol and smoked weed outside of the facility on the side of the house near the garage, but Ms. Ward cannot remember the date this occurred. Ms. Ward stated she informed the home manager, Jessica Kibiloski of what Resident A told her. Ms. Ward stated Resident A reported that this happened only once, and she has never known Resident A to do anything like this in the past or on a regular basis.

On 04/16/2021, I conducted an inspection at the facility and attempted to interview Resident B who declined to be interviewed at this time, he left the facility grounds and began to walk down the road.

On 04/16/2021, I received and reviewed Resident A’s assessment plan for AFC residents dated 07/27/2020 and signed by Relative #1, Licensee Designee, Kevin Kalinowski and Leah Brink, Ottawa County CMH, MSW. The assessment plan documents that Resident A is capable of moving independently in the community with no restrictions, Resident A smokes and appropriately uses alcohol/drugs with no descriptive needs in place.

On 05/12/2021 I received and reviewed Resident B’s assessment plan for AFC residents dated 01/06/2021 and signed by Molly Chase, legal guardianship services, Mr. Kalinowski and Alisha Jackson, MSW. The assessment plan documents that

Resident B cannot move about independently in the community and explains that Resident B *'has a behavior plan that has community restrictions. Staff will follow his plan and encourage (Resident B) and report and document concerns.'* The assessment plan documents that *'(Resident B) 'smokes tobacco products. Staff will encourage to use in the designated areas'* and Resident B *'does not appropriately use alcohol/drugs, does have a history of using alcohol and marijuana use, staff will encourage (Resident B) to make safe decisions while in the community and follow all protocols.'*

On 05/12/2021, I received and reviewed Resident B's Person-Centered Plan (PCP) dated 10/18/2020-09/30/2021, written by Christin Colon, Summit Point Mental Health Professionals. The PCP documents that *'staff will accompany* (Resident A) *when he is out in the community for safety reasons unless otherwise discussed and approved in conjunction with BCBA (*Board Certified Behavior Analyst-therapist*), CM* (case manager), *and guardian*.'

On 05/12/2021, I interviewed Molly Chase, legal guardian for Resident B via telephone. Ms. Chase stated staff knew that Resident B smokes marijuana and drinks alcohol and is under the influence in the home. Ms. Chase stated she spoke to home manager, Jessica Kibiloski and received reports from Ms. Kibiloski that Resident B was high or drunk at the facility. Ms. Chase stated Resident B is a Type I diabetic and his blood sugars dip very low when he is using alcohol, so she cautioned Ms. Kibiloski and asked that Resident B is closely supervised in an attempt to prevent him from substance use. Ms. Chase stated she is "puzzled as to why (Resident B) has so much community access" without staff supervision per his behavior plan.

On 05/14/2021, I interviewed Ms. Kibiloski via telephone. Ms. Kibiloski stated Resident B gets unsupervised time in the community up to 5 hours based on a 03/03/2021 behavior treatment plan. Ms. Kibiloski stated that is why Resident B is allowed to walk away from the facility on his own. Ms. Kibiloski stated she did not realize that the Assessment plan for AFC Residents still reflects that Resident B is not able to be independent in the community without staff supervision.

On 05/14/2021, I received and reviewed an extensive 22-page updated behavior treatment plan from Ms. Kibiloski, and it documents Resident B *'currently can travel up to 5 miles away for the AFC home for 4-5 hours.'* The plan signed by the plan developer Kendra Combs, MA, BCBA, LBA, Sparks Behavioral Services, on 03/04/2021.

On 05/18/2021, I conducted an Exit Conference with Licensee Designee, Kevin Kalinowski. Mr. Kalinowski stated he will review Resident B's assessment and PCP plans, clear up the confusion regarding Resident B's access to the community and submit an acceptable corrective action plan.

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:	The complainant reported that Resident A stated he used alcohol and marijuana with Resident B at the facility and that Resident B obtained the alcohol and marijuana while away from the facility. Resident A is documented as able to be independent in the community. Resident B's 01/06/2021 assessment plan and 10/18/2020 PCP documents that Resident B requires staff supervision while in the community. An updated PCP dated 03/04/2021 gives Resident B some community access with no staff supervision but is unsigned by case management and Resident B's legal guardian. Based on investigative findings, there is a preponderance of evidence to show that supervision is not being provided by staff at the facility per Resident B's assessed needs as documented on the AFC assessment plan and original PCP plan. While there is an updated PCP plan with unsupervised community access documented, there is not common knowledge between the facility and Resident B's legal guardian about this new plan and Resident B's assessment plan for AFC residents is not updated to reflect this change. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

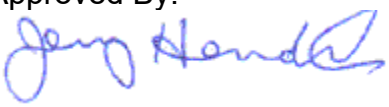
IV. RECOMMENDATION

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

05/18/2021

Elizabeth Elliott Date
Licensing Consultant

Approved By:



05/18/2021

Jerry Hendrick Date
Area Manager