



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 7, 2021

Kevin Kalinowski
The Country House, LLC
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AM040291143
Investigation #: 2021A0009036
Beacon Home at Ossineke

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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

A handwritten signature in cursive script that reads "Adam Robarge".

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

| | |
|---------------------------------------|--|
| License #: | AM040291143 |
| Investigation #: | 2021A0009036 |
| Complaint Receipt Date: | 08/10/2021 |
| Investigation Initiation Date: | 08/11/2021 |
| Report Due Date: | 09/09/2021 |
| Licensee Name: | The Country House, LLC |
| Licensee Address: | 890 N. 10th St., Suite 110 Kalamazoo, MI 49009 |
| Licensee Telephone #: | (989) 471-8482 |
| Administrator: | Roxanne Goldammer |
| Licensee Designee: | Kevin Kalinowski |
| Name of Facility: | Beacon Home at Ossineke |
| Facility Address: | 10685 Spruce Rd Ossineke, MI 49766 |
| Facility Telephone #: | (989) 471-1192 |
| Original Issuance Date: | 12/17/2009 |
| License Status: | REGULAR |
| Effective Date: | 06/12/2020 |
| Expiration Date: | 06/11/2022 |
| Capacity: | 12 |
| Program Type: | PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED |

II. ALLEGATION(S)

| | Violation Established? |
|---|-----------------------------------|
| Staff seem to be under the influence of narcotics. They may be taking and/or selling narcotics from the home. | Yes |
| The conditions of the home are filthy. | No |

III. METHODOLOGY

| | |
|------------|---|
| 08/10/2021 | Special Investigation Intake 2021A0009036 |
| 08/11/2021 | Special Investigation Initiated – Telephone call made to Community Mental Health (CMH) recipient rights officer Ms. Ruth Hewett, left message |
| 08/12/2021 | Contact - Telephone call received from CMH recipient rights officer Ms. Ruth Hewett |
| 08/12/2021 | Inspection Completed On-site Interviews with Resident A and home manager Ms. Kaitlyn Moiles |
| 08/20/2021 | APS Referral |
| 08/20/2021 | Contact – Telephone call received from DHHS adult protective services worker Mr. Terry Marzean |
| 08/24/2021 | Contact – Telephone call received from CMH recipient rights officer Ms. Ruth Hewett |
| 08/24/2021 | Contact – Document (email with attachment) received from CMH recipient rights officer Ms. Ruth Hewett |
| 08/24/2021 | Contact – Document (email with attachment) forwarded to DHHS adult protective services worker Mr. Terry Marzean |
| 08/25/2021 | Contact – Telephone call received from Melissa Williams, Beacon/The Country House, LLC administration |
| 08/25/2021 | Contact – Document (email with attachment) received from Melissa Williams, Beacon/The Country House, LLC administration |
| 08/25/2021 | Contact – Telephone call received from administrator Ms. Roxanne Goldammer, The County House, LLC |

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| 08/25/2021 | Contact – Telephone call received from Trooper James Everidge, Michigan State Police |
| 08/27/2021 | Inspection Completed On-site Interviews conducted with assistant home manager Ms. Morgan Scholz and home manager Ms. Kaitlyn Moiles. Present during interviews were DHHS adult protective services worker Mr. Terry Marzean, CMH recipient rights officer Ms. Ruth Hewett and administrator Ms. Roxanne Goldammer |
| 08/27/2021 | Contact – Telephone call made to Trooper James Everidge, Michigan State Police |
| 09/02/2021 | Contact – Telephone call made to licensee designee Mr. Kevin Kalinowski |
| 09/02/2021 | Exit conference with licensee designee Mr. Kevin Kalinowski |

ALLEGATION: Staff seem to be under the influence of narcotics. They may be taking and/or selling narcotics from the home.

INVESTIGATION: I spoke with CMH recipient rights officer Ms. Ruth Hewett by phone on August 12, 2021. She reported that the Beacon Home at Ossineke adult foster care (AFC) home has several Community Mental Health residents living there. She stated that she is not familiar with Resident A or these specific allegations.

I conducted an unannounced site inspection at the Beacon Home at Ossineke on August 12, 2021. I wore personal protection equipment to protect myself and others. After some discussion with home manager Ms. Kaitlyn Moiles, I spoke with Resident A. He said that he did not want to live at the home any longer. Resident A stated that he did not like the staff or the other residents. I asked him if there was any specific concern that he wanted to report. Resident A stated that sometimes he does not receive his medication. He said that he knew that the assistant home manager Ms. Morgan Scholz handles the medication and Ms. Scholz has asked him not to tell anyone that he sometimes does not get his medication. Resident A stated that Ms. Scholz has given him marijuana at times so that he would not say that he missed his medication. Resident A said that this happened when she took him from the home on outings. No one else knew about it. This happened about two or three weeks ago and happened in her car. She let him use her vape pen which he believed contained marijuana. Resident A stated that he believes Ms. Scholz was sometimes under the influence of marijuana when she came into work and “guessed” that some of the other staff were “under the influence” as well when they came into work. He did not have any specific reason why he believed that. Resident A spoke of wanting to move from the home into a place of his own. He was not interested in moving to another AFC home. He stated that things would be

the same in any AFC home he moved to and that he only wished to have his own apartment. I spoke with him about having a goal of independence in his CMH service plan. Resident A said that he is not aware of him having any goal of independence. He mentioned that his CMH caseworker does not return his calls. He denied that he knew her name or that he could remember her having monthly contact with him. I spoke with him about how to ensure that he has a goal of independence in his service plan and about meeting that goal. Resident A was not interested in talking with me further after he believed that he would not be moved immediately into his own apartment.

I spoke again with home manager Kaitlyn Moiles. She stated that Resident A is currently "having some issues". He does not like what his current CMH psychiatrist tells him so is trying to get a new psychiatrist. I asked Ms. Moiles about his claim that he is not always getting his medication. Ms. Moiles stated that it has been her experience that the only time he does not get his medication is when he refuses it. She stated that her assistant manager, Ms. Morgan Scholz, orders and monitors the residents' medication. Ms. Moiles stated that they use a local pharmacy that ensures that they always have at least a week supply of each resident's medication. She showed me Resident A's medication administration logs and I observed they are up to date. She said that the infrequent blanks in the logs are due to their Medication Administration Record System (MARS) sometimes being off-line and staff forgetting to go back and record the medication pass later. I observed Resident A's medication logs for June, July and August of 2021. According to the logs, Resident A has mostly received his medication except for some instances when he refused it. According to the logs, Ms. Morgan Scholz infrequently was the one who administered Resident A's medication. Ms. Moiles stated that she believed that Resident A was receiving his medication except for the times when he refused it. She said that Resident A has a history of substance abuse and that he has been found with marijuana or been under the influence of marijuana when returning from the community. They do not know where he has obtained the marijuana. She explained that Resident A is able to go into the community without assistance and often does that. They have documented when he has been found with marijuana or when they have believed he returned from an outing under the influence. At those times he also does not receive his medication. They have been instructed not to give him his medication 8 hours after he is found to be under the influence of an unknown drug.

I observed and interacted with staff members Ms. Kaitlyn Moiles, Ms. Heather Cadieux, Ms. Amanda Davis and Ms. Desiree Woods during my visit. None of them seemed to be under the influence of a narcotic or other substance.

On August 20, 2021, I spoke with adult protective services worker Mr. Terry Marzean. He stated that he was investigating a matter of Resident A saying that he was assaulted by another resident. Resident A reported that another resident hit him on the arm and that the staff stood by and laughed about it. He said that he planned on going to the home that day and interviewing the involved parties. I

asked him to let me know if he discovered any wrongdoing on the part of the facility. Mr. Marzean called back later in the day to report that the allegation of assault was unfounded. He said that the staff reported there was nothing physical that happened between Resident A and another resident. There was only an argument between Resident A and another resident. Staff intervened before it became physical. Resident A did not have any injuries. Mr. Marzean did not believe that Resident A was assaulted or harmed in any way. The staff responded to the incident appropriately. Mr. Marzean stated that he had also contacted Resident A's guardian who reported that Resident A is known to be a "story-teller". I asked him if any of the staff present seemed under the influence of any narcotic during his time there. He replied that none of the staff there presented as being under the influence of any narcotic.

On August 24, 2021, I received a telephone call from CMH recipient rights officer Ms. Ruth Hewett. She said that their office had received an anonymous fax regarding the Beacon Home at Ossineke. The fax was of a screen shot of text messages between two individuals, one of which appeared to be Ms. Morgan Scholz. The texts seemed to indicate that Ms. Scholz was looking to sell narcotics which were located at the AFC home. Ms. Hewett said that she would forward me the document. She said that she also planned on contacting law enforcement after speaking with her director about the matter.

I reviewed the document from Ms. Hewett. The name Morgan was at the top of the screen shot. One person was asking if she wanted to "sale". She replied "yes" and stated that she had 15 Ativan and 30 Gabapentin. She texted that, "The pills are at the office. I left them locked up in my office." I forwarded the document to adult protective services worker Mr. Terry Marzean.

On August 25, 2021, I spoke with Ms. Melissa Williams who is an administrator with Beacon/The Country House, LLC. She reported that they had received a screen shot of what appeared to be a text conversation between Ms. Morgan Scholz and someone else regarding a possible sale of narcotics from the Beacon Home at Ossineke. She provided me with a copy of several screen shots. One screen shot was the same as the one I had received from Mr. Hewett. The other screen shots contained what appeared to be her talking to a friend outside of work and using disparaging terms when referring to the residents in the home. Other texts seemed to indicate that Ms. Scholz was misusing company funds. There was a phone number for the person who sent the screen shots.

I called the telephone number provided to me by Beacon/The Country House, LLC. on August 25, 2021. The person who answered the phone identified herself as someone who knew Ms. Scholz. She stated that she had obtained the screen shots and had one more to share with me. She texted me another screen shot. This screen shot appeared to be between Ms. Scholz and another person asking if they wanted to purchase Ativan or Gabapentin. Ms. Scholz texts, "I got my hands on some that aren't accounted for at work." Like the other screen shot, this one

appeared to be authentic. It contains Ms. Scholz's name and phone number which matched that which I had been provided.

I spoke with administrator Roxanne Goldammer on August 25, 2021, who was on-site at the Beacon Home at Ossineke to conduct her own investigation. She was there with the home manager Kaitlyn Moiles to "reconcile" the resident medications. She stated that she asked Ms. Moiles to open the floor safe where petty cash is kept. Ms. Moiles opened the safe, saw that there were pills in there and her first reaction was to shut it quickly. Ms. Goldammer stated that they found pills in the safe which shouldn't have been there. Ms. Moiles stated the pills were medications that came with Resident A in November of 2020. Resident A had been on his own when he first came into care. Many of the pills were in unmarked pill bottles or in pill bottles which did not match what was inside. There were no prescriptions with the pills so a physician had authorized all new medications at that time. Therefore, the old medications had sat in the safe since then. Ms. Moiles admitted to her that they had not done a count at that time to document what was there. Ms. Scholz had been on duty when Resident A arrived and had handled the admission. Ms. Goldammer reminded Ms. Moiles of their policy of documenting all medication that comes with a new resident and the disposing of medication that is no longer required by a resident. Ms. Goldammer reported that the pills in the safe, including Ativan and Gabapentin, matched what was discussed in the screen shots. Ms. Goldammer stayed on site for several hours to reconcile Resident A's other medications. She did pill counts herself, checked the medication administration logs and shift change counts. Everything matched up. She stated that she did not believe that the complaint about Resident A not getting his medication was true. She said that she believed that the issue was Ms. Scholz taking advantage of the fact that there were undocumented narcotics. Ms. Scholz was suspended from work until they could determine what was going on. Ms. Goldammer agreed to meet again at the home but was not available until two days later.

I spoke with Trooper James Everidge with the Michigan State Police by telephone on August 25, 2021. He confirmed that he had received a copy of the screen shot regarding the possible sale of narcotics from the Beacon Home at Ossineke. I also verbally gave him the information I had including contact information for the person who had sent us the screen shots.

I conducted another inspection at the Beacon Home at Ossineke Home on August 27, 2021. I wore personal protection equipment to protect myself and others. I met DHHS adult protective services worker Mr. Terry Marzean and CMH recipient rights officer Ms. Ruth Hewett who wished to be involved in the interviews. Administrator Roxanne Goldammer was also on-site. Ms. Goldammer told us that she had done an inventory of what was in the floor safe and provided us with a copy of what was there. This included 14 Ativan pills and 36 Gabapentin pills. These matched the type and dosage of what was in the screen shots. There was also what appeared to be a small amount of loose marijuana that had also reportedly arrived with Resident A in November of 2020.

We then interviewed Ms. Morgan Scholz who had come to the facility at the request of Ms. Goldammer. After some preliminary discussion, she was asked about taking Resident A on outings. She agreed that she had. She denied that she had ever provided Resident A with marijuana. Ms. Scholz admitted that she uses marijuana herself when she is not working. She said she never used marijuana before or during work. She said that Resident A says a lot of things that are not true. He has obtained marijuana and alcohol in the community when he has been out by himself. Ms. Scholz was asked about the pills in the floor safe. She said that when Resident A arrived in November of 2020, he only had a backpack which contained his belongings. He was asked to give them his medications. Some of the medication was in bottles without labels and with no or unknown prescriptions. Ms. Scholz stated that she contacted a former administrator and asked what to do about the medication. The former administrator told her to put them in the safe and that they would need to obtain new prescriptions for Resident A. At that point, I asked Ms. Goldammer to provide Ms. Scholz with a copy of the first screen shot we had received. Ms. Scholz stared at the copy of the screen shot for some time and then admitted that she had taken the pills. She said, "I was short on cash and I did sell some of the pills from the safe." I asked her what she sold. She indicated the copy of the screen shot and stated that she sold exactly what was described in the screen shot (15 Ativan and 30 Gabapentin). She admitted that they were Resident A's medication that came with him which were undocumented. Ms. Scholz stated that it was the first and only time she stole and sold medication from the home. She stated that the two screen shots were from the same transaction. In one, she was asking someone if they knew of someone who would buy narcotics and the second one she was communicating with the person who she later sold the pills to. Ms. Scholz stated that that was the only time she had taken narcotics from the home and was unaware of anyone else stealing medication. She denied using narcotics herself and was unaware of staff being under the influence while at work. She was adamant that Resident A did receive his medication unless he refused it. Ms. Scholz stated that she knew that for sure. Ms. Scholz provided us with a written statement regarding her stealing and selling the narcotics from the safe.

We then interviewed home manager Kaitlyn Moiles. She said that she did not believe that Resident A had ever missed any of his medication unless he refused it. Resident A had been known to obtain marijuana in the community when by himself and had come back to the home under the influence. They had filled out "event reports" when that occurred. Ms. Moiles stated that they were instructed not to give him his medication for 8 hours after these instances so that his medication would not interact with whatever was in his system. Ms. Moiles stated that Ms. Scholz was in charge of all resident medication, but Ms. Moiles said she does double-check the medication administration in the home. They do narcotic counts during each shift change with two staff counting the narcotics. Ms. Moiles was asked about herself or other staff coming to work under the influence. She reported that she does use marijuana when she is not working. She denied that she ever used it before coming into work or during work. Ms. Moiles stated that she has never come in under the influence before. Resident A had complained of a staff person being under the

influence while working. Ms. Moiles stated that she had come to work to check on that person as soon as she received the report. The staff person in question was over-tired with lack of sleep. She reported having been awake with her sick children before coming into work. She did not find any evidence that the person was “under the influence”. This was the only incident that had been reported to her of a staff person being under the influence. She had not found that to be true in any other instances. She did not know anything about the report of Ms. Scholz giving Resident A marijuana and stated she was not aware of that happening. In regard to Resident A’s medication being in the safe, she said that she realized it should not have been in there this long. They should have given it to Resident A’s guardian or disposed of it properly. She admitted that they had not done a count of or documented those medications when he arrived. I told Ms. Moiles of Ms. Scholz admitting to taking narcotics from the safe and selling them. Ms. Moiles stated that she had not known anything about that.

After the interviews, Ms. Goldammer reported to us that Ms. Scholz would no longer be employed by them and would no longer have access to the facility. She would continue to investigate whether there were any inconsistencies with any of the residents’ medication.

I observed and interacted with staff members Ms. Kaitlyn Moiles, Ms. Amanda Nielsen and Ms. Courtney Wirgan during my visit. None of them seemed to be under the influence of a narcotic or other substance.

I provided Ms. Scholz’s written statement to Trooper James Everidge and updated him regarding the developments in the case.

I spoke with licensee designee Mr. Kevin Kalinowski by phone on September 2, 2021. He stated that he was aware of everything that had transpired at the Beacon Home at Ossineke recently. Mr. Kalinowski confirmed that Morgan Scholz was no longer employed by the agency. He said that the home manager Kaitlyn Moiles had also resigned since that time. He presented this as a positive development and believed that the home would be in better shape with new management. Mr. Kalinowski agreed with me that Roxanne Goldammer was dealing with the situation efficiently and was confident that the home would be better in the long run. I told him that I appreciated Ms. Goldammer’s assistance with my investigation and the seriousness in which she took the allegations.

| 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. |

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| ANALYSIS: | Information was not discovered through this investigation which would indicate that staff have been “under the influence” while caring for residents. The home manager stated that Resident A had reported that a staff person was “under the influence” while working. The home manager had responded immediately to the home while the staff person was still present. She found the staff person doing resident laundry when she arrived and the staff person explained that she was overly tired from lack of sleep and had been caring for sick children prior to her shift. I personally conducted two site inspections, one of which was unannounced, and did not observe that staff were “under the influence”. Adult protective services worker Mr. Terry Marzean also completed a site inspection during the time of this investigation and did not believe staff were “under the influence”. |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

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| APPLICABLE RULE | |
| R 400.14312 | Resident medications. |
| | (2) Medication shall be given, taken, or applied pursuant to label instructions. |
| ANALYSIS: | Information was not discovered through this investigation which would indicate that Resident A has not received his medication as prescribed. It was reported that he did not receive his medication when he refused it and during times when he came back from the community under the influence of drugs or alcohol. The medical administration records and shift count records appeared accurate and there were no missing medications from his prescribed medication. |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

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| APPLICABLE RULE | |
| R 400.14312 | Resident medications. |
| | (6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed. |

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| ANALYSIS: | It was confirmed through this investigation that the assistant home manager, Morgan Scholz, did take and sell narcotic medication from the pills that Resident A originally arrived with in November of 2020. She admitted to taking and selling 15 Ativan and 30 Gabapentin pills. At the time of her confession, there were still several narcotic pills remaining in the floor safe that were undocumented. |
| CONCLUSION: | VIOLATION ESTABLISHED |

| APPLICABLE RULE | |
|------------------------|--|
| R 400.14312 | Resident medications. |
| | (7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or pharmacist. |
| ANALYSIS: | It was confirmed through this investigation that Resident A's medication that he arrived with and which he no longer required, was not properly disposed of after consultation with a physician or pharmacist. |
| CONCLUSION: | VIOLATION ESTABLISHED |

ALLEGATION: The conditions of the home are filthy.

INVESTIGATION: I conducted an unannounced site inspection at the Beacon Home at Ossineke on August 12, 2021. I could smell bleach through my mask and observed the floors of the home were slightly wet in places from being mopped. I observed the dining room table to be cleared and clean. I did not see any food residue on the floors of the dining room or kitchen. The kitchen was also observed to be clean. I did see some rinsed dishes in the sink but nothing that would be considered unusual. I checked the bathrooms of the home which were relatively clean at the time of the visit. I also checked all resident bedrooms and common areas of the home. I did not observe anything unusual in the home to indicate that it was filthy or that it had been filthy prior to my arrival.

I spoke with home manager Ms. Kaitlyn Moiles during my inspection regarding the report of the home being dirty. She denied that the home was filthy. She said that all staff have cleaning duties and there is a "cleaning schedule". They do have a resident who will sometimes defecate on the floor of the home. This is not a regular occurrence but it does happen. They do check with him often to see if he has to use the bathroom and assist with getting him to the bathroom when he looks as if he has

to go. Ms. Moiles stated that she was not aware of any instance of a staff not cleaning up feces and disinfecting the area immediately during those times.

I spoke with DHHS adult protective services worker Mr. Terry Marzean by phone on August 20, 2021. He had just conducted a site visit at the Beacon Home at Ossineke that day. Mr. Marzean reported that he had found the home to be clean and orderly during the time of his visit. He stated that he has no concerns regarding the physical condition of the home.

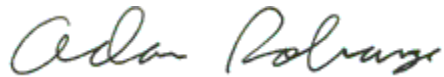
I conducted another site inspection at the Beacon Home at Ossineke on August 27, 2021. I again observed the home to be clean and free of filth during the time of my inspection.

| 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: | Information was not discovered through this investigation which would indicate the home was filthy or ill-maintained. Site inspections were conducted by myself, as well as an adult protective services worker during the time of this investigation and the home was found to be clean and orderly during. A resident at the home does sometimes defecate on the floor of the home. It was reported however that these messes are cleaned up and the area disinfected immediately after this occurs. |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

I conducted an exit conference with licensee designee Mr. Kevin Kalinowski by phone on September 2, 2021. I told him of the findings of my investigation and gave him the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

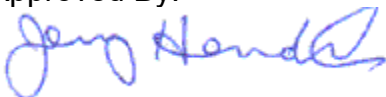


09/07/2021

Adam Robarge
Licensing Consultant

Date

Approved By:



09/07/2021

Jerry Hendrick
Area Manager

Date