STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

May 31, 2023

Chester Kwiatkowski
South Coast Home LLC
72633 M 43
South Haven, MI 49090

RE: License #: AS800397844
Investigation #: 2023A1031036
South Coast Home

Dear Mr. Kwiatkowski:

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 (616) 356-0183.

Sincerely,
Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AS800397844
Investigation #:	2023A1031036
Complaint Receipt Date:	04/18/2023
Investigation Initiation Date:	04/18/2023
Report Due Date:	06/17/2023
Licensee Name:	South Coast Home LLC
Licensee Address:	72633 M 43 South Haven, MI 49090
Licensee Telephone #:	(269) 998-9349
Licensee Designee/Administrator:	Chester Kwiatkowski
Name of Facility:	South Coast Home
Facility Address:	72633 M43 Highway South Haven, MI 49090
Facility Telephone #:	(269) 767-7688
Original Issuance Date:	05/09/2019
License Status:	REGULAR
Effective Date:	11/09/2021
Expiration Date:	11/08/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A fell out of bed and went to the hospital due to having abrasions.	No
Additional Findings	Yes

III. METHODOLOGY

04/18/2023	Special Investigation Intake 2023A1031036
04/18/2023	Special Investigation Initiated - Letter Email exchange with APS worker Mike Hartman.
04/26/2023	Inspection Completed On-site
04/26/2023	Contact - Face to Face Interview with Desiree Rickett and Resident A.
04/28/2023	Contact - Telephone Interview with Licensee Chester Kwiatkowski.
05/01/2023	Contact - Voicemail left with Harold Evans.
05/04/2023	Contact - Telephone Interview held with Tracy Kostic.
05/08/2023	Contact - Voicemail left with Harold Evans.
05/18/2023	Contact - Voicemail left with Harold Evans.
05/18/2023	Contact - Documents Reviewed.
05/18/2023	Contact - Email sent to Linda Davis.
05/19/2023	Contact – Telephone Interview with Harold Evans.
05/19/2023	Contact – Telephone Interview with Relative #1.
05/22/2023	Contact – Email Exchange with Linda Davis.
05/22/2023	Contact – Documents Received and Reviewed.
05/31/2023	Exit Conference held with Licensee Chester Kwiatkowski.

ALLEGATION:

Resident A fell out of bed and went to the hospital due to having abrasions.

INVESTIGATION:

On 4/18/23, I had an email exchange with APS Worker Mike Hartman. Mr. Hartman reported he did not find any evidence to support staff neglected Resident A. Mr. Hartman reported Resident A was checked on by AFC staff Harold Evans and Mr. Evans later returned to the room and Resident A was on the floor. Mr. Hartman reported it was determined that Resident A was able to pull himself out of the bed even though the bed had rails. Mr. Hartman reported Resident A's guardian is working with the licensee and community mental health to develop a new treatment plan.

On 4/26/23, I interviewed direct care worker (DCW) Desiree Rickett in the home. Ms. Rickett reported she was not working when Resident A fell out of his bed. Ms. Rickett reported when Resident A is in his bed, they lower the bed to the lowest setting and put the rails up. Ms. Rickett reported staff turn Resident A every two hours when he is sleeping in his bed.

On 4/26/23, I observed Resident A in the home. Resident A was not able to be interviewed due to being nonverbal.

On 4/28/23, I interviewed the licensee Charles Kwiatkowski via telephone. Mr. Kwiatkowski reported he was in contact with Mr. Evans and the home manager Tracy Kostic following the incident involving Resident A falling out of his bed. Mr. Kwiatkowski reported he was informed that Resident A had pulled himself up and fell out of the bed. Mr. Evans and Ms. Kostic assisted him back into his bed. Mr. Kwiatkowski reported Mr. Evans informed him he checked on Resident A and he was fine. Mr. Evans then went to go pass medications and came back to Resident A's room and observed him to be on the floor. Mr. Kwiatkowski reported emergency services was contacted to have Resident A assessed.

On 5/4/23, I interviewed home manager Tracy Kostic via telephone. Ms. Kostic reported she got to the home around 8:45am and Mr. Evans had asked her to come to Resident A's bedroom because he fell out of bed. Ms. Kostic reported Mr. Evans got Resident A back into his bed. Ms. Kostic noticed abrasions on Resident A's wrist and face. Ms. Kostic then contacted emergency services as she felt he needed to be assessed. Ms. Kostic reported Mr. Evans reported to her that he checked on Resident A and then went to pass medications, when he came back to the room Resident A was on the floor.

On 5/18/23, I reviewed the incident report dated 4/13/23 completed by Mr. Evans. The report indicates staff went to check on Resident A and then they left the room to pass medications to another resident. Staff went back into Resident A's bedroom to

give him his medications and he was on the floor. Staff assessed Resident A before assisting him back into his bed. The home manager also assessed Resident A and then called 911. Resident A was taken to the hospital by ambulance. I reviewed Resident A's *Individual Plan of Service (IPOS)* dated 9/16/22. The IPOS read Resident A should change positions every two hours and staff are to provide Resident A with monitoring and support to maintain overall health and wellness during hours of sleep.

On 5/19/23, I interviewed Mr. Evans via telephone. Mr. Evans reported he checked on Resident A and he was in his bed. Mr. Evans went to go give another resident a shower and pass medications. Mr. Evans went to pass Resident A his medications and he was on the ground when he went into his bedroom. Mr. Evans reported Resident A's bed was on the lowest setting for height and his bed rails were up. Mr. Evans reported he is not sure how he fell out of bed as this has not happened before. Mr. Evans reported he checks on Resident A at least every two hours when he is in his bedroom. Mr. Evans reported the home manager Ms. Kostic arrived at the home and noticed Resident A had abrasions and she called 911.

On 5/19/23, I interviewed Resident A's guardian via telephone. Relative #A1 reported Resident A has never fallen out of his bed before. Relative #A1 reported Resident A can move and change positions when he is uncomfortable. Relative #A1 reported she went to the hospital when Resident A was taken there and observed marks on his face. Relative #A1 reported she believes Resident A was laying on the ground for a long time due to him having pressure sores. Relative #A1 reported she plans to purchase a mat to put on the side of his bed in case he falls out of the bed again. Relative #A1 reported she does not want Resident A to have full segment bed rails because she feels he could get stuck. Relative #A1 reported Resident A is to be turned every two hours when he is in his bed throughout the night.

On 5/22/23, I had an email exchange with Resident A's case manager Linda Davis. Ms. Davis reported Resident a has not fallen out of his bed previously. Ms. Davis reported Resident A is strong enough to pull himself up and she witnessed him doing this when she visited him at the hospital. Ms. Davis reported there is an updated protocol for Resident A to be placed in the middle of the bed and the bed is very low to the floor. Ms. Davis reported the agency is looking into padded railings for Resident A. Ms. Davis reported Resident A's guardian is also purchasing a mat to be placed by his bed. Ms. Davis reported that Resident A's position is changed frequently throughout the day, and he is only in his bed for nighttime sleep and a nap. Ms. Davis reported "he truly had an accidental fall and his face/shoulder had abrasions consistent with a fall".

On 5/22/23, I reviewed Resident A's medical records from his visit to the emergency room on 4/13/23. Resident A is diagnosed with cerebral palsy and is non-verbal and non-ambulatory. The medical records noted that Resident A was seen due to an unwitnessed fall. Resident A had abrasions on his body and "beginnings" of pressure sores on his left shoulder, left wrist, left lower ribs, and right knee. There

were initially concerns noted for adult maltreatment. The medical records indicate the pressure sores on the left side of Resident A’s body was likely related to either the fall or prolonged immobilization in bed. Resident A was discharged in stable condition.

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:	Based on interviews and the review of supporting documentation, there is no evidence to support Resident A was not treated with dignity and his protection and safety were not attended to. Staff checked on Resident A as identified in his Individual Plan of Service and contacted emergency services as soon as they noticed he may have been hurt from the fall. Resident A falling out of his bed appears to be an isolated incident as he has not fallen out of his bed before. The home has taken the appropriate steps to address this newly identified need and is working with Resident A's guardian and case manager to implement new safety precautions in the home.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/18/23, I reviewed Resident A’s *Assessment Plan for AFC Residents* dated 2/17/23*.* The assessment plan has multiple areas that are identified as a need. The assessment does not describe Resident A’s needs and how they will be met by the home.

APPLICABLE RULE	
R 400.14303	**Resident Care;**
	(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.
For Reference: R 400.14102	**Definitions.**
	(d) "Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services, taking into account the preferences and competency of the individual.
ANALYSIS:	Resident A has multiple needs identified on the assessment plan. The assessment plan does not specify or describe how Resident A's identified needs will be met in the home. The assessment plan is blank in areas required to be completed to explain how the staff will meet the specific needs of Resident A. Therefore, the plan as written lacks the supervision, protection, and personal care need methods staff are to follow to comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 4/26/23, I completed an onsite inspection at the home. The home was observed to have smoke detectors disconnected in the kitchen and main living area.

APPLICABLE RULE	
R 400.14505	**Smoke detection equipment;**
	(1) At least 1 single-station, battery-operated smoke detector shall be installed at the following locations:

	(b) On each occupied floor, in the basement, and in areas of the home that contain flame- or heat-producing equipment.
ANALYSIS:	The home was observed to have smoke detectors disconnected in the kitchen and main living area.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

It is recommended that upon receipt of an acceptable corrective action plan, there be no change to the status of the license.

KDuda 5/31/23

Kristy Duda Date
Licensing Consultant

Approved By:
Russell Misiak 5/31/23

Russell B. Misiak Date
Area Manager