GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 20, 2022

Ramon Beltran, II
Beacon Specialized Living Services, Inc.
Suite 110
890 N. 10th St.
Kalamazoo, MI 49009

RE: License #: AM030402101
Investigation #: 2022A0350026
Beacon Home at Hammond

Dear Mr. Beltran:

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 (616) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

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 #:	AM030402101
Investigation #:	2022A0350026
Complaint Receipt Date:	05/17/2022
Investigation Initiation Date:	05/17/2022
Report Due Date:	06/16/2022
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Melissa Williams
Licensee Designee:	Ramon Beltran, II
Name of Facility:	Beacon Home at Hammond
Facility Address:	318 East Hammond Street Otsego, MI 49078
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	07/09/2020
License Status:	REGULAR
Effective Date:	01/26/2022
Expiration Date:	01/25/2024
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff Antonia Perales cussed at and grabbed and pulled Resident A, causing bruising to Resident A's arms.	Yes

III. METHODOLOGY

05/17/2022	Special Investigation Intake 2022A0350026
05/17/2022	APS referral
05/17/2022	Special Investigation Initiated - Letter Through emails, I arranged to meet Michael McClellan, Adult Protective Services investigator, at this home
05/17/2022	Contact - Face to Face I met Mr. McClellan and Officer M. Gudith at this home
05/17/2022	Contact - Face to Face I, along with APS & Law Enforcement, spoke with residents and staff
05/17/2022	Contact - Face to Face Mr. McClellan and I met with Jamara White, Home Manager
05/17/2022	Contact - Telephone call made Mr. McClellan and I interviewed Alicia Berens by speakerphone
05/17/2022	Contact - Telephone call made I left a voicemail message for Ms. Perales requesting a call back
05/18/2022	Contact - Document Sent I sent Ms. White and Ramon Beltran, II, Licensee Designee, an email
05/18/2022	Contact - Document Received I received an email from Ms. White
05/18/2022	Contact - Telephone call made I sent Ms. Perales a text message requesting that she call me
05/20/2022	Contact - Telephone call made I called Ms. Perales again but received no answer
05/20/2022	Exit conference – Held with Ramon Beltran, II, Licensee Designee

ALLEGATION: Staff Antonia Perales cussed at and grabbed and pulled Resident A, causing bruising to Resident A's arms.

INVESTIGATION: On 05/17/2022, through emails, I arranged with Michael McClellan, Adult Protective Services investigator, to meet at this home later the same day.

On 05/15/2022, I met Mr. McClellan at this home, and he informed me that he contacted the police and an officer would be meeting there with us. Shortly after I and Mr. McClellan arrived at this home, Officer Michael Gudith did as well. We all briefly discussed the allegations and then proceeded to go inside. We met with Kaitlynn Dean, Direct Care Worker (DCW), and I informed her who we were and requested to speak with Resident A. Ms. pointed out who Resident A was and I introduced myself, Mr. McClellan, and Officer Gudith to her.

On 05/17/2022, I, along with Mr. McClellan and Officer Gudith, interviewed Resident A, who showed us a faint, dime-sized bruise on her left wrist. Resident A told us the bruise was caused by Antonia Perales, DCW, who grabbed her and pulled her. Resident A also showed us another faint, dime-sized bruise on the underside of her upper right arm, and what appeared to be a rug burn on her right forearm. She reported that these marks were also caused by Ms. Perales's grabbing and pulling her during the same incident. Some of Resident A's responses were difficult to understand, and it was not clear what she said about how she got the rug burn mark, other than it was caused by Ms. Perales. Resident A stated that Ms. Perales wanted her to go to bed but she didn't want to, and they ended up arguing, calling each other names, and cussing at each other. Resident A said she called Ms. Perales a "bitch" and Ms. Perales called her a "bitch" also.

On 05/17/2022, I, along with Mr. McClellan and Officer Gudith, interviewed Ms. Dean, who said she was working at the time of this incident. Ms. Dean reported that Resident A "was having a delusion" that evening and Ms. Perales told Resident A to "stop being a baby" and "stop crying." Ms. Dean stated that at about 12:00 a.m. she, Ms. Perales, Resident A, and Resident B were sitting on the porch smoking and vaping, when Ms. Perales told Resident A it was time for her to go to bed. Resident A said she didn't want to and Ms. Perales said, "I'm not going to deal with her shit right now," and grabbed Resident A by her wrists and pulled her up and forced her all the way to her room, and yelled at Resident A, "You are going to fucking bed." I observed that the distance between the front porch sitting area to Resident A's room was approximately 40 feet. I asked Ms. Dean if we could speak with Resident B, and she said we could, but her speech is very hard to understand. Mr. McClellan, Officer Gudith, and I waited outside on the front porch and Ms. Dean brought Resident B to us.

On 05/17/2022, I, along with Mr. McClellan and Officer Gudith, interviewed Resident B, whose speech was rapid and jumbled, with a few clear words spoken now and then. We were able to understand that Resident B said that Ms. Perales "shook"

Resident A, who told Ms. Perales, “You’re hurting me.” Resident B also stated that Ms. Perales yelled at Resident A, “You’re going to bed, now,” and pulled Resident A to her room by her arms.

On 05/17/2022, while still onsite, Ms. Dean provided Mr. McClellan, Officer Gudith, and me with the name and cell phone number of DCW Alicia Berens who saw Resident A’s bruises the next morning.

Several minutes later, while I was still onsite on 05/17/2022, Jamara White, Home Manager, arrived and provided Mr. McClellan and me with the Incident Report pertaining to this situation and a copy of Resident A’s Health Care Appraisal.

On 05/17/2022, Mr. McClellan and I made calls by speakerphone to Ms. Perales and Ms. Berens. As we got Ms. Perales’s voicemail, I left a message for her to call me. Ms. Berens answered when we called her. Ms. Berens informed us that she did not witness the incident in question because she wasn’t working at the time; however, she said that when she was passing 8:00 p.m. medications on 05/14, she noticed the bruise on Resident A’s left wrist and asked her about it. Ms. Berens said that Resident A told her that Ms. Perales “abused me” because Ms. Perales told her to go to bed but she didn’t want to. Ms. Berens stated that Resident A showed her the bruise on her other arm and the rug burn mark as well, and she took pictures of them and put Triple Antibiotic ointment on the rug burn mark. Ms. Berens did not deem these injuries as needing medical attention.

On 05/18/2022, I sent Ms. Perales a text message requesting that she call me and informing her that Ms. White will advise her to speak with me.

On 05/18/2022, I sent Ms. White and Ramon Beltran, II, Licensee Designee, an email requesting that they have Ms. Perales call me.

On 05/18/2022, Ms. White sent me an email stating, “I’ve tried reaching her (Ms. Perales) also, no luck.”

On 05/20/2022, I made one more attempt to reach Ms. Perales by phone but received no answer.

On 05/20/2022, I called and held an exit conference with Ramon Beltran II, Licensee Designee. I informed Mr. Beltran that I was citing a violation of this rule and asked how he was handling this situation. Mr. Beltran said that Ms. Perales was placed on suspension as soon as he found out about this, but admitted she may have worked after this incident because he had not yet known about it. Mr. Beltran said that Ms. Perales was also not answering her phone when called and did not return any calls that management had made to her. Mr. Beltran told me that Ms. Perales will be terminated immediately.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(d)(ii) Verbal abuse.**
ANALYSIS:	Resident A stated that Antonia Perales, DCW, called her a “bitch” and also grabbed and pulled her by her arms, forcing her to go to her room to go to bed, causing bruising and a rug burn to her arm. Kaitlynn Dean, DCW, stated she observed Ms. Perales grabbing Resident A’s wrists and forcing her to her room by aggressively pulling her along. Ms. Dean also heard Ms. Perales say to Resident A, “You are going to fucking bed.” Alicia Berens, DCW, stated she noticed bruises on Resident A and asked her about them. She stated Resident A told her they were caused by Ms. Perales “abusing” her while forcing her to go to bed when she didn’t want to. Resident B reportedly saw Ms. Perales grab and pull Resident A up from sitting on the porch, forcing her to go to her room when she did not want to. Resident B also reportedly heard Resident A say, “You’re hurting me,” to Ms. Perales, and heard Ms. Perales say to Resident A, “You’re going to your room, now.” I left a voicemail message and sent a text to Ms. Perales, urging her to call me back, but she did not. I also requested that management attempt to call Ms. Perales and have her call me, but they were not able to get a hold of her either. Another call was made to Ms. Perales on 05/20/2022 but she did not answer her phone. My findings support that both parts (b) and (d)(ii) of this rule have been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

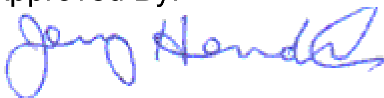
Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

May 20, 2022

Ian Tschirhart
Licensing Consultant

Date

Approved By:



May 20, 2022

Jerry Hendrick
Area Manager

Date