GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 14, 2025

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

RE: License #: AS640394552
Investigation #: 2025A0230018
Beacon Home At Hart

Dear Mr. Beltram:

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.

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,

Rhonda Richards

Rhonda Richards, Licensing Consultant
Bureau of Community and Health Systems
Suite 11, 701 S. Elmwood, Traverse City, MI 49684
(231) 342-4942

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS640394552
Investigation #:	2025A0230018
Complaint Receipt Date:	04/24/2025
Investigation Initiation Date:	04/25/2025
Report Due Date:	06/23/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110, 890 N. 10th St., Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Suzie Hunter
Licensee Designee:	Ramon Beltram
Name of Facility:	Beacon Home At Hart
Facility Address:	508 Griswold Street, Hart, MI 49420
Facility Telephone #:	(231) 301-8261
Original Issuance Date:	09/07/2018
License Status:	REGULAR
Effective Date:	03/07/2025
Expiration Date:	03/06/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff member Charle Corey told Resident A to hit him several times.	Yes

III. METHODOLOGY

04/24/2025	Special Investigation Intake 2025A0230018
04/24/2025	APS Referral
04/25/2025	Special Investigation Initiated - On Site interview with Resident A and staff member Serena Dupont
04/28/2025	Contact - Telephone call made Interview staff member Charle Corey
05/12/2025	Contact - Telephone call made Linda Wagner RRO
05/12/2025	Contact - Telephone call made Staff members Elona Leab and Serena Dupont
05/13/2025	Exit Conference With administrator Suzie Hunter

ALLEGATION: Staff member Charle Corey told Resident A to hit him several times.

INVESTIGATION: On 04/25/2025, I conducted an unannounced on-site investigation at the facility and interviewed Resident A and facility manager Serena Dupont.

Ms. Dupont stated she was aware of the allegations as Community Mental Health (CMH) Recipient Rights Officer (RRO) Linda Wagner had been in contact with her. She stated that staff member Charle Corey went to the hospital on 04/19/2025 as he stated he was hit multiple times by Resident A. Staff member Elona Leab stated she witnessed this event and that Mr. Corey told Resident A to hit him. Mr. Corey is currently not working at the facility pending the investigation.

Resident A stated he was “trying to have a good day”. He stated, “I yelled at Charle and then he yelled at me.” Resident A stated Mr. Corey told him to “hit him a few

times.” Resident A confirmed that he did hit Mr. Corey. He stated he thought that it was in Mr. Corey’s abdomen area.

On 04/28/2025, I spoke with staff member Charle Corey. Mr. Corey stated that on 04/19/2025, he was working at the facility when Resident A became agitated with Resident B who was nearby clapping his hands. Mr. Corey stated he thought Resident A appeared to be ready to hit Resident B. Mr. Corey stated he tried to diffuse the situation by stating to Resident A, “hitting is not good.” I asked Mr. Corey if he told Resident A to hit him and he replied, “I don’t know exactly what I said but that is something I might say because I would rather a resident hit me than another resident.” He stated Resident A hit him in the face stomach, chest and ribs. Mr. Corey stated he went to the hospital and was diagnosed with a concussion from the incident. He stated, “with this concussion I don’t have full knowledge of what I said.”

On 05/12/2025, I spoke with staff member Elona Leab. She stated she was working with Mr. Corey on 04/19/2025. Resident A became upset that Resident B was clapping his hands and Resident A began screaming and said something to the effect of hitting Resident B. Ms. Leab stated Mr. Corey walked over to Resident A and stated, “he can clap his hands if he wants.” Resident A stated “I’m gonna hit you.” At this time Mr. Corey stated “Go ahead” Mr. Corey stood in front of Resident A while Resident A hit him in the chest and shoulder. Mr. Corey then said, “Do it again.” At this point Ms. Leab yelled “Stop” Then Resident A stopped and went to his room. About an hour later Mr. Corey went to the hospital and did not return to work as he stated he had a concussion.

On 05/12/2025, I spoke with CMH RRO Linda Wagner who confirmed she was substantiating a case of lack of dignity and respect for Resident A on this complaint.

On 05/12/2025, I conducted an exit conference with Administrator Suzie Hunter and reviewed the findings of the investigation. She stated she had planned to move Mr. Corey to another facility as Resident A did not want to stay at the current home if Mr. Corey was going to continue working there. Additionally, she intended to require Mr. Corey to complete recipient rights training as a refresher course. This did not occur as Mr. Corey quit his employment with the company. Ms. Hunter will submit a plan of correction.

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:	Resident A stated Mr. Corey told Resident A to hit him. Resident A stated he did hit Mr. Corey.

	Staff member Charle Corey stated he was hit by Resident A. He stated he could not recall exactly what he told Resident A but telling a resident to hit him instead of another resident would be something he would say. Mr. Corey stated he was hit several times by Resident A. Staff member Elona Leab stated she observed Mr. Corey telling Resident A to hit him. Recipient Rights Officer Linda Wagner substantiated this complaint on lack of dignity and respect on the part of Mr. Corey. There is a preponderance of evidence to substantiate the allegation that staff Charle Corey told Resident A to hit him. Resident A was not treated with dignity and his personal needs, including protection and safety, were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

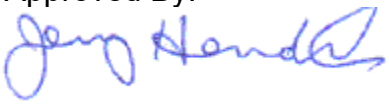
IV. RECOMMENDATION

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

05/13/2025

Rhonda Richards — Date
Licensing Consultant

Approved By:



05/14/2025

Jerry Hendrick — Date
Area Manager