GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 22, 2025

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

RE: License #: AS630413018
Investigation #: 2025A0465016
Beacon Home At Southfield

Dear Ramon 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 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 (248) 972-9136.

Sincerely,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630413018
Investigation #:	2025A0465016
Complaint Receipt Date:	03/18/2025
Investigation Initiation Date:	03/19/2025
Report Due Date:	05/17/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Ramon Beltran
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At Southfield
Facility Address:	22150 Rougemont Dr. Southfield, MI 48033
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	09/23/2022
License Status:	REGULAR
Effective Date:	03/23/2025
Expiration Date:	03/22/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 3/16/2025, direct care staff, Wanda Regular, hit Resident A three times with a 2-liter plastic pop bottle.	Yes

III. METHODOLOGY

03/18/2025	Special Investigation Intake 2025A0465016
03/19/2025	Special Investigation Initiated - Letter Email exchange with Complainant
03/19/2025	Contact – Document received Email exchange with Office of Recipient Rights Officer, Alanna Honkanen
04/01/2025	Inspection Completed On-site I conducted an onsite investigation. I completed a walk-through of the facility, reviewed resident files, observed residents, interviewed Resident A, Resident B, and direct care staff, JonMonet Hodge
04/07/2025	Contact - Document Received Email exchange with Office of Recipient Rights Officer, Alanna Honkanen
04/07/2025	Contact - Document Received Facility documents received via email
04/07/2025	Contact - Telephone call made I spoke to direct care staff/manager, Janice Jones, via telephone
04/08/2025	Contact - Document Received Facility documents received via email
04/16/2025	Contact – Telephone call made Called direct care staff, Wanda Regular; Requested return call
04/24/2025	Contact – Telephone call made Called direct care staff, Wanda Regular; Requested return call

05/02/2025	Contact - Document Received Facility documents received via email
05/02/2025	Contact - Telephone call made I spoke to ex-direct care staff, Wanda Regular, via telephone
05/06/2025	Exit Conference I conducted an exit conference with licensee designee/ administrator, Ramon Beltran, via telephone

ALLEGATION:

On 3/16/2025, direct care staff, Wanda Regular, hit Resident A three times with a 2-liter water bottle.

INVESTIGATION:

On 3/18/2025, a complaint was received, alleging that on 3/16/2025, direct care staff, Wanda Regular, threw a 2-liter bottle of Mountain Dew at Resident A three times. The complaint stated that Ms. Regular accused Resident A of drinking her Mountain Dew then proceeded to hit him with the bottle several times until she ultimately hit him with it. The complaint stated that direct care staff, JonMonet Hodge, was also on duty and witnessed this incident. The complaint stated that direct care staff and home manager, Janie Jones, received a text message from Ms. Regular, in which she admits throwing the pop bottle at Resident A. The complaint stated that Resident A did not sustain any injuries from this incident.

On 3/19/2025, I spoke to Complainant via email. Complainant reported that the information contained in this complaint is accurate.

On 3/19/2025 and 4/7/2025, I spoke to Office of Recipient Rights Officer, Alanna Honkanen, via email exchange. Ms. Honkanen stated that she has completed an investigation of this complaint. Ms. Honkanen stated that she substantiated a rights violation against Ms. Regular. Ms. Honkanen stated that her investigation is in the process of being closed.

On 4/1/2025, I conducted an onsite investigation. I completed a walk-through of the facility, reviewed resident files, observed residents, interviewed Resident A and direct care staff, JonMonet Hodge. At the time of my onsite investigation, Ms. Regular was no longer employed by the facility. I observed all residents to be properly dressed and with adequate hygiene.

The *Face Sheet* listed Resident A's admission date to the facility as 5/31/2024 and does not have a legal guardian. The *Health Care Appraisal* listed Resident A's medical diagnosis as Schizoaffective Disorder and Attention Deficit Disorder. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, has a history of verbal aggression, completes self-care tasks independently and does not require use of assistive devices. The *Incident/Accident Report,* dated 3/16/2025, stated the following:

3/16/2025 at 2:20pm; Completed by JonMonet Hodge: Staff {Ms. Hodge} and Resident B witnessed Ms. Regular accuse Resident A of drinking her pop. Resident A then reacted by saying that he did not drink her belongings. Ms. Regular then threw a 2-liter pop bottle at Resident A three times. The first time, Ms. Regular missed and then the next two times she landed her hit. Staff {Ms. Hodge} then stopped Ms. Regular from yelling at, or hitting Resident A again, and redirected Resident A to his room and called the house manager. Ms. Regular and Resident A were redirected to prevent Resident A from being exposed to additional verbal or physical abuse. Ms. Regular was suspended pending investigation; Staff will continue to treat residents with dignity and respect.

I reviewed the *Beacon Specialized Living Change of Status* document, dated 4/17/2025, which stated that Ms. Regular's employment with Beacon was involuntary terminated on 3/17/2025 due to the 3/16/2025 incident related to Resident A.

I spoke to Resident A, who stated that he likes living at the facility. Resident A stated, "I remember what happened that day. Ms. Regular bought a pop to the facility, and she thought I was going to drink it. She put it away in the fridge and I didn't see it again. I went and took a nap. When I woke up, I came into the kitchen and Ms. Regular yelled at me and said that I drank her pop. She then threw the pop bottle at me three times. I didn't say anything when it was happening, but then Ms. Hodge came in and saw what was happening and she stopped it. Nothing like this has happened again. I didn't get hurt or anything, it just hit my arm, but I didn't like it." Resident A acknowledged that this complaint is true.

I spoke to Resident B, who stated that he witnessed the incident on 3/16/2025. Resident B stated, "I was in the kitchen, and I saw Ms. Regular hit Resident A with a pop bottle. She threw it at him three times. She was screaming at Resident A while she was throwing the bottle at him. She was really angry. Staff came and then things were okay. Staff have never mistreated me, and no one has done anything bad to me here." Resident B acknowledged that this complaint is true.

I spoke to direct care staff, JonMonet Hodge, who stated that she has worked at the facility for five months. Ms. Hodge stated, "I was working the day of the incident. I was

on shift with Ms. Regular. I was in the living room when I heard loud yelling. I heard Ms. Regular yelling, so I went into the kitchen, and I saw Ms. Regular at Resident A and saying that he drank her pop. She was yelling at him and then she threw the pop bottle at Resident A three times. One of the times, the bottle hit his arm. I immediately intervened and took Ms. Regular outside so she could calm down. I also told Resident A to go to his room so he could also be safe and remain calm too. I told Ms. Regular that it was not okay to yell or throw things at a resident. I called the on-call manager, and they sent Ms. Regular home for the remainder of her shift. I then went and spoke to Resident A and apologized to him and helped him to calm down. I have not seen a staff behave the way that Ms. Regular did that day. I haven't seen any staff display this type of behavior since this one incident." Ms. Hodge acknowledged that this complaint is true.

On 4/7/2025, I spoke to direct care staff/Home Manager, Janice Jones, via telephone. Ms. Jones stated that she has worked at the facility for two years. Ms. Jones stated, "I was not working the day of this incident. I received a call from Ms. Hodge, and she informed me that Ms. Regular hit Resident A with a pop bottle. Ms. Regular also at this time sent me a text admitting to this behavior as well. It was decided to send Ms. Regular home for the remainder of her shift. I immediately went to the facility and interviewed Resident A and made sure that he was okay. I did not observe any injuries on Resident A. The next day, I interviewed Ms. Regular, and she said she had purchased a pop, and she thought Resident A had drunk it although Resident A denied that he drank it. Ms. Regular was ultimately terminated due to this incident." Ms. Jones acknowledged that this complaint is true.

On 5/2/2025, I spoke to ex-direct care staff, Wanda Regular, via telephone. Ms. Regular stated, "I no longer work for the facility. There was an incident. I thought Resident A drank my pop. I got mad and I threw a 64 oz bottle of pop at him three times. But it wasn't full. It was almost empty so it wouldn't have hurt him. I have nothing else to say." Ms. Regular acknowledged that this complaint is true.

On 5/6/2025, I conducted an exit conference with licensee designee/administrator, Ramon Beltran, via telephone. Mr. Beltran is in agreement with the findings of this report.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or

	physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	According to the *Incident/Accident Report*, on 3/16/2025, Wanda Regular threw a 2-liter pop bottle at Resident A three times and was subsequently relieved of the remainder of her shift. According to the *Beacon Specialized Living Change of Status*, Ms. Regular's employment was involuntary terminated on 3/17/2025. According to Resident A, on 3/16/2025, Ms. Regular threw a plastic pop bottle at him three times, subsequently hitting him on the arm. Resident A stated he did not sustain any injuries. Resident A acknowledged that this complaint is true. According to Resident B, on 3/16/2025, he witnessed Ms. Regular hit Resident A with a pop bottle three times. Resident B acknowledged that this complaint is true. According to Ms. Hodge, on 3/16/2025, she observed Ms. Regular yell at Resident A and throw a pop bottle at him three times. Ms. Hodge stated that Ms. Regular hit Resident A at least one time with the bottle. Ms. Hodge acknowledged that this complaint is true. According to Ms. Jones, she interviewed Ms. Regular regarding this incident, and Ms. Regular admitted that she did yell at Resident A and threw a pop bottle at him three times, subsequently hitting his arm one time. According to Ms. Regular, on 3/16/2025, she thought Resident A drank her pop and threw a 64 oz bottle of pop at him three times. Ms. Regular acknowledged that this complaint is true. Based on the information above, there is sufficient information to confirm that on 3/16/2025, Ms. Regular exposed Resident A to both emotional and physical harm when she yelled and screamed at him, accused him of drinking her pop and then threw a pop bottle at him three times, subsequently hitting him on the arm.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the license be closed with no change to the status of the license.

5/7/2025

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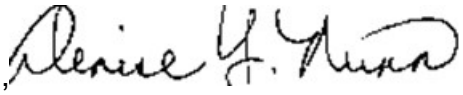
Stephanie Gonzalez Date
Licensing Consultant

Approved By:



05/22/2025

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Denise Y. Nunn Date
Area Manager