GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 18, 2025

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

RE: License #: AS370413382
Investigation #: 2025A1033039
Beacon Home At Nottawa

Dear Mr. Beltran:

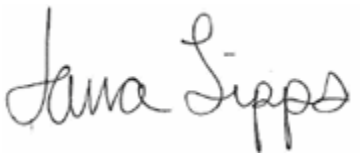
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (517) 335-5985.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

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 #:	AS370413382
Investigation #:	2025A1033039
Complaint Receipt Date:	05/29/2025
Investigation Initiation Date:	05/29/2025
Report Due Date:	07/28/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At Nottawa
Facility Address:	7302 S Nottawa Rd Mount Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/14/2022
License Status:	REGULAR
Effective Date:	12/21/2024
Expiration Date:	12/20/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 5/27/25 direct care staff, Marilyn Swan, was observed using marijuana and offering marijuana to residents while she was working as a direct care staff member on a community outing with four residents.	Yes

III. METHODOLOGY

05/29/2025	Special Investigation Intake 2025A1033039
05/29/2025	Special Investigation Initiated - Letter Email correspondence with Complainant.
06/09/2025	Inspection Completed On-site Interviews conducted with direct care staff/Care Team Manager, Tierza Kellogg, Resident A, and Resident B. Review of resident records, staff schedule, Resident Register initiated today.
06/09/2025	Inspection Completed-BCAL Sub. Compliance
06/09/2025	Contact – Document received Email correspondence received from direct care staff/Care Team Manager, Tierza Kellogg.
06/11/2025	Contact – Document received Email correspondence received from direct care staff/Care Team Manager, Tierza Kellogg.
06/17/2025	Contact – Telephone call made Interview conducted with direct care staff, Aaron Guy, via telephone.
06/17/2025	Contact – Telephone call made Attempt to interview direct care staff, Marilyn Swan, voicemail message left. Awaiting response.
06/17/2025	Exit Conference Conducted via telephone with licensee designee, Ramon Beltran.

ALLEGATION:

On 5/27/25 direct care staff, Marilyn Swan, was observed using marijuana and offering marijuana to residents while she was working as a direct care staff member on a community outing with four residents.

INVESTIGATION:

On 5/29/25 I received an online complaint regarding the Beacon Home At Nottawa, adult foster care facility (the facility). The complaint alleged that direct care staff, Marilyn Swan, had used marijuana while on a community outing with the residents of the home and offered marijuana to the residents. The allegation stated that direct care staff, Aaron Guy, observed Ms. Swan engaging in this behavior. On 6/5/25 I had email correspondence with Sarah Watson, Office of Recipient Rights with Central Michigan Community Mental Health, regarding the allegations. Ms. Watson reported that she had made an onsite visit to the facility on 5/30/25 and confirmed that the allegations are true. Ms. Watson did not provide any additional details regarding the interviews she conducted.

On 6/9/25 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/Care Team Manager, Tierza Kellogg, on this date. Ms. Kellogg reported that Ms. Swan does not typically work at the facility and is a direct care staff at another licensed adult foster care home in the local area, which is operated by the same licensee, Beacon Specialized Living Services, Inc. Ms. Kellogg reported that on the date, 5/27/25, Ms. Swan was requested to cover a shift at the facility due to staffing issues. She reported that on this date Ms. Swan was assigned to provide one-on-one supervision to Resident A, as his *Individualized Plan of Service* (IPOS) identifies that he requires one-on-one supervision while in the community. Ms. Kellogg reported that Ms. Swan and Mr. Guy took four of the residents (Resident A, Resident B, Resident C, and Resident D) on an outing into the community on 5/27/25. Ms. Kellogg reported that while on this outing Mr. Guy made telephone contact with direct care staff, Allie Roman (who was at the facility), stating he observed Ms. Swan “pack a bowl” with marijuana while she was in the facility van and then smoked from this device and offered it to Resident B, who also smoked from the device. Ms. Kellogg reported that it was reported by Mr. Guy that Resident C then asked to smoke from the device and Ms. Swan told him that it was empty and they would need to wait until they returned to the facility, and she would refill the device with marijuana for Resident C. Ms. Kellogg reported that when Ms. Swan returned to the facility a telephone conversation was had with Program Director, Jacob Barr, and Human Resources, Mariam Khan, and Ms. Swan. Ms. Kellogg reported that Mr. Barr and Ms. Khan informed Ms. Swan that she was going to be suspended pending an investigation into the allegations made against her. Ms. Kellogg reported that she did make a statement to Ms. Swan that a resident had stated she was smoking marijuana on the community outing and Ms. Swan reported, “I didn’t know I couldn’t do that, some houses allow it.” Ms. Kellogg reported that Ms. Swan then stated that she did not use marijuana on the outing.

On 6/9/25, during the on-site investigation, I interviewed Resident A regarding the allegations. Resident A reported that Ms. Swan smoked marijuana on the community outing on 5/27/25 when she was assigned to be his one-on-one direct care staff supervision during this outing. He reported that she also allowed Resident B and Resident C to use the marijuana on this date. He reported that they were smoking the

marijuana outside of the van. Resident A reported, “she smoked weed, and I didn’t like that.”

On 6/9/25, during the on-site investigation, I interviewed Resident B regarding the allegations. Resident B reported that on 5/27/25 Ms. Swan had brought her own marijuana on a community outing with four of the residents, “packed a bowl”, and smoked it outside of the van while they were waiting for Mr. Guy to buy groceries at the store. Resident B reported that Ms. Swan offered him marijuana and he did smoke from her device on this date. He reported, “I took a hit. I shouldn’t have done that.” He reported that Resident A was upset by Ms. Swan smoking marijuana on this date.

During the on-site investigation on 6/9/25, I reviewed the following documents:

- *AFC Licensing Division – Incident/Accident Report* (IR) for Resident A, dated 5/27/25. Under the section, *Explain What Happened/Describe Injury (if any)*, it reads, “[Resident A] was on an outing and his one-to-one staff took out a metal can containing marijuana and a pipe from her backpack and smoked it while at a stop. [Resident A] and other residents could see and smell it. The staff also shared it with a resident that asked if he could hit it. The staff returned to the home and in front of [Resident A] filled another resident’s pipe with her marijuana and had [Resident A] out in the back yard almost to where the other residents were smoking the marijuana off the property. [Resident A] told [Ms. Swan] that she should not be smoking the marijuana and also told her she better hope Nottawa’s AVP doesn’t find out. He used her name, when he said it. [Resident A] asked another staff to help him write a recipient rights complaint toward the staff that was sharing the marijuana. He did not like when the one-on-one staff told another staff he was mistaken what the pipe had in it. Management opened the event report so that the staff could change tobacco to marijuana it should have said, she packed a bowl of her marijuana not tobacco.” Under the section, *Action taken by Staff/Treatment Given*, it reads, “Staff that was driving on the outing told the staff who smoked and shared marijuana that it was not a good idea to smoke it and/or talk about it with the residents. Staff reported it to the home manager and then wrote recipient rights complaint for violating the right to not have harm come to them. Staff also helped [Resident A] fill out a recipient rights form against the staff that smoked marijuana, because he felt she was mean to him because she said what he told another staff was wrong, that he was mistaken, that she did not have marijuana.”
- *AFC Licensing Division – Incident/Accident Report* for Residents B, C, D, dated 5/27/25. These reports contain similar information and allegations to the IR reviewed for Resident A on the same date.

On 6/9/25 Ms. Kellogg sent email correspondence which included resident assessment plans and IPOS documents that were requested during the on-site investigation. I reviewed the following documents:

- *Assessment Plan for AFC Residents*, for Resident A, dated 4/1/25. On page one, section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, it reads, “Needs 12 hours of 1 on 1 enhanced staffing and full

supervision in the community. He can become agitated in large crowds." Under subsection, *L. Exhibits Self Injurious Behavior*, it reads, "In extreme cases, when upset, will engage in self harm. Staff will be in line of sight during waking hours."

- *Community Mental Health for Central Michigan, PCP,* for Resident A, dated 4/3/25. On page three, the document notes, "[Resident A] has one on one staff for 12 hours per day. The remainder of the time, there is two staff that are awake throughout the night."
- *Beacon IPOS In-Service Signature Form,* for Resident A. This document was signed by Ms. Swan and Mr. Guy.
- *Assessment Plan for AFC Residents,* for Resident D, dated 11/26/24. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *O. Appropriately Uses Alcohol/Drugs*, it reads, "[Resident D] has a history of substance use. Staff will report and document when needed."
- *Community Mental Health for Central Michigan, PCP Addendum,* for Resident D, dated 12/5/24.
- *Beacon IPOS In-Service Signature Form,* for Resident D. This document was signed by Mr. Guy and not Ms. Swan.

On 6/11/25 I received the following documentation, via email correspondence, from Ms. Kellogg:

- *Michigan Workforce Background Check*, eligibility letter for Ms. Swan, dated 4/28/25.
- *Assessment Plan for AFC Residents,* for Resident B, dated 2/25/25. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *O. Appropriately Uses Alcohol/Drugs*, it reads, "Goes off property when using marijuana."
- *Gogebic CMH IPOS Meeting,* for Resident B, dated 7/23/24. On page three, under section, *Substance Related History*, it reads, "Substance use is a concern as it has a negative impact on [Resident B's] physical and mental health and has also resulted in legal charges in the past. Ongoing monitoring, education and assessment is necessary as well as supporting [Resident B] with linking/coordinating to SUD treatment and support group options when he does return to the community." Under section, *Risk to Self/Others/Property*, it reads, [Resident B] appears to be in the action stage of change in reference to his mental health and SUD at this time. He has gained some insight into his SUD and MI and notes that he understands that he needs to continue his medications and mental health treatment as well as continuing with SUD outpatient TX and support groups to maintain his sobriety and stability. He is medication adherent with his prescribed medications at Caro Center. He attends groups currently at Caro. When [Resident B] is not using substances and is med adherent, he does appear to be less of a risk to self/others/property, but has continued to struggle some with hospitalization and legal issues even with medication changes. This is an area to continue to monitor and provide support."
- *Beacon IPOS In-Service Signature Form* for Resident B, was signed by Mr. Guy, but not Ms. Swan.

- *Assessment Plan for AFC Residents,* for Resident C, dated 8/8/24. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *O. Appropriately Uses Alcohol/Drugs*, it reads, "[Resident C] has a history of misusing his mediations, marijuana, meth, and alcohol. Staff will continue to work with [Resident C] and monitor him."
- *Community Mental Health for Central Michigan PCP,* for Resident C, dated 11/22/24. On page two, under section, *Co-Occurring Disorder*, it reads, "[Resident C] is not interested in stopping the marijuana." Under section, *Indicate the Need for Supports in any of the Following Safety Domains*, subsection, *Behavioral Safety*, it reads, "[Resident C] will smoke in the house despite having a house mate who uses oxygen across the hall from him. He will smoke marijuana both on the property and in the community. He has fallen asleep outside of the business and was arrested after the police found he had a warrant out on him." On page four, under section, *Goal 1*, subsection, *D.*, it reads, "[Resident C] will work with AFC staff and CMHCM Case Manager to move from contemplation from preparation for substance use. [Resident C] will attempt to not use substances while at AFC home. [Resident C] has substance issues with alcohol, caffeine, cigarettes, marijuana, and methamphetamines. The team will meet with [Resident C] and facilitate a conversation around this. [Resident C] will engage in AA or NA as he sees beneficial. [Resident C] will be open and honest about his use. He will participate in regular UDS to ensure that he is being safe and that there are no interactions with his medications."
- *Beacon IPOS In-Service Signature Form* for Resident C was signed by Mr. Guy, but not Ms. Swan.

On 6/17/25 I interviewed Mr. Guy via telephone regarding the allegations. Mr. Guy reported that on 5/27/25 he was working at the facility with Ms. Swan. He reported that Ms. Swan was assigned to be the one-on-one support for Resident A on this date. He reported that he and Ms. Swan took Residents A, B, C, & D on a community outing where they made multiple stops. Mr. Guy reported that Ms. Swan had asked multiple times during the day about whether she could use marijuana while working for the facility. Mr. Guy reported that Ms. Swan had "obsessed" about marijuana on this date. He reported that they had made a stop at a store, and she went into the store with Resident A and when they returned to the vehicle, Resident A stated he wanted to smoke a cigarette. Mr. Guy reported that at this time Ms. Swan stated that she was going to smoke too and pulled a pipe and a lighter out of her backpack. He reported that when Ms. Swan lit the pipe it was apparent that she was smoking marijuana, by the smell that was emitted. Mr. Guy reported that Resident A stated to Ms. Swan that she better hope the facility Administrator, Roxanne Goldammer, does not find out that Ms. Swan was smoking marijuana while providing care for the residents. Mr. Guy reported that everyone got back into the van and started driving to another store. Mr. Guy reported that Resident B then asked Ms. Swan about the marijuana she had been smoking and Ms. Swan pulled a metal can from her backpack, opened it and let the residents smell the contents. Mr. Guy reported that Resident B then asked if he could "take a hit" from Ms. Swan's pipe, to which she replied, "Sure." Mr. Guy reported that he stated to Resident B and Ms. Swan, "I don't think that is a good idea." He reported that

Ms. Swan replied, “It will be fine”. Mr. Guy reported that at the next stop Resident B and Ms. Swan got out of the van together and Ms. Swan shared her marijuana with Resident B. Mr. Guy reported that he took Resident C into the store and Ms. Swan stayed at the van with Residents A, B, and D. He reported that when he and Resident C returned to the van Resident C asked Ms. Swan if he could have a hit of her marijuana to which Ms. Swan replied that she was all out of marijuana and would get him some when they returned to the facility. Mr. Guy reported that he made a telephone contact to the facility to alert management to the situation. Mr. Guy reported that when they returned to the facility from the outing Ms. Swan went into the backyard with Resident A, Resident B, and Resident D and filled Resident D’s pipe with marijuana. He reported that Resident B and Resident D then walked off the property to smoke marijuana together. Mr. Guy stated that he reported this information to Ms. Kellogg, who then took Ms. Swan into her office to discuss the situation. Mr. Guy reported that Ms. Swan left the office in a rage and was using profanity, slammed the front door, got in her vehicle and pressed the horn very loudly as she drove away. He reported that she then called Ms. Kellogg, threatening her by saying, “You messed with the wrong bitch!” Mr. Guy reported that the facility has a protocol in working with residents who want to use marijuana. He reported that their marijuana needs to be locked up and when they want to use their marijuana they must go off site. He further reported that when a resident wants to use their marijuana, if it is one hour between administering medications or having medications administered, the direct care staff are to contact the on-call manager to seek nursing approval to ensure there are no negative interactions that may result with the marijuana and their current medications. Mr. Guy reported that of the residents who were present on the stated outing on 5/27/25, Resident B’s plan of care states that he should stay away from substances due to his history of substance abuse and his goal to maintain sobriety.

On 6/18/24 special investigation report #2024A1029042 cited a rule violation of Rule 305.3 regarding resident dignity, protection, and safety. The *Corrective Action Plan*, dated 6/21/24, and completed by then licensee designee, Roxanne Goldammer, identified a plan of correction which noted, “All new staff will be trained on all treatment plans prior to working with the resident”, as well as identifying multiple individuals who were no longer employed by the facility who were involved in the investigation.

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 upon interviews conducted and documentation reviewed during this investigation there is sufficient evidence to determined that direct care staff, Marilyn Swan, did not attend to the protection and safety of Resident A, B, C, & D while working for the facility on 5/27/25. There are numerous statements identifying that Ms. Swan was smoking marijuana while providing direct care to Resident A, B, & D and that she supplied Resident B with marijuana on this date. Resident A's assessment plan and PCP both identify that he is to receive one-on-one supervision for 12 hours each day due to his tendencies to self-harm. Ms. Swan was assigned to be his one-on-one supervision on 5/27/25 and was noted by Resident A, Resident B, and Mr. Guy, to be smoking marijuana while performing this assigned duty. Residents B, C, & D's assessment plans and PCP documents indicate that each has difficulties with substance abuse history, including the use of marijuana. However, Resident A, Resident B, and Mr. Guy all confirmed that Ms. Swan offered Resident B marijuana and allowed him to consume marijuana while she was providing direct care on 5/27/25. Due to Ms. Swan choosing to use marijuana personally and providing marijuana to residents on 5/27/25, a violation has been established as her actions were not providing for the protection and safety of the residents on this date.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2024A1029042 AND CAP DATED 6/21/24].**

APPLICABLE RULE	
R 330.1806	**Staffing levels and qualifications.**
	(2) All staff who work independently and staff who function as lead workers with clients shall have successfully completed a course of training which imparts basic concepts required in providing specialized dependent care and which measures staff comprehension and competencies to deliver each client's individual plan of service as written. Basic training shall address all the following areas:

ANALYSIS:	Based upon interviews conducted and documentation reviewed it can be determined that direct care staff, Marilyn Swan, was not properly trained to all resident IPOS/PCP documents on 5/27/25 when she was assigned to work at the facility. Ms. Swan did sign Resident A's PCP training log, but her signature does not appear upon the pages of Residents B, C, and D's IPOS/PCP training logs. Mr. Guy reported that Ms. Swan was left as the only direct care staff providing supervision to Residents A, B, & D when he took Resident C into a store, during their outing on 5/27/25. Due to her being left to provide direct care/supervision/protection for these residents and not having signed that she was properly trained in their IPOS/PCP documents for Resident B and Resident D, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

6/17/25

_____

Jana Lipps Date
Licensing Consultant

Approved By:

06/18/2025

_____

Dawn N. Timm Date
Area Manager