



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 13, 2025

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

RE: License #: AS250412389
Investigation #: 2025A0779052
Beacon Home at Clío

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 (517) 643-7960.

Sincerely,

A handwritten signature in cursive script that reads "Christopher A. Holvey".

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

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 #:	AS250412389
Investigation #:	2025A0779052
Complaint Receipt Date:	08/21/2025
Investigation Initiation Date:	08/22/2025
Report Due Date:	10/20/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
LicenseeAddress:	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 Clio
Facility Address:	1491 Bondy Dr., Clio, MI 48420
Facility Telephone #:	(810) 368-4621
Original Issuance Date:	09/07/2022
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?
On 08/14/2025, Beacon staff member Kenedy Miller cussed at Resident A and threatened to throw a mop bucket at him.	Yes
Other residents are physically abusing Resident D and staff do nothing about it.	No

III. METHODOLOGY

08/21/2025	Special Investigation Intake 2025A0779052
08/22/2025	Special Investigation Initiated - Telephone Voicemail message left with ORR investigator.
08/25/2025	APS Referral Complaint was referred to APS centralized intake.
08/26/2025	Contact - Telephone call received Spoke to ORR.
08/26/2025	Contact - Telephone call made Spoke to APS worker.
08/26/2025	Inspection Completed On-site
08/26/2025	Contact - Face to Face Interview conducted with Resident C.
08/26/2025	Contact - Telephone call made Spoke to Program director.
08/26/2025	Contact - Telephone call made Spoke to Resident C's guardian.
08/26/2025	Contact - Telephone call made Spoke to staff person, Demarkus Smith.
09/09/2025	Inspection Completed On-site
10/02/2025	Contact - Telephone call made Spoke to APS worker.
10/02/2025	Exit Conference Held with licensee designee, Ramon Beltran.

ALLEGATION:

On 08/14/2025, Beacon staff member Kenedy Miller cussed at Resident A and threatened to throw a mop bucket at him.

INVESTIGATION:

On 8/26/2025, a phone conversation took place with Rachel Moore, an investigator for Office of Recipient Rights (ORR), who confirmed that she was investigating the same allegations. ORR Moore stated that she had already spoken to Resident A and Resident B. ORR Moore stated that both Resident A and Resident B confirmed that these allegations are true. ORR Moore reported that Resident A told her that staff person, Kynnade Miller, threatened and cussed at him by saying "I am going to hit you with this fucking bucket if you don't put down that pot". ORR Moore stated that Resident B claims that he heard Staff Miller make that threat. ORR Moore stated that she also spoke to staff person, Heather Bice, who claims to be a witness to the incident and stated that Staff Miller cussed at and threatened to throw a bucket at Resident A.

On 8/26/2025, an on-site inspection was conducted and Resident A was interviewed. Resident A admitted that he got into a verbal altercation with Staff Miller and that they cussed at each other. Resident A admitted that he was having a behavior and grabbed a pot. Resident A stated that when he grabbed a pot, Staff Miller picked up a mop bucket and threatened to hit him with it. Resident A claimed that he could not remember everything that was said, but that Staff Miller did call him a "bitch".

On 8/26/2025, staff person Heather Bice, was interviewed and confirmed that she was a witness to the incident between Resident A and Staff Miller. Staff Bice stated that Resident A was having a behavior, threw a pot into the sink, was cussing and called Staff Miller the "N" word. Staff Bice stated that Staff Miller picked up a mop bucket and told Resident A that if he keeps it up, she was going to throw it at him. Staff Bice claimed that Staff Miller used the "F" word and called Resident A a "bitch". Staff Bice reported that when she stepped between Resident A and Staff Miller, Resident A left the room.

On 9/9/2025, a second on-site inspection was conducted and Resident B was interviewed. Resident B confirmed that he was in the other room and did not see the incident between Resident A and Staff Miller but did hear Staff Miller threaten to hit Resident A with the mop bucket.

On 9/9/2025, Resident A changed his story regarding the incident he had with Staff Miller. Resident A stated that Staff Miller did have a mop bucket, but she only said what she did because he thinks he scared her, when he threw the pot in the sink. Resident A stated that Staff Miller did not cuss at him or call him names. When it was expressed to Resident A the importance of knowing the truth of what happened, Resident A stated that he did not want to get anyone into trouble. Resident A stated that he has no problems with Staff Miller.

On 10/2/2025, an exit conference was held with licensee designee, Ramon Beltran, who was informed of the one licensing rule violation and that a corrective action plan is required. LD Beltran stated that the alleged incident that happened between Resident A and staff person, Kynnade Miller, took place while he was on a leave of absence. LD Beltran stated that it appears that Staff Miller is no longer employed at this home.

Special Investigation Report #2023A0779011 dated January 11, 2023, cited R 400.14308 (2)(f), due to a staff person yelling and cussing at residents. On January 16, 2023, a corrective action plan (CAP) was submitted and signed by licensee designee, Kimberly Rawlings. The CAP stated that disciplinary action was taken against the staff person in question and the staff had to attend training regarding resident rights.

Special Investigation Report #2025A0779030 dated April 30, 2025, cited R400.14308 (2)(f), due to a staff person making threats to physically harm a resident. On May 6, 2025, a corrective action plan was submitted and signed by licensee designee, Ramon Beltran. The CAP stated that the staff person involved was terminated and all staff attended a training on mandatory reporting requirements.

APPLICABLE RULE	
R 400.14308	Resident behavior interventions prohibitions.
ANALYSIS:	<p>(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:</p> <p style="padding-left: 40px;">(f) Subject a resident to any of the following:</p> <p style="padding-left: 80px;">(ii) Verbal abuse.</p> <p style="padding-left: 80px;">(iv) Threats.</p>
	<p>It was confirmed that on 8/14/2025, Resident A and staff person, Kynnade Miller, got into a verbal altercation. Resident A initially stated that Staff Miller grabbed a mop bucket, cussed at him and threatened to hit him with it. Staff Person, Heather Bice, stated that she witnessed the incident and stated that Staff Miller used the “F” word, called Resident A a “bitch” and threatened to throw a mop bucket at Resident A. Resident B stated that he was in the other room and did not see the incident but heard Staff Miller threaten to hit Resident A with a mop bucket. There was sufficient evidence found to prove that Staff</p>

	Miller both verbally abused and threatened physical harm toward Resident A.
CONCLUSION:	REPEAT VIOLATION ESTABLISHED SIR #2023A0779011 dated January 11, 2023. SIR #2025A0779030 dated April 30, 2025

ALLEGATION:

Other residents are physically abusing Resident D and staff do nothing about it.

INVESTIGATION:

On 8/26/2025, a phone call was made to APS worker, Melanie Gallego, who confirmed that she was investigating the same allegations. APS Gallego stated that she had seen Resident D at the hospital and he had a bruise under the left eye, but that Resident A was in the hospital for other health related issues. APS Gallego stated that Resident D claimed that staff Demarkus Smith pokes him in the nose and that staff Heather Bice pokes him in the chest and he demonstrated this to her by using one finger. APS Gallego reported that Resident D said the bruised eye happened a long time ago but would not say how it happened. APS Gallego stated that Resident D claims he has told staff at the home and his guardian about the abuse and nothing has changed. APS Gallego stated that Resident D told her that he is schizophrenic and has been having visions.

On 8/26/2025, Staff Bice denied that she has ever poked Resident D in the chest. Staff Bice stated that Resident D gets into verbal conflicts with other residents frequently and that Resident D has been hit by a couple of other residents, but that she has not actually witnessed those incidents. Staff Bice stated that the bruised eye to Resident D took place about one month ago, when Resident A punched him and that the bruised eye is the only known injury resulting from a physical altercation with other residents. Staff Bice reported that staff try to keep a closer eye on Resident D and redirect him away from conflicts with others.

On 8/26/2025, Resident A admitted that he punched Resident D, that it happened “a while ago” and that Resident D did get a black eye. Resident A claims that Resident D wouldn’t leave him alone and that Resident D hit him first. Resident A stated that he has not had any physical altercations with Resident D since that incident.

On 8/26/2025, staff person, Kynnade Miller, said that she has never witnessed Resident D get hit by another resident. Staff Miller stated that Resident D seems to frustrate the other residents and they argue a lot, but do not get physical. Staff Miller stated that she has only worked at this home for 3-4 weeks.

On 8/26/2025, Resident C stated that he has never hit Resident D. Resident C stated that Resident D is always in other people's business and that he frequently has conflicts with Resident A and Resident E. Resident C reported that he was only aware of the one time when Resident A punched Resident D in the eye, but never Resident E. Resident C stated that staff do their best to keep Resident D away from others and avoid conflicts.

On 8/26/2025, face-to-face contact was made with Resident D at the hospital. The nurse in charge of Resident D's care that day said that Resident D has some significant medical issues going on and would be there for a while. Nurse stated that Resident D tells a lot of stories and that it is hard to determine if what he says is true. Resident D stated that Resident A and Resident E hit him but could not say how often this happens. Resident D stated that the last time he was hit by another resident was when Resident A punched him in the eye about 1-2 months ago. Resident D reported that he hasn't had any physical altercations at the home since that incident. Resident D stated that he does not like it at this home and wants to move but did not elaborate on that. It was hard to keep Resident D focused, as he kept wanting to talk about things that were not making sense. The interview ended when Resident D closed his eyes and no longer responded to questions.

On 8/26/2025, a phone call was made to program director, Jacob Barr, who stated that Resident D unintentionally instigates issues with the other residents frequently and staff try to redirect Resident D away from others. PD Barr stated that he is aware that Resident E can verbally bully other residents, especially Resident D, but has not been physical. PM Barr reported that he is only aware of one physical altercation regarding Resident D and that was when Resident A punched him in the eye. PM Barr stated that he is not aware of any physical altercations involving Resident D since or any incidents involving issues with Resident D and staff. PM Barr stated that none of the residents in the home are required to have any enhanced staffing patterns.

On 8/26/2025, a phone call was made to Resident D's legal guardian, who stated that she was not aware of Resident D being physically abused by other residents. Guardian stated that she visits Resident D at this home once monthly, with the last being in the beginning of August 2025, and that Resident D has never mentioned anything about being abused by other residents. Guardian stated that Resident D can be difficult at times and that conflicts will happen when you have six male residents with mental health issues living in the same home, but she does not know of any incidents that would be classified as Resident D being physically abused. Guardian stated that Resident D has expressed wanting to be on Hospice and wanting to move, but never because of physical abuse. Guardian reported that she has witnessed one other resident who appears to try and verbally bully other residents, but that staff were doing a good job of intervening and redirecting that resident. Guardian stated that she has no concerns regarding Resident D's care at this home, except that Resident D's worsening medical issues may result in her finding a new placement for him.

On 8/26/2025, a phone interview took place with staff person, Demarkus Smith, who stated that he has never seen any physical abuse of Resident D take place. Staff Smith stated that Resident D has a habit of antagonizing other residents and getting into verbal altercations with Resident A and Resident E, but never anything physical. Staff Smith reported that he would definitely report any abuse if he ever witnessed it. Staff Smith denies that he has ever poked Resident D anywhere on his body and stated that when Resident D gets upset, he will make up strange stories.

On 9/9/2025, Resident B stated that he has never gotten physical with Resident D or witnessed anyone else ever punch Resident D. Resident B stated that Resident D is annoying and is always in everyone's business and that he tries to avoid him.

On 9/9/2025, Resident E admitted that he did punch Resident D once about two months ago, but that it was a one-time thing and that he did not hurt him. Resident E confirmed that Resident D can be very frustrating and annoying, but that staff try and keep him away from other residents. Resident E stated that Resident D is a good guy but is always begging for cigarettes and getting into people's business.

On 9/9/2025, Resident F stated that he has never been physical with Resident D or witness any other resident hit Resident D. Resident F stated that Resident D had a habit of provoking situations, then calling someone a bully and saying that he was scared. Resident F stated that staff do a good job of deescalating situations before they become physical altercations.

On 9/9/2025, an interview took place with staff person, Sarina McFadden, who stated that she witnessed the incident between Resident D and Resident A. Staff McFadden stated that Resident D and Resident A got into a verbal conflict outside and when they came inside, Resident D hit Resident A in the back of the head and Resident A responded by punching Resident D in the face twice. Staff McFadden stated that the incident happened very fast and that they were immediately separated. Staff McFadden confirmed that Resident D does annoy the residents and is always following them around begging for cigarettes and that Resident A can be very mean to Resident D as a result. Staff McFadden reported that she is only aware of that one incident of Resident D ever being physically hit by another resident.

The home provided a copy of an *AFC Licensing Division Incident/Accident Report (IR)* that documents the incident between Resident A and Resident D. The IR stated that incident took place on 7/21/2025. The information on the IR matched the information obtained during the interview with Staff McFadden.

On 10/2/2025, a phone conversation took place with APS worker, Melanie Gallego, who stated that she was told that the incident between Resident D and Resident A, which resulted in Resident D's bruised eye, went both ways. APS Gallego stated that she found no evidence of Resident D being physically abused, neglected or lack of protection by staff and that she is closing her case.

On 10/2/2025, an exit conference was held with licensee designee, Ramon Beltran, who was informed of the one licensing rule violation and that a corrective action plan is required. LD Beltran stated that the alleged incident that happened between Resident A and staff person, Kynnade Miller, took place while he was on leave of absence. LD Beltran stated that it appears that Staff Miller is no longer employed at this home. LD Beltran stated that Resident D's health conditions have worsened and that he may not be returning to this home.

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:	Through interviews with all six residents and multiple staff at this home, it was confirmed that Resident D has only been in two possible physical altercations with other residents. The last known incident took place on 7/21/2025, which resulted in Resident D getting a bruised eye, but Resident A initiated the physical confrontation by hitting Resident A in the head first. Residents stated that staff attempt to redirect verbal conflicts to avoid physical altercations. There was insufficient evidence found to prove that Resident D is being physically abused by other residents or being inadequately protected by staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remains unchanged.

Christopher A. Holvey

10/13/2025

Christopher Holvey
Licensing Consultant

Date

Approved By:

Mary Holton

10/13/2025

Mary E. Holton
Area Manager

Date