



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 4, 2025

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

RE: License #: AS810393269
Investigation #: 2026A0122003
Beacon Home At Ypsilanti

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) 284-9720.

Sincerely,

A handwritten signature in cursive script that reads "Vanita Bouldin".

Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS810393269
Investigation #:	2026A0122003
Complaint Receipt Date:	10/27/2025
Investigation Initiation Date:	10/28/2025
Report Due Date:	11/26/2025
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 Ypsilanti
Facility Address:	7862 Tuttle Hill Road Ypsilanti, MI 48197
Facility Telephone #:	(734) 221-5424
Original Issuance Date:	05/24/2018
License Status:	REGULAR
Effective Date:	11/24/2024
Expiration Date:	11/23/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED
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II. ALLEGATION(S)

	Violation Established?
Insufficient staffing provided for the residents.	Yes

III. METHODOLOGY

10/27/2025	Special Investigation Intake 2026A0122003
10/28/2025	APS Referral
10/28/2025	Special Investigation Initiated - On Site Reviewed Residents A, B, C, and D's files. Observed Resident A and B. Completed interviews with staff members, Kehlsi Haynes and Katie Noiles.
10/29/2025	Contact – telephone calls made Completed interviews with home manager, Trisha Porter and Guardian C1. Left voice message for staff member, Kelicia Arrington to return my phone call.
10/29/2025	Contact – documents received Information from Resident A, B, C, and D's files.
11/03/2025	Contact – Telephone calls made Completed interviews with case manager, Travis Wolf (Resident B) and supports coordinator, Debra Eggleston (Resident D).
11/04/2025	Exit Conference Discussed findings with licensee designee, Ramon Beltran.

ALLEGATION: Insufficient staffing provided for the residents.

INVESTIGATION: On 10/28/2025, I conducted an onsite inspection. I observed two staff members on site, Katie Noiles and Kehlsi Haynes, present. Both reported that there were six residents present, four were in their bedrooms while Residents A and B were observed up throughout the facility. I observed that both Residents A and B went in and out of the facility several times for cigarette breaks, during those times staff members, Ms. Noiles and Ms. Haynes, either accompanied them or they made certain they had knowledge of their locations. I observed both of them to be clean and appropriately dressed for the weather.

Both residents responded appropriately to my introduction of myself, however I observed Resident A mumbling appearing to have a conversation based upon internal stimuli. At times, Resident A would make loud outbursts.

On 10/28/2025, I reviewed Resident A, B, C, and D's files. Resident A is diagnosed with schizoaffective disorder, bipolar disorder, cannabis abuse, etc. He has a Behavior Assessment dated 06/12/2023. The Behavior Assessment addresses "history of engagement in challenging behaviors including elopement, inappropriate contact with emergency services, medication refusal, drug-seeking behaviors, physical aggression, verbal aggression, and nudity in public spaces." The assessment documents that staff response to Resident A's elopement attempts should be to, "follow him in a vehicle if necessary..."

I reviewed Resident A's Behavioral Assessment Sheet dated September 2025. The sheet documents that Resident A made elopement attempts on 09/12, 09/14, and 09/17. He had incidents with verbal aggression on 09/06, 09/07, 09/12, 09/14, 09/16, and 09/17. He had an incident with physical aggression on 09/29/25.

Resident B is diagnosed with schizoaffective disorder and bipolar. His assessment plan documents that staff must supervise him while out in the community, he is verbally aggressive and independent in all personal hygiene and activities of daily living tasks, but staff encourages him in these areas.

Resident C is diagnosed with paranoid schizophrenia, alcohol disorder, cocaine abuse with intoxication. He has a Psychologist Evaluation dated 01/30/2025 which documents that Resident C has issues with elopement. In the event that Resident C attempts to elope staff are given the following directions, if Resident C "leaves the home/space unsupervised staff should provide supervision. Follow him only if you believe it is safe to do so, and do so from a distance..."

Resident C's Assessment Plan dated 07/18/2025, documents that he cannot move independently in the community, nor does he appropriately use alcohol/drugs but defers to his behavior treatment plan for direction and that information is documented in the Psychologist Evaluation mentioned earlier in this report. Per the Psychologist Evaluation, Resident C has the ability to go out in the community for

outings that are “scheduled in advance,” he is given specific instructions, and a return time. The report does make a distinction between a scheduled outing and Resident C’s elopement risk and provides staff instructions for the latter.

Resident D’s assessment plan documents that he has a history of aggressive behavior when symptomatic and not compliant with psychiatric medication and psychiatric recommendations, as well as a history of substance abuse. Per Resident D’s Individual Plan of Service dated 05/05/2025, he has a history of “bank robbery, cocaine abuse, hallucinations, mania, a suicide attempt, non-compliance (which has led to violence), homelessness, sleep apnea, asthma, GERD...” The plan states that Resident D will “attend three support groups weekly, two of which are directly related to substance use...”

On 10/29/2025, I conducted an interview with home manager, Trisha Porter. Ms. Porter was knowledgeable regarding Resident A’s behaviors and behavior assessment dated 6/23/2023. I had a discussion with Ms. Porter regarding staff response to Resident A’s elopement behaviors, i.e., when Resident A is attempting to leave the facility, his behavior assessment states, “staff should follow him, in a vehicle if necessary...” Ms. Porter responded by stating Resident A elopes during the day and there is always two staff members present to assist him and provide supervision to the other residents.

I questioned, what would happen if Resident A attempted to elope on the overnight shift (7:30 p.m. – 7:30 a.m.) – walking away from the property, how would one person follow him in the facility vehicle and stay to provide supervision to the remaining residents in the facility. Ms. Porter’s response was that obviously that could not be done by one staff member.

Per Ms. Porter, she and one other staff provide coverage for the overnight shift at the facility. Ms. Porter stated she can confidently handle Resident A’s behaviors, including when he attempts to elope but does not feel that the other full-time employee, Kelicia Arrington, can sufficiently handle his behaviors.

Ms. Porter reported there are moments when Resident A will not follow the direction that typically works when he attempts to elope, i.e. offering him a cigarette, but she is able to eventually get him to comply with her request to return to the facility without incident. Ms. Porter is uncertain whether her other staff members can do the same. Ms. Porter also reported that it is difficult to keep staff employed at this facility as they are often intimidated by Resident A and terminate their employment. She stated this is an issue that is being discussed with her supervisors.

On 10/29/2025, I left a voice message for staff member, Kelicia Arrington, to return my phone call to participate in an interview. As of 11/04/2025, I have received no contact from Ms. Arrington.

On 10/29/2025, I conducted an interview with Guardian C1 who reported the following: Resident A was placed in the facility July 2025. Guardian C1 stated there have been no issues or concerns with the care Resident C has received thus far, however she reported that he has eloped from his former placement walking from Southfield, MI to Monroe county (over an hour away using a vehicle) seeking illegal drug substances. Guardian C1 has concerns that Resident C could make attempts to elope from the facility due to insufficient staffing.

On 11/03/2025, I conducted an interview with case manager for Resident B, Travis Wolf. Mr. Wolf described Resident B as complicated, mean, and states he uses volatile/inappropriate racial statements against other residents in the facility. Mr. Wolf stated that although Resident B is receiving appropriate care from the staff of Beacon Home at Ypsilanti, it is his professional opinion that the facility should be staffed with two staff members per shift to meet the needs of Resident B and the other residents in the facility based upon his knowledge of working with Resident B for years and what he observes of the other residents behaviors during his onsite visitation with Resident B.

On 11/03/2025, I conducted an interview with supports coordinator, Debra Eggleston. Ms. Eggleston reported that per Resident D's Individual Plan of Service dated 05/05/2025, he should be taken to weekly Alcohol Anonymous Meetings, however this has not been done in months due to insufficient staffing issues at the facility. Ms. Eggleston reported that Resident D has a history of elopement of well.

On 11/04/2025, I conducted an exit conference with licensee designee, Ramon Beltran and discussed my findings with him. Mr. Beltran stated he understood and would submit a corrective action plan to address the rule violation found.

APPLICABLE RULE	
R 400.14206	Staffing requirements.
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with facility staff members, Katie Noiles and Kehlsi Haynes, facility home manager, Trisha Porter, Guardian C1, case manager, Travis Wolf, and supports coordinator, Debra Eggleston, and a review of pertinent documents relevant to this investigation, there is enough evidence to substantiate the allegation that there is insufficient staff assigned to meet the needs of residents at the adult foster care facility, Beacon Home at Ypsilanti. Several residents, Residents A, C, and D, have issues with elopement, with staff instructions to follow Residents A and C should they attempt to elope. Residents D has substance abuse issues and needs to attend weekly Alcohol and Narcotic Anonymous meetings but has not been able to do so due to insufficient staffing. Therefore, the licensee does not have sufficient direct care staff on duty at all times for supervision, protection and to provide the services specified in the resident's assessment plans.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan, I recommend no change in the license status.



 Vanita C. Bouldin
 Licensing Consultant

 Date: 11/04/2025

Approved By:



 Ardra Hunter
 Area Manager

 Date: 11/04/2025