



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
ACTING DIRECTOR

October 23, 2023

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

RE: License #: AM030402101  
Investigation #: 2023A1024052  
Beacon Home at Hammond

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.
- 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 (616) 356-0183.

Sincerely,

A handwritten signature in black ink that reads "Ondrea Johnson". The signature is written in a cursive style with a large initial "O".

Ondrea Johnson, Licensing Consultant  
Bureau of Community and Health Systems  
427 East Alcott  
Kalamazoo, MI 49001

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AM030402101
<b>Investigation #:</b>	2023A1024052
<b>Complaint Receipt Date:</b>	08/29/2023
<b>Investigation Initiation Date:</b>	08/31/2023
<b>Report Due Date:</b>	10/28/2023
<b>Licensee Name:</b>	Beacon Specialized Living Services, Inc.
<b>Licensee Address:</b>	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
<b>Licensee Telephone #:</b>	(269) 427-8400
<b>Administrator:</b>	Aubry Napier
<b>Licensee Designee:</b>	Ramon Beltran
<b>Name of Facility:</b>	Beacon Home at Hammond
<b>Facility Address:</b>	318 East Hammond Street Otsego, MI 49078
<b>Facility Telephone #:</b>	(269) 427-8400
<b>Original Issuance Date:</b>	07/09/2020
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	01/26/2022
<b>Expiration Date:</b>	01/25/2024
<b>Capacity:</b>	12
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A was left unattended for hours in the facility's vehicle.	Yes

## III. METHODOLOGY

08/29/2023	Special Investigation Intake 2023A1024052
08/31/2023	Special Investigation Initiated - Face to Face with direct care staff members Jana Melton, Rachel Cornell, Resident A and Resident B
09/13/2023	Contact - Face to Face with Executive Agency Director
09/15/2023	Contact - Telephone call made with licensee designee Ramon Beltran
09/15/2023	Exit Conference with licensee designee Ramon Beltran
09/21/2023	Contact - Document Received-employment termination verification for Dayzia Brown-Outlaw and Shawna Speikes

**ALLEGATION: Resident A was left unattended for hours in the facility's vehicle.**

### **INVESTIGATION:**

On 8/29/2023, I received this complaint through the Bureau of Community and Health Systems (BCHS) online compliant system. This complaint alleged Resident A was left unattended for hours in the facility's vehicle.

On 8/31/2023, I conducted an onsite investigation at the facility with direct care staff members Jana Melton and Rachel Cornell who both stated that they were made aware direct care staff members Dayzia Brown-Outlaw and Shawna Speikes had Resident A wait alone in the facility's vehicle while they both went to a job interview with another company. Jana Melton and Rachel Cornell also both stated that these two direct care staff members were terminated from their employment after this incident.

While at the facility, I also interviewed Resident A and Resident B. Resident A stated that she was riding all over town with "two girls" and they left her in the car while the key was in the ignition. Resident A stated they went to three different places and purchased her snacks to eat while she waited alone in the car. Resident A stated she did not know

where they were going however, she was scared while waiting in the car alone without a direct care staff being present. Resident A stated eventually after waiting for many hours, a gentleman direct care staff member from the facility picked her up from the vehicle and transported her back to the facility. Resident A stated she has never been left alone without direct care staff supervision at any given time.

Resident B stated Resident A is her roommate and she was informed by Resident A that two direct care staff members left her in a vehicle while the vehicle was running. Resident B stated Resident A reported to her that she was in the vehicle for many hours however was eventually picked up by another direct care staff member.

On 9/13/2023, I conducted an interview with Executive Agency Director who stated that her company conducted a job interview with two female applicants and found a female resident sitting in their vehicle alone while the direct care staff members conducted interviews at their corporate office as well while these same two direct care staff members took a tour of one of their adult foster care homes. Executive Agency Director stated the vehicle the applicants were driving stated Beacon Specialized Services therefore she contacted the human resource (HR) department of Beacon Specialized Services and informed them that their staff members were allowing one of their residents to sit in their facility vehicle alone without staff supervision.

On 9/15/2023, I conducted an interview with licensee designee Ramon Beltran who stated Executive Agency Director contacted his HR department to notify them that direct care staff members, Dayzia Brown-Outlaw and Shawna Speikes, were there at their adult foster care home participating in a job interview while Resident A waited in the facility's vehicle. Ramon Beltran stated he immediately went to their location and picked up Resident A who was sitting in the facility's vehicle while the vehicle was running and windows down. Ramon Beltran stated when he arrived to pick up Resident A, she informed him these two direct care staff members had been inside the house, and she was asked to sit in the vehicle to wait for them. Ramon Beltran stated these two direct care staff members were immediately terminated from employment after this incident.

On 9/21/2023, I received employment termination verification for direct care staff members Dayzia Brown-Outlaw and Shawna Speikes dated 8/23/2023.

<b>APPLICABLE RULE</b>	
<b>R 400.14305</b>	<b>Resident protection.</b>
	<b>(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.</b>

<b>ANALYSIS:</b>	Based on my investigation which included interviews with direct care staff members Jana Melton, Rachel Cornell, licensee designee Ramon Beltran, Executive Agency Director, Resident A, Resident B, and review of employment termination verification, there is evidence Resident A was left unattended for hours in the facility's vehicle while two direct care staff members attended an interview at another agency. Executive Agency Director stated while conducting job interviews it was discovered direct care staff members Dayzia Brown-Outlaw and Shawna Speikes had left Resident A alone in the facility vehicle while conducting their job interview and attending a tour of one of the adult foster care homes. Ramon Beltran stated he was notified by this incident and immediately picked up Resident A who was found sitting in the facility's running vehicle alone while these two direct care staff members were inside the business property. I confirmed both direct care staff members were immediately terminated. During this incident, Resident A's supervision and protection was not attended to while she sat in the facility's vehicle alone.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 9/15/2023, I conducted an exit conference with licensee designee Ramon Beltran. I informed Ramon Beltran of my findings and allowed him an opportunity to ask questions or make comments.

**IV. RECOMMENDATION**

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

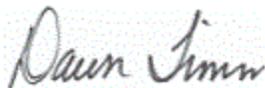


Ondrea Johnson  
Licensing Consultant

10/17/2023

Date

Approved By:



10/23/2023

Dawn N. Timm  
Area Manager

Date