GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 3, 2025

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

RE: License #: AS580394004
Investigation #: 2025A0116021
Beacon Home At Carleton

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 licensee designee 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 (313) 456-0439.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS580394004
Investigation #:	2025A0116021
Complaint Receipt Date:	03/20/2025
Investigation Initiation Date:	03/20/2025
Report Due Date:	05/19/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nicole VanNiman
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At Carleton
Facility Address:	13426 Capernall Road Carleton, MI 48117
Facility Telephone #:	(734) 587-6056
Original Issuance Date:	11/13/2018
License Status:	REGULAR
Effective Date:	05/09/2023
Expiration Date:	05/08/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was eating and choked to death. Complainant has concerns whether staff were present or if any cardiopulmonary resuscitation and first aid (CPR/FA) measures were taken by staff.	No
Additional findings	Yes

III. METHODOLOGY

03/20/2025	Special Investigation Intake 2025A0116021
03/20/2025	Special Investigation Initiated – Telephone Complainant.
03/20/2025	APS Referral Not required as the resident is deceased.
03/24/2025	Inspection Completed On-site Home manager, Deann Talanges, reviewed incident report, and Resident A's heath care appraisal. Verified that Ms. Talanges, Ms. Sharpe and Ms. Williams are all FA/CPR trained.
03/25/2025	Contact - Telephone call made Staff, Sasha Sharpe.
03/25/2025	Contact - Telephone call made Monroe County Guardian, Raykel Price.
03/25/2025	Contact - Telephone call made Left a message for Resident A's supports coordinator, Mark Parrish, requesting a return call.
03/26/2025	Contact - Telephone call received Supports coordinator, Mark Parrish.
03/26/2025	Document received. Copy of Resident A’s individual plan of service (IPOS) and Notes from swallow study.
03/28/2025	Referral-Recipient Rights.

03/31/2025	Contact - Telephone call made Staff, Mikayla Williams. Left a message requesting a return call.
03/31/2025	Contact - Telephone call made West Michigan recipient rights investigator, Kara Rose. Left a message requesting a return call.
04/07/2025	Contact - Telephone call received Recipient rights investigator, Kara Rose.
04/07/2025	Contact - Telephone call received Staff, Mikayla Williams.
04/10/2025	Contact - Document received Copy of death certificate.
04/24/2025	Inspection Completed On-site Residents B-D.
04/25/2025	Exit Conference Licensee designee, Ramon Beltran.
04/29/2025	Contact-Telephone call received. Complainant.
04/29/2025	Contact-Document received 911 audio.
05/06/2025	Exit conference Licensee designee, Ramon Beltran.
05/13/2025	Contact-Telephone call made Monroe Community Ambulance. Left a message requesting a return call.
05/13/2025	Contact-Telephone call made Monroe Community Ambulance Supervisor's Office. Left a message requesting a return call.
05/19/2025	Contact-Telephone call made Monroe Community Ambulance. Left a message requesting a return call.
05/19/2025	Contact-Telephone call made. Monroe Community Ambulance Supervisor's office. Left a message requesting a return call.

ALLEGATION:

Resident A was eating and choked to death. Complainant has concerns whether staff were present or if any cardiopulmonary resuscitation and first aid (CPR/FA) measures were taken by staff.

INVESTIGATION:

On 03/20/25, I interviewed Complainant. Complainant reported that Resident A choked and died on 03/19/25 and there are questions that need answers regarding how it happened and where the staff were at the time. Complainant reported that she did not have any major concerns regarding the care the home provided prior to this incident. Complainant reported in the past during a visit to the home that Resident A did not have a proper dresser in his bedroom, however, did not report it at the time. Complainant reported that Resident A did not have any eating guidelines in place to her knowledge.

On 03/24/25, I conducted an unscheduled onsite investigation and interviewed home manager, Deann Talanges, and reviewed Resident A's health care appraisal, and a copy of the incident report. Ms. Talanges reported that she, along with staff, Sasha Sharpe, and Mikayla Williams were on shift on 03/19/25, at the time of the incident. Ms. Talanges stated she was in her office. Ms. Talanges reported being called by staff, Mikayla Williams, and Sasha Sharpe, alerting her that something was wrong with Resident A. Ms. Talanges stated Staff, Mikayla Williams, reported observing a trail of fecal matter leading to the bathroom while heading to Resident B's bedroom, to wake him for lunch. Ms. Talanges stated Ms. Williams began cleaning the floor, following the trail that led to the bathroom while Resident A was in the bathroom. Ms. Talanges stated the door was cracked and Ms. Williams reported knocking on the door and asking Resident A if he was okay. Ms. Talanges stated Ms. Williams reported Resident A did not respond, so she (Ms. Williams) entered the bathroom, saw him on the toilet, pants and underwear at his ankles, holding a sandwich in his right hand, appearing unresponsive. Ms. Talanges stated Ms. Williams called out to her and staff, Sasha Sharpe. They entered the bathroom, checked Resident A's pulse, and got him on the floor. Ms. Talanges stated she did a sweep of his mouth and reported the one bite he had taken from the sandwich came out during the sweep. Ms. Talanges stated Resident A did not have a pulse, and his hands had turned a gray like color, so Ms. Talanges immediately began CPR, while Ms. Williams called 911. Ms. Talanges reported between her, Ms. Williams, and Ms. Sharpe, they completed about seven rounds of CPR, before EMS arrived and took over. The police arrived first, followed by EMS. Ms. Talanges reported that the EMTs attempted to put a tube down Resident A's throat, to no avail. EMTs continued CPR efforts but were unsuccessful. Resident A's remains were later picked up by the coroner.

Ms. Talanges reported that Ms. Williams and Ms. Sharpe told her that Resident A had eaten his lunch. Ms. Talanges reported Ms. Sharpe was at the table in the kitchen doing some charting, and Ms. Williams was prepping lunch for the residents who were still asleep prior to this incident. Ms. Sharpe and Ms. Williams reported to her that at some point Resident A swiped one of the sandwiches from the plates that were being prepared for the other residents, without either of them seeing him do it and went into the bathroom with it. Ms. Talanges reported Resident A had a habit of sneaking food and once he had it, it was impossible to get it back from him. The

confusing part of this situation was that the one bite that was missing from the sandwich was still in Resident A's mouth when they found him in the bathroom, confirming to her that he did not choke on the sandwich he had taken. Ms. Talanges reported her belief that Resident A may have had a heart attack further stating Resident A did not exhibit any signs of discomfort or distress and was his normal self that day. Ms. Talanges confirmed Resident A did not have eating guidelines, nor did he require 1:1 staffing. In the past Resident A did have eating guidelines with his food consistency pureed, however, Resident A was not happy about that and was non-compliant. Resident A would refuse to eat a pureed diet and in June of 2024 Resident A's supports coordinator had an order sent in for a new swallow test. The swallow test was completed in July of 2024 and Resident A was put back on a regular diet. ProMedica Regional Hospital Radiology recommended that staff cut tougher meats into 1-inch bites and encourage Resident A to drink out of a straw to slow down his impulsive chugging.

I reviewed Resident A's health care appraisal dated 03/06/25, which documented a regular diet. I also confirmed that Ms. Talanges, Ms. Sharpe and Ms. Williams were all trained in CPR/FA.

On 03/25/25, I interviewed staff, Sasha Sharpe, and she reported she was one of the staff on shift on 03/19/25. She reported that Resident A was his normal self that day and recalled prior to him eating lunch she had checked his blood sugar levels which were a little low, she reported she followed the protocols in place to address his low levels, while he waited to eat lunch. Resident A ate lunch, and she told him that she wanted to check his levels again. Resident A told her after he used the restroom, she could check him. Ms. Sharpe was in the kitchen completing her charting notes and did not see Resident A take the sandwich. While walking to the bathroom, Resident A began defecating and there was a trail of fecal matter leading to the bathroom door. Staff, Mikayla Williams, began cleaning up the fecal matter and then knocked on the door to check on Resident A. When he did not respond, Ms. Williams opened the door and observed him on the toilet with the sandwich in his right hand. Ms. Williams called for her and Ms. Talanges and they went to see what was going on. Ms. Talanges checked for a pulse and was unable to find one, she also did a mouth sweep, and the one bite of sandwich came out of Resident A's mouth. They got Resident A onto the floor and began CPR while Ms. Williams called 911. Ms. Talanges started the initial round of CPR. They rotated rounds of CPR and reported doing about seven before EMS arrived and took over. Ms. Sharpe does not believe Resident A choked as the one bite of the sandwich he had taken, came out of his mouth when Ms. Talanges did the mouth sweep. Resident A did not have current eating guidelines and did not have special staffing requirements.

On 03/25/25, I interviewed Resident A's public Guardian Raykel Price. Ms. Price reported she had been notified of Resident A's passing by home manager, Deann Talanges. Ms. Price reported that the funeral was 03/24/25 and it appears that Resident A may have aspirated. Ms. Price reported that the guardianship case is closed. She reported having no concerns regarding the care the staff at the home

provided, and reported that Ms. Talanges always kept her abreast of what was going on with Resident A.

On 03/26/25, I interviewed supports coordinator, Mark Parrish. Mr. Parrish reported that he has been Resident A's supports coordinator for years and reported that he has not had any concern regarding the staff at the home or the care they provided. Ms. Talanges called and informed him that Resident A had passed as well as the events leading up to his death. Resident A could be a handful and was not happy during the time he was put on a pureed diet. Resident A was non-compliant and would refuse to eat his food pureed, often referring to it as baby food. Resident A would steal food and once he got his hands on it, it was no way the staff would be able to get it back. In July 2024, another swallow test was completed, and Resident A was put back on a regular diet. The staff would still cut most of Resident A's food to prevent him from shoveling it in his mouth. Resident A did not require 1:1 staffing.

On 03/26/25, I received and reviewed Resident A's IPOS dated 09/14/24 and it documents that Resident A is no longer on a pureed diet after his swallow test July 10, 2024. The plan does not document any special staffing requirements for Resident A. I also reviewed the notes from Resident A's swallow test that determined he no longer required a pureed diet and was placed on a regular diet. ProMedica Regional Hospital Radiology recommended that staff cut tougher meats in 1-inch bites and encourage Resident A to drink liquids from a straw to slow down his impulsive chugging.

On 04/07/25, I interviewed recipient rights investigator, Kara Rose. Ms. Rose reported that her office would not be investigating the matter after completing a root cause analysis. Ms. Rose did not have any concerns regarding the care the staff provided during the time Resident A resided in the home.

On 04/07/25, I interviewed staff, Mikayla Williams. Ms. Williams reported that she was on shift on 03/19/25, when the incident occurred. Ms. Williams prepared Resident A's lunch and reported he sat at the table and ate it. She sat at the table while he ate and cut his turkey and cheese sandwich in 4 pieces so that he would not shovel the entire sandwich in his mouth. Resident A ate all his lunch. Once he was done, she began making a sandwich for Resident B who was in his bedroom. She only had the bread and cheese on the sandwich, and covered it up, while she went to ask Resident B what type of deli meat he wanted on his sandwich. Ms. Williams believes this may have been when Resident A snuck the sandwich. Ms. Williams saw a trail of fecal matter on the floor leading to the bathroom and began cleaning it up. The trail led to the bathroom. Ms. Williams knocked on the cracked door and asked Resident A if he was okay and did not receive a response. Ms. Willams entered the bathroom and observed Resident A sitting on the toilet, pants and underwear at his ankles, with the sandwich (missing a bite) in his right hand. Ms. Williams yelled for Ms. Sharpe and Ms. Talanges who came to assist. They moved Resident A onto the floor, Ms. Talanges checked for a pulse and could not find one, did a sweep of his mouth and the piece of sandwich he had bitten came

out. Resident A's hand was gray in color, and it was evident that he was deceased. While she called 911, Ms. Talanges began CPR. Ms. Williams reported she, Ms. Shape and Ms. Talanges alternated seven rounds of CPR and continued until EMS arrived and took over chest compressions. EMTs worked on Resident A for a while but were unable to resuscitate him.

Ms. Williams reported that Resident A had a history of sneaking and shoveling food when he ate. Ms. Williams reported that although Resident A didn't have current eating guidelines in place, staff were diligent about monitoring him while he ate and giving verbal reminders for him to slow down while eating.

On 04/10/25, I received and reviewed Resident A's death certificate. The manner of death was listed as internal airway obstruction by food bolus.

On 04/24/25, I conducted a scheduled on-site inspection and interviewed Residents B-D. Residents B-D all reported that they were in their bedrooms and did not know what was going on until they heard all the commotion. Resident B reported when he came out of his room he saw Ms. Talanges, Ms. Sharpe, and Ms. Williams "working" on Resident A, but he was gone."

Resident C reported that Resident A always tried to sneak food and was smart enough to wait to do it when staff were busy assisting other residents or cleaning the home. Resident C reported that Resident A was fast.

Residents B-D all reported that there are three staff per shift and that the staff are always in the home and keeping an eye on them. Resident B reported that the staff are all really good and very helpful. He reported that is one of the reasons he enjoys living at the home.

On 04/25/25, I conducted the exit conference with licensee designee, Ramon Beltran, and informed him of the findings of the investigation. Mr. Beltran agreed with the findings and reported that this was an unfortunate situation.

On 04/29/25, I received a call from the complainant. Complainant reported that she had obtained the audio from the 911 call and reported that the staff did not attempt CPR, although they reported doing so.

On 04/29/25, I received and listened to the audio of the 911 call. Staff, Mikayla Williams made the call and remained on the line throughout. Below is a portion of the call.

- Ms. Williams: *(Resident A) went to the bathroom, is on the toilet and has no pulse.*
- 911 operator: *Is anyone doing CPR?*
- Ms. Williams: *No, he's stuck on the toilet.*
- 911 operator: *Are you saying you are unable to get him off the toilet?*

- Ms. Williams: *Can you hold on a minute?*
- 911 operator: *Yes*.
- Ms. Williams: *She is asking are we going to get him off the toilet and do CPR. [Someone in the bathroom responds] "No he's gone."*
- Ms. Williams*: He's gone.*
- 911 operator: *Do you have a defibrillator in there?*
- Ms. Williams: *No, actually I don't know, it may be in the med room, let me check. I'm sorry, I'm trying to check our med room real quick. No, there is no defibrillator. He's turning gray.*
- 911 operator: *Are you advising that you are not going to try to pull him off the toilet and do CPR? Is that correct? I just have to know, I'm not judging,*
- Ms. Williams: *uhhh, I guess not.*
- 911 operator: *We have everybody on the way. Is lights and sirens okay?*
- Ms. Williams: *Okay*.

On 05/06/25, I conducted a second exit conference with licensee designee, Ramon Beltran, and informed him of the additional information received, as well as the findings of the investigation. Mr. Beltran agreed with the findings and will be addressing the matter with the staff involved.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based on the investigative findings there is insufficient evidence to substantiate that a preponderance exists to establish this rule violation. Ms. Talanges, Ms. Williams and Ms. Sharpe, provided supervision, protection and personal care as defined in the act and as specified in Resident A's written assessment plan. Ms. Talanges, Ms. Sharpe and Ms. Williams all reported that Resident A did not have current eating guidelines in place, nor did he require 1:1 staffing. Mr. Parrish confirmed that Resident A did not have any current eating guidelines in place and did not require 1:1 staffing. Mr. Parrish reported the staff at the home provided good care to Resident A and reported not having any concerns. Ms. Rose reported that her office did not open an investigation into the matter after conducting a root cause analysis and had no concerns regarding the staff and the care they provided. Ms. Price reported having no concerns regarding the care provided in the home. I reviewed Resident A's IPOS and swallow test notes and his health care appraisal. I confirmed that Resident A did not have current eating guidelines, a special diet, nor did he require 1:1 staffing. Once Ms. Williams discovered Resident A unresponsive in the bathroom, she yelled for help from Ms. Talanges and Ms. Sharpe. Ms. Williams called 911, Ms. Talanges performed a mouth sweep and reported dislodging the piece of sandwich from Resident A's mouth. Ms. Williams communicated her observations appropriately to the 911 operator and cooperated with emergency personnel when onsite. Ms. Talanges followed facility protocols and immediately contacted her management team, Resident A's guardian and supports coordinator, informing them of the incident. Although additional information was received during the course of my investigation, contradicting what Ms. Talanges, Ms. Sharp and Ms. Williams, reported to me regarding engaging in CPR, there is insufficient evidence to establish that CPR should have been performed in this instance, based on their descriptions and observations of Resident A when they found him.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

On 04/29/25, I received a telephone call from the complainant. Complainant reported that she had the audio and transcript 911. The staff lied and did not perform CPR or other life saving measures. I asked the complainant to forward the information.

On 04/29/25, I received and listened to the 911 audio and confirmed that home manager, Deann Talanges, and staff Sasha Sharpe and Mikayla Williams, did not engage in CPR as reported to me during my interviews with them on 03/24/25, 03/25/25, and 04/07/25 respectively. During those interviews Ms. Talanges, Ms. Sharpe and Ms. Williams all reported while in the bathroom with Resident A, they engaged in CPR. They reported that Ms. Talanges started, then Ms. Williams and Ms. Sharpe alternated rounds (7 rounds) of CPR until the police and EMS arrived and took over.

On 05/06/25, I conducted the exit conference with licensee designee, Ramon Beltran, and informed him of the findings of the investigation. Mr. Beltran reported an understanding. Mr. Beltran will be addressing the matter with the three staff involved and will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; foodservice staff.**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.

ANALYSIS:	Based on the investigative findings there is sufficient evidence to substantiate that a preponderance exists to establish this violation. Ms. Talanges, Ms. Williams, and Ms. Sharpe, through their actions, were not suitable to assure the welfare of Resident A, evidenced by their untruthfulness. Complainant reported that the staff who were on shift at the time of the incident lied about administering CPR to Resident A. Complainant reported having the audio and transcript of the 911 that confirms the staff were not being truthful. I listened to the audio of the 911 call and determined that the home manager, Ms. Talanges, staff, Ms. Sharpe and Ms. Williams, were not forthcoming about not performing CPR. They all previously reported in their interview with me that they alternated doing seven rounds of CPR. The audio of the 911 call contradicts their statements. Additionally, there was no indication that CPR was initiated after the conclusion of the 911 call.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Pandrea Robinson
Licensing Consultant

05/06/25
Date

Approved By:

Dawn Timm
Area Manager

06/03/2025
Date