GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2025

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

RE: License #: AM590387866
Investigation #: 2025A0622043
Beacon Home At The Bunkhouse

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.
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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) 335-5985.

Sincerely,

Amanda Blasius, 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 #:	AM590387866
Investigation #:	2025A0622043
Complaint Receipt Date:	05/23/2025
Investigation Initiation Date:	05/23/2025
Report Due Date:	07/22/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At The Bunkhouse
Facility Address:	1550 E. Colby Road Stanton, MI 48888
Facility Telephone #:	(989) 831-0627
Original Issuance Date:	12/21/2018
License Status:	REGULAR
Effective Date:	06/21/2023
Expiration Date:	06/20/2025
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A required two person assistance in the bathroom and DCW Lorriane Walker became agitated with Resident A and began to yell at him.	No

III. METHODOLOGY

05/23/2025	Special Investigation Intake 2025A0622043
05/23/2025	Special Investigation Initiated - Letter
05/23/2025	APS Referral- Complaint received from APS and they declined to investigate.
06/02/2025	Inspection Completed On-site- Interview with Resident A
06/02/2025	Contact- phone call to direct care worker (DCW) Lorriane Walker
06/09/2025	Inspection Completed-BCAL Sub. Compliance
06/10/2025	Contact- phone call to Resident B
06/11/2025	Exit conference with administrator, Roxanne Goldammer

ALLEGATION: Resident A required two person assistance in the bathroom and DCW Lorriane Walker became agitated with Resident A and began to yell at him.

INVESTIGATION:
On 05/23/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, adult protective services denied the referral and it was sent to licensing for investigation. The complaint stated that Resident A is in a wheelchair and he requires two direct care workers to assist with personal care due to previous accusations. According to the complaint, Resident A began to yell out for help, and he was told to wait a minute. The complaint stated direct care worker(DCW) Shelby VanHorn informed, DCW Lorriane Walker that Resident A needed help in the bathroom, but when DCW Walker came out of using the bathroom, she went over to the main office and upon her return to the facility, she went to the medication room. According to the complaint, at this point, Resident A became verbally aggressive because he was tired of waiting. DCW Walker was told to hurry as Resident A was becoming

agitated. The complaint stated that DCW Walker walked into the bathroom where Resident A was and said, "If you're going to be yelling, I'm not going to help you and slammed the door." The compliant reported that a few minutes later DCW Walker returned and asked Resident A, "Are you done yelling?" The complaint stated Resident A began to yell more causing a loud verbal altercation between Resident A and DCW Walker. DCW VanHorn tried calming them down but was unsuccessful and according to the complaint the manager came over to deescalate the situation. According to the complaint, DCW Lorriane Walker was sent home for the day.

On 05/23/2025, I reached out to Recipient Rights to obtain additional information.

On 06/02/2025, I completed unannounced onsite investigation to Beacon Home at the Bunkhouse. During the unannounced onsite investigation, I interviewed Resident A and direct care workers.

On 06/02/2025, I interviewed Resident A in person. Resident A reported that DCW Lorrianne Walker and DCW Shelby VanHorn were at the home during the incident. He stated another worker was on an outing with other residents. Resident A stated that he had a video call coming up and needed to get into the shower. Resident A explained that when he was done in the shower he yelled for help, and he heard DCW VanHorn ask DCW Walker to help Resident A. Resident A explained that he continued to wait in the shower with the water off and was getting cold. Resident A stated that he thinks DCW Walker was outside smoking and taking her time. Resident A reported that DCW Walker finally came into the bathroom, and he was yelling because it was taking so long. Resident A stated that DCW Walker came into the bathroom and then slammed the door in his face. Resident A stated that DCW Walker came into the bathroom three times yelling and slammed the door three times. Resident A reported that he was very upset and does not remember what he said to DCW Walker. Resident A explained that he heard DCW Walker call the manager, Mandy Betancourt on the phone. Resident A explained that DCW Mandy Betancourt came over to the home and was in the middle between him and DCW Walker. Resident A explained that DCW Betancourt asked DCW Walker to leave and she and DCW VanHorn helped him get dressed. Resident A explained that DCW VanHorn assisted him with filing a rights complaint. Resident A reported that later DCW Walker came up to him and apologized and stated that she had a lot going on in her personal life.

On 06/02/2025, I interviewed direct care worker, Shelby VanHorn in person. DCW VanHorn stated that she was sitting at the kitchen table while Resident A was in the shower and DCW Walker had been in the other bathroom for 45 minutes. DCW VanHorn reported that after DCW Walker was done in the bathroom, she then went to see management in the office and when she returned to the home she went to the medication room. DCW VanHorn reported that while DCW Walker was getting ready to head to the office, Resident A started asking for help. DCW VanHorn stated that Resident A needs two direct care staff assistance in the bathroom, due to previous allegations that have been made. DCW VanHorn reported that DCW Walker

returned from the medication room and opened the bathroom door and said the following: “If your going to fucking yell at me, I’m not going to help you.” and then she slammed the door. DCW VanHorn explained that DCW Walker was yelling at Resident A on and off and slammed the door a total of three times. DCW VanHorn reported that Resident A was also yelling back at DCW VanHorn and was swearing and calling her names. DCW VanHorn explained that DCW Walker then called manager Mandy Betancourt and asked for help as she was not going to deal with Resident A. DCW VanHorn stated that she attempted to diffuse the situation, but she was unable to calm Resident A. DCW VanHorn reported that she observed DCW Betancourt have to physically hold back DCW Walker twice as DCW Betancourt was in between Resident A and DCW Walker. DCW VanHorn reported that she observed DCW Walker try to push through DCW Betancourt and also have her fist in the air. DCW VanHorn stated that she also observed DCW Betancourt tell DCW Walker to go outside. DCW VanHorn reported that DCW Walker only came back into the home later on to grab her items and sign off on medications. DCW VanHorn stated that DCW Betancourt helped with getting Resident A dressed and Resident A probably waited 20 minutes before being helped after his shower. She explained that she assisted Resident A with filing a rights complaint.

On 06/02/2025, I interviewed DCW Mandy Betancourt in person. She stated that she is the home manager for Beacon Home at the Bunkhouse. DCW Betancourt stated that she had asked for DCW Walker to come over to the office to grab new medications. DCW Betancourt explained that DCW Walker did not state to her that Resident A was out of the shower or close to getting out of the shower when she called her over. DCW Betancourt reported that she received a phone call from the facility and she could hear yelling in the background from Resident A and a staff member, therefore she headed over to the home. When she arrived, Resident A was in the bathroom yelling and DCW Walker was in the doorway of the bathroom. DCW Betancourt reported that Resident A can target certain staff members. DCW Betancourt reported that she was in the middle of Resident A and DCW Walker in the bathroom. She explained that DCW Walker started to step towards her and Resident A and she told DCW Walker to stay there and then told her to go outside. DCW Betancourt reported that she did not observe DCW Walker yell, swear or raise her fist while she was in the home. DCW Betancourt reported that she told DCW Walker to keep her emotions at home. DCW Betancourt stated that she helped Resident A get dressed. She explained that she was able to find coverage for DCW Walkers shift and she was sent home for the day. DCW Betancourt reported that DCW Walker has not been scheduled to work at the facility since the incident but has worked at other homes on the property.

On 06/03/2025, I interviewed DCW Lorriane Walker via phone. DCW Walker reported that Resident A got in the shower and then she went to the bathroom. DCW Walker reported that she will be in the bathroom for a long time due to medicine she has to take. She explained that when she came out of the bathroom, DCW Shelby VanHorn told her that the manager wanted her to come over to the office to grab medications. DCW Walker stated that when she returned to the home, she heard

Resident A yelling from the bathroom. She explained that she still had to put the medications away in the medication room and she told Resident A to give her a few minutes. She explained that DCW VanHorn also stepped in and asked Resident A to wait a minute as they must have two staff to assist him. DCW Walker stated that Resident A was accusing her of smoking outside. DCW Walker reported that when she opened the bathroom door, Resident A was screaming and yelling at her. DCW Walker reported that she said the following to Resident A: “If you’re going to be screaming and yelling at me, I’m not going to come in there.” She reported that she then shut the door and waited a minute. DCW Walker reported that Resident A has been threatening to hurt staff members. DCW Walker stated that Resident A kept swearing and yelling and she kept opening the door and telling him he needed to calm down before she could help him. DCW Walker reported that she then called the manager DCW Mandy Betancourt and she could hear Resident A yelling in the background and said she would be right over. DCW Walker reported that she did raise her voice at Resident A and told him he needed to stop. DCW Walker denied swearing at Resident A and could not remember if she slammed the door, but reported that she did not think she was slamming the bathroom door. DCW Walker reported that DCW Betancourt was in the bathroom between her and Resident A. DCW Walker stated that she was starting to get really mad at Resident A and the situation and DCW Betancourt told her to go outside. DCW Walker explained that DCW Betancourt and DCW VanHorn helped get Resident A dressed and Resident B walked with her outside.

On 06/11/2025, I interviewed Resident B via phone. DCW Walker identified Resident B being in the home during the incident. Resident B is not a resident of Beacon Home at the Bunkhouse, but lives at the other home on property and visits often. Resident B reported that he came in towards the end of the incident. Resident B stated that it’s his understanding that Resident A was upset about the shower and DCW Walker was busy doing other things at that time. Resident B reported that he witnessed DCW Walker and Resident A arguing with each other. Resident B reported that he did not observe DCW Walker raise her fist or swear at Resident A. Resident B did report that DCW Walker should have walked away sooner instead of continuing to stay in the home and argue with Resident A. Resident B explained that he did walk with DCW Walker outside and she explained that she had some personal things going on in her life. Resident B reported that he overheard DCW Betancourt say to DCW Walker “don’t bring your personal problems to work.”

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or

	the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **2. A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on interviews with direct care workers and residents it was found that direct care worker, Lorriane Walker did not treat Resident A with consideration and respect after raising her voice back at Resident A, arguing with him and not respecting his personal dignity by understanding that Resident A was cold and had been waiting a long time for assistance with getting dressed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, I recommend no change in the status of the license.

06/11/2025

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Amanda Blasius Date
Licensing Consultant

Approved By:

06/11/2025

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Dawn N. Timm Date
Area Manager