GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 1, 2025

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

RE: License #:	AS250413017
Investigation #:	2025A0872040
	Beacon Home At Lennon

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,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250413017
Investigation #:	2025A0872040
Complaint Receipt Date:	06/02/2025
Investigation Initiation Date:	06/02/2025
Report Due Date:	08/01/2025
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:	Ramon Beltran
Name of Facility:	Beacon Home At Lennon
Facility Address:	5328 Lennon Rd Swartz Creek, MI 48473
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/29/2022
License Status:	REGULAR
Effective Date:	05/29/2025
Expiration Date:	05/28/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 05/10/2025, staff was instructed to take Resident A to the ER due to UTI symptoms. On 05/12/25, Resident A still had not been medically treated.	Yes

III. METHODOLOGY

06/02/2025	Special Investigation Intake 2025A0872040
06/02/2025	APS Referral I made an APS complaint
06/02/2025	Special Investigation Initiated - Letter I made an APS complaint
06/05/2025	Inspection Completed On-site Unannounced
06/09/2025	Contact - Document Sent I emailed the licensee designee requesting information related to this complaint
06/11/2025	Contact - Document Received I received documentation from the LD
06/30/2025	Contact - Document Received I exchanged emails with APS Belanger
07/01/2025	Exit Conference I conducted an exit conference with the licensee designee, Ramon Beltran
07/01/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: On 05/10/2025, staff was instructed to take Resident A to the ER due to UTI symptoms. On 05/12/2025, Resident A still had not been medically treated.

INVESTIGATION: On 06/05/2025, I conducted an unannounced onsite inspection of Beacon Home at Lennon. I interviewed Resident A. I reviewed the allegations with her, and she acknowledged that she was experiencing symptoms of a urinary tract infection last month and she was taken to Hurley hospital. Resident A said she was given antibiotics which staff administered, and she is fine now. I asked Resident A if there was a delay in her medical treatment and she said no. She said that she believes staff took her to the hospital as soon as she told them she was not feeling well.

On 06/16/2025, I reviewed AFC paperwork related to this complaint. Resident A was admitted to Beacon Home at Lennon on 01/19/2023. I reviewed an Incident/Accident Report (IR) dated 05/12/2025 at 1:00pm completed by the home manager, Eleanor Frye. According to this report, on 05/10/2025, Resident A was complaining of pain, discomfort and spotting while using the bathroom. Staff contacted the home manager to inform her of the situation. The home manager, (HM) Eleanor Frye, instructed staff Shanareyha Johnson to contact the on-call nurse for further instructions. The on-call nurse advised staff to take Resident A to urgent care.

On 5/12/2025, HM Frye discovered that staff had not sought medical attention for Resident A. The corrective measures taken were, “Care Team Manager (CTM) emailed leadership on Monday morning to let them know that on call medical told staff to take (Resident A) to the urgent care on Saturday the staff didn’t complete that action. CTM told staff to take her to urgent care on Monday when informed she was not taken the day advised. Staff took her to urgent care (and) did find UTI. CTM completed a write-up with training with the staff about reporting and completed chart notes in a timely manner. Staff advised to follow all nurse and CTM direction to ensure health and safety.”

On 06/30/2025, I exchanged emails with Adult Protective Services (APS) Worker, Samantha Belanger. APS Belanger said that she has concluded her investigation and is substantiating neglect.

On 07/01/2025, I conducted an exit conference with the licensee designee, Ramon Beltran. I discussed the results of my investigation and explained which rule violation I am substantiating. LD Beltran agreed to complete and submit a corrective action plan upon the receipt of my investigation report.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 05/10/2025, Resident A complained of pain, discomfort, and spotting when urinating. Staff Shanareyha Johnson contacted management who advised her to contact the on-call nurse. The on-call nurse advised Staff Johnson to take Resident A to urgent care. On 05/12/2025, the care team manager, Elenor Frye discovered that Resident A had still not received medical treatment, so Resident A was transported to the hospital where she was diagnosed with a urinary tract infection. I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

Susan Hutchinson July 1, 2025

Susan Hutchinson Licensing Consultant	Date

Approved By:

Mary Holton July 1, 2025

Mary E. Holton Area Manager	Date