GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 20, 2025

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

RE: License #: AS630387840
Investigation #: 2025A0611026
Beacon Home at Lake Orion

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 (248) 972-9136.

Sincerely,

Sheena Worthy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd, Suite 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630387840
Investigation #:	2025A0611026
Complaint Receipt Date:	08/06/2025
Investigation Initiation Date:	08/07/2025
Report Due Date:	10/05/2025
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 Lake Orion
Facility Address:	175 E. Silverbell Rd. Lake Orion, MI 48360
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/10/2017
License Status:	REGULAR
Effective Date:	08/08/2024
Expiration Date:	08/07/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 7/26/25, residents were left alone until staff arrived.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/06/2025	Special Investigation Intake 2025A0611026
08/07/2025	Special Investigation Initiated - Letter An email was sent to recipient rights specialist Rishon Kimble regarding the allegation.
08/07/2025	Contact - Document Received I received an email from recipient rights specialist Rishon Kimble regarding the investigation.
08/13/2025	Inspection Completed On-site I completed an unannounced onsite. I interviewed the home manager Amanda Rondo, Resident M, Resident K, and Resident J. I received a copy of the residents MAR and incident report.
08/19/2025	Contact - Telephone call made I made a telephone call to staff member Donisha Johnson. The allegations were discussed.
08/19/2025	Contact - Telephone call made I made a telephone call to staff member Janeen Rondo. The allegations were discussed.
08/19/2025	Contact - Telephone call made A voice message was left for Donovan Burton requesting a call back.
08/19/2025	Contact - Telephone call made I made a telephone call to the home manager Amanda Rondo. Ms. Rondo provided additional information regarding Resident K's MAR.
08/19/2025	Exit Conference I completed an exit conference with the licensee designee Ramon Beltran via telephone.

ALLEGATION:

On 7/26, residents were left alone until staff arrived.

INVESTIGATION:

On 08/06/25, a complaint was received and assigned for investigation alleging that staff member Donisha informed the manager Amanda Rondo that when she arrived for her shift on 07/26/25, staff member Burton was not present and the residents were alone in the home without staff.

On 08/07/25, I received an email from recipient rights specialist Rishon Kimble. A copy of the email is below:

> *"I interviewed the three Oakland County residents yesterday. One of them reported waking up around 1 or 2 am and the staff was gone and the home manager (Amanda) said that Staff Doneisha informed her that Donovan (the staff) was gone when she arrived at 6:52 a.m. The other two residents said they were asleep and did not know he was gone until morning when they heard about it".*

On 08/13/25, I completed an unannounced onsite. I interviewed the home manager Amanda Rondo, Resident M, Resident K, and Resident J. I received a copy of the residents MAR and incident report.

On 08/13/25, I interviewed the home manager Amanda Rondo. Ms. Rondo stated the allegations are true. Ms. Rondo stated on 07/26/25 around 6:50am, she was informed by staff member Donisha Johnson that staff member Donovan Burton was not present when she arrived at the AFC group home for her shift and; the residents were left unsupervised. Ms. Johnson and staff member Kyle Wilson were scheduled to work the day shift on 07/26/25 from 7:00am to 7:30pm. Mr. Burton was scheduled to work the midnight shift on 07/25/25 from 7:00pm to 7:30am. Ms. Rondo stated one or two residents may have been awake when the day shift arrived but she is not certain.

Ms. Rondo stated the last time she confirmed that Mr. Burton was present at the group home was on 07/25/25 between 10:30pm-11:00pm when she had to send staff member Jannen Rondo to the AFC group home to unlock the medication room because Mr. Burton had locked himself out of the medication room. Ms. Rondo stated she worked the night of 07/26/25. Ms. Rondo assured the residents that they do not have to worry about being left unsupervised again. On 07/26/25, Ms. Rondo contacted Mr. Burton but he did not answer her call. Mr. Burton contacted Ms. Rondo three days later. Mr. Burton did not admit to leaving the residents unsupervised. Ms. Rondo stated according to the staff mobile app, his location did not indicate that he clocked out near the AFC group home. Mr. Burton was terminated due to not finishing his shift and leaving the residents unsupervised.

On 08/13/25, I interviewed Resident M. Resident M has lived at the AFC group home for five months. Resident M stated he likes living at the AFC group home. Resident M stated Mr. Burton works the midnight shift. Resident M stated on the day in question, he woke up around 6:30am and came out of his bedroom to ask Mr. Burton for a PRN however; Mr. Burton was nowhere to be found. Resident M knocked on the office door and there was no answer. Resident M stated the residents have never been left alone before. Ms. Johnson arrived at the AFC group home around 7:30am.

On 08/13/25, I interviewed Resident K. Resident K has lived at the AFC group home for five years. On the day in question, Resident K stated Mr. Burton was working the midnight shift but he left early. Resident K stated between 10:00pm-11:00pm, Mr. Burton stated he was about to quit. Resident K stated during this timeframe, he saw Mr. Burton's girlfriend in the laundry room that leads to the garage door. Resident K went to bed around 12:00am. Resident K woke up between 1:00am-2:00am. Resident K checked the laundry room and the office and did not find Mr. Burton. Resident K stated he looked outside and saw Mr. Burton's car was gone. Resident K went back to bed.

On 08/13/25, I interviewed Resident J. Resident J has lived in the AFC group home for six years. Resident J stated he likes living at the AFC group home and the staff treat him well. Regarding the allegations, Resident J stated Mr. Burton no longer works at the AFC group home because he left the residents unsupervised in the middle of the night. Resident J stated he was asleep when Mr. Burton left the home. Resident J does not remember what time he woke up but, he heard from the other residents about what happened. Resident J stated the residents have never been left unsupervised prior to this incident. Resident J denied any resident leaving the home or getting hurt during the time Mr. Burton left the home.

On 08/13/25, I received a copy of an incident report. The incident report is dated 07/26/25 at 1:00am. The incident report was written by Amanda Rondo. According to the incident report, it was reported that Mr. Burton left before first shift came in the next day; which means the residents were left alone in the home for an unknown period of time. Mr. Burton was terminated.

On 08/19/25, I made a telephone call to staff member Donisha Johnson. Regarding the allegations, Ms. Johnson stated she arrived to the AFC group home around 6:50am. Ms. Johnson sat in her car until it was time for her to clock in at 7:00am. Ms. Johnson stated she did not see Mr. Burton's car outside. When Ms. Johnson entered the home, she did not see Mr. Burton. Ms. Johnson stated the only resident that was awake was Resident M. Resident M was in the living area. Resident M stated he had not seen Mr. Burton all night. Ms. Johnson stated at 7:30am, she asked Resident T if he had seen Mr. Burton and he stated he saw him between 5:00am and 6:00am. Ms. Johnson stated she contacted the home manager Ms. Rondo and advised her about Mr. Burton absence. Ms. Johnson stated the residents have never been left home alone before.

On 08/19/25, I made a telephone call to staff member Janeen Rondo. Regarding the allegations, Janeen stated she arrived to the AFC group home at 10:45pm to bring Mr. Burton another set of keys to open the medication room because he locked his keys inside the room. Janeen stated Mr. Burton was not in a good mood. Janeen left the home shortly after providing Mr. Burton with the keys. Janeen was told later on that Mr. Burton left his shift early. Janeen is not aware of the residents being left unsupervised prior to this incident.

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 on the information gathered, there is sufficient evidence to support the allegation. The staff and the residents interviewed confirmed the allegations pertaining to Mr. Burton leaving his midnight shift early; which lead to the residents being left alone in the AFC group home for an unknown period of time until Ms. Johnson arrived for her shift at 7:00am.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/13/25, Resident J stated he and the other residents did not receive their 8:00pm medications until 11:00pm. Resident J stated another staff came from a different AFC group home to give Mr. Burton the medication keys.

On 08/13/25, I received a copy of all the residents MAR for the month of July, and I took a screenshot from the electronic MAR indicating the actual time Mr. Burton administered the residents 8:00pm medications. According to the MAR's for every resident indicates that Mr. Burton administered their 8:00pm medications on 07/25/25. However, during the onsite, Ms. Rondo was able to look up the charting information on the QuickMar system and show that Mr. Burton administered the 8:00pm medications at 11:37pm. Furthermore, Resident K is prescribed a C-PAP 13cm H2O full face mask nightly however; there are only four staff initials on the MAR for the entire month of July. One of the missing initials includes the date of 07/25/25.

On 08/19/25, I made a telephone call to the home manager Amanda Rondo. Ms. Rondo confirmed that Resident K is prescribed a C-PAP face mask every night. Ms. Rondo stated the staff should be initialing the MAR each night regarding Resident K's face mask. Ms. Rondo stated a lot of her staff are new and she will reiterate the requirement of initialing the MAR.

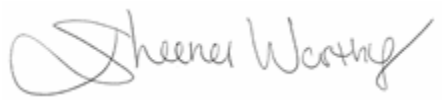
On 08/19/25, I completed an exit conference with the licensee designee Ramon Beltran. Mr. Beltran was informed about the allegations and that they will be substantiated. Mr. Beltran was advised that a corrective action plan will be required

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 07/25/25, Resident J stated he and the other residents did not receive their 8:00pm medications until 11:00pm. Ms. Rondo confirmed on the QuickMAR system that Mr. Burton did not administer the 8:00pm medications until 11:37pm.
CONCLUSION:	**VIOLATION ESTABLISHED**

R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	According to Resident K MAR, he is prescribed a C-PAP 13cm H2O full face mask nightly however; there are only four staff initials on the MAR for the entire month of July. One of the missing initials includes the date of 07/25/25.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

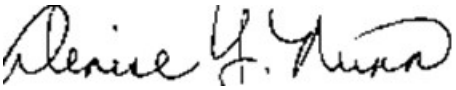


08/19/25

Sheena Worthy
Licensing Consultant

Date

Approved By:



08/20/2025

Denise Y. Nunn
Area Manager

Date