



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 30, 2025

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

RE: License #:	AS250387910
Investigation #:	2025A1039047
	Beacon Home at Goodrich

Dear Ramon Beltran:

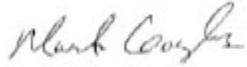
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,

A handwritten signature in cursive script, appearing to read "Martin Gonzales".

Martin Gonzales, 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**

I. IDENTIFYING INFORMATION

License #:	AS250387910
Investigation #:	2025A1039047
Complaint Receipt Date:	09/15/2025
Investigation Initiation Date:	09/15/2025
Report Due Date:	11/14/2025
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 Goodrich
Facility Address:	9186 Washburn Rd. Goodrich, MI 48438
Facility Telephone #:	(810) 636-9598
Original Issuance Date:	09/07/2017
License Status:	REGULAR
Effective Date:	06/10/2025
Expiration Date:	06/09/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED
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II. ALLEGATION(S)

	Violation Established?
A staff member got injured during a transfer and had to ask for assistance from other residents because they do not have any other staff working to help her.	Yes

III. METHODOLOGY

09/15/2025	Special Investigation Intake 2025A1039047
09/15/2025	Special Investigation Initiated - Letter Email to GHS ORR Matt Potts concerning allegation.
09/17/2025	APS Referral Referral made via phone
09/17/2025	Contact - Document Received Complaint denied by APS for investigation.
10/16/2025	Inspection Completed On-site I interviewed the home manager, direct care worker, Resident B, C and D.
10/17/2025	Contact - Document Received Received requested documents from Home Manager.
10/27/2025	Contact - Telephone call made Attempted phone call with Staff Teir Chin-Kee-Fatt. Phone is no longer in service.
10/27/2025	Exit Conference Completed with Licensee Designee Ramon Beltran.
10/27/2025	Contact - Telephone call made Phone interview with Guardian A1.
10/27/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

It was alleged that a staff member asked for assistance from other residents because they do not have any other staff working to help her.

INVESTIGATION:

On 09/15/2025, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Staff Teir Chin-Kee-Fatt has had to ask for assistance from other residents because they do not have any other staff working to help her.

On 09/17/2025, an Adult Protective Services referral was made reporting this allegation. The Department of Health and Human Services Centralized Intake denied the complaint and did not assign it for investigation.

On 10/16/2025, I completed an unannounced onsite investigation at Beacon Home of Goodrich. I interviewed the following people: Home Manager Nataysha Kellar, Direct Care Worker Maliah Spencer, Resident B, C and D.

On 10/16/2025, I completed an interview with Home Manager (HM) Nataysha Kellar concerning the allegations. HM Kellar stated that she was not aware of the allegations but was stated that staff did ask for an additional staff to help with Resident A. HM Kellar stated that there are no two-person assist residents in the home and that Resident A was not a two person assist. HM Kellar stated that Staff Teir Chin-Kee-Fatt was the staff working with Resident A at night and requested an additional staff. HM Kellar stated that an additional staff was added to the 3rd shift schedule. HM Kellar showed me the staff schedule for the month that Resident A was in the home. The staff schedule shows that an additional staff was added to the schedule to assist with Resident A. HM Kellar stated that when Resident A moved into the home, she was diagnosed with Intellectual development disorder, Intermittent explosive disorder, Post traumatic stress disorder and onset Dementia. HM Kellar stated that Resident A's dementia was farther along than they initially thought, and Resident A was a little harder to care for because of her dementia. HM Kellar stated that Resident A had difficulty with understanding minor redirection and being able to accomplish tasks without multiple redirections from staff and encouragement from other residents. HM Kellar stated that Staff Chin-Kee-Fatt resigned her position and no longer works at the home. HM Kellar stated that Resident A is no longer in the home, and she was in the home for less than a month. HM Kellar stated that she was not working the day that Resident A left the home. HM Kellar stated that Resident A was transported to a medication review and while at her appointment she was sent to Trinity Health Livingston Hospital by her psychiatrist to be evaluated. HM Kellar stated that staff drove Resident A to Trinity Health Livingston Hospital where she was admitted and she never came back to the home after that.

On 10/16/2025, I completed an interview with Direct Care Worker (DCW) Maliah Spencer concerning the allegations. DCW Spencer stated that she was not familiar with the allegations but there was a staff who worked at night that needed help with Resident A. DCW Spencer stated that there are always two staff on duty in the morning and afternoon

but at night there was only one staff member working when Resident A was admitted. DCW Spencer stated that they do not have any two-person assist residents in the home but when Resident A moved into the home that she needed more care due to her dementia. DCW Spencer stated that the other residents always encouraged Resident A when a staff would give her redirection. DCW Spencer stated that the other residents encouraged Resident A if they were getting ready to eat dinner and they all were going to the dinner table. DCW Spencer stated that staff would redirect Resident A, but it was really hard to get her to do things as she was kind of out of it and seemed lost. DCW Spencer stated that Resident A's roommate, Resident B, helped Resident A out a lot. Resident B even helped a staff member at night with getting Resident A into bed. DCW Spencer stated that shortly after Resident A moved into the home that a second staff member was put on the schedule for 3rd shift to help with anything that might require two staff members. DCW Spencer stated that Resident A was not in the home very long and is not exactly sure where she went.

On 10/16/2025, I was unable to interview Resident A as she left the home on 09/30/2025. I reviewed Resident A's assessment plan dated 08/22/2025. The plan noted that Resident A understands directions and that staff may need to speak loudly and slowly as she is hard of hearing even with hearing aids. Resident A does not need assistance with toileting, but she does need help with hygiene, hair, nail and prompts for teeth brushing. Resident A uses a walker within the home and a wheelchair in the community. Resident A is unable to move fast or walk long distances due to her pain and swelling in her legs.

I reviewed an Incident Report (IR) dated 09/12/2025. The IR notes that Resident A refused staff's help after getting off the toilet, so staff watched her go back to her room. Resident A cannot get into her bed alone and because there is only one staff member on shift, the staff member asked the other resident occupying the room for help. While the staff member put Resident A in the bed she was being aggressive towards staff and scratched the staff. The staff member tried to redirect Resident A, but it was too late so the staff member put Resident A in the bed and gave her space to calm down. Staff continued to monitor Resident A for health and safety.

On 10/16/2025, I completed an interview with Resident B. Resident B was sitting on her bed in her room at the time of the interview. Resident B appeared neat and clean and was able to communicate. Resident B stated that she was not aware of the allegations but that she did observe residents help staff with Resident A. Resident B stated that she helped staff with Resident A on multiple occasions. Resident B stated that staff asked her to help lift Resident A's legs into bed. Resident B had also helped staff get Resident A out of her bed and into a chair before. Resident B stated that she did not witness Staff Chin-Kee-Fatt asking anyone else to help with Resident A. Resident B stated that she did not help staff every day and that she only helped with Resident A a few times. Resident B stated that she has not seen Resident A in a few weeks and doesn't think that she is coming back.

On 10/16/2025, I completed an interview with Resident C. Resident C was sitting in her chair in her room at the time of the interview. Resident C appeared neat and clean and was able to communicate. Resident C stated that she was not aware of the allegations but that she did witness residents help staff with Resident A. Resident C stated that she likes it at the home and doesn't want to get in trouble for saying anything. Resident C

stated that the staff are nice there and they help everyone out a lot. Resident C stated that residents would help Resident A with little things like putting her slippers on her feet or if she had to go to the bathroom then they would help. Resident C said some residents helped Resident A get in and out of bed. Resident C stated that staff never asked her for any help with Resident A. Resident C stated that Resident A's roommate helped the most. Resident C stated that since she has been this is the first time that residents have helped staff with another resident.

On 10/16/2025, I completed an interview with Resident D. Resident D was sitting in her chair in her room at the time of the interview. Resident D appeared neat and clean and was able to communicate. Resident D stated that she was not aware of the allegations, but she was Resident A's roommate and helped her a lot while she lived there. Resident D stated that she mostly helped her with little things around the room because Resident A couldn't get around too good. Resident D stated that staff did ask her to help with Resident A on occasion as there was only one night staff in the home when Resident A first moved in there. Resident D stated that she liked her roommate, and it wasn't a bother for her to help her at all. Resident D stated that two staff started working the night shift and once the 2nd staff started working at night, they didn't ask her for help anymore.

On 10/27/2025, I attempted to contact Staff Teir Chin-Kee-Fatt via telephone. The phone number was disconnected and there is no forwarding number. Beacon Home of Goodrich had no other contact numbers for Staff Teir Chin-Kee-Fatt.

On 10/27/2025, I completed a phone interview with Resident A's guardian, Guardian A1. Guardian A1 stated that she was not aware of the allegations but did believe they were true based on an Indent Report (IR) that was sent to her regarding Resident A. Guardian A1 stated that other than the IR that she received from Beacon Home of Goodrich that she was not aware of any issues with staff asking residents for help with Resident A. Guardian A1 stated that Resident A was not in the home very long and that she is currently in a long term memory care unit to address her dementia needs. Guardian A1 stated that she has no issues with the care that Resident A received while she was in the home. Guardian A1 stated that it appeared that they provided adequate care to Resident A.

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:	It was alleged that a staff member asked for assistance from other residents because they do not have any other staff working to help her.
	I interviewed the Home Manger, Direct Care Worker, Guardia A1 and Resident B, Resident C and Resident D. Of the parties interviewed they believe that the allegations are true and that staff did ask for assistance from residents to help with the care of another resident. I reviewed an Incident Report dated 09/12/2025, which details that Staff Teir Chin-Kee-Fatt asked another to assist her with the care of Resident A. Upon completion of my investigation, it has been determined that there is a preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	VIOLATION ESTABLISHED

On 10/27/2025, I completed an exit conference with Licensee Designee (LD) Ramon Beltran. I explained the results of the investigation to LD Beltran. LD Beltran did not have any follow up questions.

IV. RECOMMENDATION

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



10/29/2025

Martin Gonzales Licensing Consultant	Date
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Approved By:



10/30/2025

Mary E. Holton Area Manager	Date
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