



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 20, 2026

Karrie Beilfuss  
LifeSpan...A Community Service  
P.O. Box 1978  
Jackson, MI 49204

RE: License #: AS380379307  
Investigation #: 2026A0007014  
Seymour Road Home

Dear Karrie Beilfuss:

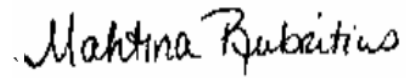
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9720.

Sincerely,

A handwritten signature in black ink that reads "Mahtina Rubritius". The signature is written in a cursive style with a small dot at the end of the last letter.

Mahtina Rubritius, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa  
P.O. Box 30664  
Lansing, MI 48909  
(517) 262-8604

Enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS380379307
<b>Investigation #:</b>	2026A0007014
<b>Complaint Receipt Date:</b>	01/23/2026
<b>Investigation Initiation Date:</b>	01/26/2026
<b>Report Due Date:</b>	03/24/2026
<b>Licensee Name:</b>	LifeSpan...A Community Service
<b>Licensee Address:</b>	PO Box 1978 2111 Bondsteel Drive Jackson, MI 49202
<b>Licensee Telephone #:</b>	(517) 748-7071
<b>Administrator:</b>	Karrie Beilfuss
<b>Licensee Designee:</b>	Karrie Beilfuss
<b>Name of Facility:</b>	Seymour Road Home
<b>Facility Address:</b>	4361 Seymour Road Jackson, MI 49201
<b>Facility Telephone #:</b>	(517) 395-4309
<b>Original Issuance Date:</b>	12/29/2015
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	06/29/2024
<b>Expiration Date:</b>	06/28/2026
<b>Capacity:</b>	5
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

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

	<b>Violation Established?</b>
Kamari Robinson (a former direct care worker), used a blocking pad in an improper way on Resident A.	Yes

**III. METHODOLOGY**

01/23/2026	Special Investigation Intake - 2026A0007014
01/23/2026	Contact - Document Sent - Email to ORR.
01/26/2026	Special Investigation Initiated – Letter - APS referral made.
01/26/2026	APS Referral Made.
01/26/2026	Contact - Telephone call received from LaShanda Walker, Office of Recipient Rights. Discussion.
01/26/2026	Contact - Document Received from ORR. Staff contact information.
01/29/2026	Inspection Completed On-site - Unannounced - Face to face contact with Micheal Dorerty, Kevin Williams, DCW, Resident B, Resident C, Resident D, and Nate Hills, DCW Home Manager.
02/04/2026	Contact - Document Received - APS Referral Denied.
02/27/2026	Contact - Document Sent - Email to LaShanda Walker, Office of Recipient Rights.
02/27/2026	Contact - Document Received - Office of Recipient Rights Summary Report.
03/19/2026	Contact - Telephone call made - Interview with Kamari Robinson previous direct care worker.
03/19/2026	Contact - Telephone call made to Avery Pierce, DCW. Message left.
03/20/2026	Contact - Telephone call made to Employee #1. Interview.
03/20/2026	Exit conference conducted with Karrie Beilfuss, Licensee Designee.

**ALLEGATION: Kamari Robinson (a former direct care worker), used a blocking pad in an improper way on Resident A.**

**INVESTIGATION:**

On January 26, 2026, I spoke with LaShanda Walker, Office of Recipient Rights. She has a pending investigation, as they received allegations that on December 29, 2025, Kamari Robinson, DCW, shoved blocking pads at Resident A to “teach him a lesson.” Kamari Robinson has been terminated. LaShanda Walker informed me that she was trying to get a hold of Kamari Robinson, but his phone number was not working. She interviewed Employee #1, who reported to her that he was outraged by Kamari Robinson’s behavior. Employee #1 informed her that on December 29, 2025, Resident A tore up the staff schedule, and he informed the staff that they might need to figure out a different way to get the information because it was ripped up (by Resident A). Then Kamari Robinson got mad and was going to teach him (Resident A) a lesson. Kamari Robinson went up to Resident A and pushed him with the pads, as if they were “riot shields.” Employee #1 informed her that Kamari Robinson pushed Resident A into the swing. Employee #1 reported to LaShanda Walker that he went outside to cool off, as he was upset and did not want to do anything that would jeopardize his employment.

Avery Pierce, DCW, informed her (ORR) that he was in the living room talking with a consumer (resident) when Kamari Robinson got a pair of blocking pads and shoved them into Resident A. This caused him to stumble into the swing. He removed the other consumers from the area.

She (ORR) also interviewed Jermaine Goodloe, and he reported that Kamari Robinson was told about Resident A ripping up the staff schedule. Kamari Robinson then grabbed the blocking pads and went into the living room. Jermaine Goodloe reported to be in the kitchen with another consumer (resident) and did not see what happened.

On January 29, 2026, I conducted an unannounced on-site investigation and made face to face contact with Micheal Dorerty, DCW, Kevin Williams, DCW, Resident B, Resident C, and Resident D. The staff informed me that Nate Hills, DCW, who also has the role of home manager, was out in the community. The staff also informed me that they heard about the incident but were not at the facility when it occurred. They also informed me that Resident A was at school. I asked if I would be able to interview Resident A and the staff informed me that due to his diagnosis, he would mainly repeat my questions back to me.

I interviewed Resident B, and when I asked how Karmari Robinson treated Resident A, he immediately stated “He used the pads.” Resident B informed me that Kamari Robinson used the (blocking) pads to hit Resident A in his face, when he goes into behaviors. When asked if Resident A had any marks after being hit with the blocking

pads, Resident B replied, "probably not." Resident B also stated that Resident A will try to hit him (Resident B) when he is in behaviors.

I was unable to interview Resident C, due to his diagnosis.

I interviewed Resident D. When asked how Karmari Robinson treated Resident A, he stated "Bad. Get a pad on him." Resident D informed me that this occurred by the couch. According to Resident D, Resident A told Kamari Robinson to "stop it."

Nate Hills, Home Manager, arrived at the facility while I was there. He informed me that he was not at the facility when the incident occurred, but that Karmari Robinson had been let go.

As a part of this investigation, I reviewed the Office of Recipient Rights Summary Report. It was noted that ORR reviewed the *Specialized Residential Progress Note*, dated December 29, 2025, authored by Kamari Robinson. Kamari Robinson documented that Resident A "had a good time today with staff, who went on a car ride and spent some time in the living room afterwards. Talked to parents for a bit then proceeded to go to his room. Took all meds with no issues no behaviors to report all care was met 100%."

It was also noted that ORR reviewed the *Behavior Treatment Plan* for Resident A, which was dated 12/24/2025. The following was documented for the target behavior, Physical Aggression: Staff are to provide "clear verbal prompts to stop the behavior and guide [Resident A] toward an appropriate alternative ("Let's take a break" or "Hands to self"). Repeat 2x.

Intrusive Strategies: Physical Aggression/Property Destruction/Clothes Shredding/Elopement/Inappropriate Urination/Defecation

Ded. staffing-arm's length. Must have staff with [Resident A] 1:1 on second shift 4:00-12:00am and weekends are first shift 8:00-4:00, second shift 4:00-12:00.

Fading plan:

Phase 1 – Arms-Length to Line-of-Sight 1:1

Fade when:

No aggression, elopement attempts, major property destruction, or inappropriate urination/defecation for 4 weeks.

Follows redirection without escalating.

Phase 2 – Line-of-Sight 1:1 to 1:2 Support

Fade when:

No crisis behaviors or safety concerns for 6 weeks.

No aggression, elopement, or bathroom incidents.

Demonstrates regulation during routine activities.

### Phase 3 – 1:2 Support to Standard Staffing

Fade when:

No unsafe behaviors for 8 weeks.

Uses coping skills and break requests independently.

Maintains safety and stability across all shifts.”

On March 19, 2026, I interviewed Kamari Robinson. I introduced the topic and inquired about the incident; he stated that it never happened. He stated that his previous employer was just going off what someone else said but they had no proof and no blocking pad was ever used. He stated he knew how to use the blocking pad if needed. Kamari Robinson expressed frustration, stating that this situation was keeping him from obtaining other employment in this field. He stated that he may get an attorney because they expect him to just live with this information on his record and it's not correct. He stated that when they (previous employer) first told him about it, he didn't get mad because he knew it wasn't true. Kamari Robinson went on to say that when he tried to talk to them (previous employer), they said that multiple people had reported. I asked about the staff schedule, and he stated he wasn't there when it occurred. He had left to go get lunch and when he came back, Avery Pierce told him that he (Resident A) had ripped it up. Kamari Robinson stated that he asked Resident A what was wrong and what made him do that. Kamari Robinson stated that Resident A replied stating "I don't know." Kamari Robinson recalled that pictures had also gotten taken of the wall and thrown into the trash, and he asked Resident A to go and get them, which he did. During the interview, Kamari Robinson was adamant stating that he never used the pad to push Resident A. Kamari Robinson stated that Resident A only had behaviors when his medications were being switched, and that he would also hit other residents. Kamari Robinson reported to get along with Resident A, that he was often assigned as his 1:1 staff, and Resident A knew his schedule when he would be working. He stated that Resident A enjoyed going for rides in the car.

On March 20, 2026, I interviewed Employee #1. On December 29, 2025, he went to work and everything was normal in the house. Karmari Robinson and Jermaine Goodloe took two residents out in the community for approximately 45 minutes. Employee #1 and Avery Pierce were at the facility with the other residents. While they were at the facility, Resident A went into the kitchen and ripped up the staff schedule and threw it on the floor. Employee #1 stated it was no big deal, and he was like whatever. Employee #1 asked Resident A to pick up the papers, which he did, with only one verbal prompt. Once Karmari Robinson and Jermaine Goodloe returned to the facility, Avery Pierce told Kamari Robinson that Resident A had ripped up the staff schedule. Resident A was in his bedroom and Karmari Robinson went and grabbed a defensive pad, went into the room and while holding the pad above his head he then hits Resident A with it. Resident A ran out of the bedroom and Karami Robinson followed him, hitting him with the pad while in the living room. Employee #1 stated that Karmari Robinson was offensively using the pads, not defensively using them. Employee #1 stated that Karmari Robinson was using the pad like a riot shield that police officers use to shove people in a crowd. Employee

#1 stated that Resident A was not hitting Karmari Robinson or having a behavior. Employee #1 confirmed that Karmari Robinson stated he wanted to teach Resident A a lesson. Employee #1 stated that he was so upset that he had to step outside for a couple of minutes. He was very upset with how Kamari Robinson was treating Resident A. He stated that Kamari Robinson should never work as a direct care provider again. He stated that Resident A shreds his clothing often, and that Resident A had (physical aggression) behaviors on occasion, but staff usually could talk to him and redirect him.

As a part of this investigation, I reviewed a previous investigation SIR# 2025A0007023, dated June 17, 2025. The allegations were regarding a direct care staff member yelling at and poking a resident because he repeatedly asked to go on an outing. The direct care worker charged at the resident, cornering him, wrestling him and broke the door frame. These allegations were substantiated (R 400.14305 (3)), as it was found that the direct care staff member mistreated the resident. The licensee submitted a written corrective action plan which documented the following related information:

- “1. LifeSpan will reinforce a zero-tolerance policy for physical aggression or unprofessional conduct to ward residents. All staff will complete a refresher training in Safety Care, focusing on de-escalation techniques.
2. Trauma-informed care principles will be integrated into all staff training to strengthen support for residents with behavioral health needs.
3. Monthly supervisory check-ins will be conducted to assess staff-resident interactions and ensure continued staff support and accountability.”

On March 20, 2026, I conducted the exit conference with Karrie Beilfuss, Licensee Designee. We discussed the investigation and my recommendations. I explained my concerns regarding the current investigation and previous investigations with related allegations. We discussed that disciplinary action against the license could be recommended, if there continued to be substantiated allegations such as these. Karrie Beilfuss stated that she agreed with me regarding my concerns and reported to be equally concerned. Karrie Beilfuss expressed frustration regarding staff who made these inappropriate decisions and actions. She also stated that they immediately address any issues brought to their attention, suspending the individual, and they continue to have a zero-tolerance policy for physical aggression and unprofessional conduct towards residents. We discussed staffing, revisiting training modules, staff burnout, mental health breaks, and scheduling. Karrie Beilfuss agreed to submit a written corrective action plan to address the established violation.

<b>APPLICABLE RULE</b>	
<b>R 400.641</b>	<b>Resident behavior interventions.</b>
	<b>(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.</b>
<b>ANALYSIS:</b>	Based upon my investigation, which consisted of an unannounced on-site investigation, interviews with ORR, facility staff, residents, previous staff, and review of relevant information, it's concluded that there is a 51% preponderance of the evidence to support the allegations that on December 29, 2025, Kamari Robinson mistreated Resident A by hitting and pushing him with blocking pads after learning that Resident A had torn up the staff schedule.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Contingent upon receipt of a detailed written corrective action plan, it's recommended that the status of the license remains unchanged.

*Mahtina Rubritius*

3/20/2026

Mahtina Rubritius  
Licensing Consultant

Date

Approved By:

*Dawn Timm*

03/20/2026

Dawn N. Timm  
Area Manager

Date