GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 5, 2025

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

RE: License #: AM590387872
Investigation #: 2025A1029048
Beacon Home At The Cottage

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 licensee designee 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. 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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

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 #:	AM590387872
Investigation #:	2025A1029048
Complaint Receipt Date:	07/16/2025
Investigation Initiation Date:	07/16/2025
Report Due Date:	09/14/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St. Suite 110, Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At The Cottage
Facility Address:	1550 E. Colby Road, Stanton, MI 48888
Facility Telephone #:	(989) 831-0625
Original Issuance Date:	01/30/2018
License Status:	REGULAR
Effective Date:	07/30/2024
Expiration Date:	07/29/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member Tasha Smith has been disrespectful to Resident A and Resident B.	Yes

III. METHODOLOGY

07/16/2025	Special Investigation Intake 2025A1029048
07/16/2025	Special Investigation Initiated – Letter to ORR Keegan Sarker
07/22/2025	Contact - Email and telephone call to Cheryl Shook
07/22/2025	APS Referral made to Centralized Intake
07/23/2025	Inspection Completed On-site- face to face with Cheryl Shook, Resident A, Resident B, Resident C, Dana Strong, Kennedy Wernette, Tammy Everest at Beacon Home at the Cottage
07/23/2025	Contact - Document Sent- Email sent to Ms. Fairris
07/24/2025	Contact - Telephone call made to Janet Hollister, # unavailable
07/25/2025	Contact - Document Received from Emily Fairris
07/29/2025	Contact - Telephone call made to AFC Licensing consultant Matthew Sonderquist
07/30/2025	Contact - Telephone call made to Tasha Smith (left message) and called Beacon house phone to reach her (she has been terminated), email to Emily Fairris, Janet Hollister, administrator Roxanne Goldammer
07/31/2025	Contact – Telephone call made to Tasha Smith. Left message and sent text message, ORR Keegan Sarker (left message/sent email), licensee designee Ramon Beltran
07/31/2025	Exit conference with licensee designee Ramon Beltran.
08/01/2025	Contact – Document received from Emily Fairris.

ALLEGATION: Direct care staff member Tasha Smith has been disrespectful to Resident A and Resident B.

INVESTIGATION:

On 07/16/2025 a complaint was received via Bureau of Community and Health Systems online complaint system alleging direct care staff member Tasha Smith has been disrespectful to residents because she bangs on Resident A's door to wake him up each day and then proceeds to kick his bed.

On 07/23/2025 I completed an unannounced on-site investigation at Beacon Home at the Cottage and interviewed direct care staff member, whose current role is home manager, Ms. Shook. Ms. Shook stated she observed Ms. Smith knocking repeatedly on Resident A's door to alert Resident A that it was time for medication and she told Ms. Smith that she had already tried to wake Resident A so she needed to give it some time. Ms. Shook stated she was able to verify in the Beacon Specialized Living policy manual that direct care staff members are to prompt a resident three times for medications and there is a two hour window to administer medications so she should not have been urgently trying to wake Resident A at 7 AM. Ms. Shook stated they have now discovered Resident A plans to set an alarm and wakes up at 8:30 AM however this was not communicated to direct care staff members when he moved in. Ms. Shook stated Ms. Smith was prompting Resident A too much because she kept knocking on his door every three minutes to get him to wake up. Ms. Shook stated she did not observe Ms. Smith kicking Resident A's bed.

I interviewed Resident A who stated he had an issue with Ms. Smith because she bangs on his door repeatedly starting at 7 AM and he can wake himself up with an alarm. Resident A stated he did not know if he told Ms. Smith about the alarm. Resident A stated she stopped banging on his door because supervisor Ms. Shook let her know that he shouldn't be prompted that much. Resident A stated when he did not get up Ms. Harris came into his room and put her foot on his mattress and started to kick at it. Resident A stated he did not know what was on her shoes and he thought it was gross she would put her foot on his bed. Resident A stated he didn't know how many days she banged on his door; however, she put her foot on his bed and kicked it two separate times.

I interviewed Resident B who stated he heard Ms. Smith prompting Resident A to get up several times. Resident B stated Ms. Smith has told him he stinks and needs to take a shower. Resident B stated Ms. Smith has told him "I don't give a flying fuck" when he tries to talk to her. Resident B stated he was going to give her a drink and she told him "Please don't fucking touch my drink" but he said he wasn't going to drink it, he just was going to give it to her. Resident B stated he didn't feel safe when she works because of how she acts.

I interviewed Resident C who stated his room is upstairs so he didn't know how direct care staff Ms. Smith prompted residents who live downstairs to get up but Resident C

stated direct care staff Ms. Smith yells up the stairs for them to get up. Resident C stated she was yelling so she could be heard upstairs not to be mean. Resident C stated Ms. Smith has never kicked his bed at any time and he's always witnessed positive interactions with her.

I interviewed direct care staff members Dana Strong, Kennedy Wernette and Tammy Everest. Ms. Strong stated direct care staff are required to prompt residents for medications three times per Beacon policies and typically this is done in half hour intervals so no direct care staff member should be repeatedly pounding on a resident's door. Ms. Everest stated she overheard Ms. Smith being disrespectful to Resident B and she heard Ms. Smith tell Resident B it was his fault that she was suspended for five days. Ms. Wernette stated she observed Ms. Smith swear at residents and specifically stated that, "she (Ms. Smith) likes to use the F word with [Resident B]" when she's working. Ms. Wernette stated she has heard Ms. Smith tell Resident B that "his feet were fucking disgusting." Ms. Strong and Ms. Everest also confirmed they heard Ms. Smith say this to Resident B. Ms. Strong stated Resident B is one of the more challenging residents and that Ms. Smith does not seem to be able to handle his behaviors. Ms. Strong stated she informed Ms. Smith that she cannot talk to the residents like this but she argues back to her.

I was able to verify Ms. Smith completed all required AFC trainings. Ms. Smith had a "Counseling Form" in her employee record from 06/12/2025 for telling Resident B that his "fucking feet stink and this upset the resident. The resident filed a recipient rights complaint that resulted in substantiation."

I was able to review the "Change of Status" form showing she was terminated effective 07/20/2025 and was not eligible for rehire.

On 07/30/2025 I interviewed direct care staff member Janet Hollister. Ms. Hollister stated Resident A now gets up at 8:30 AM but she had observed Ms. Smith knocking hard on the door and Resident A informed her she stomped hard on the mattress to wake him up. Ms. Hollister stated she was told direct care staff had to bang hard on Resident A's door to wake up because he uses a CPAP machine. Ms. Hollister stated her process in waking Resident A up was to knock, open the door, and then flip the light on. Ms. Hollister stated she heard Ms. Smith knocking and it was probably about 15 minutes apart trying to get him up. Ms. Hollister stated it was excessive because they should be waiting longer to wake someone up. Ms. Hollister stated she does not know if there is a set limit on how many times to prompt a resident but direct care staff start medication administration at 7 AM and an hour window is scheduled medications at 8 AM.

Ms. Hollister stated Ms. Smith and Resident B did not get along well because Resident B was rude with Ms. Smith who would "get rude back to him" and they argued. Ms. Hollister stated she has never heard Ms. Smith swear at Resident B but she stated Ms. Smith told her one time she got so upset with Resident B and blew up on him because he was acting like he was going to drink her drink so she said, "that's my drink, don't

you fucking touch it." Ms. Hollister stated she has heard Ms. Smith tell the residents they smell bad. Ms. Hollister stated she believed Ms. Smith was "all right but gets a little rude when she's overwhelmed" at times.

On 07/30/2025 I interviewed administrator Roxanne Goldammer. Ms. Goldammer stated Office of Recipient Rights was also investigating concerns regarding Ms. Smith's demeanor toward Resident B which resulted in a substantiation for dignity and respect leading to Ms. Smith's termination from her position on 07/20/2025. Ms. Goldammer stated she remembers reading the report regarding her over prompting Resident A and knows that she was kicking his bed and being rude about waking him up.

On 07/31/2025 I interviewed former direct care staff member Ms. Smith. Ms. Smith stated Resident B was continuously upset with her and she was getting ready to redo her recipient rights training when she was fired. Ms. Smith stated she did swear at Resident B because she told him his "fucking feet stunk" and that's why she had to do the recipient rights training again. Ms. Smith stated Resident A has a CPAP machine so she had to knock more than normal because he could not hear with the machine. Ms. Smith stated she did not know that was an issue until after the incident and she apologized to Resident A. Ms. Smith stated they did fix the issue because now he has an alarm that is set and they only prompt him twice now after the alarm. Ms. Smith stated she did go into the room one time and nudged her foot on the bed but she did not aggressively kick the bed, but she did not know it was an issue until he told the managers that he did not want someone's foot on the bed. Ms. Smith stated she felt she was "super nice to the residents and treated them like humans". Ms. Smith stated telling Resident B about his feet was the only time she swore at a resident and she knows that it should not have been said but she stated it was "in a moment", she thought he was sleeping, and "her mouth got the best of her" so she verbally said it out loud.

On 07/31/2025 I interviewed licensee designee Mr. Beltran. Mr. Beltran stated he did not have additional information about Ms. Smith's demeanor with the residents. Mr. Beltran stated Ms. Smith has been terminated from her position after they received the report showing the substantiation for dignity and respect from Recipient Rights. Mr. Beltran stated he would prepare a corrective action plan to address these issues moving forward and submit a copy of Ms. Smith's termination paperwork.

On 07/31/2025 I interviewed ORR Ms. Sarker. Ms. Sarker stated she investigated concerns about Ms. Smith being rude about waking Resident A up by kicking the bed, however she did not have the investigation for Resident B. Ms. Sarker stated she is investigating the concerns regarding Resident A and will be substantiating for "dignity and respect." Ms. Sarker stated it's possible there is another investigation with a different Recipient Rights office but she did not have the information regarding Ms. Smith's treatment toward Resident B because he is not a recipient of services through Community Mental Health of Central Michigan.

On 08/01/2025, I received a document from Beacon Specialized Living Director of Compliance, Emily Fairris titled "Administration In-Service and Evaluation" which

outlines the steps which show if a direct care staff member is ready to administer medications. This form includes the following instructions under #28:

> *"Refusal of Medication procedures (prompt **3** times, then complete IR/ER as applicable) If medication has been popped, store in a sealed baggie labeled with their initial, time, and date in their medication folder. If medication is not administered per approval as applicable dispose at end of shift."*

There were two previous special investigations for Beacon Home at the Cottage which also included this violation. This violation is a repeat violation because of Special Investigation 2024A0622019 dated 03/25/2024 and 2023A1038003 dated 08/28/2023 cited this violation. A corrective action plan was completed for both investigations.

- 2024A0622019 dated 03/25/2024 – Direct care staff member Nathan Combs was driving erratically and swearing in the presence of residents.

- 2023A1038003 dated 08/28/2023 – Direct care staff member Cassandra Lewis used derogatory language in front of a resident and argued with a coworker in his presence.

APPLICABLE RULE	
R400.14304	**Resident rights; licensee responsibilities.**
	Rule 304. (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 the interviews with Ms. Shook, Ms. Everest, Ms. Hollister, Ms. Strong and Ms. Wernette along with Resident A and Resident B, there is evidence Resident A and Resident B were not treated with dignity because Ms. Smith repeatedly knocked on Resident A's door and then proceeded to kick Resident A's mattress while trying to wake him up. Ms. Smith also used profanity while speaking to Resident B resulting in ORR substantiating concerns against Ms. Smith for dignity and respect. According to Ms. Goldammer, she was terminated from her position on 07/20/2025.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SIR # 2024A0622019 DATED 03/24/2024 AND 2023A1038003 DATED 08/28/2023. CAP COMPLETED FOR BOTH INVESTIGATIONS.]**

IV. RECOMMENDATION

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

Jennifer Browning _____08/05/2025_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 08/05/2025

_____

Dawn N. Timm Date
Area Manager