



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

October 15, 2025

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

RE: License #: AS370405093  
Investigation #: 2025A1029058  
Beacon Home At Mt Pleasant

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated by the licensee designee.

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,

A handwritten signature in black ink that reads "Jennifer Browning". The script is cursive and fluid, with the first letter of each word being capitalized and larger than the others.

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

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS370405093
<b>Investigation #:</b>	2025A1029058
<b>Complaint Receipt Date:</b>	09/15/2025
<b>Investigation Initiation Date:</b>	09/16/2025
<b>Report Due Date:</b>	11/14/2025
<b>Licensee Name:</b>	Beacon Specialized Living Services, Inc.
<b>Licensee Address:</b>	890 N. 10th St. Suite 110, Kalamazoo, MI 49009
<b>Licensee Telephone #:</b>	(269) 427-8400
<b>Administrator:</b>	Roxanne Goldammer
<b>Licensee Designee:</b>	Ramon Beltran
<b>Name of Facility:</b>	Beacon Home At Mt Pleasant
<b>Facility Address:</b>	4659 S Leaton Rd, Mt Pleasant, MI 48858
<b>Facility Telephone #:</b>	(269) 427-8400
<b>Original Issuance Date:</b>	11/16/2020
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	05/16/2025
<b>Expiration Date:</b>	05/15/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
On 09/11/2025 direct care staff member Annmarie Hagle did not provide the required 1:1 line of sight supervision to Resident A while he was outside which resulted in injury to his shoulder.	Yes

**III. METHODOLOGY**

09/15/2025	Special Investigation Intake 2025A1029058
09/16/2025	Special Investigation Initiated – Letter to ORR Katie Hohner
09/18/2025	Inspection Completed On-site - Face to Face with Resident A, direct care staff members Ms. Foster, Ms. Carter, Ms. Jones, Ms. Pannill at Beacon Home at Mt. Pleasant
09/23/2025	APS Referral made to Centralized Intake
10/02/2025	Contact - Telephone call made to direct care staff member Ms. Beals, licensee designee Ramon Beltran
10/09/2025	Contact - Telephone call made to direct care staff member Annmarie Hagle, Ms. Beals, licensee designee Mr. Beltran, and administrator Ms. Goldammer
10/09/2025	Exit Conference with licensee designee Ramon Beltran
10/14/2025	Contact – Telephone call received from APS Caitlin Fick

**ALLEGATION: On 09/11/2025 direct care staff member Annmarie Hagle did not provide the required 1:1 line of sight supervision to Resident A while he was outside which resulted in injury to his shoulder.**

**INVESTIGATION:**

On 09/15/2025 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns that on 09/11/2025 direct care staff member Annmarie Hagle did not provide the required line of sight supervision to Resident A while he was outside which resulted in injury to his shoulder. Office of Recipient Rights (ORR) advisor Katie Hohner was also assigned to investigate these concerns.

On 09/18/2025 I completed an unannounced on-site investigation at Beacon at Mt. Pleasant and interviewed direct care staff member Diamond Jones. Ms. Jones stated

she worked from 1-9 PM on 09/09/2025 and she was assigned as 1:1 coverage for Resident B. Ms. Jone stated when she arrived to work at 1 PM she noticed that Resident A was outside lying on the grass with a comforter and Annmarie Hagle who was assigned to provide 1:1 staffing coverage to Resident A was sitting in the chair in the living room. Ms. Jones stated Resident A still requires 1:1 staffing supervision at all times except when he's in the bedroom. Ms. Jones stated if Resident A is outside or anywhere within the community, direct care staff must be able to see Resident A at all times. Ms. Jones stated Ms. Hagle is a new employee but she was aware she was assigned as Resident A's 1:1 coverage. Ms. Jones stated Resident A did not start complaining about his arm hurting until he refused his 3 PM medications. Ms. Jones stated Resident A stated his arm hurt but he was asking for ice cream before telling her he ran into a tree.

I interviewed direct care staff members Arkeshia Foster and Alajah Carter who both worked on 09/09/2025. Ms. Foster stated they alternate direct care staff members who are providing 1:1 staffing coverage because Resident A and Resident B are the only residents who require 1:1 staffing now. Ms. Foster stated she worked on 09/09/2025 from 5 AM -1 PM and was not aware of Resident A hurting his arm until she came to work the following day. Ms. Carter stated at first Resident A said he did not know how he was hurt but then he stated he ran into a tree. Ms. Carter stated Resident A has behaviors often and he will bang his head so it is likely that he could have hurt himself on a tree.

On 09/18/2025 I interviewed direct care staff member, whose role is home manager, Kendra Pannill. Ms. Pannill stated Resident A was taken to the emergency room because he was in his bedroom saying his arm hurt. Ms. Pannill stated she believes this incident occurred between 12 PM - 1 PM because the log states that he was outside and Ms. Hagle was in his room cleaning. Ms. Pannill stated this should not have occurred because Ms. Hagle would not be able to see Resident A from his bedroom while he was outside. Ms. Pannill stated when she arrived to work at 1:45 PM she assumed Resident A was in his bedroom because Ms. Hagle was sitting in the chair in the living room. Ms. Pannill stated she did not have any reason to think he was not in his room so she went back to her office to begin work. Ms. Pannill stated she did not realize Resident A was outside. Ms. Pannill stated Resident A did not want to take his medication and informed the direct care staff members his arm hurt around 2:30 PM and she did look it over and offered him ice. Ms. Pannill stated when she did this, Ms. Hagle stood up and said "I know his arm isn't broken" but did not offer additional explanation about what occurred. Ms. Pannill stated she informed Ms. Beals to wait for Resident A's medications and then she received a call at 7:30 PM from Ms. Beals because they noticed his right shoulder looked out of place but there was no bruise on it when he was taking a bath. Ms. Pannill stated Ms. Hagle has been suspended pending the outcome of this investigation.

I also interviewed Resident A who informed me he hit his arm on the tree because he said that he "walked into the tree and it went boom" and could not give additional

information regarding the concerns. Resident A appeared to be holding his arm during the interview but stated that it did not hurt.

During the on-site, I reviewed the following documents pertaining to this incident:

1. I reviewed the *AFC Incident / Accident Report* for the incident which states:
  - a. Explain what happened: He [Resident A] was screaming his arm hurt left alone in his room because he was having a behavior for 10 minutes to calm down.
  - b. Action taken by staff: DMA called on call and they said to call on call medical. On call medical stated Resident A needed to go to ER. Staff took Resident A to the ER.
  - c. Corrective measures: As the care team manager of the home, I looked into the situation and heard from a couple staff that the 1:1 was not in line of sight with Resident A. I called Recipient Rights. Staff will be trained again on Resident A's line of sight per his Behavior Treatment Plan. Management will continue to reach out to the Office of Recipient Rights when needed.
2. I also reviewed the hourly enhanced CLS staffing documentation sheets filled out by Ms. Hagle.
  - 9 to 10 AM [Resident A] was awake when staff arrived. [Resident A] was walking around. Staff was cleaning up the kitchen.
  - 10 AM to 11 AM [Resident A] was hungry. Staff made him toast. Staff did the dishes. [Resident A] ate all his toast.
  - 11 AM to 12 PM [Resident A] and staff went for a sensory van ride came back and eat lunch while staff swept the living room.
  - 12 PM to 1 PM [Resident A] was good sitting outside while staff cleaned his room.
  - 1 PM to 2 PM [Resident A] was redirected when they were cutting the grass. He did not want to listen.
  - 2 PM to 3 PM [Resident A] refused his medications, said that he was afraid to come out.
  - 3 PM to 4 PM [Resident A] refused the second time with medication saying his arm hurts but nothing happened. Staff was watching him.
  - 4 PM to 5 PM [Resident A] went into the tub to take a bath. Staff assisted him.
  - [Resident A] was taken to the emergency room at 7 PM according to this log.
3. Staffing schedule for 09/09/2025 showing Ms. Hagle was scheduled to work from 9 AM – 9:30 PM and was assigned to provide 1:1 staffing coverage for Resident A.
4. Attestation for Resident A's *IPOS In-service Form* showing that Ms. Hagle has read and understood the documents in his plan of service on 07/30/2025.

5. Resident A's *Assessment Plan for AFC Residents* which states he requires 1:1 at all times.
6. Resident A's *Community Mental Health Person Centered Plan* from 10/30/2024 which states:  
*"He [Resident A] requires 24/7 supervision and assistance with his activities of daily living and life skills and has one to one enhanced staffing. Due to [Resident A]'s aggressive and physically destructive behaviors he requires enhanced staffing in the home and community to provide adequate support and ensure the safety of him and others."*
7. Resident A's *Community Mental Health Behavior Treatment Plan (BTP)* updated 02/10/2025:  
*"[Resident A] will be provided with 1:1 line of sight staffing for 16 hours during the waking hours when he is not in his bedroom. The designated staff should be able to see him but may be at a distance of several feet or more staff may need to be closer to him to provide needed support and intervention for periods of time but this is not required at all times. The 1:1 supervision must be provided by a designated staff member that does not have any other supervision responsibilities while providing support to [Resident A]."*
8. Provider Contact form showing he was taken to the emergency room on 09/09/2025 for his right shoulder and was given a sling, Tylenol, and instructions to follow up with family members doctor. After Visit Summary for this incident shows a diagnosis of anterior dislocation of right shoulder; initial encounter.

On 10/02/2025 I interviewed direct care staff member Cindra Beals. Ms. Beals worked on 09/09/2025 from 9 AM - 9:30 PM and was assigned as the DMA who is responsible for meals, laundry, and medications for all residents. Ms. Beals stated Ms. Hagle was assigned to provide 1:1 staffing to Resident A for the day. Ms. Beals stated Ms. Hagle went into Resident A's room to clean but while she was in there Resident A went outside to the backyard and Ms. Hagle came out to the living room to sit down. Ms. Beals stated she told Ms. Hagle, "you know you cannot leave him outside by yourself, right?" and she said "I know... I will go check in on him in a minute". Ms. Beals stated she resumed working and Resident A came in, went to his room and he said "My arm hurts" around 2:30 PM and refused to take his medication. Ms. Beals stated they informed Ms. Pannill Resident A refused to take his medication and she said to wait to ask him again. Ms. Beals stated at 3:30 he still would not take it so she put it down as a refusal. Ms. Beals stated Resident A informed her that his arm hurt so she looked at it and did not observe any obvious injury or bruising. Ms. Beals stated there are times when Resident A will fake an injury so he can go to the emergency room. Ms. Beals stated that Ms. Hagle gave him a bath and he continued to hold his arm. Ms. Beals stated around 7PM when he came back to the living room and was sitting on the couch, she could tell his shoulder was out of place. Ms. Beals stated she told the other staff she thought his shoulder was out so she informed Ms. Pannill his shoulder was sore and they advised her to call medical. Ms. Beals stated Ms. Hagle was scheduled to

begin work again at 5 AM so she decided to take Resident A to the emergency room instead. Ms. Beals stated although there are two windows in Resident A's bedroom, that does not count for 1:1 staffing supervision. Ms. Beals stated Ms. Hagle could not see Resident A when he was outside and she was in the living room.

On 10/09/2025 I interviewed direct care staff member Annmarie Hagle. Ms. Hagle stated she was assigned to provide 1:1 supervision for Resident A on 09/09/2025 and the whole day she was with him and checking on him. Ms. Hagle stated Resident A was having a behavior where he was swearing and upset so Ms. Beals told her not to be in the room with him because he gets very violent. Ms. Hagle stated because of that she left him alone in his room and would check on him and he was fine. Ms. Hagle stated that he started to say that his arm hurt and he wouldn't let anyone look at it or touch it. Ms. Hagle stated she does not know what happened because "she just left him for a couple minutes." Ms. Hagle stated he was outside around 1-2 PM and she was in his room straightening up and she could see right outside the window. Ms. Hagle stated there was no point he was outside and she was sitting in the living room. Ms. Hagle stated she was trained on Resident A's 1:1 supervision requirement and she has worked there for a couple months. Ms. Hagle stated Resident A did not say anything to her about what happened. Ms. Hagle stated there was no time when he was outside that she could not see him. Ms. Hagle stated when she was watching him, he was sitting on the grass with a blanket around him. Ms. Hagle stated around 7 PM after he came out of the bath that he came out without a shirt on Ms. Beals noticed his shoulder did not look well. Ms. Hagle stated she is no longer working at Beacon Home at Mt. Pleasant because she was terminated two days ago as a result of this incident.

On 10/09/2025 I interviewed Ms. Beals again and Ms. Beals denied she ever told Ms. Hagle that she should stay away from Resident A due to his behaviors but she did tell her that she should be with Resident A outside. Ms. Beals stated the manager Ms. Pannill was also there so if Ms. Hagle had any questions about what to do she could have gone to her.

On 10/09/2025 I interviewed licensee designee Ramon Beltran. Mr. Beltran stated he heard about this incident with Resident A and he said Ms. Hagle was suspended pending the investigation. Mr. Beltran stated all direct care staff members are trained regularly on Resident A's supervision requirements and this training will continue.

On 10/9/2025 I interviewed administrator Roxanne Goldammer. Ms. Goldammer stated Ms. Hagle was substantiated for the ORR investigation and she was terminated from her position as a result. Ms. Goldammer stated she does not know how Resident A hurt his shoulder because he is very quick but Ms. Hagle was not providing the required supervision at the time of this injury. Ms. Goldammer stated Ms. Hohner and her have trained direct care staff members several times specifically telling staff that Resident A cannot be supervised while staff are working in his bedroom and he is elsewhere. Ms. Goldammer stated she does not believe that Ms. Beals would have told her to stay away from Resident A due to his behaviors.

Special Investigation Report #2024A1029008 from 12/15/2023 also cited rule 400.14303 (2) because on 10/20/2023 direct care staff member Arden Pitts was not providing Resident A 1:1 staffing coverage when he left the facility and walked down the street approximately .5 mile to the church with no shoes on and covered in mud. A corrective action plan was approved on 12/08/2025 which stated training acknowledgments would be completed with all staff on 1:1 staffing duties, a discussion took place at a staff meeting regarding supervision, and the staff involved in that incident received a written disciplinary notice that would be placed in their employment record.

<b>APPLICABLE RULE</b>	
<b>R 400.14303</b>	<b>Resident care; licensee responsibilities.</b>
	<b>(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.</b>
<b>ANALYSIS:</b>	Based on the interviews with Ms. Hagle, Ms. Jones, Ms. Pannill, Ms. Foster, Ms. Carter, administrator Ms. Goldammer, and licensee designee Mr. Beltran there is evidence to determine Resident A was not supervised according to his <i>Assessment Plan for AFC Residents</i> and <i>Person Centered Plan</i> which mandates 1:1 staffing coverage at all times. Ms. Hagle was not supervising him appropriately because she was not outside with Resident A. Resident A's shoulder was injured during this time and Ms. Hagle has no information about how the injury occurred. Resident A was taken to the doctor and he was diagnosed with an anterior dislocation of his right shoulder.
<b>CONCLUSION:</b>	<b>REPEAT VIOLATION ESTABLISHED [SIR # 2024A1029008 DATED 10/24/2023. CAP COMPLETED.]</b>

**IV. RECOMMENDATION**

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

*Jennifer Browning*

Jennifer Browning  
Licensing Consultant

10/15/2025

Date

Approved By:

*Dawn Timm*

10/15/2025

Dawn N. Timm  
Area Manager

Date