GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 9, 2026

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

RE: License #: AS370405093
Investigation #: 2026A0622009
Beacon Home At Mt Pleasant

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 (517) 335-5985.

Sincerely,

Amanda Blasius, 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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS370405093
Investigation #:	2026A0622009
Complaint Receipt Date:	11/25/2025
Investigation Initiation Date:	11/25/2025
Report Due Date:	01/24/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldammer
Licensee Designee:	Ramon Beltran
Name of Facility:	Beacon Home At Mt Pleasant
Facility Address:	4659 S Leaton Rd Mt Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/16/2020
License **Status:**	REGULAR
Effective Date:	05/16/2025
Expiration Date:	05/15/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care workers Alajah Carter and Paula Brenner were redirecting residents to stay in their rooms and were denying them food or drinks.	No
Direct care workers, Alajah Carter, Paula Brenner, and Cindra Beals were calling residents names and using profanity toward residents.	No
On 11/21/2025, direct care worker, Arkesha Foster left her one on one shift for Resident A early, leaving another staff member to supervise Resident A and the other residents within the home. On 11/22/25, direct care worker, Jacob Barr found Staff Diamond Jones sleeping and Staff Alajah Carter was not at work but then returned to work about 40 minutes later.	Yes

III. METHODOLOGY

11/25/2025	Special Investigation Intake 2026A0622009
11/25/2025	Special Investigation Initiated - Telephone
12/09/2025	Contact – Voicemail left for DCW Jacob Barr
12/12/2025	Inspection Completed On-site
01/02/2026	Inspection Completed-BCAL Sub. Compliance
01/05/2026	Contact- telephone call to direct care workers, Aaron Guy, Kendra Pannill and Jacob Barr.
01/07/2026	Voicemail left for direct care worker, Diamond Jones
01/08/2026	Voicemail left for direct care worker, Diamond Jones. Documentation received.
01/08/2026	Exit conference with licensee designee, Ramon Beltran
01/12/2026	APS referral made

ALLEGATION: Direct care workers Alajah Carter and Paula Brenner were redirecting residents to stay in their rooms and were denying them food or drinks.

INVESTIGATION:
On 12/04/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, on 11/30/2025, direct care workers (DCWs) Alajah Carter and Paula Brenner were redirecting residents to stay in their rooms and were denying them food or drinks.

On 12/04/2025, additional contact information and details was obtained through the office of Recipient Rights.

On 12/09/2025, a voicemail was left for direct care worker, Jacob Barr.

On 12/12/2025, I completed an unannounced onsite investigation to Beacon Home at Mt. Pleasant. During the unannounced onsite investigation, I interviewed direct care workers. Residents were unable to be interviewed due to their developmental disabilities.

On 12/12/2025, I interviewed direct care worker Paula Brenner in person. DCW Brenner reported that on 11/30/2025, she worked her shift with Alajah Carter and Aaron Guy. DCW Brenner stated that the only reason why residents would be told to stay in their rooms is when Resident A goes into a behavior, he tends to throw things and hurt others. Therefore for the safety of the other residents they encourage them to go to their rooms until Resident A is calmer. DCW Brenner explained that they do not force the residents to go to their rooms, nor stay in their rooms, they just encourage and ask them for their own safety. DCW Brenner reported that she would not deny residents any food or drink. She explained that if they are getting ready to serve lunch or dinner, they do ask the residents to wait a few minutes instead of having a snack right before the meal is served. DCW Brenner also stated that on 11/30/2025, Resident A was given many snacks and drinks, but he kept dumping them out on the floor. She reported that after several times of dumping his snack and drink onto the floor, he was told that he could not have any more if he was going to continue to dump it onto the floor.

On 12/12/2025, I interviewed direct care worker, Alajah Carter in person. She reported that she worked on 11/30/2025 from 9am-9pm. DCW Carter confirmed that she did not force residents to stay in their bedrooms. She explained DCWs only encourage residents to go to their rooms if Resident A is having a behavior as he can become very physical towards staff and others. DCW Carter stated that the only reason they would deny any snacks would be if they ask for a snack right before a meal and then staff would ask them to wait until after the meal. DCW Carter stated that the residents eat snacks throughout the day, and staff are not denying them any snacks or drinks if it’s between mealtimes.

Resident A's *Person Centered Plan* (PCP) was reviewed. According to his PCP, Resident A will have at least four snacks per day, in addition to regular meals to help curb his target behaviors as evidenced by staff report, progress notes and data charting. Resident A's PCP also stated the following:

"Risk related to eating: [Resident A] has PICA and is a risk to eating inedible items. He also is a risk to choking due to his PICA. Staff report that [Resident A] would binge food if he had the opportunity. [Resident A] has made himself vomit when he has eaten too much food in the past. Staff to monitor [Resident A] to ensure his environment is safe and that he is eating the appropriate amount of food."

Resident B's PCP was reviewed and stated the following:

"Redirecting [Resident B] does not always work, and staff will work to maintain his safety and the safety of others around him, until the episode has run it's course."

On 01/05/2025, I interviewed direct care worker, Aaron Guy via phone. He reported that he was filling in at Beacon Home at Mt. Pleasant on 11/30/2025 from 9:20am-5pm. DCW Guy reported that every time residents would come out of their rooms, staff would tell them that the lunch or dinner was not ready yet and to go back to their bedrooms. DCW Guy stated that most of the residents are non-verbal and cannot communicate their needs, therefore staff were unable to determine what the residents really needed. DCW Guy stated he was providing one on one supervision for Resident A and Resident A would often come out with his cup and want more milk. DCW Guy stated that he would fill his cup up with milk and then he would go back to his room. DCW Guy reported that when the other direct care workers, Paula Brenner and Alajah Carter intervened, they told Resident A no more milk or drinks and he would then enter into a behavior. DCW Guy stated that he witnessed Resident A throw his cup and try to pinch DCW Brenner and Carter. DCW Guy stated that he attempted to intervene and explain the behavior to DCW Brenner and Carter, but he was told that he did not understand Resident A's behaviors as it was not his primary work location. DCW Guy reported that he did not observe Resident A dump his drinks or empty his snack onto the ground during his shift. He also stated that the residents were not told to stay in their rooms due to safety during another residents behavior and it was more due to the convenience for staff members. DCW Guy clarified that DCW Brenner and Carter did not force the residents to stay in their rooms and only encouraged them to return to their rooms when they would come out.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(e) Withhold food, water, clothing, rest, or toilet use.**

ANALYSIS:	Based upon the interviews with direct care workers, Paula Brenner, Alajah Carter and Aaron Guy conflicting details were obtained. DCW Brenner and Carter denied all allegations that they denied residents food and drinks. Both reported that if residents asked for a snack or drink when the meal was being prepped to be served, they would encourage residents to wait until the meal was served. DCW Guy reported that both DCW Brenner and Carter refused to fill up Resident A's cup, which resulted in negative behaviors from Resident A. DCW Guy also reported that DCW Brenner and Carter did not force the residents to stay in their bedrooms, but would just encourage them to return to their bedrooms if they entered the kitchen and living room. Due to direct care workers, Paula Brenner and Alajah Carter denying the allegations of denying food and drink to residents and no additional evidence available, a violation was not established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care workers Alajah Carter, Paula Brenner, and Cindra Beals were calling residents names and using profanity toward residents.

INVESTIGATION:
On 12/04/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, on 11/30/2025, direct care workers, Alajah Carter and Paula Brenner were calling residents in the home names including "dumbass" and "asshole". The complaint also stated that direct care worker, Cindra Beals told a resident to "get the fuck away from me."

On 12/04/2025, additional contact information and details was obtained through the office of Recipient Rights.

On 12/09/2025, a voicemail was left for direct care worker, Jacob Barr.

On 12/12/2025, I completed an unannounced onsite investigation to Beacon Home at Mt. Pleasant. During the unannounced onsite investigation, I interviewed direct DCWs. Residents were unable to be interviewed due to their developmental disabilities.

On 12/12/2025, I interviewed DCW Cindra Beals in person. She reported that she worked briefly with DCWs Aaron Guy, Alajah Carter and Paula Brenner on 11/30/2025. She explained that she was coming in for another staff member later in the day. DCW Beals denied saying the following statement: "get the fuck away from me." DCW Beals also denied hearing direct care workers Alajah Carter and Paula

Brenner call the residents “dumbass” or “asshole.” She stated that she works with both of them often and has never had any concerns regarding them respecting the residents.

On 12/12/2025, I interviewed DCW Paula Brenner in person. She reported that she worked at the home on 11/30/25 from 7:30am-1pm, when she had to transfer to another home to assist with staffing. DCW Brenner denied calling any residents “dumbass” or “asshole.” DCW Brenner reported that she does not call any residents names. DCW Brenner stated that she did not hear direct care worker, Alajah Carter call the residents “dumbass” or “asshole”, nor hear her say anything else disrespectful. DCW Brenner also reported that she never heard direct care worker, Cindra Beals say the following: “get the fuck away from me.”

On 12/12/2025, I interviewed DCW Alajah Carter in person. She reported that she worked on 11/30/2025 from 9am-9pm. DCW Carter denied calling any resident a “dumbass” or an “asshole.” She also reported that she did not hear DCW Paula Brenner call any residents “dumbass” or an “asshole.” DCW Carter stated that she is respectful to the residents, nor did she hear direct care worker, Cindra Beals say the following to a resident: “get the fuck away from me.”

On 01/05/2025, I interviewed DCW Aaron Guy via phone. He reported that he was filling in at Beacon Home at Mt. Pleasant on 11/30/2025 from 9:20am-5pm. DCW Guy stated that he was providing 1:1 supervision for Resident A and when DCW Cindra Beals came on for her shift, she went to clock in near the back room and Resident A followed her and tried pinching her. DCW Guy stated that he then heard DCW Beals tell Resident A the following: “get the fuck away from me.” DCW Guy stated that when the residents try to pinch or grab at DCW Carter or Brenner, they respond to the residents with name calling. DCW Guy explained that the only resident they didn’t call names to was Resident C as he is more aware of what they are saying. DCW Guy gave the example of Resident D coming out of his room and having soiled himself and DCW Alajah Carter called Resident D disgusting and told him to go change and shower. DCW Guy reported that he could not remember the exact other words they used, but stated that they were very disrespectful towards the residents and called them many names when they didn’t like what they were doing.

On 01/05/2025, I interviewed direct care worker Kendra Pannill via phone. She identified as the home manager. She reported that she was not working on 11/30/25. DCW Pannill reported that she has never heard DCW Brenner, Carter or Beals use any disrespectful language towards residents when she has been working.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks.** **(iv) Threats.**
ANALYSIS:	Based upon the interviews conducted with direct care workers, there was not enough evidence to determine if direct care workers Paula Brenner, Alajah Carter and Cindra Beals used derogatory remarks or verbal abuse towards the residents as all three direct care workers denied the derogatory remarks and denied hearing each other use the verbal abuse towards residents. Due to no other witnesses and the residents not being able to be interviewed, a violation was not established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On 11/21/2025, direct care worker, Arkesha Foster left her one on one shift for Resident A early, leaving another staff member to supervise Resident A and the other residents within the home. On 11/22/25, direct care worker, Jacob Barr found Staff Diamond Jones sleeping and Staff Alajah Carter was not at work but then returned to work about 40 minutes later.

INVESTIGATION:
On 11/25/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, on 11/21/25, DCW Arkesha Foster was assigned as Resident A's 1:1 and Arkesha Foster left work at 6:10pm before another staff arrived to take over her assignment. The complainant stated that additionally DCW Diamond Jones left to pick up the covering DCW Diamond Alspaugh leaving two residents that require one-on-one supervision and three other residents to be supervised by only DCW Cindra Beals for approximately 40 minutes. On 12/01/2025, an additional complaint came through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint on 11/22/2025, DCW Jacob Barr went to Beacon Home at Mt. Pleasant and found DCW Dimond Jones sleeping and DCW Alajah Carter gone from the home and her shift. The complaint stated that DCW Cindra Beals was at the home supervising five residents and two of the residents required one-on-one supervision. On 12/04/2025, an additional complaint came through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint on 11/30/2025, DCW Alajah Carter left the home and her shift to go to a co-workers home. While DCW Carter was gone, it left direct care

workers, Aaron Guy and Paula Brenner to supervise two residents that require one-on-one supervision, along with two additional residents.

On 11/25/2025, additional contact information and details were obtained through the office of Recipient Rights.

On 12/09/2025, I interviewed DCW Cindra Beals via phone. DCW Beals reported that she mainly works during the day at the home. She stated that she was working at the home on 11/21/2025. DCW Cindra Beals confirmed that DCW Arkesha Foster left her shift early around 6:10pm, and did not arrange for another staff member to cover her shift. DCW Beals stated DCW Foster was terminated from her position on 11/24/25 for leaving early. DCW Beals stated that during her shift on 11/21/2025, her other co-worker, Diamond Jones left the house around 6:50pm to go pick up another co-worker, Diamond Alspaugh at her home. DCW Beals stated that DCW Alspaugh did not have a ride to work. She explained that Diamond Jones did tell her that she was leaving her shift to pick up DCW Alspaugh, but did not ask her if it was okay or if she felt comfortable supervising all the residents. DCW Beals reported that she had to supervise two residents that required a one-on-one staff member, along with three other residents from 6:50pm- about 7:30pm. DCW Beals stated that one of the residents had a behavior at 7:10pm and destroyed a pumpkin in his bedroom. DCW Beals reported that on 11/21/2025, during the time of 6pm-7:30pm the home was not in the required staffing ratio. DCW Beals also confirmed that on 11/22/2025, during the day shift, Diamond Jones was sleeping in the back room when she was supposed to be providing 1:1 supervision to Resident A during this time. DCW Beals also stated that during the same time DCW Jones was sleeping, DCW Alajah Carter left her shift to run home, which left her to supervise two residents who required 1:1 supervision and three other residents.

On 12/12/2025, I completed an unannounced onsite investigation to Beacon Home at Mt. Pleasant. During the unannounced onsite investigation, I interviewed direct care workers and reviewed documentation. Residents were unable to be interviewed due to their developmental disabilities.

On 12/12/2025, I interviewed DCW Alajah Carter in person. DCW Carter reported that on 11/22/2025, she had a feminine hygiene accident and needed to run home quickly. DCW Carter stated that she was gone from the home for about 15-20 minutes. DCW Carter confirmed that when she returned to the home, DCW Jacob Barr was at the home. DCW Carter explained that DCW Diamond Jones was in charge of supervising Resident A and was sitting in the back room by Resident A’s bedrooms. DCW Carter stated that when she left, she did not see DCW Diamond Jones sleeping. DCW Carter reported that on 11/30/25, she was working and left the home to pick up another co-worker at her home. DCW Carter stated that she took one resident with her to pick up her co-worker.

On 12/12/2025, I interviewed DCW Paula Brenner in person. DCW Brenner confirmed that on 11/30/2025, DCW Carter left the home to pick up a co-worker

whose car broke down and took one resident with her. DCW Brenner stated that this left her, and another co-worker to supervise two residents who require 1:1 supervision, along with two other residents.

On 01/06/2025, I interviewed DCW Jacob Barr via phone. He reported that on 11/22/2025, he received notification that Beacon Home at Mt. Pleasant was out of staffing ratio. He stated that he arrived at the home around 11:40am and found DCW Cindra Beals to be awake and present. DCW Barr stated that he found DCW Diamond Jones sleeping on the couch in the back room near Resident A's bedroom. DCW Barr stated that he found Diamond Jones curled up on the couch with a blanket and he had to wake her up when he arrived. DCW Barr stated that Resident A was in his bedroom at the time he arrived. DCW Barr also reported that when he arrived DCW Alajah Carter was not present at the home, and she arrived about 40 minutes after he arrived. DCW Barr stated that both DCW Carter and Jones were written up for not being present for their shift. DCW Barr explained that there were four residents at the home when he arrived and two of the residents require 1:1 supervision. DCW Barr stated that Resident A requires bedrooms checks at least every 10-15 minutes when he is in his bedroom. DCW Barr stated that by the time he received the notice regarding sleeping staff and drove to the home, it had been about two hours, therefore DCW Jones was not completing her required checks for Resident A.

On 01/06/2025, I interviewed DCW Aaron Guy via phone. DCW Guy reported that on 11/30/2025, DCW Alajah Carter left the home with one resident to check on another co-worker at her home. DCW Guy stated that while DCW Carter was gone, the staff level was out of ratio as two residents required 1:1 supervision and then two additional residents were at the home still. DCW Guy also reported that he found the medication keys on the floor after DCW Carter left. DCW Guy stated that he picked them up, before a resident had access to them. DCW Guy reported that DCW Carter was the staff assigned to administer medication for the shift.

Resident A's PCP states the following:
"[Resident A] receives 1:1 line of sight staffing for 12 hours a day at home. [Resident A] should be in staff's line of sight while in the common areas (living room, dining room, kitchen and den). Staff may stand at a distance of five feet or more but must also be ready to immediately provide necessary supports. When [Resident A] is in his bedroom and awake, he requires periodic monitoring (every 10 minutes). Staff should scan his environment and ensure that there are not items available to him that he could place in his mouth and choke on."

Resident B's PCP states the following:
"[Resident B] will be provided with 1:1 line of sight staffing for 16 hours during his waking hours when he is not in his bedroom. The designated staff should be able to see [Resident B] but may be at a distance of several feet or more. 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 B]. When

[Resident B] is not receiving 1:1 supervision, staff will provide periodic monitoring in which a staff member checks on [Resident B] at least every 15 minutes. This is to occur when [Resident B] is awake or sleeping. While [Resident B] is in his bedroom and awake, the designated 1:1 staff should remain outside of his bedroom within eye sight of the room. Staff will verbally prompt [Resident B] to leave the door open. If [Resident B] closes or locks his door, AFC staff will unlock and open the door. If [Resident B] leaves his bedroom, staff should remain in line of sight. Line of sight supervision is not needed when [Resident B] is in the restroom at home, however if [Resident B] may request staff to assist him, if needed.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	Based upon interviews and documentation reviewed, it can be determined that Beacon Home at Mt. Pleasant did not have sufficient staff to meet the needs of all five residents on the following dates during day shifts: 11/21/2025, 11/22/2025 and 11/30/2025. On 11/21/2025, direct care worker, Cindra Beals confirmed that she was in the home supervising two residents who required 1:1 supervision, along with three other residents for 50 minutes. According to the person-centered plan requirements for Residents A and B, there was not sufficient staffing on 11/21/2025 for 50 minutes. On 11/22/2025, direct care worker, Jacob Barr completed a pop in visit at Beacon Home at Mt. Pleasant and found DCW Diamond Jones to be sleeping, while she should have been completing her checks on Resident A and he also found DCW Alajah Carter away from the home during her shift. It was determined through interviews with direct care worker, Cindra Beals, Jacob Barr and Alajah Carter that the home did not have sufficient staff on duty to meet the needs of the five residents on 11/22/2025. On 11/30/2025, it was determined that there was not sufficient staff on duty to care for the four residents within the home, as DCW Alajah Carter left the home during her shift to check on another co-worker. When DCW Carter left her shift on 11/30/2025, there were no staff members to provide supervision for Resident D and E.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains unchanged.

01/09/2026

Amanda Blasius Date
Licensing Consultant

Approved By:

01/09/2026

Dawn N. Timm Date
Area Manager