GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 7, 2026

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

RE: License #: AS370405093
Investigation #: 2026A0577042
Beacon Home At Mt Pleasant

Dear Ms. Goldammer:

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,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	AS370405093
Investigation #:	2026A0577042
Complaint Receipt Date:	05/12/2026
Investigation Initiation Date:	05/12/2026
Report Due Date:	07/11/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Licensee Designee:	Roxanne Goldammer
Administrator:	Roxanne Goldammer
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?
Resident A is being mistreated by direct care staff causing Resident A to have a black eye and multiple bruises on his arms.	No
Resident A was observed being hit by direct care staff with a broom.	No
Additional Findings	Yes

III. METHODOLOGY

05/12/2026	Special Investigation Intake, 2026A0577042
05/12/2026	APS Referral, Complainant filed APS.
05/12/2026	Special Investigation Initiated – Telephone, Adam Bundy, CMHCM-ORR.
05/13/2026	Referral - Recipient Rights
05/13/2026	Contact - Telephone call made, Interview with Guardian A1
05/13/2026	Inspection Completed On-site
05/14/2026	Contact - Document Sent, Requested copies of IR's and photos.
05/14/2026	Contact - Telephone call made, Isabella County Road Commission.
05/14/2026	Contact - Document Sent Adam Bundy, ORR-CMHCM, schedule interviews with DCS.
05/15/2026	Contact - Document Received, Photos of Resident A's bruises and IR’s .
05/18/2026	Contact - Telephone call made, Interview with DCS Alaja Carter.
05/18/2026	Contact - Document Sent, Via email to Kendra Pannill, requested Resident A's MAR.
05/20/2026	Inspection Completed On-site
05/20/2026	Contact - Document Received

	via email from Kendra Pannill, HM, Staff Trainings.
05/21/2026	Contact - Face to Face, Interview with DCS.
05/21/2026	Contact - Telephone call made, Interview with DCS.
05/21/2026	Contact - Document Received via email from Kendra Pannill, HM, Photo of Resident A's bedroom.
05/27/2026	Contact - Telephone call received, Interview with Jayla Cocker, DCS.
05/28/2026	Contact - Document Received Kendra Pannill, HM via email, requested and Received PCP's/BTP's for residents in care.
06/01/2026	Contact - Document Received Kendra Pannill, Staff Schedule for May 2026.
06/10/2026	Contact - Document Received, Adam Bundy, ORR-CMHCM.
06/10/2026	Contact - Telephone call made, Adam Bundy, ORR-CMHCM.
06/11/2026	Contact-Telephone call made, Interviews
07/01/2026	Contact-Document Sent Email to Roxanne Goldammer, Administrator, requesting information.
07/01/2026	Contact-Document Received, via email to CMHCM.
07/07/2026	Exit Conference-Roxanne Goldammer, LD.

ALLEGATION: Resident A is being mistreated by direct care staff causing Resident A to have a black eye and multiple bruises on his arms.

INVESTIGATION:

On May 12, 2026, a complaint was received alleging that Resident A had a black eye on Friday, May 08, 2026, as well as having multiple bruises on his arms which were alleged to be caused from direct care staff grabbing Resident A too hard.

On May 12, 2026, I contacted Adam Bundy, Office of Recipient Rights with Community Mental Health Central Michigan (ORR-CMHCM) who reported that he has an open investigation regarding the concerns of Resident A being abused by direct care staff.

On May 13, 2026, I interviewed Guardian A1 who reported that she was aware of Resident A having a black eye and bruising stating, “on May 08, 2026, I received a text message from Kendra Pannill, with a photo of [Resident A] having a black eye and also had a mark on his forehead.” Guardian A1 reported that she went to the facility on May 08, 2026, around 4:30 pm and that when she arrived at the facility program director Jacob Barr and direct care staff (DCS) Kendra Pannill, whose role is home manager, were at the facility. Guardian A1 stated direct care staff stated that through their internal investigation, it was determined that Resident A had thrown himself on his bed causing these injuries. Guardian A1 reported that Resident A’s has a solid wood frame and vinyl mattress, stating, “there is nothing for [Resident A] to hit his eye on.” Guardian A1 reported that she returned to the facility on May 10, 2026, and found that the bruise on Resident A’s eye was yellowing but found additional bruises on both Resident A’s arms, plus a large bruise on his left hand. Guardian A1 reported that since February 2026, she has observed Resident A with bruising on his body, rug burn marks on his elbows, and scratches on his arms. Guardians A1 stated direct care staff reported that Resident A has a lot of behaviors and sometimes during these behaviors, Resident A runs outside getting scratches, throws himself on his bed or hits himself causing bruises.

On May 13, 2026, I completed an unannounced onsite investigation and reviewed and received copies of Resident A’s *Behavior Treatment Plan* (BTP), *Person Centered Plan* (PCP), *Assessment Plan for AFC Residents,* and *Behavior Tracking Records*. I observed Resident A, who was walking around the facility naked with direct care staff following him, but could not interview Resident A because he is non-verbal.

During onsite investigation I interviewed direct care staff (DCS) Kendra Pannill who reported that on May 08, 2026, she arrived at the facility and found Resident A with a black eye. Ms. Pannill stated she took pictures of the black eye. Ms. Pannill reported that upon review of the IR from May 07, 2026, and speaking with DCS Christopher Kall, it was determined that Resident A’s black eye came from Resident A hitting his face on the frame of his wood bed frame during a behavior.

On May 15, 2026, via email to DCS Kendra Pannill, I requested and received *AFC Licensing Division-Incident/Accident Reports* (IR) dated May 07, 2026. This IR was completed by DCS Christopher Kall, who was working with DCS Tabitha Bush at the time of the incident. The IR explained that around 2:00pm Resident A went into an extremely violent behavioral outburst during lunch time which extended until 7PM. Staff prompted him to try taking a sensory shower or calm down in his bedroom which only further angered him. He began following staff and attempting to choke, bite, and dig his nails into staff's arms and throats. When staff refused to allow him to get close enough to bite them, he began biting his bed until his teeth bled and pounding his face into his bed. Once finished pounding his face into the bed frame and biting the wood, he went running outside and was biting the swing set and slamming on the walls. Staff noticed

he had swelling around his eye and mouth as well as bleeding on his hands. In the section of the IR titled, '*Action taken by Staff / Treatment',* it documented that, *"*Staff kept their distance while he was deep in his behavior and kept him from getting ahold of our arms and face as much as possible." The *Corrective Measures Taken to Remedy and/or Prevent Recurrence* section documented that, "Staff will continue to monitor [Resident A] for health and safety and attempt to redirect when he is becoming aggressive or engaging in self-injurious behavior."

Mr. Kall reported that at times the physical intervention technique of hand over hand, described as placing their hand on Resident A's shoulder and back, is used to lead Resident A to a safer space. Mr. Kall stated that most of the time verbal prompting is used to redirect Resident A because Resident A's aggressiveness makes it difficult for direct care staff to get close to Resident A without Resident A harming direct care staff.

On May 18, 2026, I interviewed DCS Alaja Carter who reported she worked on the night of May 08, 2026, and observed Resident A having a black eye. DCS Carter reported she inquired about Resident A's black eye with the other staff members working and no one knew what happened. DCS Carter reported that she did not inquire further about Resident A's black eye, nor did she notify management of the black eye.

On May 21, 2026, Adam Bundy CMHCM-ORR and I interviewed DCS Cindra Beals who reported that she provided Resident A with 1:1 enhanced supervision on May 07, 2026, and stated she did not know how Resident A received the black eye. DCS Beals reported that Resident A was upset all day and acted aggressively. DCS Beals reported around 5:30pm Resident A came out of his bedroom, screamed, and ran after DCS Christpher Kall while DCS Kall was in the living room and began hitting, pushing, biting, and throwing things at DCS Kall. DCS Beals reported that she tried to verbally prompt and redirect Resident A away from DCS Kall with no success. DCS Beals reported that DCS Kall also was attempting to redirect Resident A by saying, "no thank you, safe hands, no pinching, please do not scratch, no thank you" until Resident A finally went to his bedroom where DCS Kall and DCS Bush followed Resident A while DCS Beals stayed out of Resident A's bedroom. DCS Beals reported she was told by DCS Kall that Resident A removed his mattress from the bed frame and started hitting his face on his wood bed frame. DCS Beals reported that she heard DCS Bush and DCS Kall attempt to verbally redirect Resident A to stop biting his bedframe and/or hitting his head on the bedframe. DCS Beals reported prior to her shift ending, Resident A calmed down, laid down, and then came out for medications around 7:30pm. DCS Beals stated that upon leaving her shift did not see that Resident A had a black eye or any other injury other than redness on his forehead. DCS Beals reported that she is fearful of Resident A due to his aggression and strength.

On May 21, 2026, Adam Bundy and I also interviewed DCS Tabitha Bush who reported that on May 07, 2026, DCS Cindra Beals was assigned to provide Resident A with 1:1 supervision. DCS Bush reported she was in the main living room with DCS Kall and other residents when Resident A ran from the hallway toward DCS Kall and began hitting and pinching DCS Kall. DCS Bush reported that DCS Kall attempted to verbally

redirect Resident A while the pinching continued. DCS Bush reported that DCS Beals was also attempting to verbally redirect Resident A by saying, “nice hands, that hurts” but Resident A ignored the verbal prompts. DCS Bush reported that DCS Kall and herself were able to verbally redirect Resident A to the back den area where DCS Beals continued to provide Resident A with 1:1 supervision. DCS Bush reported later that she heard DCS Beals yelling for help from the den and upon DCS Bush and DCS Kall entering the den, they observed Resident A pinching and biting DCS Beals. DCS Bush reported that DCS Kall entered the den to assist DCS Beals by verbally prompting and redirecting Resident A, when Resident A ran outside followed by DCS Beals. When both returned inside, Resident A again attempted to attack DCS Kall. DCS Bush reported that she and DCS Kall together redirected Resident A to the back room and Resident A proceeded into his bedroom, where he moved his mattress partially off his bed and threw himself on his bed frame while biting his mattress and the wooden bed frame. DCS Bush reported that she also observed Resident A hit his head on the bed frame a couple of times. DCS Bush reported that while Resident A was biting his mattress and his bed frame he was hitting/rubbing his head on the bed frame causing a red mark on Resident A’s forehead and above right eye. DCS Bush reported that DCS Beals did not initially assist with helping to manage Resident A when in a behavior because DCS Beals is afraid of Resident A.

On May 21, 2026, Andy Bundy and I interviewed DCS Christopher Kall who reported that on May 07, 2026, Resident A was assigned 1:1 supervision with DCS Cindra Beals. DCS Kall reported beginning at lunchtime and continuing throughout the day, Resident A had continuously been attacking direct care staff by pinching, biting, and hitting them, which required constant verbal redirection. DCS Kall reported that throughout the shift, both DCS Tabitha Bush and he frequently prompted and redirected Resident A to safer areas of the home while Resident A was acting out. DCS Kall reported that Resident A repeatedly lunged at DCS Kall, grabbing his arms and digging in his nails. DCS Kall reported that CPI techniques were used to maintain safety as DCS Kall moved away from the area while attempting to prevent escalation. DCS Kall reported that he used hands-up positioning to maintain distance while backing away. DCS Kall reported that Resident A went into his bedroom, slid his mattress part way off his bed and began biting his mattress and his wooden bed frame. DCS Kall reported Resident A was also throwing himself on his bed frame and at times hitting his head on the bed frame. DCS Kall reported he attempted to provide verbal redirection to Resident A but was unsuccessful and Resident A continued to bite his bed and mattress. DCS Kall reported that no physical intervention was used on Resident A at this time. DCS Kall reported that when Resident A was done with his behavior, himself, DCS Bush and DCS Beals all observed a small welt on Resident A’s upper eyelid and a red mark in the middle of Resident A’s forehead. DCS Kall reported that by the next day, the red area around Resident A’s eye had developed into a black eye. DCS Kall reported physical intervention is not often used on Resident A as it often escalates his behavior rather than providing a calming effect. DCS Kall reported that Resident A’s behaviors have become less predictable and more severe than previously observed, with no clear trigger identified. DCS Kall reported that when Resident A reaches out to pinch or claw,

staff typically extend their arms to maintain distance, lower his arm safely, and then guide him back to his bedroom.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Direct care staff interviewed all reported that Resident A's black eye injury was caused by self-injurious behavior that occurred during an extensive, aggressive behavior event on May 7, 2026. Direct care staff used continual verbal redirection to move Resident A to safer areas of the facility while also trying not to further escalate Resident A's behavior. Resident A was treated with dignity and respect, while being provided protection and safety.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A was observed being hit by direct care staff with a broom.

INVESTIGATION:

On May 12, 2026, I interviewed Adam Bundy, ORR-CMHCM who reported he received additional information from DCS Ariel Molina. Mr. Bundy stated DCS Molina reported that after starting her shift on May 11, 2026, she saw DCS Cindra Beals hitting Resident A with a broom handle while in the backyard. Mr. Bundy reported he was not aware of any other residents or direct care staff witnessing this incident. Mr. Bundy reported that DCS Beals is currently suspended due to the investigation.

During the onsite investigation, on May 13, 2026, I interviewed DCS Ariel Molina, who reported on May 11, 2026, upon arriving to the facility to start her shift at 9:00am, DCS Molina saw Resident A outside by the road with DCS Cindra Beals. DCS Molina reported Resident A was grabbing trash from the receptacle and throwing trash across the road. DCS Molina reported DCS Beals was screaming at Resident A, stating, "get into the house now, stop throwing the trash, get into the house" and every time she screamed this at Resident A, DCS Beals hit Resident A with the bristle end of the broom. DCS Molina reported she observed DCS Beals screaming at and hitting Resident A with the broom at least four times. DCS Molina reported there were two cars that drove by and witnessed this interaction between Resident A and DCS Beals. DCS Molina reported that the Isabella County Road Commission was also grating the road at the time of the incident. DCS Molina reported she walked towards Resident A and asked Resident A to come into the house and Resident A followed DCS Molina into the home. DCS Molina reported DCS Beals stated, "I am leaving now, have someone pick

up the trash out by the road." DCS Molina reported DCS Jayla Cocker was in the facility during the incident and told DCS Molina she did not observe anything happening between Resident A and DCS Beals. DCS Molina reported she notified DCS Kenra Pannill about what she observed.

On May 13, 2026, I interviewed DCS Kendra Pannill who reported she arrived at the facility on May 11, 2026, around 8:00am and DCS Cindra Beals and DCS Jayla Cocker were working. Ms. Pannill reported Resident A was walking around the living room and appeared to be happy. Ms. Pannill reported DCS Beals was assigned to provide 1:1 enhanced supervision to Resident A. Ms. Pannill reported she left around 8:30am and at that time there were no concerns. Ms. Pannill reported around 9:00am she received a phone call from DCS Cindra Beals asking for permission to leave work which Ms. Pannill granted. Ms. Pannill reported she then received a call from DCS Cocker asking why DCS Beals left before picking up the trash Resident A had thrown out in the road while DCS Beals was providing 1:1 supervision. Ms. Pannill reported she came back to the facility, took photos of the trash, and sent a text message to DCS Beals asking what had happened and if DCS Beals had completed an incident report. Ms. Pannill reported DCS Beals reported she did not complete an incident report and left due to being upset. Ms. Pannill stated DCS Molina reported the interaction that occurred between Resident A and DCS Beals. Ms. Pannill stated she understood that Resident A was going through the trash receptacles by the road and throwing trash all over the road. Ms. Pannell reportedly that DCS Molina stated that DCS Beal was screaming at Resident A and hitting Resident A with a broom. Ms. Pannell reported that she contacted DCS Beale to notify her of being removed from the schedule until an investigation was completed regarding this incident.

On May 21, 2026, Adam Bundy from CMHCM-ORR reported he interviewed DCS Cindra Beals who reported she worked on May 10, 2026, from 9:00pm-9am after having worked a 12-hour shift prior to this. DCS Beals reported Resident A woke up on the morning of May 11, 2026, around 6:30-7:00am. DCS Beals reported that Resident A was angry from the time he woke up and went straight to the refrigerator, cupboards, and trash can and starting throwing things onto the floor. DCS Beals reported Resident A was also running in and out of the facility naked while DCS Beals was trying to pick up the items Resident A had thrown on the floor and trying to redirect A back into the home. DCS Beals reported Resident A then ran out to the road, threw the track cans over, ripped open the trash bags and started throwing garbage onto the road. DCS Beals reported that she was verbally redirecting Resident A to pick up the garbage and return to the facility. DCS Beals reported that Ariel Molina arrived for her shift around 9:00am and encouraged Resident A to come into the home. DCS Beals reported that she had a broom in her hand due to picking up the trash that was thrown on the porch and out into the road when DCS Molina arrived. DCS Beals reported that she was running toward Resident A while she had a broom in her hand and while out by the road with Resident A. DCS Beales denied hitting Resident A with a broomstick, stating, "I was more than arm's length away at all times and just holding the broom in my hand."

On May 27, 2026, I interviewed DCS Jayla Cocker who reported that she was working on May 11, 2026, with DCS Cindra Beals. Ms. Cocker reported that DCS Beals was Resident A's 1:1 staff supervision. Ms. Cocker reported Resident A woke up around 3:00am and was agitated all morning, running in and out of the facility with DCS Beals following Resident A. Ms. Cocker reported that she remained in the home to provide supervision to Resident D and observed Resident A and DCS Beals while they were outside. However, Ms. Cocker reported she did not observe DCS Beals hitting Resident A with the broom, but was told about it as soon as DCS Ariel Molina came into the facility with Resident A.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(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.
ANALYSIS:	Based on the information gathered through interviews, there was insufficient evidence found that DCS Cindra Beals mistreated Resident A by hitting Resident A with a broom.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On May 13, 2026, I reviewed Resident A's BTP which was completed on March 10, 2026, and documented that Resident A requires enhanced supervision, "Due to behaviors, [Resident A] requires extra staffing for 16 hours per day to support needs in the home and community. During the day, [Resident A] should have 8 hours of 1:1 staffing during waking hours and 8 hours of 2:1 staffing from 1pm-9pm when [Resident A] is more likely to be unsafe." Resident A's BTP documents that Resident A is provided 2:1 enhanced supervision while Resident A is in the common areas of the home and in the community which includes the yard or exterior of the property of the AFC Home.

On May 15, 2026, I reviewed an IR dated May 06, 2026, at 1:00pm which documented, "there is only one staff for the 2:1, staff remained in the line of site of [Resident A], and staff will continue to fill out documentation when there is only 1 staff for the 2:1." On July 01, 2026, I emailed Adam Bundy from ORR-CMHCM and requested and received copies of IRs from April 2026 through June 2026 documenting that Resident A was not provided with 2:1 enhanced supervision as required per Resident a's BTP. I received seven IRs dated April 8, 9, 11, 17, 20, 22 and June 13, 2026, documenting when the licensee did not have sufficient staff available to provide Resident A's required 2:1 enhanced supervision needs.

On May 20, 2026, I requested and received May 2026 staff schedule and upon review noted that on the following dates Resident A was only provided 1:1 supervision from 1:00pm-9:00pm despite requiring 2:1 enhanced supervision during this time frame per Resident A's BTP: May 6, 7, 8, 10, 11, 12, 13, 14, 15, 17, 18, 20, 21, 22, 25, 27, and 29, 2026.

On June 10, 2026, I contacted Adam Bundy (ORR-CMHCM) regarding May IRs received from the licensee that documented insufficient staffing because the licensee could not provide the 2:1 supervision required by Resident A's BTP. Mr. Bundy stated that his review of April 2026 IRs identified seven instances noting only one staff present to provide Resident A's required 2:1 supervision. He stated the specific dates were April 8, 9, 11, 17, 20, 22, and 26, 2026.

On July 01, 2026, I interviewed administrator Roxanne Goldammer who reported that CMHCM authorized the 2:1 enhanced supervision for Resident A for the days the licensee had sufficient staff to provide 2:1 supervision for Resident A, stating, "at the time they realized that our staffing was such that we would not be able to immediately staff those shifts." Ms. Goldammer reported that the facility worked with Erin Rubingh, Case Manager with CMHCM and the Katie Hohner, ORR-CMHCM, who both provided the preferred wording to use when completing an IR for insufficient staffing. Ms. Goldammer reported that the facility worked with area homes and other homes throughout the state to assist with staffing these shifts, stating, "unfortunately, due to the staffing shortage across the state the shifts were not staffed until recently."

On July 01, 2026, I interviewed Katie Hohner, ORR-CMHCM Supervisor who reported she advised the licensee to actively working towards finding staff to provide the 2:1, stating that, "if they could not staff the 2:1, they needed to write an IR each time that included what they are doing to keep the person safe during the time they do not have 2:1." Ms. Hohner reported that she advised the facility that their IR's should reflect all they are doing to correct this issue.

*SIR 2026A0622009, dated January 09, 2026, cited rule 400.671 (1) after it was determined that Beacon of Mt. Pleasant did not have sufficient staff to meet the needs of all of the five residents after one direct care staff was providing supervision to two residents who require 1:1 supervision, along with supervising the remaining three other residents. The *Correction Action Plan* documented that staff were given a written counseling and put in their personnel files.

*SIR 2025A1029058, cited rule R400.14303, after it was determined that residents were not provided with 1:1 staffing supervision as required per the resident's BTP and *Assessment Plan for AFC Residents.* The *Correction Action Plan* documented direct care staff was terminated and written disciplinary action in the form of written counseling was placed in the employee personnel file. **Please note on November 03, 2025, a new AFC rules were promulgated and Rule 400.633 (1) is equivalent to Rule 400.14303 cited in SIR 2025A1029058.*

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:	Per Resident A's BTP, Resident A requires 2:1 supervision from 1:00pm-9:00pm. The documentation across April 2026 and May 2026 demonstrated repeated instances when the licensee did not provide Resident A with the required 2:1 staffing ratio from 1:00pm through 9:00pm. Required 2:1 supervision was not provided to Resident A 17 times during May 2026 and seven times during April 2026 and was further documented by direct care staff through incident reports and confirmed after reviewing staff schedules for that timeframe. The pattern indicates systemic staffing deficiencies rather than isolated incidents on the part of the licensee however Resident A's responsible agency was aware of the licensee's inability to consistency meet the 2:1 supervision requirement yet allowed Resident A to remain at the facility.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR #2026A0622009, DATED 01/09/2026 AND CAP DATED 01/27/26.]**

IV. RECOMMENDATION:

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

Bridget Vermeesch

07/07/2026

_____

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm

07/07/2026

_____

Dawn N. Timm Date
Area Manager