GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 18, 2025

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

RE: License #: AS390403202
Investigation #: 2025A1024009
Beacon Home at Kal-Haven

Dear Nichole VanNiman:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On January 15, 2025, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390403202
Investigation #:	2025A1024009
Complaint Receipt Date:	12/30/2024
Investigation Initiation Date:	12/30/2024
Report Due Date:	02/28/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimbery Howard
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Kal-Haven
Facility Address:	5359 N. 8th Street Kalamazoo, MI 49009
Facility Telephone #:	(269) 214-4341
Original Issuance Date:	05/05/2020
License Status:	REGULAR
Effective Date:	11/05/2024
Expiration Date:	11/04/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff refused Resident A medical treatment after he was bitten by another resident.	No
Additional Findings:	Yes

III. METHODOLOGY

12/30/2024	Special Investigation Intake 2025A1024009
12/30/2024	APS Referral- APS is the complainant so no referral necessary
12/30/2024	Special Investigation Initiated – Telephone with administrator Kimberly Howard
01/06/2025	Inspection Completed On-site with direct care staff members Seth Brunn and Theresa Carpenter
01/06/2025	Contact - Telephone call made with AFC Licensing Consultant Cathy Cushman
01/06/2025	Contact - Telephone call made with previous licensing designee Ramon Beltran
01/07/2025	Contact - Document Received-Email correspondence from Recipient Rights Officer (RRO) Candice Kinzler
01/07/2025	Inspection Completed-BCAL Sub. Compliance
01/07/2025	Exit Conference with licensee designee Nichole VanNiman
01/07/2025	Corrective Action Plan Requested and Due on 01/22/2025
01/15/2025	Corrective Action Plan Received
01/15/2025	Corrective Action Plan Approved

ALLEGATION: Staff refused Resident A medical treatment after he was bit by another resident.

INVESTIGATION:

On 12/30/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged direct care staff refused Resident A medical treatment after he was bit by another resident.

On 12/30/2025, I conducted an interview with administrator Kimberly Howard who stated that she has been the administrator for this facility since April 2024 and she has no knowledge of Resident A residing in the facility. Kimberly Howard further stated all staff in the home are new hires that have been working in the home for no more than six months.

On 1/6/2025, I conducted an onsite investigation at the facility with direct care staff members Seth Brunn and Theresa Carpenter who both stated that they have been working in the facility for a few months and they are not familiar with Resident A and have no knowledge of Resident A residing in the facility.

On 1/6/2025, I conducted an interview with AFC licensing consultant Cathy Cushman who stated that she is familiar with Resident A and conducted a special investigation regarding staff mistreating Resident A in June of 2023. Cathy Cushman stated in her investigation, SIR #2023A0581040, she found substantial evidence to support the allegation that a staff member was verbally aggressive towards Resident A however there was no mention of Resident A getting bit by another resident or not getting medical treatment when needed during her investigation. Cathy Cushman stated Recipient Rights was also involved in her investigation and they also dd not report these allegations.

On 1/6/2025, I conducted an interview with previous licensee designee Ramon Beltran who stated that Resident A resided in the facility from May 2023 to August 2023 and he has no knowledge of Resident A getting bit by another resident or not receiving medical treatment for any reason.

On 1/7/2025, I reviewed email correspondence from RRO Candice Kinzler who stated that she does not recall any complaints made in her investigation regarding Resident A getting bit by another resident or not receiving medical treatment.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Based on my investigation which included interviews with previous licensee designee Ramon Beltran, administrator Kimberly Howard, direct care staff members Seth Brunn and Theresa Carpenter, AFC licensing consultant Cathy Cushman, and email correspondence with RRO Candice Kinzler there is no evidence to support the allegation staff refused Resident A medical treatment when he was bit by another resident. According to Ramon Beltran, Resident A resided in the facility from May 2023 to August 2023 and no complaints were made regarding Resident A getting bit by another resident or not getting medical treatment. It should also be noted during Cathy Cushman's special investigation in June of 2023 involving a separate allegation there was also no mention from anyone regarding Resident A getting bit by another resident or not getting medical treatment therefore Resident A has not been refused medical treatment.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 12/30/2024, Kimberly Howard stated that she has no knowledge of Resident A residing in the facility. I asked to review the *Resident Register* but there was no resident register to verify his admission/discharge dates.

APPLICABLE RULE	
R 400.14210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**
ANALYSIS:	Kimberly Howard stated that she has no knowledge of Resident A residing in the facility. The licensee was not able to provide a resident register upon request for the department to review.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/7/2025, I conducted an exit conference with licensee designee Nichole VanNiman. I informed Nichole VanNiman of my findings and allowed her an opportunity to ask questions or make comments.

On 1/15/2025, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

I received an acceptable corrective action plan therefore I recommend the current license status remain unchanged.

02/17/2024

Ondrea Johnson
Licensing Consultant

Date

Approved By:

02/18/2025

Dawn N. Timm
Area Manager

Date