GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2025

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

RE: License #: AS390406167
Investigation #: 2025A1024028
Beacon Home at Interlochen

Dear Ms. 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 June 11, 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
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406167
Investigation #:	2025A1024028
Complaint Receipt Date:	04/28/2025
Investigation Initiation Date:	04/28/2025
Report Due Date:	06/27/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kimberly Howard
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Interlochen
Facility Address:	8038 Interlochen St. Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-6941
Original Issuance Date:	06/21/2021
License **Status:**	REGULAR
Effective Date:	12/21/2023
Expiration Date:	12/20/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A found staff member sleeping while working on 3rd shift.	Yes

III. METHODOLOGY

04/28/2025	Special Investigation Intake 2025A1024028
04/28/2025	Special Investigation Initiated – Telephone with Recipient Rights Officer (RRO) Kate Koyak
04/28/2025	APS Referral not warranted
05/08/2025	Contact - Telephone call made with direct care staff member Kennedy VanNiman
05/08/2025	Contact - Document Received-*AFC Licensing Division Incident/Accident Report*
05/19/2025	Inspection Completed On-site-with direct care staff member David Wells and Resident A
05/19/2025	Contact - Telephone call made with direct care staff member Madeline Warren
05/29/2025	Contact - Telephone call received with Terrence Brunn staff member
06/02/2025	Exit Conference with licensee designee Nichole VanNiman
06/02/2025	Inspection Completed-BCAL Sub. Compliance
06/02/2025	Corrective Action Plan Requested and Due on 06/16/2025
06/11/2025	Corrective Action Plan Received
06/11/2025	Corrective Action Plan Approved

ALLEGATION: Resident A found staff member sleeping while working on 3rd shift.

INVESTIGATION:

On 4/28/2025, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged Resident A found a direct care staff member sleeping while working on 3rd shift.

On 4/28/2025, I conducted an interview with RRO Kate Koyak who stated that she is also investigating this allegation and found that staff member Qwadri Bradsher was sleeping on the couch when he was supposed to be working in the evening. RRO Kate Koyak stated Qwadri Bradsher was alone with residents and Resident A notified staff member Madeline Warren of this incident when she came in the next morning.

On 5/8/2025, I conducted an interview with direct care staff member Kennedy VanNiman who stated that she is the home manager of the facility and was contacted on 4/16/2025 at 6:45am by staff member Madeline Warren. Kennedy VanNiman reported Madeline Warren stated that when she arrived to the facility for her shift, Resident A ran outside and informed her that staff member Qwadri Bradsher was sleeping on the couch leaving the residents without staff supervision. Kennedy VanNiman stated Madeline Warren reported she immediately went inside the house and also observed Qwadri Bradsher sleeping. Kennedy VanNiman stated she then advised Madeline Warren to contact the program director of the facility. Kennedy VanNiman stated she spoke to Qwadri Bradsher about this incident who reported to her that he did not have anything else to complete and was under the impression that he was allowed to sleep while working. Kennedy VanNiman stated that Qwadri Bradsher has completed various trainings and understands he is supposed to conduct routine hourly bedroom checks and perform cleaning duties while he is working during 3rd shift. Kennedy VanNiman stated it is against company policy for staff members to sleep while working during any shift therefore Qwadri Bradsher was disciplined and received a counseling form.

On 5/8/2025, I reviewed the facility's *AFC Licensing Division Incident/Accident Report* dated 4/16/2025 written by Kennedy VanNiman. According to this incident report, staff was sleeping while on 3rd shift and when the 1st shift staff member arrived at the home Resident A notified her that the staff member was still sleeping.

On 5/19/2025, I conducted an onsite investigation at the facility with direct care staff member David Wells who stated that he works regularly with Resident A who recently reported to him that he saw direct care staff member Qwadri Bradsher sleeping on the living room couch when he was working by himself with the residents. David Wells

stated Resident A now makes jokes about the incident with other residents. David Wells stated he has no direct knowledge about this incident.

While at the facility, I also conducted an interview with Resident A who stated that on 4/15/2025, he woke up late in the evening and found staff member Qwadri Bradsher sleeping on the couch in the living room without any other staff members present. Resident A stated he immediately took a picture on his cell phone and went back to sleep however the next morning while Qwadri Bradsher was still sleeping, he went outside to inform staff member Madeline Warren about the incident when she arrived at the home for her shift. Resident A stated all the other residents were sleeping at the time however he notified the other residents about the incident the next morning.

On 5/19/2025, I conducted interviews with direct care staff member Madeline Warren who stated that as she was parking in the driveway when she arrived to work on the morning of 4/16/2025, Resident A ran outside and reported to her that staff member Qwadri Bradsher has been sleeping on the couch since the night before. Madeline Warren stated she then went inside the house and saw Qwadri Bradsher sleeping on the couch in the living room with no other staff members present in the home. Madeline Warren stated she called the manger and program director. Madeline Warren stated she works with Qwadri Bradsher regularly and she has no knowledge of him ever sleeping while on shift in the past and to her knowledge all staff members are aware that they are not supposed to sleep while on shift.

On 5/29/2025, I conducted an interview with staff member Terrence Brunn who stated that he is the program director of the facility. Terrence Brunn stated he was contacted by Madeline Warren when she arrived to work on 4/16/2025 and she informed him that she and Resident A observed Qwadri Bradsher sleeping while he was supposed to be working. Terrence Brunn stated that due to this company violation, he received disciplinary action.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on my investigation which included interviews with staff members Kennedy VanNiman, David Wells, Madeline Warren, Terrence Brunn, Resident A, RRO Kate Koyak, and my review of facility's incident report there is evidence to support the allegation that direct care staff member Qwadri Bradsher was sleeping while working on 3rd shift. Madeline Warren and Resident A both reported that they observed Qwadri Bradsher sleeping on the couch in the living room with no other staff members present while he was supposed to be working. Kennedy VanNiman and Terrence Brunn further reported that staff contacted them on the morning of 4/16/2025 and stated that Qwadri Bradsher was observed sleeping while on shift with no other staff members present. The licensee did not have sufficient staff on duty to provide supervision and protection.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/2/2025, 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 and make comments.

On 6/11/2025, I received and approved an acceptable correction action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was approved; therefore, I recommend the current license status remain unchanged.

Ondrea Johnson

6/16/2025

Ondrea Johnson
Licensing Consultant

Date

Approved By:

Dawn Timm

06/17/2025

Dawn N. Timm
Area Manager

Date