GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 24, 2025

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

RE: License #: AS130411523
Investigation #: 2025A1030039
Beacon Home At East Ave South

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 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.

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) 356-0100.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130411523
Investigation #:	2025A1030039
Complaint Receipt Date:	06/27/2025
Investigation Initiation Date:	06/30/2025
Report Due Date:	08/26/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kim Howard
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At East Ave South
Facility Address:	20271 East Ave N Battle Creek, MI 49017
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	04/13/2022
License Status:	REGULAR
Effective Date:	12/12/2024
Expiration Date:	12/11/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A staff member intentionally slammed on the breaks while Resident A was unbuckled in the facility van.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/27/2025	Special Investigation Intake 2025A1030039
06/30/2025	Special Investigation Initiated - Telephone Interview with referral source
06/30/2025	Contact - Document Received Received and reviewed two incident reports
07/02/2025	Contact - Face to Face Interview with Resident A
07/02/2025	Contact - Face to Face Interview with Heather Martinez
07/02/2025	Contact - Face to Face Interview with Katelynn Ashley
07/02/2025	APS Referral APS referral made
07/03/2025	Contact - Face to Face interview with Kaylyn Greer
07/03/2025	Contact - Document Received Received and reviewed Resident A Behavior Support Plan
07/15/2025	Exit Conference

ALLEGATION:

A staff member intentionally slammed on the breaks while Resident A was unbuckled in the facility van.

INVESTIGATION:

On 6/30/25, I interviewed the referral source by phone. The RS reported that direct care staff member (DCSM) Kaylyn Greer was transporting Resident A home from the hospital when the incident occurred. The RS reported Resident A and Ms. Greer were alone in the van so there were no witnesses however Ms. Greer "bragged" to other staff members that Resident A unbuckled her seatbelt while they were driving and she slammed on the breaks to "teach her a lesson." The RS reported a staff members completed an incident report about what Ms. Greer told them and Ms. Greer was suspended pending the investigation.

On 6/30/25, I received two Incident Reports (IR) from the RS. IR#1 authored by DCSM Marquita Robinson. IR #1 indicated Ms. Greer told Ms. Robinson that she "slammed on the breaks" when Resident A was having behaviors in the van and that Resident A hit her head on the back of the seat. IR#1 also reported Ms. Greer admitted to telling Resident A to "sit the fuck down."

IR #2 was authored by Ms. Greer and indicated while transporting Resident A home from the hospital she asked to be taken for a ride, to the vape store and to the gas station, however was informed that she could not be taken anywhere right now due to her behavior support plan (BSP.) IR# 2 also reported that Resident A unbuckled her seat belt several times, called her names and hit her in the arm. IR #2 reported Ms. Greer responded each time by pulling the van over and asking Resident A to put her seatbelt back on.

On 7/2/25, I interviewed home manager Heather Martinez at the facility. Ms. Martinez reported she is aware of the investigation. Ms. Martinez reported Resident A has a significant mental illness and does not always aware of what is going on around her. Ms. Martinez reported Resident A told her that she did not have a good ride home from the hospital but did not tell her what happened. Ms. Martinez reported Resident A hit her head but did not sustain any injuries.

On 7/2/25, I attempted to interview Resident A, however she was in the bathroom and did not want to be interviewed.

On 7/2/25, I interviewed DCSM Katelynn Ashley at the facility. Ms. Ashley reported she was working on 6/20/25 when Ms. Greer brought Resident A back from the hospital. Ms. Ashley she overheard Ms. Greer talking to DCSM Marquita Robinson about the ride home and she "bragging" about hitting the breaks when Resident A began having behavioral problems. Ms. Ashley reported Ms. Greer did not buckle Resident A into the

van, which she should have done because Resident A needs assistance because she has limited use of her hands.

On 7/3/25, I interviewed DCSM Kaylyn Greer at the ISK office in Kalamazoo. Also present at the interview was Recipient Rights Officer Suzie Suchyta. Ms. Greer reported she was working on 6/20/25 when Resident A had to go to the hospital due to a fall at the facility. Ms. Greer reported she was asked to go to the hospital to supervise Resident A and drove the agency van as Resident A was transported via EMS. Ms. Greer reported Resident A was treated and released and she was transported Resident A back to the facility. Ms. Greer reported that shortly after they left the hospital Resident A asked to be taken to lunch. Ms. Greer reported she informed Resident A that she had lunch saved for her at the facility. Ms. Greer reported Resident A then asked to go to the "vape shop" and got upset when Ms. Greer told her she was not able to take her on an outing by herself in the community. Ms. Greer reported Resident A then got out of her seat and moved closer to Ms. Greer while the van was moving. Ms. Greer reported Resident A then was able to calm down and sat back in her seat and buckled her seat belt.

Ms. Greer reported Resident A then got out of her seat again and asked to go to the gas station and was again informed that Ms. Greer was not able to take her to the gas station. Ms. Greer reported Resident A then began hitting her and pulled her hair. Ms. Greer reported she asked Resident A to sit down again, which she did. Ms. Greer reported she called the home manager and informed her that Resident A was having behaviors and that someone may need to assist her to get Resident A home. Ms. Greer reported she pulled the van over each time Resident A unbuckled her seat belt and got out of her seat. Ms. Greer reported they eventually got back to the house. Ms. Greer denied ever telling Resident A to "sit the fuck down" or slamming on the breaks to teach her a lesson. Ms. Greer reported she did hit the brakes hard when Resident A pulled her hair but only hit the brakes hard when her hair was pulled because of it being a safety issue and not to punish her. Ms. Greer also denied that Resident A hit her head.

Ms. Greer reported Resident A's Behavior Support Plan indicates she is a 2-1 while in the community. Ms. Greer reported she was the only DCSM at the hospital even though there should have been staff members because they were in the community. Ms. Greer reported she has worked with Resident A for more than a year and feels comfortable being alone with her in the agency van.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a

	resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	It was alleged that a staff member intentionally slammed on the breaks while Resident A was unbuckled in the facility van. Based on interviews and review of documents this violation will be established. Although staff member Kaylyn Greer denied the allegation, there were two staff working with Ms. Greer on 6/20/25 and indicated Ms. Greer admitted to slamming on the brakes in the facility van in response to Resident A having behavioral issues on the way home from the hospital.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 7/3/25, I received and reviewed Resident A's Behavior Treatment Plan (BTP.) Resident A's BSP indicated Resident A should be "accompanied by two staff members" due to concerns of elopement, stealing, threatening aggression, physical aggression and unsafe community behaviors.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(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.
ANALYSIS:	According to Resident A's Behavior Treatment Plan she is supposed to be accompanied by two staff members when in the community due to several safety concerns. On 6/20/25, DCSM Kaylyn Greer transported Resident A home from the hospital by herself in spite of the safety concerns established by her treatment team.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/15/25, I shared the findings of my investigation with licensee designee Nichole VanNiman. Ms. VanNiman acknowledged the findings and agreed to submit a corrective action plan.

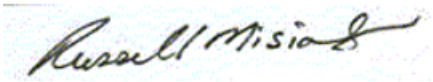
IV. RECOMMENDATION

Contingent upon submission of an acceptable corrective action plan, I recommend no change to the current license status.

8/4/25

Nile Khabeiry Date
Licensing Consultant

Approved By:



8/6/25

Russell B. Misiak Date
Area Manager