



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 10, 2025

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

RE: License #: AM800267885
Investigation #: 2025A1031045
Beacon Home at Anchor Point North

Dear Licensee Designee:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

A handwritten signature in blue ink that reads "KDuda".

Kristy Duda, 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 #:	AM800267885
Investigation #:	2025A1031045
Complaint Receipt Date:	07/23/2025
Investigation Initiation Date:	07/23/2025
Report Due Date:	09/21/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St. Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Israel Baker
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Anchor Point North
Facility Address:	28720 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/03/2005
License Status:	REGULAR
Effective Date:	04/24/2024
Expiration Date:	04/23/2026
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff did not provide 1:1 supervision and Resident A eloped from the facility.	Yes

III. METHODOLOGY

07/23/2025	Special Investigation Intake 2025A1031045
07/23/2025	Special Investigation Initiated - Letter Email sent to Annalise Murray.
07/23/2025	Contact – Document Received.
07/31/2025	Contact - Face to Face Interview with Resident A.
08/07/2025	Contact - Telephone call made Interview with Markena Curtis.
08/15/2025	Inspection Completed-BCAL Sub. Non-Compliance
08/22/2025	Contact – Documents Received and Reviewed.
09/10/2025	Exit Conference held with Nichole VanNiman.

ALLEGATION:

Staff did not provide 1:1 supervision and Resident A eloped from the facility.

INVESTIGATION:

On 7/23/25, I received an online complaint through the Bureau of Community and Health Systems. It was alleged that direct care worker (DCW) Markena Curtis was assigned to Resident A for enhanced 1:1 staffing. Ms. Curtis walked away when she thought Resident A was asleep and left him unattended for 15 minutes while she did laundry. Resident A eloped and was located by the police within an hour.

On 7/23/25, I exchanged emails with Kalamazoo County recipient rights officer Annalise Murray. Ms. Murray reported she is completing an investigation into the same allegations and determined that Ms. Curtis did leave Resident A unattended and he eloped from the facility. Ms. Curtis provided Resident A’s individual plan of

service (IPOS), behavior treatment plan, incident report, and Beacon's bed check policy.

On 7/23/25, I reviewed Resident A's individual plan of service (IPOS), behavior treatment plan, correspondence with community mental health case manager, and incident report.

Resident A's IPOS read that he requires 1:1 supervision to keep him safe in the home and community 12.5 hours per day. Resident A requires staff to be within arm's length while in the community.

Resident A's behavior treatment plan read that he will be assigned enhanced 1:1 staffing while in the home and community. Staff are to be within arm's length from him. Enhanced staffing is required to provide Resident A with additional monitoring of behaviors such as stealing, physical aggression, and verbal aggression.

Resident A's case manager Emily McCollum through Integrated Services of Kalamazoo sent email correspondence regarding the expectations for required staffing for Resident A. Ms. McCollum reported that Resident A requires 12.5 hours per day of enhanced 1:1 staffing while he is awake. Ms. McCollum reported enhanced staff are to be scheduled during wake hours and not nighttime/overnight shifts. 1:1 staff are to remain with Resident A at all times and if he is asleep during wake hours, staff can sit in the hallway outside of the bedroom or in the lobby area to ensure they are aware of when Resident A leaves his bedroom. Ms. McCollum reported staff should not be doing any other task.

The incident report dated 6/19/25 read that around 5pm Resident A was getting upset about something he purchased during an outing. Resident A reported he wanted to be left alone and went to play on his tablet. Around 7:30pm, Ms. Curtis went to do laundry while Resident A was asleep in his room, which took approximately 15 minutes. At 7:45pm, Curtis went to go check on Resident A and noticed he was not in his bedroom. Ms. Curtis then began searching inside and outside the facility and Resident A was not located. Multiple staff drove around the area to look for Resident A. Approximately 30 minutes later, the facility was notified by the sheriff's department of Resident A's whereabouts. Staff went to the address where Resident A was and picked him up and transported him back to the facility. Staff noticed scratches on Resident A's legs which were caused by him squeezing through the gate to leave the premises. The on-call nurse was contacted to assess Resident A's wounds, and it was determined he had superficial scratches which were treated by the nurse.

On 7/31/25, AFC licensing consultant Nile Khabeiry interviewed Resident A at the facility. Resident A confirmed that he eloped from the facility on 6/19/25. Resident A reported he eloped when his "one on one was not watching me." Resident A reported she told him to stay in his room because she was going to do laundry. Resident A reported that he got mad at the staff member and went into the

kitchen, pulling the fire alarm which released the gate outside so he could leave the facility. Resident A confirmed that the fire alarm did go off when he pulled the alarm. Resident A reported he ran into the woods, got lost and ended up at a home where he contacted the owner who happened to be a police officer. Resident A reported the police officer contacted other police officers who then contacted the facility about his whereabouts. Resident A reported he was then brought back to the facility.

On 8/7/25, I interviewed Ms. Curtis via telephone. Ms. Curtis reported Resident A was upset after coming back from an outing. Resident A went to his bedroom to take a nap, and Ms. Curtis went to do laundry after he fell asleep. While Ms. Curtis was doing laundry, Resident A eloped from the facility. Ms. Curtis attempted to locate Resident A by checking inside and outside the facility. Ms. Curtis reported she also drove around for about half an hour and was notified that he was located by the police. Ms. Curtis reported she was assigned to Resident A as his 1:1 enhanced staffing. Ms. Curtis reported she received adequate training regarding responsibilities related to being an enhanced staff. Ms. Curtis reported she was aware that Resident A has 1:1 supervision during waking hours.

On 8/22/25, I received and reviewed Resident A's *Assessment Plan for AFC Residents and Beacon's Enhanced Staffing Policy*.

The assessment plan dated 5/20/25 read that Resident A needs to be monitored at all times while in the community and currently has 12.5 hours of enhanced staffing to ensure his health and safety. Resident A has a history of noncompliance by causing disturbances by taking items from others and pulling fire alarms. Resident A has a history of physical altercations with peers and sexually inappropriate behaviors. Resident A should not be left alone with others due to him making claims of sexually inappropriate touching between him and other residents.

Beacon's enhanced staffing policy read "one-on-one staff is to always be by the side of the individual they are assigned to no matter what they are doing or where they are going. This means no more than arm's length away from the individual. The safety and security of the individual is the first obligation. However, if the staff have the ability to complete other duties while performing this role it is the policy of Beacon that they should do so."

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:	There was sufficient evidence found to support that Ms. Curtis did not provide supervision as specified in Resident A's assessment plan which resulted in Resident A eloping from the facility. Ms. Curtis admitted to leaving Resident A unsupervised for 15 minutes while she did laundry in another area of the facility.
CONCLUSION:	REPEAT VIOLATION ESTABLISHED For reference special investigation reports #2025A1031010 and #2025A1031019

IV. RECOMMENDATION

Consistent with special investigation reports #2025A1031010 and #2025A1031019, revocation of the license is recommended.

8/15/25

Kristy Duda
Licensing Consultant

Date

Approved By:

9/10/25

Russell B. Misiak
Area Manager

Date