



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 6, 2026

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

RE: License #: AM800267885
Investigation #: 2026A1032013
Beacon Home at Anchor Point North

Dear Nicole VanNiman:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 black ink, appearing to read "Dwight Forde".

Dwight Forde, 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 #:	2026A1032013
Complaint Receipt Date:	01/13/2026
Investigation Initiation Date:	02/12/2026
Report Due Date:	03/14/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110, 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Isreal 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 smoke marijuana while on shift or while driving residents.	No
Staff are assaulting residents.	No
Additional Findings	No

III. METHODOLOGY

01/13/2026	Special Investigation Intake 2026A1032013
02/12/2026	Special Investigation Initiated - On Site
02/26/2026	Exit Conference
02/26/2026	APS Referral

ALLEGATION:

Staff smoke marijuana while on shift or while driving residents.

INVESTIGATION:

On 2/12/26, I interviewed Resident A in the facility. Resident A denied observing members of staff assaulting residents, nor did he witness anyone driving while under the influence of smoking marijuana while on shift. Resident A expressed confidence in the staff's driving record, expressing a hope that one of them could transport him to see a sick relative.

I interviewed Resident B in the facility. Resident B denied witnessing employees driving residents to appointments while under the influence.

I interviewed employee Melanie Bryant in the facility. Ms. Bryant denied reports that staff drove residents while under the influence of substances.

I interviewed Administrator Israel Baker in the facility. Mr. Baker denied receiving complaints about staff driving residents while under the influence.

APPLICABLE RULE	
R 400.629	Direct care staff; qualifications and training.
	(4) Direct care staff shall possess all of the following qualifications before working independently: (a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.
ANALYSIS:	I interviewed employees and residents, who denied observing members of staff driving residents to appointments while under the influence. One resident went so far as to say that he hoped he could get a ride to a family member who was ill.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff are assaulting residents.

INVESTIGATION:

On 2/12/26, Resident A denied observing members of staff assaulting residents.

Resident B denied witnessing employees assaulting residents He reported that on 2/11/26, he destroyed property and tried to engage in self-injurious behavior. He credited the staff with true professionalism in the face of his outburst and denied that they physically managed him inappropriately. He stated that he had a mostly good day but was triggered by a call from a relative.

Ms. Bryant stated that she was Resident B's 1:1 staff. She denied reports that staff had assaulted residents.

Mr. Baker denied being in receipt of reports of staff assaults. He stated that typically, residents would complain to him about staffing issues and he would then notify the respective office of recipient rights, Adult Foster Care licensing or adult protective services to lodge a complaint.

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 interviews with two members of staff and two residents, there is insufficient evidence to establish a violation. Those interviewed denied witnessing any staff assaults, and a resident who had to be physically managed due to self-injurious behavior, reported that the staff intervened in an appropriate fashion.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 2/26/26, I provided an update to Administrator Israel Baker, where I shared my findings in an exit conference.

IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

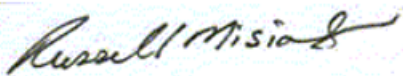


2/26/26

Dwight Forde
Licensing Consultant

Date

Approved By:



3/6/26

Russell B. Misiak
Area Manager

Date