GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2026

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

RE: License #: AM800299049
Investigation #: 2026A1030035
Beacon Home at Woodland

Dear Ms. VanNiman:

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

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 #:	AM800299049
Investigation #:	2026A1030035
Complaint Receipt Date:	05/28/2026
Investigation Initiation Date:	05/28/2026
Report Due Date:	07/27/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Woodland
Facility Address:	56832 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	09/12/2016
License Status:	REGULAR
Effective Date:	03/12/2025
Expiration Date:	03/11/2027
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not protected from being assaulted by several residents.	Yes
Additional Findings	No

II. METHODOLOGY

05/28/2026	Special Investigation Intake 2026A1030035
05/28/2026	APS Referral APS referral made
05/28/2026	Special Investigation Initiated - Telephone Interview with Danyell Baltazar
05/29/2026	Contact - Document Received Reviewed a video
06/02/2026	Contact - Face to Face Interview with Lynsey Ritchie
06/02/2026	Contact - Face to Face Interview with Resident A
06/02/2026	Contact - Face to Face Interview with Resident B
06/02/2026	Contact - Face to Face Interview with Resident C
06/02/2026	Contact - Face to Face Interview with Resident D
06/03/2026	Contact - Telephone call made Interview with Nikia White
06/03/2026	Contact - Telephone call made Interview with Jennifer Conwell
06/04/2026	Contact - Document Received Received and reviewed a video

06/05/2026	Contact - Document Received Received documtation
06/09/2026	Contact - Document Received Received training manual
06/09/2026	Contact - Telephone call made Interview with Amy Rathbun
06/10/2026	Exit Conference

ALLEGATION:

Resident A was not protected from being assaulted by several residents.

INVESTIGATION:

On 5/29/26, I interviewed with home manager, Danyell Baltazar by phone. Ms. Baltazar reported that there was an incident between Resident A and several other residents on 5/24/26 that resulted in Resident A being assaulted. Ms. Baltazar reported there were three staff members working and did not act quickly enough to de-escalate the situation and did not follow agency policy on physical intervention resulting in Resident A not being appropriately protected. Ms. Baltazar reported one of the staff members recorded part of the incident which she forwarded to be to be reviewed.

On 5/29/26, I received and reviewed a 37 second video from Ms. Baltazar. The video was taken by direct care staff member (DCSM) Nakia White and documented a physical altercation between Resident A and four other residents that occurred outside of the facility. The video did not have any sound but it clearly documented that Resident A was pushed and punched by two residents and then pushed to the ground as two other residents joined in and began kicking and stomping Resident A. In total there were four residents who assaulted Resident A. The video also clearly showed DCSM Lynsey Ritchie and DCSM Jennifer Conwell watching the altercation and did not appear to be disturbed by the situation or attempted to intervene.

On 6/2/26, I interviewed DCSM Lynsey Ritchie at the facility. Ms. Ritchie reported that she had worked at the facility for a little less than two months. Ms. Ritchie confirmed that she was working on 5/24/26 when the fight occurred between Resident A and several other residents. Ms. Ritchie described Resident A as being an “instigator” with the other girls at the facility and had been verbally and physically aggressive with Resident B during the day. Ms. Ritchie reported that Resident A also called Resident C the “N word” which upset Resident C and then advanced towards her in a combative

manner. Ms. Ritchie reported that she took Resident C for a short walk to defuse the situation and then when they returned the fight began.

Ms. Ritchie was shown the 37 second video of the fight and indicated she believed she did the right thing not to intervene and just watch the assault of Resident A. Ms. Ritchie reported that she "did what she was trained to do" and not to intervene in a physical confrontation. Ms. Ritchie also reported that the facility discontinued using the CPI system for non-violent physical intervention and is now using the "Ukeru" system which utilizes small and large pads to block individuals that may be in a physically dangerous situation. Ms. Ritchie reported that she was trained in the Ukeru system and that the pads are located in the living room but chose not to use them because she felt it would not work for the type of residents at the facility. Ms. Ritchie reported that did she did not grab the pads because she did not want to walk in the middle of the physical confrontation even though the video clearly showed that there was a unobstructed path into the home. Ms. Ritchie also reported that she and the other staff members gave three verbal prompts for the residents to use their coping skills during the incident and could not encourage the residents any more or would be in violation of harassment.

On 6/2/26, I interviewed Resident A at the facility. Resident A reported that there was a high level of stress at the facility and believed that all the residents had been traumatized in their lives. Resident A struggled to discuss the events of 5/26/26 due in part to her mental illness but did confirm that it occurred. Resident A reported the staff members Nakia White and Lynsey Ritchie were helpful but DCSM Jennifer Conwell was not helpful and thought it was "funny."

On 6/2/26, I interviewed Residents B, C and D at the facility. All three residents indicated that they assaulted Resident A. However, they felt justified as Resident A had been verbally and physically assaulting them the entire day leading up to the fight. They all reported that the staff members gave them three verbal prompts to try and calm down but the situation escalated and they fought with Resident A.

On 6/3/26, I interviewed DCSM Nikia White by phone. Ms. White confirmed that she, Lynsey Ritchie and Jennifer Conwell were working on 5/24/26. Ms. White reported she in the facility dealing with another resident who was having behaviors when the assault occurred outside. Ms. White reported she witnessed the assault and felt very disturbed about the entire situation. Ms. White reported she had physical limitations due to a medical condition and couldn't physically intervene to de-escalate the situation. Ms. White reported she did not believe the other two staff members did enough to defuse the situation and just watched the incident. Ms. White reported that she was informed by the two other staff members that they used their three prompts to de-escalate the residents. Ms. White confirmed that the facility switched from CPI to Ukeru as a form of physical intervention and all staff had been trained. Ms. White reported that none of the staff working used the new system. Ms. White reported that she did not respond appropriately to the situation and did not do enough to protect the residents.

On 6/3/26, I interviewed DCSM Jennifer Conwell by phone. Ms. Conwell confirmed that she worked on 5/24/26 and that Resident A had been antagonizing several of the other residents throughout the day. Ms. Conwell reported that the residents had been using their coping skills to ignore Resident A. Ms. Conwell reported that at dinner time Resident A went outside to eat her dinner and had a verbal altercation with Resident C. Ms. Conwell reported that Ms. Ritchie took Resident C for a walk to help her de-escalate. Ms. Conwell reported that Resident A then began targeting other residents, including Resident D and they had a physical confrontation inside of the facility. Ms. Conwell reported that she used her body positioning to help de-escalate the fight inside the facility, however the residents made their way outside where Resident A began choking Resident D. Ms. Conwell reported that Resident B and Resident E tried to help Resident D get away from Resident A. Ms. Conwell reported that the residents all started fighting at this point as they were outside in the driveway. Ms. Conwell reported that she called her supervisor and law enforcement.

Ms. Conwell was informed of the 37 second video of the altercation which appeared to show Resident A being attacked by four other residents while she and Ms. Ritchie watched and did not appear to be very concerned about the situation. Ms. Conwell reported that she may have been smiling on the video but was very concerned about the situation. Ms. Conwell reported that the facility was trained in a new method of physical intervention but did not use the new method because she did not have time. Ms. Conwell reported that the staff are only allowed to verbally prompt a resident three times when they are having behaviors and would get written up for harassment and they had used up their three prompts. Ms. Conwell reported that the facility also had a 15 minute rule which meant that if a behavioral situation ended for 15 minutes and then started again the staff could use thee more verbal prompts to de-escalate the situation. Ms. Conwell reported that she did not physically intervene to break up the fight because she was told by supervisor Tony Giancaspro that it would not be safe if there were multiple residents fighting.

On 6/4/26, I reviewed a 30-minute video of the incident on 5/24/26 which showed about 15 minutes before the physical confrontation occurred, the confrontation and roughly 15 minutes after the confrontation ended. It should be noted that there was no audio so I could not determine what was said by staff or residents. I noted that Resident A and Resident D had physically fought outside of the facility several times before the altercation that included the other three residents. I also noted that Resident D seemed to be the aggressor and that Ms. Conwell and Ms. Ritchie were outside during that time and witnessed the fights without making any efforts to get between them or physically redirect either resident.

On 6/4/26, I interviewed facility supervisor, Danyell Baltazar at the facility. Ms. Baltazar reported that Ms. Conwell was incorrect with her interpretation of agency policies regarding prompting and verbal redirection of residents during times of behavioral problems. Ms. Baltazar also reported that there was no policy that would prevent staff from intervening if multiple residents were in a physical confrontation, however the staff would have to ensure that they don’t put themselves in an unsafe situation.

On 6/5/26, I received the certificate of completion of training dated 4/2/26 for Ms. Ritchie, Ms. Conwell and Ms. White regarding the Ukera Training on Trauma-Informed Care (Full presentation, blocking techniques, protective skills and releases.)

On 6/9/26, I received and reviewed the Ukeru training manual for the facility. I noted in Section 8: Introduction to Protective Physical Skills section it indicated that blocking may be necessary for the following situations, when prevention and de-escalation efforts failed, when unexpected or uncontrollable provocation occurs, when the person is dissociated or has other neuropsychiatric disturbance or when a person feels the need to discharge strong emotions.

On 6/9/26, I interviewed Amy Rathbun, the facility's director of training regarding the investigation and the Ukeru system that replaced the CPI system. Ms. Rathbun reported she had the opportunity to review the two videos of the incident at the facility and indicated that staff did not follow their training and instead "did nothing" to manage the situation.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	It was alleged that Resident A was not protected from being assaulted by several residents. Based on interviews, documentation and review of video evidence, this violation will be established. On 5/24/26, Resident A was assaulted by four residents of the facility. The assaulted was captured on video by a staff member and on the facility's outside camera and clearly demonstrated that all three staff members did not protect Resident A from being assaulted and did not follow the facility's polices on physical intervention and safety of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/11/26, I shared the findings of the investigation with licensee designee, Nichole VanNiman by phone. Ms. VanNiman acknowledged and agreed to submit a corrective action plan.

III. RECOMMENDATION

Upon the submission of an acceptable corrective action plan, I recommend no changes to the current license status.

Nile Khabeiry, LMSW

6/15/26

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

6/16/26

Russell B. Misiak Date
Area Manager