GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 28, 2026

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

RE: License #: AS230404895
Investigation #: 2026A0007026
Beacon Home at Arlene

Dear Nichole 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.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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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 (517) 335-5985.

Sincerely,

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS230404895
Investigation #:	2026A0007026
Complaint Receipt Date:	04/02/2026
Investigation Initiation Date:	04/02/2026
Report Due Date:	06/01/2026
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 Arlene
Facility Address:	4219 Arlene Drive Lansing, MI 48917
Facility Telephone #:	(517) 253-7112
Original Issuance Date:	10/02/2020
License Status:	REGULAR
Effective Date:	03/29/2025
Expiration Date:	03/28/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Caregivers at the Arlene home used a spray bottle to spray residents, including in the face, during behavioral incidents.	Yes

III. METHODOLOGY

04/02/2026	Special Investigation Intake - 2026A0007026
04/02/2026	Special Investigation Initiated – Telephone - Interview with the complainant.
04/02/2026	Contact - Telephone call made - Interview with Jody Marsh, ORR.
04/06/2026	Inspection Completed On-site - Unannounced - Face to face contact with Michelle Hitsman, Shareese Farr, Destiny Jimenz, and Resident A.
04/13/2026	Contact - Telephone call received from Emily Presendieu, APS Worker. Discussion.
04/14/2026	Contact - Document Received- Emails from and to Emily Presendieu, APS. This is happening to all residents in the home. Names of the other residents provided.
04/14/2026	Contact - Telephone call made to Emily Presendieu, APS Worker. Discussion.
04/14/2026	Contact - Document Received - Email from Emily Presendieu, APS.
04/15/2026	Contact - Document Sent - Email to Emily Presendieu, APS. SIR number provided.
04/16/2026	Contact - Telephone call received from Jody Marsh, ORR. Discussion. At least three staff members failed to report.
04/30/2026	Contact - Telephone call received from Cheryl Corden, Pathways ORR.
04/30/2026	Contact - Telephone call made to Brook Landis, Program Manager.

05/05/2026	Contact - Telephone call received from Melissa Gekeler, Network 180. She was provided with new information regarding Resident A. Note these allegations were addressed in SIR# 2026A0007020.
05/06/2026	Contact - Telephone call made to Melissa Gekeler, Network 180. Message left.
05/11/2026	Contact - Telephone call received from Melissa Gekeler, Network 180. Discussion.
05/13/2026	Contact - Telephone call received from Emily Presendieu, APS. Discussion. Pictures of spray bottle and bleach sent.
05/26/2026	Contact - Telephone call made to Employee #3. Message left. I requested a return phone call.
05/26/2026	Contact - Telephone call made - Interview with Employee #2.
05/26/2026	Contact - Telephone call made - Interview with Employee #3.
05/26/2026	Contact - Telephone call made to Johnathan Davis. Interview.
05/26/2026	Contact - Telephone call made to Employee #1 message left. I requested a return phone call.
05/28/2026	Contact – Document Sent – Email to Nichole VanNiman, Licensee Designee, regarding conducting the exit conference.
05/28/2026	Contact – Document Received – Email from Nichole VanNiman, Licensee Designee, regarding conducting the exit conference.
05/28/2026	Exit Conference conducted with Nichole VanNiman, Licensee Designee.

ALLEGATIONS: Caregivers at the Arlene home used a spray bottle to spray residents, including in the face, during behavioral incidents.

INVESTIGATION:
As a part of this investigation, I reviewed the written complaint, and a summary of the following was noted: The dates of the incidents are unknown. Employee #1 observed staff members engaging in concerning interactions with the residents. Employee #1 disclosed that Michelle Hitsman, Home Manager, and other direct care staff “utilized a water-filled spray bottle to spray residents during behavioral escalations. [Employee #1] reported that this was primarily observed when a resident’s behaviors had escalated, and that the spray bottle was reportedly used by staff as a response to those behaviors, including being sprayed toward the resident’s

face. [Employee #1] identified that this was initially implemented by staff member, Shereese Farr, and was later continued by the home manager, Michelle Hitsman."

On April 2, 2026, I spoke with Jody Marsh, ORR. She informed me that Employee #1 used to work at Beacon Home at Arlene, but she was forced to transfer to Beacon Home at Cogswell. Beacon Clinician #1 was attempting to establish rapport with Employee #1. Employee #1 then informed her of the allegations; regarding the staff using a spray bottle to spray the residents during behaviors. This happened at the end of 2024. Jody Marsh asked Beacon Clinician #1 how often she was in the home and she informed it was two to three times a month. Beacon Clinician #1 has not seen a spray bottle in the home. All of the residents are non-verbal. Employee #1 said she told Kelly Krutsch, and she (Kelly Krutsch) said not to worry about it. Brook Landis, Program Manager, was contacted and she informed Jody Marsh that she was going to send someone out to the house to see if there was a spray bottle. Brook Landis also informed that they made a call to HR to see if Employee #1 told anyone about these allegations and nothing was documented. Brook Landis was not able to remove all staff from the schedule, but Michelle Hitsman, who has the role of home manager, and Sherice Farr, were taken out of the home, without pay. There is also a question about there being drama amongst the staff. According to Jody Marsh, there will be a rights violation as Employee #1 failed to report. All CMH's know about the allegations, and it's believed that APS has been contacted, regarding Resident A.

On April 6, 2026, I conducted an unannounced on-site investigation and made face to face contact with Michelle Hitsman, who has the role of home manager, Shareese Farr, direct care worker (DCW), Destiny Jimenz, DCW, and Resident A.

I informed staff that I received a complaint and asked if there were any residents I would be able to speak with. I was informed that three of the residents were non-verbal and one resident would repeat what I said back to me. I made face to face contact with Resident A, as the other residents were not home.

I interviewed Michelle Hitsman and inquired about Resident A's behaviors and how they were supposed to be addressed, based upon the *Behavioral Treatment Plans*. She explained that Resident A's behaviors included inappropriate urination, and he's redirected to the bathroom. If he urinates on the cardboard boxes or toys, they removed them, sanitized the toys and return them within 24 hours. For Resident B, his behaviors also include inappropriate urination and defecation. Resident B is prompted to redress, shower, and clean up. Resident C will sometimes hit himself, and they utilized the assistive devices (helmet and mitts). If he goes five minutes without the behavior, then the helmet/mitts are removed, and reapplied if he goes back into the behavior. Resident D's behaviors included physical aggression. Staff are to redirect him and remind him of safe hands. Resident D is to be redirected if he engages in property destruction. Resident D also likes to sleep during waking hours and he is redirected. This is part of his plan as if he sleeps during the day, then he doesn't want to sleep at night. I inquired about the spray bottles being utilized when

the residents were in behaviors, and Michelle Hitsman denied the allegation. She stated they used spray bottles like water guns in the summer. Michelle Hitsman stated she had never heard of the spray bottles being used while residents were in behaviors, and that she has never done that. Michelle Hitsman stated that when she gives the residents a shower, she doesn't even spray them in the face while they're in the shower.

While at the facility, I looked around to see if I observed any spray bottles sitting out; nothing was observed. Michelle Hitsman also unlocked each of the cabinets in the kitchen area so that I could check them. I completed a walk-through of the facility. Michelle Hitsman also stated to me "This is my office, you're more than welcome to look around." I looked around the office, and then I observed a spray bottle with a substance behind the office door, on the floor. It appeared that it had been tossed behind the door, as it was on top of some other items. I also observed two bottles of all-purpose bleach. Michelle Hitsman informed me that she removes things as she sees them, that don't belong, and the spray bottle was taken from the laundry room. She informed me that she removed it quite a while ago. I asked her what was in the spray bottle, as it was not labeled, and she stated it was bleach water. I opened the container to smell it. It smelled like peppermint oil and water. I asked Michelle Hitsman to smell the substance in the container, and she did, stating that she could not smell anything. I also took photos for the file. Michelle Hitsman emptied the container in the kitchen sink, prior to the conclusion of the on-site investigation.

I interviewed Shareese Farr, DCW. She described the behaviors for each resident and the steps to follow per the *Behavioral Treatment Plans*. I inquired about the spray bottle being utilized to address behaviors and she stated, "Not that I've seen." In addition, she had not heard of this being an issue. She also denied spraying the residents in the face to address their behaviors.

I interviewed Destiny Minace, DCW. She was cooperative with the investigation. She also described the behaviors for each resident and the steps to follow per their *Behavioral Treatment Plans*. I inquired about the spray bottle being utilized to address behaviors and she informed me that she had never heard of staff doing that, she had not witnessed it, and she had not done that herself.

On April 13, 2026, I spoke with Emily Presendieu, APS Worker. She informed me that APS had responded to the facility and conducted interviews with the staff. Approximately nine staff were interviewed. Michelle Hitsman was interviewed, and during her interview, she appeared nervous, as her voice was shaking. Brook Landis, Program Manager, informed her that Michelle Hitsman and Johnathan Davis were suspended. The allegations would be substantiated.

On April 14, 2026, I received an email from Emily Presendieu, APS. During her investigation she was told that this was also happening to the other residents in the home (use of the spray bottle).

On April 14, 2026, I spoke with Emily Presendieu, APS. We discussed the investigation. She informed me that she had spoken with Jody Marsh, ORR, that morning. She now has cases on all four residents. During her investigation, she was informed that Employee #2 observed Resident C being sprayed (not in the face), but on the upper part of his body. Resident C would then scurry to his room. Emily Presendieu was also informed that Resident B jumps up and down, staff would spray him, and he would calm down. Aurora Cimmerer was a new worker, who was also interviewed, and she had never seen the residents sprayed but was told about it. Johnathan Davis was off on leave (suspended). He was interviewed by APS and denied allegations. All but one of the guardians/parents have been contacted and notified of the allegations and investigation.

On April 30, 2026, I received a call from Cheryl Corden, Pathways ORR. She informed me that she had just been notified of the allegations regarding Resident D. We discussed the investigation. She has also been in contact with Emily Presendieu regarding the investigation. Cherly Corden informed me that Resident D would not be able to report what was occurring, or he may have moved out of the way.

On April 30, 2026, I spoke with Brook Landis, Program Manager, who reported that Michelle Hitsman had been suspended, pending the investigation.

On May 11, 2026, I spoke with Melissa Gekeler, from Network 180, ORR. Resident A is on her caseload. She spoke with Employee #1 who informed her that she saw Michelle Hitsman spray the resident. When Melissa Gekeler started her investigation, Michelle Hitsman had already been suspended. She will send over a copy of her report and the conclusion of the investigation.

On May 26, 2026, I interviewed Employee #2. Employee #2 recalled that the incident occurred when she first started the job as a direct support professional. She stated in August of 2025, she was on a shadow shift, and she observed the home manager (Michelle Hitsman), and a few others, who no longer work there, spray the residents. When asked who the others were, she informed it was Kalissa (Last name unknown) and JD (Johnathan Davis). She stated that Kalissa (Last name unknown), no longer works there. She also stated that she has not seen JD (Johnathan Davis), since the investigation started. Employee #2 stated that she saw them spray Resident B and Resident C near their stomachs. She denied witnessing them spraying the residents in the face. The water was in a spray bottle for chemicals. When asked why the residents were sprayed, she stated that one resident got too close and was in staff's personal space, and the other resident was in a behavior and not listening. After the residents were sprayed, they would go away. She stated that Resident B would mainly be in the living room, and after being sprayed he would go and sit down. Resident C would go back to his room. Employee #2 observed the residents being sprayed a couple times each. She stated she knew it wasn't right, but didn't know what to do, and didn't want to start drama because it involved the home manager. Employee #2 stated she hadn't received Recipient Rights' training yet. Employee #2

stated that she adored the residents and confirmed that she now knows what to do if she observed staff mistreating the residents.

On May 26, 2026, I interviewed Employee #3. She stated it was a while ago that the incident occurred but recalled it was her first or second day on the job. She informed that one of Resident C's behaviors is that he will get into the personal space of others. He will either stand to close or even try to kiss the individual. Employee #3 stated that all she remembers was Michelle Hitsman grabbing the spray bottle and spraying Resident C in the face. She stated that he flinched. Employee #3 saw this occur one time as she was then transferred to a different home. I inquired if she notified anyone and she stated that it was her first or second day on the job, she didn't know who to call, and she did not want to lose her job as quickly has she had gotten it. She stated she thought it was absurd that she [Michelle Hitsman] was spraying people like they were a cat. Employee #3 stated she now knows what to do if she were to observe inappropriate treatment of the residents.

On May 26, 2026, I interviewed JD (Johnathan Davis), DSP, regarding the allegations. He informed me that he worked for Beacon for five years in the juvenile program and transferred to Beacon Home at Arlene once that program closed. He worked in the facility for about 7 months. He confirmed that he had spoken with ORR. He denied that he or any staff have used water bottles or squirt bottles to spray the residents to de-escalate them. He stated that since November, he was in the on-call status and had not worked in the facility since February, due to a pending investigation. He stated there is a lot of drama between the staff, and that is one reason he had reduced his schedule to on call. He stated that he has been in the field a long time and he had no reason to treat the residents in that manner.

On May 26, 2026, I spoke with Kelly Krutsch. She stated that she's no longer the program manager. She stated that Employee #1 was being transferred to Beacon Home at Cogswell and Michelle Hitsman did not want to address it, so she handled the transfer. She stated that Employee #1 never reported the allegations to her. Kelly Krutsch informed me that they do have spray bottles for cleaning in the facilities, they are to be labeled and locked up. I informed her that I found a spray bottle that smelled like peppermint oil and water in the facility. She stated she has known Michelle Hitsman for a long time, and she could not see Michelle Hitsman spraying the residents.

On May 28, 2026, I conducted the exit conference with Nichole VanNiman, Licensee Designee. We discussed the allegations, the investigation, and my recommendations. We also discussed issues regarding staff's understanding of recipient rights. She stated that Michelle Hitsman was currently suspended, pending the investigation, and she would be recommending termination. She agreed to follow up regarding the final decision and submit a written corrective action plan to address the established violation.

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 upon my investigation, which consisted of an unannounced on-site investigation and observations, interviews with multiple staff, APS and ORR, it's concluded that while it's alleged that Michelle Hitsman and other staff mistreated the residents, it's clear that there is a preponderance of the evidence to support the allegations that Michelle Hitsman, who had the role of home manager, mistreated the residents by intentionally spraying them, with a spray bottle, when they were either in a behavior or too close to staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of a detailed and approved written corrective action plan, it's recommended that the status of the license remains unchanged.

5/26/2026

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Mahtina Rubritius Date
Licensing Consultant

Approved By:

05/26/2026

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Dawn N. Timm Date
Area Manager