



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 18, 2026

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

RE: License #: AS250412389
Investigation #: 2026A0779031
Beacon Home at Clío

Dear Nichol VanNiman:

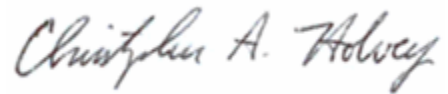
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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) 643-7960.

Sincerely,

A handwritten signature in cursive script that reads "Christopher A. Holvey".

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250412389
Investigation #:	2026A0779031
Complaint Receipt Date:	05/13/2026
Investigation Initiation Date:	05/15/2026
Report Due Date:	07/12/2026
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 Clio
Facility Address:	1491 Bondy Dr. Clio, MI 48420
Facility Telephone #:	(810) 368-4621
Original Issuance Date:	09/07/2022
License Status:	REGULAR
Effective Date:	03/07/2025
Expiration Date:	03/06/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 05/12/2026, staff person Tashara Marshall threw water on Resident A.	Yes

III. METHODOLOGY

05/13/2026	Special Investigation Intake 2026A0779031
05/13/2026	APS Referral Complaint was received from APS centralized intake.
05/15/2026	Special Investigation Initiated - On Site
05/18/2026	Contact - Telephone call made Spoke to staff person, Ken Clinton.
05/18/2026	Contact - Telephone call made Spoke to staff person, Megan Lotts.
05/21/2026	Contact - Telephone call made Soke to staff person, Tashara Marshall.
06/18/2026	Exit Conference Held with licensee designee, Nichole VanNiman.

ALLEGATION:

On 05/12/2026, staff person Tashara Marshall threw water on Resident A.

INVESTIGATION:

On 5/15/2026, an on-site inspection was conducted and Resident A was interviewed. Resident A had a hard time staying focused and was a little fuzzy on the details of the incident. Resident A did state that he remembered staff person, Tashara Marshall, throwing water on him. Resident A stated that Staff Marshall is rude and petty with him all the time and also cusses at him.

On 5/15/2026, Resident B stated that he witnessed Staff Marshall pour water over Resident A's head to get him to stop talking. Resident B did not think that anyone else

witnessed the incident. Resident B confirmed that Staff Marshall cusses at him and other residents but did not provide any further details.

On 5/15/2026, staff person, Najiyah Cureton, stated that she worked with Staff Marshall on 5/12/2026. Staff Cureton stated that Staff Marshall was frustrated with Resident A that day and was arguing with Resident A, but she did not witness Staff Marshall throw water on Resident A. Staff Cureton reported that she has witnessed Staff Marshall cuss at residents out of frustration, but she was not comfortable sharing any more details or examples.

On 5/15/2026, home manager, Haley Moore, stated that staff called her on 5/12/2026 saying that Resident A was upset and wanted to talk to her about an incident he had with Staff Marshall. HM Moore stated that Resident A was extremely upset on the phone and told her that Staff Marshall threw water on him.

On 5/18/2026, a call was made to staff person, Ken Clinton, who confirmed that he worked on 5/12/2026, the shift after Staff Marshall worked. Staff Clinton stated that when he arrived at the home, Resident A was on the front porch, was visibly wet, very upset and was crying. Staff Clinton reported that Resident A told him that Staff Marshall had just threw water on him, had cussed at him, made fun of him, and told him that he was slow and stupid. Staff Clinton stated that when he entered the home he saw that there was water on the floor of the kitchen area.

On 5/18/2026, a call was made to staff person, Megan Lotts, who confirmed that she worked on 5/12/2026. Staff Lotts stated that when she arrived at the home to start her shift, she noticed that there was water on the floor and Resident A was very upset. Staff Lotts stated that Resident A said that Staff Marshall threw water on him, laughed at him and called him stupid. Staff Lotts reported that she has witnessed Staff Marshall be disrespectful toward residents in the past and personally antagonizing them, by saying things like that she does not care about what they want and telling residents to go away from her.

On 5/21/2026, a phone interview was conducted with staff person, Tashara Marshall, who confirmed that she was aware of the allegations against her. Staff Marshall stated that Resident A became upset with her when she told him that he could not smoke on the front porch and had to go to the back deck, but that nothing else happened. Staff Marshall denied throwing water on Resident A or ever teasing him, cussing at him or ever disrespecting any residents.

On 6/18/2026, an exit conference was held with licensee designee (LD), Nichole VanNiman, who confirmed that she was aware of these allegations. LD VanNiman stated that Staff Marshall was immediately suspended pending further investigation. LD VanNiman stated that further evaluation will be done to determine if termination of her employment is warranted. LD VanNiman reported that staff will be retrained on reporting requirements related to disrespect of residents. LD VanNiman was informed of the outcome of this investigation and that a written corrective action plan is required.

Special Investigation Report #2024A0779049 dated October 11, 2024, cited the home for lack of dignity and respect of a resident. There was sufficient evidence found to prove that staff person, Rashandra Bennett, did not treat a resident with dignity and respect by yelling and cussing at him. On October 11, 2024, a corrective action plan (CAP) was submitted by Licensee Designee Ramon Beltran. The CAP stated that staff person Rashandra Bennett's employment for this organization had been terminated.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	<p>Resident A confirmed that staff person, Tashara Marshall, threw water on him and stated that Staff Marshall is rude and cusses at him.</p> <p>Two staff persons reported that on 5/12/2026, Resident A was very upset, visibly wet, and told them that Staff Marshall threw water on him, as well as teased him and called him stupid.</p> <p>Resident B stated that he witnessed Staff Marshall pour water over Resident A's head and stated that Staff Marshall does cuss at him and other residents.</p> <p>There was sufficient evidence found to prove that Staff Marshall did not treat Resident A with dignity and respect.</p>
CONCLUSION:	REPEAT VIOLATION ESTABLISHED SIR #2024A0779049 dated October 11, 2024.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this home's license remains unchanged.

Christopher A. Holvey

6/18/2026

Christopher Holvey
Licensing Consultant

Date

Approved By:

Mary E. Holton

6/18/2026

Mary E. Holton
Area Manager

Date