GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2026

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

RE: License #: AS390396198
Investigation #: 2026A0581031
Beacon Home At Augusta

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.

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390396198
Investigation #:	2026A0581031
Complaint Receipt Date:	06/17/2026
Investigation Initiation Date:	06/18/2026
Report Due Date:	08/16/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At Augusta
Facility Address:	817 Webster St. Augusta, MI 49012
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/29/2018
License Status:	REGULAR
Effective Date:	04/03/2025
Expiration Date:	04/02/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION

	Violation Established?
Direct care staff, Melinda Sheddan, verbally and physically abused Resident A by yelling at him, overturning a loveseat to force him to stand, and shoved him into a door.	Yes

III. METHODOLOGY

06/17/2026	Special Investigation Intake - 2026A0581031
06/18/2026	Referral - Recipient Rights - ISK ORR received allegations and are investigating.
06/18/2026	Special Investigation Initiated – Letter - Email correspondence with ISK RRO, Suzie Suchyta. Received IR.
06/24/2026	Contact - Face to Face - In conjunction with ISK RRO, Suzie Suchyta, we interviewed via MiTeams direct care staff/home manager, Kelly Fox
06/24/2026	Contact - Document Received - Email correspondence from Kelly Fox.
06/24/2026	Contact - Face to Face - Via MiTeams, interview with direct care staff, Ashley Gibson and Allison Haines. Interview with Suzie Suchyta, ISK RRO.
06/24/2026	Contact - Telephone call made - Interview Cheyenne Deskin.
06/25/2026	Contact - Telephone call made - Attempted to contact Melinda Sheddan; however, phone message indicated the number was disconnected. I was unable to leave a voicemail.
06/25/2026	APS Referral - Referral made online.
07/02/2026	Inspection Completed On-site - Observed Resident A. Interviewed Resident B.
07/02/2026	Contact - Telephone call made - Attempted to contact Melinda Sheddan again. Left a message requesting a call back.
07/29/2026	Inspection Completed-BCAL Sub. Compliance

07/29/2026	Contact – Document Sent – Email to Adult Protective Services Specialist, Melissa Pachota, requesting update.
07/29/2026	Contact – Document Sent – Email to Administrator, Aubry Napier.
07/29/2026	Contact – Telephone call made – Interview with Melinda Sheddan.
07/29/2026	Contact – Document Sent – Email to Kelly Fox.
07/30/2026	Contact – Document Received – Email from Kelly Fox.
07/30/2026	Exit conference with Administrator, Aubry Napier.

ALLEGATION: Direct care staff, Melinda Sheddan, verbally and physically abused Resident A by yelling at him, overturning a loveseat to force him to stand, and shoved him into a door.

INVESTIGATION: On 06/17/2026, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on or around 06/15/2026, direct care staff, Melinda Sheddan, became upset with Resident A, who is nonverbal, after he began pulling his pants down while seated on a loveseat. The complaint alleged Melinda Sheddan yelled at Resident A to go downstairs and, when he did not comply, she overturned the loveseat, causing him to stand. The complaint further alleged Melinda Sheddan continued yelling and shoved Resident A into the front door.

The complaint also documented Integrated Services of Kalamazoo (ISK) Office of Recipient Rights received the allegations and ISK Recipient Rights Officer (RRO), Suzie Suchyta, was investigating.

On 06/18/2026, I received an email from ISK RRO, Suzie Suchyta, who documented she had scheduled interviews with direct care staff, Cheyenne Deskin and Melinda Sheddan, for later that day. She further documented Melinda Sheddan had been suspended pending the investigation and forwarded me the facility's Incident Report (IR) pertaining to the incident.

The IR, dated 06/16/2026 and completed by Cheyenne Deskin, documented that on 06/15/2026 at approximately 8:30 pm, Resident A began pulling his pants down while seated in the living room. The IR documented Melinda Sheddan directed Resident A to pull up his pants or go downstairs. The IR documented when Resident A did not comply, Melinda Sheddan rotated the loveseat and then lifted it with Resident A seated, causing him to stand, and then pushed him down the hallway until he contacted the door. Resident A then pulled up his pants, returned to the

living room, and sat down. The IR documented Cheyenne Deskin looked Resident A over for any injuries and then attempted to contact her manager. The IR documented Melinda Sheddan was suspended for the duration of the investigation.

On 06/24/2026, I interviewed home manager, Kelly Fox, in conjunction with ISK RRO, Suzie Suchyta. Kelly Fox stated Cheyenne Deskin contacted her at approximately 7:20 am on 06/16/2026 and reported that Melinda Sheddan had shoved Resident A into a door and that she did not how to handle the situation. Kelly Fox stated she didn't work that day and another manager handled the situation.

Kelly Fox stated the licensee utilizes the Ukeru System, which is a trauma informed, restraint free crisis management program. She stated the facility does not utilize blocking pads and that staff are trained to de-escalate situations by giving residents space, redirecting them, removing other residents from the area, and monitoring from a safe distance. Kelly Fox stated physical management is only appropriate when there is an immediate safety risk, such as when a resident is in public or in the roadway. She further stated staff may use environmental modifications, such as retreating out of the sliding door or repositioning the loveseat to create a barrier, to maintain a safe distance from Resident A if he was becoming physically assaultive towards staff and residents.

Kelly Fox stated Resident A's behaviors can appear intimidating but are often misinterpreted by staff. She described Melinda Sheddan as an experienced employee but stated Melinda Sheddan tends to overreact to Resident A's behaviors and use language that exaggerates his actions. Kelly Fox stated Resident A may remain seated if he is removing his clothing and does not need to be physically removed from a chair or loveseat. She further stated staff may prompt Resident A to pull up his pants but should not physically intervene if he is refusing assistance.

I interviewed direct care staff, Ashley Gibson, who stated she's worked at the facility for approximately two years. Ashley Gibson's statements regarding staff's response to Resident A's behaviors were consistent with Kelly Fox's statement. Ashley Gibson stated staff verbally prompt Resident A to pull up his pants, but do not physically guide him to his bedroom or use physical management. She further stated she had never observed staff moving furniture with Resident A seated on it or use body positioning to encourage him to leave an area. Ashley Gibson stated she had occasionally worked with Melinda Sheddan and had not observed concerning behavior or physical management by her toward Resident A.

I interviewed direct care staff, Allison Haines, who stated she had worked at the facility for approximately 2.5 years on the day shift. Her statements were consistent with Ashley Gibson's and Kelly Fox's statements. Additionally, she stated staff do not attempt to escort Resident A to his bedroom because doing so may escalate his behaviors and that his behaviors typically resolve within two to three minutes if he's left alone. Although Allison Haines described Melinda Sheddan as sometimes abrupt

in her communication, she stated she had never witnessed Melinda Sheddan abuse a resident or violate resident rights.

I interviewed ISK RRO, Suzie Suchyta, who summarized her interview with Melinda Sheddan. Suzie Suchyta stated Melinda Sheddan admitted she moved the couch Resident A was sitting in to force him to stand and move toward the hallway where the basement stairs are located. Suzie Suchyta stated Melinda Sheddan reported Resident A was disrobing and touching himself in the common area and stated she had been trained to direct him toward the hallway and stairs by holding his upper arms and guiding him down the hallway to prevent him from swinging at her.

Melinda Sheddan further reported to Suzie Suchyta that she pushed the loveseat to create space between herself and Resident A, then lifted the loveseat to get him to stand before pushing it towards the hallway. Suzie Suchyta stated Melinda Sheddan also reported Resident A scratched her during the incident; however, Suzie Suchyta stated she did not observe any injuries on Melinda Sheddan.

Suzie Suchyta stated Melinda Sheddan reported that Ashley Gibson and Allison Haines had previously instructed her to manage Resident A's disrobing behaviors in a similar manner. Suzie Suchyta stated that Resident A was unable to be interviewed due to being nonverbal.

On 06/25/2026, I interviewed direct care staff, Cheyenne Deskin. Her statement was generally consistent with the content of the IR she completed regarding the incident; however, she provided additional details during her interview. Cheyenne Deskin stated she did not witness Resident A being physically aggressive during the incident involving Melinda Sheddan. She stated Resident A did not comply with Melinda Sheddan's repeated instructions to go downstairs to his bedroom and instead remained seated with his pants down throughout the incident. Cheyenne Deskin stated she did not witness Melinda Sheddan attempt to pull up Resident A's pants or clothe him. She stated Melinda Sheddan positioned a chair to block Resident A from returning to the living room after she directed him toward the hallway. According to Cheyenne Deskin, Resident A eventually moved around the chair and loveseat barricade created by Melinda Sheddan, sat in another chair in the living room for approximately 10-15 minutes, then pulled up his pants and went downstairs to his bedroom. Cheyenne Deskin estimated the incident lasted approximately 30 minutes. Cheyenne Deskin also stated she received Ukeru training from the licensee.

On 07/02/2026, I conducted an unannounced inspection at the facility. Though Resident A was present, I was unable to interview him as he was sleeping; however, he is also nonverbal. Resident A appeared well cared for and no concerns were identified. I interviewed Resident B who stated he's resided in the facility for approximately four years. He stated he was familiar with both Melinda Sheddan and Cheyenne Deskin. He stated when Resident A "acts up" by pulling his pants down and exposing himself staff will prompt and request Resident A to go downstairs. He

stated staff will also prompt the other residents to leave the area. Resident B denied ever seeing Melinda Sheddan force Resident A downstairs and had never seen her physically manage him by pushing or flipping over a chair or couch. Resident B stated he's observed Resident A put his hands in front of staff's faces, but staff will redirect or prompt him to his room or make request for him to stop the behavior. He stated he's also observed staff distance themselves from Resident A if he's getting in their face, but stated he had never seen staff push or shove Resident A.

Resident C and Resident D were also present during the investigation; however, I was unable to interview them due to their cognitive delays and diminished mental capacities. Resident E was on an outing during the inspection and unable to be interviewed.

On 07/29/2026, I interviewed Melinda Sheddan regarding the incident on 06/15/2026. She stated Resident A became upset after consuming a snack and began disrobing, screaming, exposing himself and attempting to approach other residents. She stated Resident A struck her in the eye, grabbed at other residents, and continued escalating despite verbal redirection and offers of additional snacks. Melinda Sheddan stated she and Cheyenne Deskin separated the other residents by moving them into the kitchen and outside while she continued monitoring Resident A.

Melinda Sheddan stated she moved the loveseat toward the hallway to encourage Resident A to go downstairs to his bedroom and created a barrier between Resident A and the other residents. She stated she lifted the loveseat no more than a few inches to encourage Resident A to stand and later flipped it over to create a barrier after he stood. She stated she flipped the loveseat to discourage him from sitting back down on it. She stated moving furniture is a last resort to encourage Resident A to leave the area when he is exposing himself and behaving aggressively. Melinda Sheddan denied shoving Resident A into a door or physically escorting him down the hallway. She acknowledged briefly holding Resident A's wrists for approximately 10 seconds after he began swinging at her but denied using physical management. She stated Resident A went downstairs after letting go of his wrists.

Melinda Sheddan stated she had been trained to direct Resident A toward his bedroom when he disrobes and that staff commonly used furniture to create barriers between Resident A and other residents. She stated the facility had not yet received protective mats that staff had been told would be used during these types of situations but acknowledged she was trained in Ukeru. Melinda Sheddan estimated the incident lasted approximately 2.5 hours and stated Resident A did not sustain any injuries.

On 07/29/2026, I reviewed documentation confirming Melinda Sheddan and Cheyenne Deskin both completed Ukeru training on trauma informed care, which was a full presentation including blocking techniques, protective skills and releases on 12/10/2025 and 05/07/2026, respectively.

On 07/30/2026, I reviewed Resident A's *Assessment Plan for AFC Residents*, dated 01/31/2026, which documented Resident A as non-verbal. It also documented Resident A masturbates and disrobes in public and has a history of yelling and physical altercations towards others. The assessment plan did not identify what the expectation of staff was if Resident A was displaying these behaviors.

I reviewed Resident A's ISK *Individual Plan of Service* (IPOS), dated 04/01/2026, which documented Resident A's history of disrobing in public and physical aggression. The IPOS documented staff are to monitor, provide encouragement, and praise Resident A's progress towards his goals.

I reviewed Resident A's ISK Behavior Treatment Plan (BTP), dated 07/25/2025. According to my review, Resident A has diagnoses of Intermittent Explosive Disorder, Intellectual Disability (Moderate), and Attention Deficit/Hyperactivity Disorder (Combined presentation). The BTP directed staff to respond to disrobing and other target behaviors using proactive interventions including verbal prompting, redirection, positive reinforcement, offering alternative activities, clear communication, and the least restrictive interventions appropriate to the situation. I did not identify any documentation within Resident A's IPOS or BTP authorizing staff to move furniture to block Resident A or to lift or force Resident A from furniture.

Documentation provided also confirmed both Melinda Sheddan and Cheyenne Deskin were both trained on Resident A's IPOS and BTP.

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 my investigation, which included interviews with the facility's home manager, Kelly Fox, direct care staff, Melinda Sheddan, Ashley Gibson, Allison Haines, and Cheyenne Deskin, and Integrated Services of Kalamazoo Recipient Rights Officer, Suzie Suchyta, and review of the facility's Incident Report, there is insufficient evidence to conclude Resident A was mistreated by direct care staff, Melinda Sheddan, through verbal or physical abuse on or around 06/15/2026.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(2) Interventions must be specified in the resident's assessment plan and performed in accordance with that plan. Interventions must ensure that the safety, welfare, and rights of the resident are adequately protected. If an intervention is needed to address the unique programmatic needs of a resident, the intervention must be developed in consultation with, or obtained from, a professional or professionals licensed, certified, or registered in that scope of practice.
ANALYSIS:	Based on my investigation, which included interviews with the facility's home manager, Kelly Fox, direct care staff, Melinda Sheddan, Ashley Gibson, Allison Haines, and Cheyenne Deskin, and Integrated Services of Kalamazoo Recipient Rights Officer, Suzie Suchyta, review of the facility's Incident Report, and review of Resident A' assessment plan, dated 01/31/2026, ISK Individual Plan of Service, dated 04/01/2026, and Behavior Treatment Plan, dated 07/25/2025, there is substantial evidence to conclude Resident A was subjected to behavior interventions on or around 06/15/2026 that were not identified in his Behavior Treatment Plan. Resident A's BTP identified proactive interventions, including verbal prompting, redirection, positive reinforcement, offering alternative activities and clear communication to address disrobing and other target behaviors. The investigation did not identify overturning or lifting furniture while Resident A was seated on it as an approved behavioral intervention. Although Melinda Sheddan reported she was attempting to create distance between Resident A and other residents, there was insufficient evidence establishing she or residents were at imminent risk because of Resident A's behaviors. Consequently, direct care staff, Melinda Sheddan, by her own admission, subjected Resident A to a behavior intervention that was not identified in his Behavior Treatment Plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/30/2026, I attempted to conduct my exit conference with Nichole VanNiman. I was unable to contact her; therefore, I contacted Administrator, Aubry Napier, and

explained my findings. Aubry Napier agreed staff did not implement an approved intervention and would speak to staff about the incident.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

07/30/2026

Cathy Cushman Date
Licensing Consultant

Approved By:

07/30/2026

Dawn N. Timm Date
Area Manager