GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 14, 2026

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

RE: License #: AS500390453
Investigation #: 2026A0604017
Beacon Home At New Haven

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 (248) 972-9136.

Sincerely,

Kristine Cilluffo

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500390453
Investigation #:	2026A0604017
Complaint Receipt Date:	05/01/2026
Investigation Initiation Date:	05/01/2026
Report Due Date:	06/30/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St., Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At New Haven
Facility Address:	36790 28 Mile Road Lenox Township, MI 48048
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	03/13/2018
License Status:	REGULAR
Effective Date:	09/18/2024
Expiration Date:	09/17/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A is being mistreated by staff which is making her want to harm herself. They have taken belongings out of her bedroom and will not take her on outings.	No
Resident A is not being taken to required medical appointments.	Yes
Staff are not allowing Resident A to go to hospital or mental health clinic when requested.	No

III. METHODOLOGY

05/01/2026	Special Investigation Intake 2026A0604017
05/01/2026	APS Referral Referral received from Adult Protective Services (APS). APS denied referral and sent to licensing.
05/01/2026	Special Investigation Initiated - On Site Completed unannounced onsite investigation. Interviewed Staff Becky Wolenski, Arianna Castellano, and Resident A.
05/01/2026	Contact - Telephone call received Received message from Home Manager, Pamela Grawbarger
05/06/2026	Contact - Document Sent Email to Home Manager, Pamela Grawbarger, to request documents
05/07/2026	Contact - Document Received Email from Pamela Grawbarger. Sent return email.
07/09/2026	Contact- Document Sent Email to Home Manager, Pamela Grawbarger. Received return email.
07/10/2026	Contact- Document Received Email from Pamela Grawbarger. Sent return email.
07/13/2026	Contact- Document Sent Email to Pamela Grawbarger. Received return email.
07/13/2026	Exit Conference

	Completed exit conference with Licensee Designee, Nichole VanNiman

ALLEGATION:

Resident A is being mistreated by staff which is making her want to harm herself. They have taken belongings out of her bedroom and will not take her on outings.

INVESTIGATION:

I received a licensing complaint regarding Beacon Home At New Haven on 05/01/2026. The complainant alleged that Resident A had a hysterectomy several years ago and is supposed to have 6-month checkups for life because she has HPV (human papillomavirus), which causes cancer. She has not been to a checkup in years, and the staff tell her that her surgery never took place. Her old group home had records, so it is believed that the new group home lost her records. A few days ago, Resident A was having vaginal pain, and she told staff she needed to go to the hospital. The staff told her they would not take her, until her mother threatened to call APS over the phone. Then, they took her to urgent care. Resident A wants to harm herself because of the way she is treated at the home. They will not take her out of the home to go shopping or on field trips. They tell her she is never "getting out" of the AFC home and they have taken her stuff out of her bedroom. Resident A has asked to go to the mental health walk in clinic, and they will not take her, nor will they let her call 911 for her suicidal ideations.

I completed an unannounced onsite investigation at Beacon Home At New Haven on 05/01/2026. I interviewed staff, Becky Wolenski and Arianna Castellano, and Resident A.

On 05/01/2026, I interviewed staff, Becky Wolenski. She stated that Resident A was having behavioral issues yesterday. She was throwing stuff around in the garage. She indicated that Resident A gets upset and starts throwing things around. She also gets upset when she does not have nicotine. She indicated that residents go shopping every week and on Saturdays. They go to places such as the Dollar Tree, Five Below, Meijer, the thrift store, and gas station. Ms. Wolenski indicated that Resident A has belongings in her bedroom.

On 05/01/2026, I interviewed staff, Arianna Castellano. She stated that Resident A was upset yesterday. She woke up in a bad mood. Resident A also gets upset that she cannot vape in the home. Resident A was saying she was going to kill herself and grabbed a knife. The home manager and clinical staff were contacted. Resident A also wanted to call 911. Resident A kept trying to lock herself in the bedroom with a knife. She eventually stopped the behavior. Ms. Castellano indicated that items were taken out of Resident A’s bedroom that she could harm herself with such as hygiene products

and a cord. Ms. Castellano stated that Resident A and other residents go on outings every Saturday. They go to stores such as Five Below or wherever else they want to go.

On 05/01/2026, I interviewed Resident A. She stated that yesterday staff took a crocheting needle, yarn, and blanket out of her room. They also took hygiene items; however, they were returned. I observed the bedroom with Resident A. Her bedroom had multiple personal items. Resident A stated that the home manager, Pam, told her that she cannot go shopping. She has been going on outings and shopping; however, was told that she cannot go on future trips.

On 05/07/2026, I received an email from the home manager, Pamela Grawbarger. She indicated that Resident A always attends activities and participates in home activities such as baking, cards, and she also crochets. Ms. Grawbarger provided examples of activity sheets and calendars, which showed Resident A has participated in activities including church, shopping, bowling, and lunch with family and friends.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(a) Use any form of punishment.**
ANALYSIS:	There is not enough information to determine that Resident A is being mistreated or punished by staff. On 04/30/2026, Resident A had items taken from her bedroom by staff for her safety when she was exhibiting aggressive and self-harming behaviors. The items were returned to Resident A. On 05/07/2026, copies of activity logs and calendars were provided that documented that Resident A has been on multiple outings.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.679	**Resident recreation.**
	(1) A licensee shall provide and promote activities and the use of leisure and recreational equipment that are appropriate to the number, care, needs, age, and interests of residents.

ANALYSIS:	There is not enough information to determine that Resident A has not been able to participate in activities. On 05/07/2026, I received an email from the home manager, Pamela Grawbarger. She indicated that Resident A always attends activities and participates in home activities such as baking, cards, and crocheting. Ms. Grawbarger provided examples of activity sheets and calendars which showed Resident A has participated in activities including church, shopping, bowling, and lunch with family and friends. On 05/01/2026, I interviewed Resident A. She stated that she has been on outings; however, was told she could not go on future outings.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(i) Participate in social and community group activities of choice.** **(k) Have reasonable access to and use of personal clothing and belongings.**
ANALYSIS:	There is not enough information to determine that Resident A is not allowed to participate in activities. On 05/07/2026, copies of activity logs and calendars were provided that documented that Resident A has been on multiple outings. There is also not enough information to determine that Resident A does not have reasonable access to her personal belongings. On 05/01/20206, Resident A stated that her crocheting needles, yarn and blanket were taken from her bedroom; however, the items have been returned. I observed multiple personal belongings in Resident A's bedroom. Staff reported that items were taken from Resident A on 04/30/2026 for her safety.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **Resident A is not being taken to required medical appointments.**
- **Staff are not allowing Resident A to go to the hospital or mental health clinic when requested.**

INVESTIGATION:

On 05/01/2026, I interviewed staff, Becky Wolenski. She indicated that Resident A attends medical appointments. Resident A has an appointment today at Community Mental Health for an injection and medication review. Ms. Wolenski indicated that Resident A also recently received psychiatric treatment at Harbor Oaks Hospital for about two and a half weeks.

On 05/01/2026, I interviewed staff, Arianna Castellano. She stated that Resident A goes to Community Mental Health (CMH) for appointments. She has not taken Resident A to medical appointments.

On 05/01/2026, I interviewed Resident A. She stated that she had a hysterectomy in Kalamazoo, MI because she had cancer when she was 23-24 years old. She is 31 now. Resident A stated that she is supposed to have checkups every six months; however, she has not been to a gynecologist in about three and a half years. She is seen by a doctor that comes to the home; however, they only take her vitals. The doctor comes to the home randomly, maybe every six to nine months. Resident A stated that she also goes to Community Mental Health for medication reviews and an injection once a month. Resident A stated that staff told her she cannot go to the hospital anymore and if she calls, they will tell the ambulance or officer she cannot go.

On 05/07/2026, I received an email from the home manager, Pamela Grawbarger. Ms. Grawbarger stated that the nurse has reached out to Resident A's doctor regarding OB/GYN (obstetrician/gynecology) appointments. She stated that there is no order for Resident A to have appointments with an OB/GYN every 6 months. Ms. Grawbarger indicated that it has been alleged in the past that Resident A had cancer, HPV, herpes and was sexually assaulted; however, the doctor found it to be untrue.

On 05/07/2026, I received copy of Resident A's Individual Plan of Service (IPOS) dated 09/22/2025. The IPOS indicates that Resident A will be provided with medication treatment/monitoring at least every 90 days or more, as determined necessary by treating psychiatrist. Resident A will be provided with up to 12 medication reviews at CMH North. The IPOS also indicates that the primary care physician (PCP) will provide medical treatment as often as agreed upon by the PCP and Resident A. The plan does not indicate that Resident A is to have six-month check ups due to a history of cancer.

On 05/07/2026, I received copy of Resident A's health care appraisal dated 06/26/2025. The health care appraisal indicates that Resident A does not have any sexually transmitted diseases.

On 05/07/2026, I received provider contact sheets for Resident A's appointments including the following:

07/06/2025- Foot doctor
09/15/2025- Injection and medication review
10/14/2025- Injection, case manager, medication review
11/04/2025- Primacy Care Physician (PCP)
11/06/2025- Labs/Blood draw
12/08/2025- Medication review
12/11/2025- Dental exam
01/09/2026- Injection and medication review
02/19/2026- Medication review
03/02/2026- PCP
03/05/2026- Injection and medication review
04/24/2026- CMH Follow up
04/29/2026- Exam due to vaginal pain
05/01/2026- Injection and medication review

On 05/07/2026, I received copy of Resident A's medical record from Corewell Health Beaumont Grosse Pointe Hospital Emergency dated 04/29/2026. The chief complaint is listed as vaginal problem. The report states that Resident A does not have a gynecologist and does not receive routine pelvic exams. Report states, "Conversation with patient regarding personal hygiene was had. Patient instructed to follow up with gynecologist for further evaluation". A referral for a gynecologist was provided in the report. Also, the report advised to follow up with the PCP/Nurse Practitioner in one week.

On 05/07/2026, I received copies of incident reports for Resident A. An incident report dated 04/09/2026 indicates that Resident A came out of her bedroom and told staff she called 911 and let Macomb County Sheriff in the house. She stated that she called them due to being suicidal. The corrective measures indicate that they will work with clinical team to help find other coping skills rather than calling 911.

An incident report dated 04/29/2026 indicates that Resident A reported that her vagina hurt after showering. Resident A and her mother began to threaten to call APS, stating that Resident A had diseases and conditions that she has no documentation of ever having. Resident A was taken to the emergency room for a pelvic exam. The report indicates that hygiene issues were found.

An incident report dated 04/30/2026 indicates that Resident A became upset regarding an appointment the previous day and called 911. The care team manager stopped 911 from taking her and Resident A grabbed a butter knife and attempted to harm herself. Resident A attempted to steal the van and refused to get out of the driver's seat. She began throwing things in the garage and attempted to break a window. She scratched her arm with the tab from a pop can. The home manager and three staff members

monitored and kept the other residents safe. The guardian was contacted about Resident A's misuse of 911. All of Resident A's yarn, cords, and anything else she could harm herself with were removed from her bedroom. The corrective measures include working with clinical.

On 07/10/2026, I received an email from Pamela Grawberger. She stated that the doctor came out to the home on 05/04/2026 at 2 pm to see Resident A; however, Resident A was with her aunt and missed the appointment. She indicated an appointment has been made for Resident A at Corewell Family OB/GYN for 07/23/2026. On 07/13/2026, I received email from Pamela Grawberger. She indicated that Resident A has been placed at Beacon Home at New Haven since 06/21/2023.

I completed an exit conference with the licensee designee, Nichole VanNiman, on 07/13/2026. I sent Ms. VanNiman an email and informed her of the violation found. I also informed her that a copy of the special investigation report would be mailed once approved and that a corrective action plan would be requested. I also requested that she contact me with any questions regarding the findings or report.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Resident A has been placed at Beacon Home At New Haven since 06/21/2023. There is no record of her attending any appointments with a gynecologist since her placement; however, there is no known order for her to attend check-ups every six months due to a history of cancer. On 04/29/2026, Resident A was taken to Corewell Health Beaumont Grosse Pointe Hospital Emergency due to a complaint of vaginal pain. The report from Corewell Health dated 04/29/2026 states that Resident A does not have a gynecologist and does not receive routine pelvic exams. The report states, "Conversation with patient regarding personal hygiene was had. Patient instructed to follow up with gynecologist for further evaluation". A referral for a gynecologist was provided in the report. The report also advised Resident A to follow up with her PCP/Nurse Practitioner in one week. As of 07/13/2026, Resident A has not had a follow up appointment with a gynecologist. On 07/10/2026, the home manager, Pamela Grawbarger, stated that an appointment has been made for 07/23/2026. Resident A also did not have a follow up appointment with her PCP/Nurse Practitioner within one week

	as recommended. Ms. Grawbarger stated that appointment was missed, as Resident A went on an outing with her aunt.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	There is not enough information to determine that Resident A is not allowed to go to the hospital or mental health clinic when requested. Resident A was reported to have had a recent hospitalization at Harbor Oaks Hospital and was taken to Corewell Health Emergency on 04/29/2026. Incident reports note that Resident A contacted 911 on 04/09/2026 and 04/30/2026. The clinical team and her guardian were notified. Staff are working with the clinical team to help Resident A find other coping skills rather than calling 911. Resident A is also receiving regular treatment through Community Mental Health.
CONCLUSION:	VIOLATION NOT ESTABLISHED

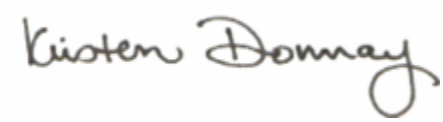
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in license status.

07/13/2026

Kristine Cilluffo Date
Licensing Consultant

Approved By:



WOC Area Manager for 07/14/2026

Denise Y. Nunn Date
Area Manager