GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 29, 2026

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

RE: License #: AS800404242
Investigation #: 2026A1030045
Beacon Home at Hartford

Dear Ms. 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 (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 #:	AS800404242
Investigation #:	2026A1030045
Complaint Receipt Date:	07/15/2026
Investigation Initiation Date:	07/16/2026
Report Due Date:	09/13/2026
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 Hartford
Facility Address:	68134 CR 372 Hartford, MI 49057
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/27/2020
License Status:	REGULAR
Effective Date:	02/27/2025
Expiration Date:	02/26/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was administered the wrong dosage of Sertraline.	Yes
Additional Findings	No

III. METHODOLOGY

07/15/2026	Special Investigation Intake 2026A1030045
07/16/2026	Special Investigation Initiated - Telephone Interview with the referral source
07/16/2026	APS Referral
07/16/2026	Contact - Document Received Received and reviewed incident report
07/22/2026	Contact - Face to Face Interview with Resident A
07/27/2026	Contact - Telephone call made Interview with Tiana Dyson
07/27/2026	Exit Conference Exit conference by phone

ALLEGATION:

Resident A was administered the wrong dosage of Sertraline.

INVESTIGATION:

On 7/15/26, I interviewed the referral source (RS) by phone. The RS reported the allegations are accurate and the facility supervisor took steps to ensure the staff member in question does not make this mistake again. The RS reported that Resident A is prescribed 75mg of Sertraline daily and the pharmacy had been putting three 25mg tablets in one bubble pack and then sent a bubble pack with one 25mg tablets per bubble and the staff member should have gotten three tablets from the bubble pack instead of one tablet.

On 7/16/26, I received and reviewed an incident report (IR) dated 7/9/26. The IR indicated that direct care staff member Tiana Dyson administered 25mg of Sertraline instead of the 75mg which is the correct dosage on 7/6/26 to Resident A. The IR also indicated that the facility took action by removing Ms. Dyson's ability to administer medications.

On 7/22/26, I interviewed Resident A at the facility. Resident A reported she had lived at the facility for one year. Resident A reported that the staff members administer her medications every day. Resident A denied knowing that there was a medication error on 7/6/26. Resident A denied any medical or mental health problems as a result of the medication error.

On 7/27/26, I interviewed direct care staff member (DCSM) Tiana Dyson by phone. Ms. Dyson confirmed that she made a medication error regarding not administering the proper dosage to Resident A. Ms. Dyson reported that is in the process of being retrained to administer medications.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	It was alleged that Resident A was administered the wrong dosage of Sertraline. Based on interviews and review of documentation this violation will be established. On 7/9/26, Resident A was administered 25mg of Sertraline by staff member Tiana Dyson in error as Resident A is prescribed 75mg of Sertraline daily. Ms. Dyson accepted responsibility for the error and will undergo additional training.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/27/26, I shared the findings of the investigation with licensee Nichole VanNiman by phone. Ms. VanNiman acknowledged the findings and agreed to submit a corrective action plan.

IV. RECOMMENDATION

Contingent upon the submission of an acceptable corrective action plan, I recommend no change to the current license status.

Nile Khabeiry, LMSW

8/3/26

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

8/4/26

Russell B. Misiak Date
Area Manager