GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 31, 2026

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

RE: License #: AS130408635
Investigation #: 2026A1030051
Beacon Home at East Ave

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 #:	AS130408635
Investigation #:	2026A1030051
Complaint Receipt Date:	08/20/2026
Investigation Initiation Date:	08/20/2026
Report Due Date:	10/19/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubrey Napier
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at East Ave
Facility Address:	20271 East Ave N Battle Creek, MI 49017
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/04/2021
License Status:	REGULAR
Effective Date:	04/04/2026
Expiration Date:	04/03/2028
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
The facility did not follow the recommendations of a health care professional in a timely manner.	Yes
Additional Findings	No

III. METHODOLOGY

08/20/2026	Special Investigation Intake 2026A1030051
08/20/2026	APS Referral
08/20/2026	Special Investigation Initiated - Telephone Interview with Ashton Byrne
08/25/2026	Inspection Completed On-site Interview with Resident A
08/25/2026	Contact - Face to Face Interview with Jennifer Benoit
08/25/2026	Contact - Face to Face Interview with Heather Martinez
08/25/2026	Contact - Document Received Received and reviewed medical documentation
08/25/2026	Contact - Telephone call made Interview with Amanda Avery RN
08/25/2026	Contact - Telephone call made Interview with Katlynn Stewart by phone
08/26/2026	Contact - Telephone call made Interview with Jessica Thurston
08/26/2026	Contact - Telephone call made Interview with Krystle Walterhouse
08/31/2026	Exit Conference

ALLEGATION:

The facility did not follow the recommendations of a health care professional in a timely manner.

INVESTIGATION:

On 8/20/26, I interviewed the referral source (RS) by phone. The RS reported that Resident A reported symptoms of a UTI on 8/15/26 and the facility nurse was contacted and recommended that she be taken Urgent Care. The RS reported that as of 8/20/26, Resident A had not been taken for medical attention due to the facility not having access to a van until last night and could not take her today as there were not enough staff to take her to Urgent Care.

On 8/25/26, I interviewed Resident A at the facility. Resident A confirmed that told a staff member on 8/15/26 that she had UTI symptoms and that staff member contacted the nurse who instructed them to take Resident A to urgent care. Resident A reported that she did not remember which staff member she spoke with but indicated that she had not been taken to Urgent Care until today. Resident A reported that the facility did not have access to the van as it had been in the repair shop and that the facility was short staffed.

On 8/25/26, I interviewed direct care staff member (DCSM) Jennifer Benoit at the facility. Ms. Benoit reported that she took Resident A to Urgent Care today and they tested her for a yeast infection. Ms. Benoit reported that Resident A had not been taken to see a doctor due to the van being in the shop and being short staffed.

On 8/25/26, I interviewed home manger, Heather Martinez, at the facility. Ms. Martinez reported that Resident A complained a lot about having various medical problems and had been taken to Urgent Care many times, including today. Ms. Martinez confirmed that the company van was being repaired and it was returned to the facility on 8/17/26. Ms. Martinez reported that they had not taken Resident A to Urgent Care, according to the nurse's instructions due to the van being in the shop and being short staffed.

On 8/25/26, I received and reviewed documentation from Wellnow Urgent Care dated 8/25/26. The documentation indicated that Resident A was diagnosed with acute Vaginitis and Type 2 Diabetes and was prescribed an antifungal (Fluconazole) to treat yeast infections.

On 8/25/26, I interviewed the facility nurse, Amanda Avery by phone. Ms. Avery reported that she had been aware of Resident A having UTI symptoms and believed that she spoke with DCSM Katlynn Stewart about it on 8/15/26 but was not certain it was Ms. Stewart who called her. Ms. Avery reported that she met with Resident A at

the facility on 8/21/26 and instructed the staff to take Resident A to Urgent Care. Ms. Avery reported that it was unacceptable that the staff did not take her until today and that they should have been more responsive. Ms. Avery reported that the van being in disrepair and the facility being short staffed is not a valid reason for postponing medical care for one of the residents.

On 8/25/26, I interviewed DCSM Katlynn Stewart by phone. Ms. Stewart reported she worked on 8/15/26 but did not remember if she contacted the on-call nurse about Resident A's potential UTI, although remembered speaking with the home supervisor, Heather Martinez. Ms. Stewart acknowledged that Resident A had not been taken to Urgent Care due to the van not being available and lack of staffing.

On 8/26/26, I interviewed DCSM Jessica Thurston by phone. Ms. Thurston confirmed that she worked on 8/15/26 but was unaware of Resident A's complaint of having a UTI. Ms. Thurston reported that the facility van was in the repair shop for a few days, which may have been the reason Resident A was not taken to Urgent care sooner. Ms. Thurston reported that she took one of the other residents to Urgent Café a few days ago.

On 8/26/26, I interviewed DCSM Krystle Walterhouse by phone. Ms. Walterhouse reported that she was aware that Resident A was having some medical concerns and thought that she had been taken to Urgent Care before 8/25/26. Ms. Walterhouse reported that the facility van was in the repair shop for a few days but is now fixed. Ms. Walterhouse indicated that the home manager would have to coordinate transportation if the van was not available which would include borrowing a van from a different licensed facility if necessary.

On 9/2/26, I reviewed the Bureau Information Tracking System (BITS) and noted that the agency had four other licensed facilities between 10-16 miles of the facility who had facility vans that could be borrowed to transport Resident A to Urgent Care.

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:	It was alleged that the facility did not follow the recommendations of a health care professional in a timely manner. Based on interviews and documentation this violation will be established. On 8/15/26, Resident A reported having symptoms of having a UTI and the facility nurse instructed the staff to take her to Urgent Care on 8/15/25 and 8/21/26,

	however Resident A was not taken to Urgent Care until 8/25/26. The staff members interviewed indicated that the delay was due to the facility van being in the repair shop and being short staffed, however they could have made alternative arrangements to get Resident A to Urgent Care.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Nile Khabeiry, LMSW

9/1/26

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

9/2/26

Russell B. Misiak Date
Area Manager