GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 14, 2026

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

RE: License #: AS370413382
Investigation #: 2026A0577059
Beacon Home At Nottawa

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 (517) 335-5985.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS370413382
Investigation #:	2026A0577059
Complaint Receipt Date:	08/11/2026
Investigation Initiation Date:	08/11/2026
Report Due Date:	10/10/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator	Roxanne Goldammer
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At Nottawa
Facility Address:	7302 S Nottawa Rd Mount Pleasant, MI 48858
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	11/14/2022
License Status:	REGULAR
Effective Date:	12/21/2024
Expiration Date:	12/20/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not supervised according to his plan and wandered into the woods.	Yes
Resident A is inappropriately touching Resident B, and direct care staff are not intervening.	No

III. METHODOLOGY

08/11/2026	Special Investigation Intake, 2026A0577059
08/11/2026	APS Referral, Caitlin Fick, Isabella Co APS.
08/11/2026	Special Investigation Initiated - Letter Caitlin Fick, Isabella APS, via email.
08/11/2026	Referral - Recipient Rights
08/21/2026	Contact - Document Received Melissa Leach, CMHCM-ORR send BTP, IR, and PCP.
09/03/2026	Inspection Completed On-site
09/08/2026	Contact - Telephone call made, Lily Gray, DCS.
09/08/2026	Exit Conference with licensee designee Nichole VanNiman.

ALLEGATION: Resident A was not supervised according to his plan and wandered into the woods.

INVESTIGATION:

On 08/11/2026, a complaint was received alleging that Resident A wandered into the nearby woods despite Resident A requiring enhanced 1:1 staffing supervision. The complaint reported that direct care staff (DCS) Lily Gray was using the restroom when Resident A left the facility.

On 08/21/2026, I interviewed Melissa Leach, Office of Recipient Rights with Community Mental Health Central Michigan (ORR-CMHCM) who reported that she interviewed DCS Lily Gray on 08/20/2026 and DCS Gray reported that she has been working at the

facility for two months and Resident A is the only resident at the home that requires 1:1 direct care staff supervision. DCS Gray reported to Ms. Leach that Resident A had been doing well, which was why she thought she could leave him for a few minutes while she used the bathroom. DCS Gray admitted to Ms. Leach that DCS Gray should have gotten another direct care staff to provide Resident A with 1:1 supervision while she took her break. DCS Gray reported to Ms. Leach that DCS Gray went inside to use the bathroom and was gone for about three minutes while Resident A was outside smoking. DCS Gray reported that upon returning outside to the porch Resident A was not outside. DCS Gray reported to Ms. Leach that she checked inside his bedroom, both bathrooms, then walked around the house. DCS Gray reported to Ms. Leach that when she walked past the tree line outside, Resident A was walking just inside the tree line. DCS Gray reported to Ms. Leach that she was counseled by upper management regarding the incident.

Ms. Leach, ORR-CMHCM, reported that she interviewed Resident A who reported that he is moving to a facility closer to family. Resident A reported to Ms. Leach that he knows that he requires 1:1 direct care staff supervision. Ms. Leach reported that Resident A stated, “Sometimes I go to the woods and staff are supposed to follow.”

On 08/21/2026, Ms. Leach, ORR-CMHCM, emailed me a copy of an *AFC Licensing Division-Incident/Accident Report* (IR) regarding this incident. The IR was dated 07/29/2026 and listed the time of incident as 3:32 pm with DCS Lily Gray and Resident A involved. The IR documented that, “Staff reminded [Resident A] that he should not walk off by himself as it could be dangerous. Staff will be staying within arms distance for the time being. Staff will be transferring 1:1 responsibility to a different staff member if one cannot be within 5 feet of [Resident A] at all times, such as using the restroom or going to a different room.” The IR documented the following corrective measures: “Staff provided support for how he was feeling. Staff let him know that they were doing the best they could. Staff will continue to monitor him for any further incidents of this nature - all documentation will continue to be completed along with reviewing 1:1 procedure with staff.”

Ms. Leach, ORR-CMHCM, provided me with copy of Resident A’s *Person Centered Plan* (PCP) completed on 07/23/2026, which documents that Resident A requires a 1:1 line of sight supervision while in the home and community while awake. This is due to Resident A leaving the facility property and entering neighboring homes and/or going into the woods behind the facility.

On 09/03/2026, I completed an unannounced onsite investigation, and Resident A was not available to be interviewed due to recently moving to a new placement.

On 09/08/2026, I left a voicemail message with Lily Gray, DCS requesting a call back.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on information gathered from reviewing Melissa Leach's, ORR-CMHCM, interviews, Resident A's PCP, and the completed IR, I determined that on 07/23/2026, Resident A was not provided with 1:1 direct care staff supervision as required. DCS Lily Gray left Resident A outside unsupervised while she used the restroom. During this short time, Resident A wandered into the woods. Consequently, Resident A was not provided with 1:1 direct care staff supervision on 07/23/2026 as specified in his PCP.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A is inappropriately touching Resident B, and direct care staff are not intervening.

INVESTIGATION:

On 08/11/2026, a complaint was received alleging that Resident A is touching Resident B's buttocks and direct care staff are not intervening.

On 08/11/2026, I interviewed Caitlin Fick, Isabella County Adult Protective Service Specialist who reported that she has on open investigation regarding this allegation. Ms. Fick stated she interviewed DCS Lisa Kappler, whose role is home manager, and DCS Kapler reported direct care staff try to intervene, but there is not much they can do about Resident A inappropriately touching other residents. DCS Kapler also reported that Resident A may be moving to a new placement.

On 09/03/2026, during my unannounced onsite investigation I interviewed Resident B who reported there were times when Resident A would walk by Resident B and slap Resident B on the butt, make kissing noises, or make a sexual comment. Resident B reported that Resident A always had a direct care staff by him so the direct care staff would tell Resident A that he needs to keep his hands to himself and try to redirect Resident A to a different area of the home. Resident B reported that he would also tell Resident A to "stop", "leave me alone", or "go away" and Resident A would just say, "I am only playing or messing around." Resident B reported that most of the time Resident A could be redirected and would stop when asked. Resident B reported that he was not concerned about Resident A's behavior and always felt safe.

On 09/3/2026 I interviewed DCS Brandon Brown and DCS Hailey Stansberry who both reported that the relationship between Resident A and Resident B was mutual, they each would tease each other, call each other names, and sit by each other. DCS Brown and DCS Stansberry reported that Resident A requires a 1:1 direct care staff supervision, so there was always a direct care staff near Resident A to redirect Resident A or step in between Resident A and Resident B when needed. DCS Brown and DCS Stansberry reported that Resident A was usually pretty easy to redirect when Resident B was not in the mood to be around Resident A. DCS Brown and DCS Stansberry reported that Resident B would tell Resident A to leave him alone and Resident A would respond well to Resident B's direction. DCS Brown and DCS Stansberry denied that direct care staff were not intervening when Resident A behaved this way rather both stated that verbal redirection was provided.

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:	Based on the information gathered during the investigation, there was no evidence found that direct care staff were not intervening when Resident A inappropriately touching Resident B. Direct care staff reported using verbal redirection and 1:1 supervision to monitor Resident A's behavior. Resident B reported he felt safe in the facility and was not concerned about Resident A's behavior.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, it is recommended that the current status of the license remains unchanged.

Bridget Vermeesch 09/09/2026

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 09/14/2026

Dawn N. Timm Date
Area Manager