



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 1, 2026

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

RE: License #: AS390406170
Investigation #: 2026A0578036
Beacon Home at Wolf Lake

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.

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.

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,

A handwritten signature in black ink, appearing to read 'Eli DeLeon', with a stylized, flowing script.

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390406170
Investigation #:	2026A0578036
Complaint Receipt Date:	07/13/2026
Investigation Initiation Date:	07/13/2026
Report Due Date:	09/11/2026
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 Wolf Lake
Facility Address:	10633 W. J Ave. Kalamazoo, MI 49009
Facility Telephone #:	(269) 353-1809
Original Issuance Date:	05/05/2021
License Status:	REGULAR
Effective Date:	11/05/2025
Expiration Date:	11/04/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents were left unsupervised in a vehicle while direct care staff shopped at local stores.	No
Direct care staff are encouraging residents to physically harm each other and use intimidating language.	Yes
Residents were not provided with meals.	No
One resident was forced to buy pizza for residents and staff.	Yes

III. METHODOLOGY

07/13/2026	Special Investigation Intake 2026A0578036
07/13/2026	Special Investigation Initiated - On Site
07/13/2026	APS Referral
07/13/2026	Special Investigation Completed On-site-Interview with direct care staff Britini Smith. Interview with Resident A. Interview with Resident B.
07/13/2026	Contact-Documentation Reviewed- <i>Assessment Plan for AFC Residents</i> for Resident A, dated 05/09/2026.
07/13/2026	Contact-Documentation Reviewed- <i>Health Care Appraisal</i> for Resident A, dated 06/17/2025.
07/13/2026	Contact-Documentation Reviewed- <i>Assessment Plan for AFC Residents</i> for Resident B, dated 05/07/2026.
07/13/2026	Contact-Documentation Reviewed- <i>Health Care Appraisal</i> for Resident B, dated 02/06/2026.
07/13/2026	Contact-Documentation Reviewed- <i>Assessment Plan for AFC Residents</i> for Resident C, dated 03/19/2026.
07/14/2026	Contact-Telephone- Interview with direct care staff Daija Dixon.
07/14/2026	Contact-Documentation Reviewed- <i>Michigan Workforce Background Check System</i> .
07/14/2026	Contact-Documentation Reviewed- <i>MyGeotab Trip History</i> .
08/27/2026	Special Investigation Completed On-site-Interview with Resident C.

08/31/2026	Exit Conference- With licensee designee Nichole VanNiman.
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ALLEGATION: Residents were left unsupervised in a vehicle while direct care staff shopped at local stores.

INVESTIGATION:

On 07/13/2026, I received allegations from Complainant. Complainant reported that residents were left unsupervised in a company vehicle while direct care staff Azariah Sykes and direct care staff Daija Dixon completed their own personal errands. Complainant alleged that residents were left unattended for several hours.

07/13/2026, I reviewed the allegations with Barry County Community Mental Health recipient rights officer Holly Hess. Holly Hess reported investigating the allegations. Holly Hess reported that multiple residents were reporting being left unsupervised in a company vehicle in the community while staff entered local stores to do their own personal shopping. Holly Hess reported residents reported these allegations happened multiple times but a reason why these allegations were not reported before was not provided. Holly Hess identified there being one occasion where residents described being left unsupervised in the company van at the mall for over two hours.

On 07/13/2026, I completed an unannounced investigation on-site at this facility and interviewed direct care staff Britini Smith regarding the allegations. Britini Smith reported serving as the home manager for this facility. Britini Smith acknowledged being made aware of the allegations when the overnight staff informed her that residents wanted to speak with her without second shift staff around. Britini Smith reported she was informed by residents that residents were being left alone in the company vehicle while direct care staff entered their personal homes or went shopping.

On 07/13/2026, I interviewed Resident A regarding the allegations. Resident A reported living at this facility for over a year. Resident A acknowledged being left in the company vehicle unsupervised with Resident B and Resident C while direct care staff Azariah Sykes and direct care staff Daija Dixon completed personal errands at a local grocery store and at their private homes. Resident A could not recall any dates related to when she was left unsupervised in the company vehicle by Azariah Sykes and Daija Dixon. Resident A clarified when she was left in this company vehicle with Resident B and Resident C, she was able to open vehicle windows and doors.

On 07/13/2026, I interviewed Resident B regarding the allegations. Resident B reported living at this facility for the last few months. Resident B acknowledged that

direct care staff Azariah Sykes and direct care staff Daija Dixon leave her and other residents unsupervised in the company vehicle while Azariah Sykes and Daija Dixon complete their own personal errands. Resident B reported the allegations occurred almost daily.

Resident B recalled accompanying Azariah Sykes and Daija Dixon and Resident A and Resident C on a company vehicle ride to the mall so that Azariah Sykes and Daija Dixon could obtain newly released shoes for their children. Resident B reported that while Azariah Sykes and Daija Dixon entered the mall, they were left unsupervised in the company vehicle outside. Resident B reported no vehicle keys were left behind and she either rolled down windows for fresh air or stepped outside of the vehicle.

Resident B reported on another occasion, Azariah Sykes and Daija Dixon brought residents to a local grocery store so that Azariah Sykes and Daija Dixon could complete their own grocery shopping. Resident B reported that she and Resident A and Resident C were left unsupervised and outside in the company vehicle. Resident B reported this occasion lasted a few hours and could not recall the date but identified this incident occurred between 12PM and 3PM.

Resident B identified six occurrences of being left unsupervised in the company vehicle by Azariah Sykes and Daija Dixon. Resident B reported the last occurrence was “three Sundays ago” or 06/28/2026.

On 07/13/2026, I reviewed the *Assessment Plan for AFC Residents* for Resident A, dated 05/09/2026. The *Assessment Plan for AFC Residents* for Resident A documented that Resident A does not move independently in the community and is to be within eyesight of direct care staff.

On 07/13/2026, I reviewed the *Health Care Appraisal* for Resident A, dated 06/17/2025. The *Health Care Appraisal* for Resident A documented that Resident A is diagnosed with bipolar disorder, psychosis, and attention deficit/hyperactivity disorder.

On 07/13/2026, I reviewed the *Assessment Plan for AFC Residents* for Resident B, dated 05/07/2026. The *Assessment Plan for AFC Residents* for Resident B documented that Resident B moves independently in the community with no restrictions.

On 07/13/2026, I reviewed the *Health Care Appraisal* for Resident B, dated 02/06/2026. The *Health Care Appraisal* for Resident B documented that Resident B is diagnosed with borderline personality disorder, schizophrenia, post-traumatic stress disorder, and recurrent major depressive disorder.

On 07/13/2026, I reviewed the *Assessment Plan for AFC Residents* for Resident C, dated 03/19/2026. The *Assessment Plan for AFC Residents* for Resident C

documented that Resident C moves independently in the community with no restrictions.

On 07/14/2026, I interviewed direct care staff Daija Dixon regarding the allegations. Daija Dixon reported working at this facility for the last nine months. Daija Dixon denied the allegations, and added the allegations were not “true at all.” Daija Dixon denied ever being present when Resident A, Resident B and/or Resident C were left unattended and unsupervised in the company vehicle. Daija Dixon clarified that she is not authorized as a driver for the company vehicle. Daija Dixon added that often Resident C refuses to enter any store and would have to be monitored by another direct care staff while residents and other staff entered the store. Daija Dixon reported Resident C simply liked riding around in the company van but not entering any store. Daija Dixon reported direct care staff Britini Smith is familiar with Resident C’s behavior and has been present when Daija Dixon and Azariah Sykes had taken residents out in the community. Daija Dixon reported being present when multiple residents were transported into the community by company vehicle and direct care staff Britini Smith was present and stayed back with residents while Daija Dixon and Azariah Sykes supervised residents that were entering any store. Daija Dixon added that she and Azaria Sykes provided supervision to residents while at the mall so that residents could engage in walking around the mall for exercise. Daija Dixon reported this activity often looked like residents purchasing pretzels, frozen drinks, or perfume sets while walking around the mall. Daija Dixon suspected the allegations were an attempt to discontinue the outings completed at this facility, as the outings at this facility have increased significantly since Resident C was admitted to this facility.

Daija Dixon denied ever being present when any resident was transported by vehicle to any direct care staff’s private residence. Daija Dixon denied that any residents were transported to her own private home or that of Azariah Sykes.

On 08/27/2026, I interviewed Resident C regarding the allegations. Resident C reported living at this facility for over three years. Resident C reported going out into the community frequently with staff and reported completing outings such as obtaining pedicures or going to the movies.

Resident C denied ever being left in the company vehicle without direct care staff supervision. Resident C denied being aware of any other resident that was left in the company van without direct care staff supervision. Resident C commented that direct care staff, “wouldn’t just leave us on our own.” Resident C acknowledged having independent community access, and clarified she only goes in the community with direct care staff due to her physical ailments.

On 07/14/2026, I reviewed the *Michigan Workforce Background Check System* for Daija Dixon and Azariah Sykes and identified their place of residency at the time of their application for employment.

On 07/14/2026, I reviewed the *MyGeotab Trip History* for the company vehicle associated with this facility by administrator Aubry Napier from 05/01/2026 to 06/30/2026. The *MyGeotab Trip History* documented multiple trips to medical facilities, community recreational areas, and public communal areas. I noted the *MyGeotab Trip History* provided did not document any trip at or near the primary addresses for Daija Dixon or Azariah Sykes.

I noted the *MyGeotab Trip History* for the company vehicle associated with this facility documented trips to a local grocery store on 06/09/2026, 06/12/2026, and 06/14/2026. I noted the *MyGeotab Trip History* documented that none of these trips occurring at the local grocery store lasted longer than twenty minutes before identifying the next location.

I noted the *MyGeotab Trip History* for the company vehicle associated with this facility documented one trip to the mall identified by Resident B between 05/01/2026 and 06/30/2026. I noted the *MyGeotab Trip History* documented this trip to the mall lasting less than twenty-five minutes before identifying the next location.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (b) 12 residents for small group and family homes.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A, Resident B, Resident C, direct care staff Daija Dixon, and direct care staff Britini Smitt, as well as a review of pertinent documentation relevant to this investigation, there was not enough evidence to substantiate the allegation that Resident A, Resident B, or Resident C were ever not provided with sufficient direct care staff to provide for their supervision and protection.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Direct care staff are encouraging residents to physically harm each other and use intimidating language.

INVESTIGATION:

On 07/13/2026, Complainant alleged that direct care staff Azariah Sykes and direct care staff Daija Dixon encouraged Resident A and Resident B to physically harm each other.

On 07/13/2026, I interviewed Barry County Community Mental Health recipient rights officer Holly Hess regarding the allegations. Holly Hess reported that multiple residents had reported to her that direct care staff Azariah Sykes and direct care staff Daija Dixon were encouraging residents to fight one another. Holly Hess reported residents also reported that Azariah Sykes and Daija Dixon would yell at residents and intimidate them. Holly Hess reported that no resident identified or described what Azariah Sykes and Daija Dixon demonstrated that was intimidating. Holly Hess reported being informed that during a disagreement between residents, either Azariah Sykes or Daija Dixon commented to Resident A or Resident B that “you don’t know how to fight” or “you lost the fight”.

On 07/13/2026, I interviewed direct care staff Britini Smith regarding the allegations. Britini Smith reported being informed that direct care staff were intimidating or really mean but was not provided with details. Britini Smith reported assisting both residents in notifying recipient rights and added that Barry County Community Mental Health recipient rights officer Holly Hess responded to the allegations in person. Britini Smith reported direct care staff Azariah Sykes and direct care staff Daija Dixon were both suspended pending investigations.

On 07/13/2026, I interviewed Resident B regarding the allegations. Resident B could not identify any intimidating language used by direct care staff but acknowledged getting into a physical altercation with Resident A and reported that Azariah Sykes and Daija Dixon were present. Resident B reported that she and Resident A had been in the company vehicle for a while when Resident A got upset and tried to attack her. Resident B reported punching Resident A in the face. Resident B reported that after this occurred, either Azariah Sykes or Daija Dixon commented “come back at her.” Resident B reported this meant to continue punching Resident A.

On 07/13/2026, I interviewed Resident A regarding the allegations. Resident A acknowledged getting into a physical altercation with Resident B and reported that Azariah Sykes and Daija Dixon were present. Resident A reported that she and Resident B had struck each other when Azariah Sykes or Daija Dixon used intimidating language such as, “are you going to take that?” Resident A reported that she did not want Azariah Sykes and Daija Dixon to return to working at this facility. Resident A reported that she felt Azariah Sykes and Daija Dixon would “give her hell.”

On 07/13/2026, I reviewed an *AFC Licensing Division Incident / Accident Report* dated 07/02/2026 and completed by direct care staff Britini Smith. The *AFC Licensing Division Incident / Accident Report* documented that Resident A was being verbally aggressive towards another resident despite all “verbal redirection”. The *AFC Licensing Division Incident / Accident Report* documented that Resident A continued to be verbally aggressive and attempted to strike another resident. The *AFC Licensing Division Incident / Accident Report* documented the other resident attempted to strike Resident A. The *AFC Licensing Division Incident / Accident Report* documented that direct care staff intervened by stepping between Resident A and Resident B. The *AFC Licensing Division Incident / Accident Report* documented that Resident A was provided with an ice pack and PRN medication. The *AFC Licensing Division Incident / Accident Report* documented the corrective measures were to continue providing Resident A with prompts and encouragement to utilize her PRN medication for agitation and coping skills to refrain from engaging in negative behavior. The *AFC Licensing Division Incident / Accident Report* identified direct care staff Daija Dixon as the assigned staff.

On 07/14/2026, I interviewed direct care staff Daija Dixon regarding the allegations. Daija Dixon acknowledged being present with direct care staff Azariah Sykes when Resident A and Resident B were involved in a physical altercation. Daija Dixon denied that she or Azariah Sykes made any kind of antagonizing or encouraging comment and simply told both residents to stop. Daija Dixon reported that Resident A had punched Resident B first, but Resident B had struck Resident A in the nose. Daija Dixon reported that Resident B was standing over Resident A while she and Azariah Sykes told her to stop. Daija Dixon reported that she called the home manager to report the incident.

On 08/27/2026, I interviewed Resident D regarding the allegations. Resident D initially denied that any direct care staff encouraged residents to harm each other but clarified that when direct care staff Azariah Sykes and direct care staff Daija Dixon worked at this facility, they provoked Resident A and Resident B into fighting each other. Resident D acknowledged being present for the physical aggression between Resident A and Resident B and could not recall specifically what direct care staff Azariah Sykes and direct care staff Daija Dixon said during the altercation but stated that direct care staff Azariah Sykes and direct care staff Daija Dixon were using intimidating language to encouraging Resident A and Resident B to fight. Resident D reported direct care staff Azariah Sykes and direct care staff Daija Dixon liked to “instigate problems” and added that she did not know why direct care staff Azariah Sykes and direct care staff Daija Dixon engaged in such behavior and suspected they were “bored” or “mean.”

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 upon my investigation, which consisted of interviews with Resident A, Resident B, Resident C, Resident D, direct care staff Daija Dixon, and direct care staff Britini Smitt, as well as a review of pertinent documentation relevant to this investigation, Resident A and Resident B were not treated with dignity and respect and free from exploitation when direct care staff Azariah Sykes and direct care staff Daija Dixon encouraged Resident A and Resident B to be physically aggressive with each other.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Residents are not provided with meals:

INVESTIGATION:

On 07/13/2026, Complainant alleged that while being out in the community for extended periods of time with direct care staff Azariah Sykes and direct care staff Daija Dixon, residents were not provided with lunch and would sometimes miss dinner. No other details or dates were provided.

On 07/13/2026, I interviewed Britini Smith regarding the allegations. Britini Smith reported never being informed of the allegations prior to the allegations being investigated. I completed an inspection of this facility and found an appropriate amount of fresh and shelf stable foods and a posted menu that identified three meals a day.

On 07/13/2026, I interviewed Resident A regarding the allegations. Resident A reported missing lunch while out in the community due to being left alone unsupervised in the company vehicle by Azariah Sykes and Daija Dixon for extended periods of time that did not allow her and other residents to return to the facility for lunch. Resident A identified the other residents as Resident B and Resident C. Resident A could not recall any dates related to when she was not provided with lunch. Resident A did not recall ever missing dinners provided at this facility for any reason.

On 07/13/2026, I interviewed Resident B regarding the allegations. Resident B acknowledged not being provided with meals by direct care staff and stated the reasons for missing meals was because direct care staff Azariah Sykes and direct care staff Daija Dixon did not feel like making dinner at this facility. Resident B

reported this behavior occurred on at least five occasions. Resident B could not recall the dates of when she was not provided with dinner.

On 07/14/2026, I interviewed Daija Dixon regarding the allegations. Daija Dixon denied that residents ever missed lunch or dinner for any reason. Daija Dixon reported that direct care staff Britini Smith usually prepares lunch for residents while they are out in the community and residents are provided with meals when they return.

On 08/27/2026, I interviewed Resident C and Resident D regarding the allegations. Resident C and Resident D reported consistently being provided with three meals a day and this facility and never missing a meal or being restricted from a meal for any reason. Resident C and Resident D denied being aware of or observing any resident missing a meal or being restricted from a meal for any reason.

On 07/14/2026, I reviewed the *MyGeotab Trip History* for the company vehicle from 05/01/2026 to 06/30/2026. The *MyGeotab Trip History* documented multiple trips in the community that demonstrated the company vehicle returned to this facility prior to 12pm or a conventional lunch hour. The *MyGeotab Trip History* for the company vehicle from 05/01/2026 to 06/30/2026 documented only one trip on 06/12/2026 which occurred during the conventional lunch hour and documented this trip was to a local restaurant. The *MyGeotab Trip History* for the company vehicle from 05/01/2026 to 06/30/2026 documented that all trips during this time concluded or returned to this facility before 5PM to 6PM.

APPLICABLE RULE	
R 400.663	Nutrition; adoption by reference.
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A, Resident B, Resident C, Resident D and direct care staff Daija Dixon, there is not enough evidence that residents were not provided with a minimum of three nutritious meals every day.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: One resident was forced to buy pizza for residents and staff.

INVESTIGATION:

On 07/13/2026, Complainant alleged that direct care staff Azariah Sykes and direct care staff Daija Dixon forced Resident C to purchase pizza for the consumption of other residents and staff. No additional details were provided.

On 07/13/2026, I interviewed Britini Smith regarding the allegations. Britini Smith denied being aware of this allegation before this investigation. Britini Smith denied that any resident funds in the form of personal spending money are accepted or documented for Resident C. Britini Smith reported that Resident C has an insurance benefits card which Resident C can use to purchase food. Britini Smith reported that Resident C carries this insurance benefit card on her person and these transactions are private and not accessible to Britini Smith.

On 07/13/2026, I interviewed Resident A regarding the allegations. Resident A reported on one occasion, while out in the community on an outing in the company van, Resident C was made to purchase everyone frozen pizza so that they had something to eat. Resident A could not recall when this incident occurred.

Resident B reported on one occasion direct care staff Azariah Sykes told Resident C to pay for frozen pizzas for all the residents for dinner. Resident B reported that if Resident C had not purchased pizzas for dinner that evening, she was not sure what they would have eaten for dinner. Resident A reported that Azariah Sykes and Daija Dixon were working that day but could not recall a date.

Resident B reported on other occasions, Resident C was told to purchase beverages for other residents while out in the community with Azariah Sykes and Daija Dixon. Resident B could not identify any dates for these transactions but clarified they occurred at a local convenience store and grocery store.

On 07/14/2026, I interviewed Daija Dixon regarding the allegations. Daija Dixon acknowledged that Azariah Sykes had told Resident C to buy pizza for all the residents and staff. Daija Dixon reported this occurred around the end of June 2026 but could not recall the exact date. Daija Dixon reported initially Resident C refused to buy the pizza but Azariah Sykes commented "just do it" and Resident C purchased the pizza.

On 08/27/2026, I interviewed Resident C regarding the allegations. Resident C reported living at this facility for over three years. Resident C described having a Healthy Foods card provided to her by insurance provider. Resident C acknowledged buying frozen pizzas for residents and staff on at least two or three occasions. Resident C denied being forced or bullied into buying these frozen pizzas by staff and clarified the direct care staff only asked her and she complied. Resident C identified the direct care staff that had asked her to purchase frozen pizza with her

insurance benefits card as Daija Dixon and Azariah Sykes. Resident C reported her total expense was only around \$6 for each occurrence of purchasing pizza for the residents.

APPLICABLE RULE	
R 400.637	Handling of resident funds and valuables.
	(11) A licensee, staff, volunteers, members of the household, and their family members cannot accept, take, or borrow money, resident funds, or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Based upon my investigation, which consisted of interviews with Resident A, Resident C, and direct care staff Daija Dixon, Resident C was either asked or instructed to purchase frozen pizza on two or more occasions for residents and staff with her own resident funds allocated to Resident C by an insurance benefits card.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.



08/31/2026

Eli DeLeon
Licensing Consultant

Date

Approved By:



09/01/2026

Dawn N. Timm
Area Manager

Date