GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 17, 2025

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

RE: License #: AL800278708
Investigation #: 2025A1031021
Beacon Home at Wave Crest

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) 356-0183.

Sincerely,

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
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 #:	AL800278708
Investigation #:	2025A1031021
Complaint Receipt Date:	01/17/2025
Investigation Initiation Date:	01/17/2025
Report Due Date:	03/18/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator/Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Wave Crest
Facility Address:	28840 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	03/21/2006
License Status:	REGULAR
Effective Date:	04/25/2023
Expiration Date:	04/24/2025
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff made derogatory comments about Resident A.	Yes

III. METHODOLOGY

01/17/2025	Special Investigation Intake 2025A1031021
01/17/2025	APS Referral
01/17/2025	Special Investigation Initiated - Letter Email exchange with Candice Kinzler.
01/23/2025	Inspection Completed On-site Interview with Teresa Merritt.
02/18/2025	Inspection Completed On-site
02/18/2025	Contact - Face to Face Interview with Teresa Merritt, Brena Curtis, Israel Baker, Ashely Williams, Resident A, Resident B, Resident C, and Resident D.
03/04/2025	Contact - Telephone Interview with Desean Brown.
03/04/2025	Contact - Voicemail left with Anna Smith.
03/13/2025	Contact - Voicemail left with Anna Smith.
03/17/2025	Exit Conference held with Nichole VanNiman.

ALLEGATION:

Staff made derogatory comments about Resident A.

INVESTIGATION:

On 1/17/25, I received an email from Van Buren Recipient Rights Director Candice Kinzler. The email contained a link to a voicemail that was sent by Resident A. Resident A reported that direct care worker (DCW) Ashely Williams violated his rights by sharing personal information about him to someone she was talking with on the telephone. Resident A reported Ms. Williams stated he was a “faking mother

fucker” to the person she was speaking to. Resident A also reported he asked her for assistance, and she refused to assist him for 38 minutes. Resident A reported Ms. Williams said she was busy, but she was sitting in the same spot doing nothing and sitting on her phone.

On 1/28/25, I conducted an unannounced visit to the facility and interviewed the facility manager Teresa Merritt. Ms. Merritt reported she was made aware of the allegations and spoke to Ms. Williams. Ms. Merritt reported Ms. Williams denied the allegations.

On 2/18/25, I interviewed Ms. Merritt, DCW Brena Curtis, district manager Israel Baker, Resident A, Resident B, Resident C, and Resident D.

Ms. Merritt reported again that Ms. Williams denied the allegations. Ms. Merritt reported Ms. Williams was demoted from her position and transferred to another home due to the district manager having concerns regarding Ms. Williams.

Ms. Curtis reported she did not have any information pertaining to the allegations. Ms. Curtis reported she never observed Ms. Williams speak negatively about Resident A.

Mr. Baker reported he was aware of the allegations but did not have any further information. Mr. Baker reported Ms. Williams was recently demoted and moved to a different facility due to how she was speaking to her peers.

Resident A reported Ms. Williams made him upset because she shared personal information about him to someone she was on the phone with. Resident A reported he was expressing concerns to her about having difficulty swallowing his food. Ms. Williams was on the phone and said, “stop being a faking mother fucker”. Resident A reported Ms. Williams then told the person on the phone that he was faking having issues swallowing and this upset him because personal information was shared to an unknown person. Resident A reported he asked Ms. Williams for assistance with calling the doctor and she said she was busy. Resident A said she sat down and was on her phone and did not come to help him for about 40 minutes. Resident A reported Ms. Williams is “lazy” and she is always on her phone. Resident A said there are many times other residents in the home ask her for help and she acts busy. Resident A reported “when she’s not talking on the phone, she’s texting. When she’s not texting, she’s on the phone”. Resident A expressed frustration as he felt that staff were there to assist residents when needed.

Resident B reported he did not hear Ms. Williams speak negatively about Resident A but Ms. Williams can be rude to residents in the facility and does not appear to want to help them. Resident B reported Ms. Williams is often dismissive and seems to be on her phone frequently instead of working.

Resident C reported he overheard an incident that occurred between Ms. Williams and Resident A but did not hear what Ms. Williams had said. Resident C reported Resident A informed him that she shared information about him and called him a “faking fucker” when he asked what happened. Resident C reported he does not like Ms. Williams because she is always doing something else other than helping them and “acting busy”.

Resident D reported he did not have any information regarding the allegations. Resident D reported he did not want to get mixed up in things and did not engage in the interview.

Ms. Williams was informed of the allegations and reported she never made negative comments about Resident A and did not share any information about him. Ms. Williams reported Resident A did approach her about having issues with his throat and she suggested that Resident A see a doctor. Ms. Williams reported Resident A never had issues with swallowing and felt it could be an attention seeking behavior. Ms. Williams reported she did not say he was faking it but informed him that this was a new issue. Ms. Williams was asked about her telephone use while working. Ms. Williams initially reported it is against company policy to be on her phone, and she never uses her phone. Ms. Williams was asked why others would report frequent phone use while working. Ms. Williams then reported she does use her phone on occasion when her son calls. Ms. Williams reported that she may have been on the phone directly after speaking with Resident A but not while speaking with him. Ms. Williams then admitted that she may use her phone more often than she should due to having personal issues to handle outside of work. Ms. Williams reported a coworker Anna Smith was present when Resident A approached her, and they had the discussion about his throat.

On 3/4/25, I interviewed the assistant facility manager Desean Brown via telephone. Mr. Brown reported Resident A informed him about the situation and he notified Ms. Merritt about the allegations. Mr. Brown reported he attempted to address the situation with Ms. Williams, but she refused to have a discussion with him about it and walked away. Mr. Brown reported Ms. Williams can be disrespectful to other staff in the home and does have a history of being on her phone all the time. Mr. Brown reported Ms. Williams tends to ignore residents and will say “give me a minute” and delays assisting them.

On 3/4/25 and 3/13/25, I left a voicemail with DCW Anna Smith.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on interviews held with residents and staff, there is sufficient evidence to support that Ms. Williams did not demonstrate the ability to ensure resident safety and protection as required. There were consistent reports that Ms. Williams is dismissive of residents needs and did not prioritize their needs while providing direct care.
CONCLUSION:	**VIOLATION ESTABLISHED**

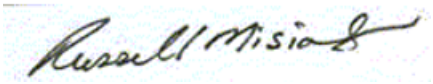
IV. RECOMMENDATION

It is recommended that upon receipt of an acceptable corrective action plan, the status of the license remain unchanged.

3/4/25

Kristy Duda Date
Licensing Consultant

Approved By:



3/14/25

Russell B. Misiak Date
Area Manager