GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 27, 2025

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

RE: License #: AM800299049
Investigation #: 2025A1030033
Beacon Home at Woodland

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 #:	AM800299049
Investigation #:	2025A1030033
Complaint Receipt Date:	05/13/2025
Investigation Initiation Date:	05/13/2025
Report Due Date:	07/12/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Kim Howard
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Woodland
Facility Address:	56832 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	09/12/2016
License Status:	REGULAR
Effective Date:	03/12/2025
Expiration Date:	03/11/2027
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II ALLEGATION(S)

	Violation Established?
A staff member engaged in an inappropriate relationship with Resident A.	Yes
Additional Findings	Yes

II. METHODOLOGY

05/13/2025	Special Investigation Intake 2025A1030033
05/13/2025	APS Referral APS referral made by AFC staff
05/13/2025	Special Investigation Initiated - Telephone Interview with Referral Source
05/14/2025	Contact - Telephone call made Interview with Danyell Baltazar
05/14/2025	Contact - Document Received Received and reviewed photograph
05/15/2025	Contact - Document Received Received and reviewed document
05/20/2025	Contact - Telephone call made Interview with Jodi Wood
05/20/2025	Contact - Telephone call made Interview with Kaylie Sharp
05/21/2025	Contact - Face to Face Interview with Resident A
05/21/2025	Contact - Face to Face Interview with Resident B
05/21/2025	Contact – Face to Face Interview with Resident C
05/21/2025	Contact - Face to Face Interview with Resident C

05/21/2025	Contact – Face to Face Interview with Paula Cummins
05/21/2025	Contact - Face to Face Interview with Adrienne Jones
05/21/2025	Contact - Face to Face Interview with Madison Brink
05/22/2025	Exit Conference Exit conference by phone

ALLEGATION:

A staff member engaged in an inappropriate relationship with Resident A.

INVESTIGATION:

On 5/13/25, I interviewed the referral source (RS) by phone. The RS reported there are concerns about direct care staff member (DCSM) Kaylie Sharp having some inappropriate behavior with Resident A. The RS reported that Ms. Sharp has allowed Resident A to rest her head on her chest and even documented the contact in a MISC. note. The RS reported Resident A is very focused on Ms. Sharp and gets upset when she is not working and that Ms. Sharp gives Resident A preferential treatment. The RS reported that Ms. Sharp works at another facility and only picks up shifts at this facility when there is an operational need. The RS reported Ms. Sharp will not be allowed to pick up any additional shifts due to this situation.

On 5/14/25, I interviewed home manager Danyell Baltazar by phone. Ms. Baltazar confirmed that she is aware of the situation and that she and other staff members have spoken with Ms. Sharp about her professional boundaries. Ms. Baltazar reported she received a picture that was taken of Ms. Sharp sitting on the couch while Resident A rested her head on her shoulder/chest area. Ms. Baltazar reported that Ms. Sharp will no longer be able to pick up shifts at the facility.

On 5/14/25, I received and reviewed a photograph of Ms. Sharp on the couch at the facility wrapped in a blanket with her eyes closed while Resident A has her head resting on her shoulder/chest area with her eyes closed which looked as though they were sleeping.

On 5/15/25, I received a reviewed Miscellaneous Note (MN) authored by Kaylie Sharp dated 5/10/25. The MN indicated that Ms. Sharp allowed Resident A to rest her head on her after Resident A asked for permission to do so. The MN also indicated that Ms.

Sharp gave Resident A a hug goodbye when she left, and that Resident A has the right to have “bonds” with staff members.

On 5/20/25, I interviewed DCSM Jodi Wood by phone. Ms. Wood confirmed that she took the picture of Ms. Sharp sleeping on the couch with Resident A’s head on her shoulder. Ms. Wood reported that the picture was taken at about 2:30am. Ms. Wood reported she gave the picture to her supervisor. Ms. Wood reported she does not think Ms. Sharp and Resident A are in an intimate relationship but does believe Ms. Sharp has very poor boundaries. Ms. Wood reported she believes the home manager, Ms. Baltazar has had several conversations with Ms. Sharp about this topic. Ms. Wood reported that Ms. Sharp is no longer allowed to work at the facility.

On 5/20/25, I interviewed Kaylie Sharp by phone. Ms. Sharp admitted to “dozing off” while working when asked about the picture I received of Resident A and her on the couch with her head on Ms. Sharp’s shoulder. Ms. Sharp confirmed that Resident A asked permission to put her head on her shoulder but denied any other inappropriate behavior between her and Resident A. Ms. Sharp reported she treats all the residents equally and does not give Resident A any special treatment. Ms. Sharp reported she believes the staff members are supposed to build healthy relationships with the residents as they often do not have much family involvement. Ms. Sharp believes she is being “singled out” by the other DCSM for personal reasons and that the residents appreciate her and how she relates to them. Ms. Sharp reported that DCSM Jodi Wood was also sleeping while at work and provided a picture she took of Ms. Wood where she is lying on the couch, under a blanket with her eyes closed.

On 5/21/25, I interviewed assistant home manager Paula Cummins at the facility. Ms. Cummins reviewed the photograph I received from Ms. Sharp and confirmed it was DCSM Jodi Wood.

On 5/21/25, I interviewed Resident A at the facility. Resident A reported she has lived at the facility since December 2024. Resident A reported her favorite staff member is Kaylie Sharp and was anxious to see her again but was unsure when she would work again. Resident A confirmed that Ms. Sharp allowed her to rest her head on her shoulder/chest area the last time she worked at the facility. Resident A reported Ms. Sharp was sleepy and was lying on the couch and she covered her up with a blanket and “tucked her in” before she put her head on her shoulder/chest area.

On 5/21/25, I interviewed Resident B and Resident C at the facility. Both residents reported Resident A stays awake all night to hang out with Ms. Sharp when she works the overnight shift and helps her with the cleaning chores. Both residents also reported Resident A only does that when Ms. Sharp is working.

On 5/21/25, I interviewed DCSM Adrienne Jones and Madison Brink at the facility. Both staff members reported although they do not work directly with Ms. Sharp reported they see her in passing and noted she will hug the residents and allow them to play with her

hair. Both staff members reported they think Ms. Sharp does not display professional boundaries while interacting with the residents.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	It was alleged a staff member engaged in an inappropriate relationship with Resident A. Based on interviews and review of documents, this violation will be established. A photograph was taken of Resident A resting her head on Kaylie Sharp's shoulder/chest area while Ms. Sharp was working the overnight shift. In addition, interviews with the staff and residents indicated Ms. Sharp has displayed very poor boundaries including hugging residents, sharing staff schedules and allowing the residents to play with her hair. Although it is not believed there was any inappropriate sexual activity, the behavior was not professional, and Ms. Sharp will not be allowed to work at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 5/20/25, I received a photograph of DCSM Jodi Wood taken while she was working the overnight shift at the facility on 5/10/25. In the photograph Ms. Wood was lying on her stomach wrapped in a blanket with her eyes closed.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services

	specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 5/10/25 staff member Jodi Wood was photographed sleeping while working, therefore was unable to provide appropriate supervision, care or protection for the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/22/25, I shared the findings of my investigation with the administrator, Kim Howard by phone. Ms. Howard acknowledged and agreed to submit a corrective action plan.

III. RECOMMENDATION

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

Nile Khabeiry, LMSW

5/27/25

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

5/29/25

Russell B. Misiak Date
Area Manager