GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 5, 2025

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

RE: License #: AS630393369
Investigation #: 2025A0626015
Beacon Home at Clarkston

Dear Nichole VanNiman:

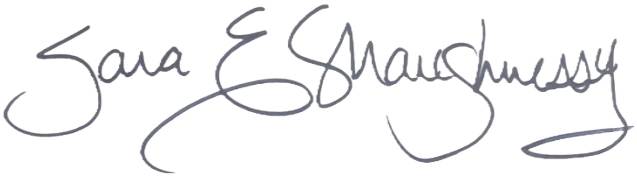
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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 (248) 972-9136.

Sincerely,



Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 320-3721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630393369
Investigation #:	2025A0626015
Complaint Receipt Date:	04/08/2025
Investigation Initiation Date:	04/08/2025
Report Due Date:	06/07/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Clarkston
Facility Address:	10358 Horseshoe Circle Clarkston, MI 48348
Facility Telephone #:	(248) 922-7413
Original Issuance Date:	10/16/2018
License **Status:**	REGULAR
Effective Date:	11/24/2023
Expiration Date:	11/23/2025
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents were left unattended in the home vehicle while the direct care staff member went into a marijuana dispensary.	Yes
Direct care staff member was using marijuana and alcohol while providing care to residents.	No
Additional Findings	No

III. METHODOLOGY

04/08/2025	Special Investigation Intake 2025A0626015
04/08/2025	Special Investigation Initiated - Telephone The special investigation was initiated via telephone interview with, Angela Wend, from Office of Recipient Rights.
04/08/2025	APS Referral APS referral was made via MI Bridges for Mandatory Reporters.
04/10/2025	Contact - Face to Face
04/10/2025	Contact - Face to Face An unannounced onsite investigation took place at Beacon Home at Clarkston. The home manager, Stephanie Dunn, was interviewed. Residents were not home; a plan was made to interview them the following week.
04/16/2025	Contact - Face to Face An announced onsite investigation took place. Interviews were completed with Resident A, Resident B, and Resident C.
05/06/2025	Contact - Telephone call made Interviews were completed, via telephone, with Relative A1, Guardian B1, and Guardian B2. A phone call was attempted with Angela Wend with Community Mental Health for Central Michigan.

05/06/2025	Contact - Document Sent Emails were sent to Angela Wend from Community Mental Health for Central Michigan, Sarah Rupkus from Oakland Community Health Network, and Heather Kiel from Community Mental Health of Livingston County, requesting updates on the status of the intake.
05/06/2025	Contact - Document Received An email was received from Sarah Rupkus from Oakland County Health Network, indicating she had a preponderance of evidence to support the allegations regarding the residents being left in the car unattended.
05/09/2025	Contact - Telephone call made A telephone interview was completed with direct care staff, Nadia Atkins.
05/16/2025	Exit Conference An exit conference took place, via telephone, with vice president of operations, Ramon Beltran.

ALLEGATION:

Residents were left unattended in the home vehicle while the direct care staff member went into a marijuana dispensary. The same direct care staff member was using marijuana and alcohol while caring for residents.

INVESTIGATION:

On 04/08/2025, I received the complaint, via email, alleging direct care staff member, Nadia Atkins, left the three residents of Beacon at Clarkston, in the vehicle, unattended, while she went into a marijuana dispensary. The allegations also stated Ms. Atkins was rolling marijuana into cigarettes and was going to the vehicle periodically during the day, to drink alcohol and use marijuana.

On 04/08/2025, I initiated the investigation by completing a phone interview with the recipient rights advisor, Angela Wend, from Community Mental Health for Central Michigan. Ms. Wend stated she received a phone call from the home manager, Stephanie Dunn, informing her that direct care staff member, Nadia Atkins, had left residents alone in the car while she went into a dispensary. Ms. Dunn became aware of the allegations after one of the residents came to her and told her. She stated Ms. Dunn showed her GPS reports for the van that show the van was parked for at least eight minutes at Moses Roses (a marijuana dispensary) in Waterford. Ms. Dunn informed Ms. Wend that Ms. Atkins was the only staff member on duty at

that time, so there was no way another staff member was in the vehicle with her. She provided me with the names of the residents involved and stated only one of them, Resident A, is one of her recipients, and it is in her individual plan of service (IPOS), that she is to have constant supervision. She stated she went to the home earlier today and interviewed the three residents. She stated Resident B was able to provide the most information and confirmed that they were alone while Ms. Atkins was in the dispensary, and the other two residents confirmed the story told by Resident B. She stated she does not feel there is enough evidence to substantiate on the allegations regarding Ms. Atkins drinking in the van. The residents told her that they saw Ms. Atkins "rolling a blunt", but she does not feel she has a preponderance of evidence to support those allegations. She stated she is substantiating Neglect Class III, for the allegations regarding leaving the residents alone in the dispensary parking lot, because it could have caused harm. She stated the residents told her that Ms. Atkins came into the home smelling like marijuana after going to the dispensary.

On 04/10/2025, I completed an onsite investigation at Beacon Home at Clarkston. I interviewed Stephanie Dunn, the home manager. Ms. Dunn has worked in her position since January of this year. Ms. Dunn stated she was approached by Resident B, on a Monday, wanting to talk to her. She stated Resident B informed her that on Saturday, direct care staff member, Nadia Atkins, had "jungle juice" in the living room. She stated on Sunday Ms. Atkins was the only staff member working and she transported Resident A and Resident B to pick up Resident C from her mother's home. Resident B told her that Ms. Atkins stopped at a marijuana dispensary and left the residents in the car while she went in. Ms. Dunn stated Resident B told her that they then stopped at a party store, where the residents were left in the car again, and Ms. Atkins bought a "Buzz Ball". Resident B informed her that Ms. Atkins kept on going out to the car during the day. Ms. Dunn stated she spoke to Resident A and Resident C. Resident C told Ms. Dunn she did not want to get anyone in trouble, but confirmed what Resident B said, while Resident A told her Ms. Atkins cooks good food. Ms. Dunn stated Ms. Atkins is suspended, pending further investigation.

Ms. Dunn shared that the van had GPS tracking, and she printed the logs for me. The logs indicate that on Sunday, March 30, after going to Walled Lake (where Resident C was), the van was parked at 5770 Dixie Highway, Waterford, which is the address for Moses Roses, a marijuana dispensary. The log indicates the van was parked in the parking lot of Moses Roses for 8 minutes and 17 seconds from 1:20 pm-1:29 pm. Later that night, at 8:52pm, the van left the home and went to 95 Brown Road, Orion Township, which is Jim's Cracker Barrel Grocery and Liquor. The van was idling at the address for 9 minutes and 31 seconds. Ms. Dunn informed me that none of the residents involved were at the home at the time of the interview. Resident A was out with staff, Resident B was at work, and Resident C was with family for the weekend. Ms. Dunn stated that if I came back on Wednesday afternoon, they should all be there.

Ms. Dunn provided me with the individual plan of service (IPOS) and resident information records for Resident A, Resident B, and Resident C. She informed me that Resident B is the only resident with full community access.

Resident A receives services through Community Mental Health for Central Michigan. Resident B receives services through Community Mental Health Services of Livingston County. Resident C receives services through Oakland Community Health Network.

On 04/11/2025, I reviewed the IPOS of Resident A and it is documented that she requires supervision to remain safe and direction/supervision while in the community. Resident A has behaviors including elopement, physical aggression, poor boundaries, inconsistent compliance with medication and appointments, nighttime enuresis, demanding behavior (per staff) and inappropriate sexual behavior. Her outbursts can be severe, and she has been on probation after an outburst. It was documented she has physically attacked staff.

On 04/11/2025, I reviewed the IPOS of Resident B and it indicates the home's responsibility with Resident B is to assist with basic needs and safety. There is no indication Resident B is required to have constant supervision.

On 04/11/2025, I reviewed the IPOS of Resident C and it states that Beacon will have staff present at all times during awake hours in the home and provide monitoring and support in the home and community.

On 04/16/2025, I completed an in-person interview with Resident A at Beacon of Clarkston. Resident A was in a bad mood because of issues with her guardian and was difficult to keep on track. Resident A reported she has lived in the home for a while. She informed me that her memory is not good, and she lashes out at people. She lashes out when people won't talk to her. She told me she likes Ms. Atkins and she remembers walking into the office and seeing her before. She stated Ms. Atkins took them to the pizza place and left her in the car with Resident B and Resident C. She denied knowing how long they were waiting in the car. She did not remember any other stops that day. She stated she sometimes feels safe at Beacon and clarified she doesn't feel safe when staff won't talk to her. She informed me she worries about not being able to be here. She ended the interview by telling me she likes Stephanie (home manager) because she is a good person.

On 04/17/2025, I conducted a private in person interview with Resident C at Beacon of Clarkston. She stated she is worried because she is getting a new roommate and doesn't want one. She has lived at Beacon of Clarkston for almost four years but wants to be home with her family. She stated Ms. Atkins took them to 7-11 and bought a "buzz ball". She stated they also went to Moses Roses and at both stops, she was left in the car with Resident A and Resident B. She stated Nadia bought wraps and rolled "weed". She described the wraps as brown and the "weed" as green. She stated Ms. Atkins was smoking it in the car, but she did not see it, she

knew because she could smell it and she knows what weed smells like. She stated they were in the car alone for 5-10 minutes and denied feeling scared or anything bad happening. She denied seeing Ms. Atkins drinking the buzz ball, she kept it in a brown bag.

On 04/16/2025, I conducted a private, in-person interview with Resident B at Beacon of Clarkston. Resident B stated they have lived at Beacon for approximately three years, they like it there, but they are getting an apartment soon. Resident B stated Ms. Atkins was drinking and stopped at a dispensary where they sell "weed". Resident B stated her, and the other two residents were left in the car at the dispensary named Moses Roses. Resident B stated Nadia was smoking "weed" in the company van and they knew it was weed because they smoke it. Resident B saw the marijuana in the car, but did not see Ms. Atkins smoke it. She stated they also went to the gas station and were left alone for a few minutes there. Resident B stated it was the first time this had happened and denied anyone being scared or anything bad happening.

On 05/06/2025, I completed a phone interview with Relative C1. Relative C1 denied any concerns regarding the care Resident C is receiving at Beacon at Clarkston. She admitted to having had previous concerns regarding Resident C having been hit by another resident, but that was a while ago and Resident C was never seriously injured. She stated the home is clean, the staff is nice, and the managers have always been fair. She denied having been told anything about Resident C being left alone in a car and explained that it would concern her, as she needs supervision.

On 05/06/2025, I completed a telephone interview with Ebonee Smith, receptionist for attorney, Denise Ketchmark, the public guardian for Resident A and Resident B. She informed me that Ms. Ketchmark is out of town at this time. She informed me that they all work together for the residents and agreed to talk to the woman who works there and does the home visits, Elizabeth Hering. She stated Ms. Hering told her there are no concerns with the residents' care. Ms. Smith stated that the residents will call if they have an issue and the only complaints they receive are from Resident A, wanting more money to go shopping.

On 05/09/2025, I completed a telephone interview with direct care staff member, Nadia Atkins. Ms. Adkins admitted to leaving the residents in the car unattended. She stated she was going to pick up Resident C and since she was the only direct care staff member on duty, she took the other two residents with her. She stated it was about a 40-minute drive and she had to go to the bathroom, so she stopped at Moses Roses. She denied knowing what type of establishment it was and buying anything. She stated she did not think there was anything wrong with it, as she had thought Resident C could have 30 minutes of unsupervised time in the community. Ms. Atkins stated she is not familiar with the area, which is why she did not know what type of establishment it was. Ms. Atkins denied buying any Buzz Balls and having jungle juice. She insisted she takes her job seriously and would never use alcohol or marijuana while working. She denied even having either of the substances

on her when she is working due to the residents sometimes breaking into cars to steal from the direct care staff members. She denied stopping to buy wraps for rolling marijuana and stated she pulled into the same plaza of the 7-11 to pick up pizza. She admitted to stopping at the liquor store so Resident C could buy a vape for Resident B, as Resident B did not have their identification on them.

On 05/16/2025, I completed an exit conference, via telephone, with vice president of operations for Beacon Specialized Living Services, Ramon Beltran. The allegations and findings were discussed with Mr. Beltran and he acknowledged he understood them.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered during my investigation, there is enough evidence to conclude that supervision was not provided as specified in the written assessment plan of Resident A or Resident C, as both are to have staff always present. Ms. Atkins admitted to leaving the residents alone in the vehicle while she went into the dispensary. The residents stated they were left alone in the vehicle and the home manager, Stephanie Dunn, provided GPS logs indicating the vehicle was parked at Moses Roses for over eight minutes.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14305	**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 the information gathered during my investigation, there is enough evidence to conclude that the protection and safety of Resident A and Resident C were not attended to. Neither Resident A nor, Resident C, are to be left unsupervised. Ms. Atkins admitted to leaving the residents alone in the vehicle while she went into the dispensary. The residents stated they were left alone in the vehicle and the home manager, Stephanie Dunn, provided GPS logs indicating the vehicle was parked at Moses Roses for over eight minutes. As for the allegations regarding Ms. Atkins using substances while caring for residents, based on the information gathered, there is not enough evidence to conclude she was using them. The residents reported she had the substances and that she was going out to the vehicle, but none of them admitted to having seen Ms. Atkins drinking alcohol or smoking marijuana.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an approved corrective action plan, I recommend no change to the license.

05/16/2025

_____

Sara Shaughnessy Date
Licensing Consultant

Approved By:

For 06/05/2025

_____

Denise Y. Nunn Date
Area Manager