GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2025

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

RE: License #: AM110413530
Investigation #: 2025A0790026
Beacon Home at Eau Claire

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Rodney Gill, 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
"THIS REPORT CONTAINS QUOTED PROFANITY"

I. IDENTIFYING INFORMATION

License #:	AM110413530
Investigation #:	2025A0790026
Complaint Receipt Date:	05/29/2025
Investigation Initiation Date:	06/04/2025
Report Due Date:	07/28/2025
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 Eau Claire
Facility Address:	7014 Clawson Rd. Eau Claire, MI 49111
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/10/2022
License Status:	REGULAR
Effective Date:	02/10/2025
Expiration Date:	02/09/2027
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff was verbally aggressive toward Resident A.	Yes
Staff physically assaulted Resident A.	Yes

III. METHODOLOGY

05/29/2025	Special Investigation Intake 2025A0790026
06/03/2025	APS Referral is not necessary because Adult Protective Services investigated these allegations.
06/04/2025	Special Investigation Initiated - On Site
06/04/2025	Inspection Completed On-site Interviewed direct care staff members (DCSMs) Shanida Johnson, Jordan Jones, and program director Kim Howard.
06/12/2025	Inspection Completed-BCAL Sub. Compliance
06/12/2025	Exit Conference with licensee designee Nichole VanNiman.
06/12/2025	Corrective Action Plan Requested and Due on 06/27/2025

ALLEGATION:

Staff is verbally aggressive toward Resident A.

INVESTIGATION:

On 6/3/25, I reviewed a LARA-BCHS Online Complaint Form dated 5/29/25. The complaint indicated DCSM Chris Watkins has been a constant problem, has been verbally aggressive toward Resident A, irate, demeaning, and speaking in a derogatory manner.

The complaint further indicated Mr. Watkins has been verbally aggressive toward Resident A several days and this verbal aggression has been witnessed by DCSMs Reyna Mejia, Jordan Jones, Andrea Ayers, and Lecia Rollins. The verbal aggression would happen multiple places in the facility. The complaint indicated Mr. Watkins has often been verbally aggressive toward his fellow DCSMs as well.

0n 6/4/25, I conducted an unannounced onsite investigation. During the onsite investigation, I interviewed DCSM Shanida Johnson. Ms. Johnson indicated Resident A moved to another facility on 5/23/25.

Ms. Johnson stated she does not have any firsthand knowledge, but has heard from other DCSMs that DCSM Chris Watkins can become angry very quickly and has been verbally abusive towards Resident A. Ms. Johnson mentioned hearing these allegations from DCSMs Reyna Mejia and Shanice Sallie and indicated she has had to write Mr. Watkins up several times as a result. Ms. Johnson stated she does not have any detailed I Information to provide regarding the verbal abuse.

On 6/4/25, I interviewed DCSM Jordan Jones. Mr. Jones admitted he has heard Mr. Watkins tell Resident A the following: “Back the fuck up, why must I tell you the same thing every day, back the fuck up!”

Mr. Jones stated he has heard Mr. Watkins verbally abusing other residents but did not recall any details.

On 6/4/25, I interviewed program director Kim Howard. Ms. Howard stated she first thought other DCSMs were ganging up on Mr. Watkins because several previously admitted they did not like him. She said she subsequently found the allegations to be true regarding Mr. Watkins verbally abusing Resident A. Ms. Howard stated Mr. Watkins admitted to verbally abusing Resident A during a Recipient Rights investigation.

Ms. Howard confirmed Resident A was transferred to a new facility on 5/23/25.

On 6/12/25, I reviewed Resident A's *Resident Records.* I reviewed Resident A's Face Sheet. I observed that Resident A was admitted to his current facility on 5/27/25. Resident A is not his own person and has a legal guardian. I observed Resident A's diagnoses. Resident A has been diagnosed with antisocial personality disorder, intermittent explosive disorder, and unspecified intellectual disability.

On 6/12/25, I reviewed an *AFC Licensing Division – Incident / Accident Report* dated 4/21/25 involving Resident A. The report indicated DCSM Reyna Mejia witnessed DCSM Chris Watkins verbally abuse Resident A. The report indicated Resident A was participating in a self-involved activity when the verbal abuse happened. Resident A had just returned inside after smoking. Mr. Watkins yelled at Resident A stating Resident A needed to move from the area because he smelled like cigarette smoke and Mr. Watkins did not it.

The report indicated Mr. Watkins continued to verbally harass Resident A by cursing at him using quoted profanity such as "get the fuck away did you hear me get the fuck away from her." The report indicated MR. Watkins continuing to make statements in a similar aggressive manner.

The report indicated DCSM Reyna Mejia intervened taking Resident A to a different location in the home and began coloring with Resident A. The report indicated Ms. Mejia did communicate with management and contacted the Office of Recipient Rights on behalf of Resident A.

The report indicated DCSMs will continue to report any abuse and/or neglect when it occurs, and especially when it is being perpetrated by DCSMs. The report indicated a counseling form will be addressed Mr. Watkins.

On 6/12/25, I reviewed an Office of Recipient Rights (ORR) Report of Investigative findings dated 5/27/25. ORR investigated two allegations involving Mr. Watkins and Resident A. The first allegation ORR was investigating was verbal abuse. The report indicated ORR investigated the following two allegations related to Mr. Watkins verbally abusing Resident A:

- On 4/21/25, It is alleged that DCSM Chris Watkins told Resident A, "Fucking move away from me", "get the fuck away from the table", "you fucking heard her, get away" and/or other similar statements.
- On 5/3/25, it is alleged Mr. Watkins told Resident A, "Stop calling me your fucking bro, that's not my name, I'm not your fucking bro."

ORR interviewed the following individuals: DCSMs Reyna Mejia, Shanice Sallie, Lecia Rollins, Andrea Ayers, Chris Watkins, and Resident A.

The report indicated ORR reviewed Resident A's Person Centered Plan (PCP), *AFC Licensing Division - Incident / Accident Report,* and email communications dated 4/24/25 and 5/6/25.

The report indicated a preponderance of evidence exists based on documentation reviewed, verbal statements from Ms. Mejia, Ms. Sallie, Ms. Rollins, Mr. Watkins, Resident A that Mr. Watkins was verbally aggressive toward Resident A. Ms. Mejia reported she was in the common area with other residents and heard Mr. Watkins cussing at Resident A. Ms. Mejia heard Mr. Watkins telling Resident A, “Fucking get away from me” and “you smell like cigarettes”. Ms.Mejia said she walked over and asked Resident A to do some other things to remove him for the hostility. Ms. Sallie reported she caught the end of the incident and heard Mr. Watkins telling Resident A “to get the fuck away from the table”. Ms. Rollins reported Resident A came to her and told her Mr. Watkins was cussing at him sometimes. Ms. Rollins said Mr. Watkins can be erratic towards the residents. She said Mr. Watkins is defensive towards the residents and rough with Resident A.

The report indicated Mr. Watkins disclosed the following: “I can get pretty aggressive with Resident A. “I can admit that sometimes I’m not very respectable with asking him to move.” Mr. Watkins disclosed the following: “To be honest, I might have come across as pretty rude, like Hey, get out.” Mr. Watkins stated sometimes Resident A does not listen and sometimes it gets on his nerves. He said, “Like, come on man.”

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(ii) Verbal abuse.**
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with DCSMs Ms. Johnson, Mr. Jones, and program director Ms. Howard there was sufficient evidence found indicating Mr. Watkins verbally abused Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff physically assaulted Resident A.

INVESTIGATION:

The complaint indicated that in the kitchen while direct care staff member (DCSM) Chris Watkins was preparing a meal with the assistance of Resident A, DCSM Reyna Mejia heard Resident A yell ouch and then state, “Why did you hit me, that hurt?”

The complaint indicated Ms. Mejia responded by going to the kitchen to check on Resident A. Resident A then came out of the kitchen and stated to a DCSM that Mr. Watkins hit him with a spatula. Resident A then asked, “Can I tell on him?” The DCSM told Resident A they would inform the appropriate individuals about the alleged altercation.

The complaint indicated Mr. Watkins’ behaviors have been reported to management, human resources, the Office of Recipient Rights, and the licensee designee. The complaint indicated DCSMs who have witnessed and/or heard Mr. Watkins display verbally and/or physically abusive behaviors have been asked to write statements regarding the altercations they witnessed between Mr. Watkins and Resident A, how Mr. Watkins treats other residents living at the facility, and his verbal aggressiveness towards DCSMs and residents alike.

The complaint indicated all these concerns have been voiced to the appropriate people, but management has indicated they feel DCSMs are targeting Mr. Watkins.

Ms. Johnson stated she has no firsthand knowledge of the alleged physical assault between Mr. Watkins and Resident A but was informed of the altercation by Ms. Mejia who was on shift at the time of the altercation.

Ms. Johnson stated Mr. Watkins came to work yesterday (6/3/25) but was sent home. Ms. Johnson stated she is unsure if Mr. Watkins has been terminated.

Mr. Jones stated Resident A admitted to him Mr. Watkins hit him on the finger with a spatula, and it really hurt. Mr. Jones indicated Mr. Watkins admitted he hit Resident A on his finger with a spatula during an Office of Recipient Rights investigation.

Ms. Howard confirmed Mr. Watkins was terminated (involuntarily) on 6/3/25.

ORR investigated a second allegation involving Mr. Watkins and Resident A. The second allegation investigated alleged Mr. Watkins physically assaulted Resident A. The report indicated ORR investigated the following allegation:

- On May 3, 2025, it is alleged DCSM Chris Watkins hit Resident A’s hand “pretty hard” with a cooking spatula.

The ORR Report of Investigative Findings indicated DCSM Shanice Sallie admitted to hearing the verbal altercation between Mr. Watkins and Resident on 5/3/25. Ms.

Sallie described in detail what she heard and indicated Resident A told her Mr. Watkins hit him on his finger with a spatula and it hurt.

The ORR Report of Investigative Findings indicated Mr. Watkins admitted he hit Resident A's finger with a spatula. Mr. Watkins described it as a "light tap**".**

On 6/12/25, I reviewed a four-page letter Ms. Mejia wrote to management. The letter was not dated but outlined her concerns regarding Mr. Watkins' inappropriate behaviors and actions. The letter gave a detailed account of Mr. Watkins' poor work ethic, hostility towards DCSMs and residents, verbal aggression towards others (both DCSMs and residents), inability to properly assist residents, inability to complete housework as assigned, failure to follow authoritative direction, disregarding advice in a hostile manner, and sleeping on the clock.

On 6/12/25, I reviewed a Beacon Specialized Living Change of Status form dated 6/6/25 for Chris Watkins. The form indicated Mr. Watkins was terminated (involuntarily) on 6/3/25.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with DCSMs Ms. Johnson, Mr. Jones, and program director Ms. Howard there was sufficient evidence found indicating Mr. Watkins physically assaulted Resident A by hitting his finger with a spatula.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/12/25, I conducted an exit conference / interview with licensee designee Nichole VanNiman via phone. Ms. VanNiman did not dispute the findings or recommendations and agreed to complete a Corrective Action Plan (CAP) within the requested timeframe.

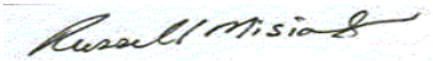
IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

6/16/25

Rodney Gill — Date
Licensing Consultant

Approved By:



6/18/25

Russell B. Misiak — Date
Area Manager