GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 5, 2025

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

RE: License #: AM800267885
Investigation #: 2025A1031037
Beacon Home at Anchor Point North

Dear Ms. VanNiman:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

Sincerely,

Kristy Duda, 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 #:	AM800267885
Investigation #:	2025A1031037
Complaint Receipt Date:	06/03/2025
Investigation Initiation Date:	06/05/2025
Report Due Date:	08/02/2025
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Israel Baker
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Anchor Point North
Facility Address:	28720 63rd Street Bangor, MI 49013
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	08/03/2005
License Status:	REGULAR
Effective Date:	04/24/2024
Expiration Date:	04/23/2026
Capacity:	10
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff grabbed Resident A's neck and pushed him against the wall.	Yes

III. METHODOLOGY

06/03/2025	Special Investigation Intake 2025A1031037
06/03/2025	Contact - Telephone Interview with Complaint #1 and Dale Edwards.
06/05/2025	Special Investigation Initiated - On Site
06/05/2025	Contact - Face to Face Interview with Israel Baker, Benjamin Sowa-Green, Ashley Williams, Patrick Westcott, and Resident A.
06/05/2025	Contact – Document Received and Reviewed.
06/11/2025	APS Referral
06/12/2025	Contact - Telephone Interview with Henry Ellis.
06/27/2025	Inspection Completed-BCAL Sub. Non-Compliance
08/05/2025	Exit Conference held with Nichole VanNiman.

ALLEGATION:

Staff grabbed Resident A's neck and pushed him against the wall.

INVESTIGATION:

On 6/3/25, I interviewed Complainant #1 via telephone. Complainant #1 reported he was in the hallway and observed direct care worker (DCW) Henry Ellis run into the day room asking for help. Complainant #1 reported he saw Mr. Ellis standing against a wall and Resident A was yelling at him. Mr. Ellis then grabbed Resident A's neck and pushed him against the wall. Mr. Ellis let go of Resident A when the facility manager Benjamin Sowa-Green came out of the office. Mr. Sowa-Green took Resident A into his office to calm him down. Complainant #1 reported what he observed was concerning and he did not feel that was an appropriate way to treat a resident.

On 6/3/25, I interviewed DCW Dale Edwards via telephone. Mr. Edwards reported he observed Resident A come after Mr. Ellis and Resident A was yelling at him. Mr. Edwards reported Mr. Ellis utilized a blocking technique by putting an open hand up and he placed his hand on Resident A's "neck or chest area". Mr. Edwards reported he did not appear to be aggressive towards Resident A but was protecting himself from Resident A.

On 6/5/25, I interviewed the district manager Israel Baker at the facility. Mr. Baker reported he was not present when the incident occurred. Mr. Baker reported Mr. Ellis was immediately suspended pending investigation when the facility was informed of the allegations.

On 6/5/25, I interviewed Mr. Sowa-Green at the facility. Mr. Sowa-Green reported he heard commotion coming from the hallway outside of his office. Mr. Sowa-Green exited his office, and it appeared to him that Mr. Ellis was struggling with managing Resident A's behaviors. Mr. Sowa-Green took Resident A into his office to talk with him in efforts to calm him down as he was visibly upset. Mr. Sowa-Green reported Resident A was upset because he bought a used vape from another resident at the facility. Mr. Sowa-Green reported Resident A informed him that he had hit and kicked Mr. Ellis when he was upset. Mr. Sowa-Green reported he did not observe any marks or bruises on Resident A. Mr. Sowa-Green reported another staff informed him of the incident and that it looked like Mr. Ellis grabbed Resident A aggressively by the neck area and also put his hand on Resident A's shoulder.

On 6/5/25, I interviewed Resident A at the facility. Resident A reported Mr. Ellis wrapped his arm around his neck and pushed him against the wall. Resident A reported he hit his head on the wall after being pushed.

On 6/5/25, I interviewed DCW Ashley Williams at the facility. Ms. Williams reported she was outside with her assigned 1:1 resident when the alleged incident occurred. Ms. Williams reported she had observed Mr. Ellis put his hands on residents before and he will often grab them by their shirt or arm. Ms. Williams reported she did not understand why he does this as he knows how to use appropriate behavioral intervention. Ms. Williams reported that staff have had to intervene when Mr. Ellis acts this way and redirect him to another area of the facility.

On 6/5/25, I interviewed DCW Patrick Westcott at the facility. Mr. Westcott reported he did not witness the alleged incident occur. Mr. Westcott reported he has observed Mr. Ellis "get loud" with residents at times but never seen him physically harm a resident.

On 6/5/25, I requested and received two incident reports. The incident report dated 5/29/25 completed by Mr. Ellis read that Resident A was outside smoking with Mr. Ellis and started asking about going on an outing. Mr. Ellis reminded Resident A that he spent his money on a vape from another resident. Resident A then started yelling

and screaming at Mr. Ellis and Mr. Ellis prompted Resident A when Resident A began to punch Resident A in the face several times. Mr. Ellis went into the facility to get assistance and used a blocking technique to prevent physical contact. The facility manager then came out and talked with Resident A to calm him down. Resident A did calm down and went outside to smoke.

The incident report dated 5/30/25 completed by Complainant #1 read that they witnessed a staff member that was working with Resident A run inside and ask for help. Resident A then entered the facility behind the staff yelling. As Resident A got closer to the staff, the staff grabbed Resident A by their neck and pushed Resident A back. The facility manager then came out of his office and talked with Resident.

On 6/12/25, I interviewed Mr. Ellis via telephone. Mr. Ellis reported he was assigned to Resident A as his 1:1 enhanced staff. Resident A was given incentive funds and went to another resident's bedroom and wanted to buy a used vape from them. Mr. Ellis encouraged Resident A to not buy the used vape as there was an outing planned where he could go out and spend his money. Resident A bought the vape and did not have funds available to go out on the outing. Resident A became upset with Mr. Ellis when Mr. Ellis informed Resident A he no longer had funds available to spend on the outing. Mr. Ellis took Resident A on a walk in attempts to calm him down. Resident A became more upset and started yelling and cursing at Mr. Ellis. Mr. Ellis redirected Resident A and walked away from Resident A to give space while ensuring appropriate supervision. Resident A then put his fists up like he was going to hit Mr. Ellis. Mr. Ellis reported he stepped further back and walked away but Resident A started running after him while they were outside. Mr. Ellis reported there were other staff outside and he yelled for help multiple times. Mr. Ellis reported staff did not assist him with redirecting Resident A, so he ran into the facility to ask for help. Resident A followed him into the facility. Resident A continued to chase him and yell at him. Mr. Ellis was charged by Resident A and then Mr. Ellis put his hand out and his hand was fully open. Mr. Ellis reported he was informed by another staff that he had put his hand around Resident A's neck. Mr. Ellis reported he thought he had an open hand and thought he was using a blocking technique. Mr. Ellis reported that "if he did it", it was not on purpose or to intentionally harm Resident A. Mr. Ellis reported he reacted in the moment and again, thought he just put his hand up to block Resident A. Mr. Ellis reported Mr. Sowa-Green then came out of the office and redirected Resident A into the office to calm him down. Mr. Ellis reported after the incident occurred, he was dizzy and "blacked out" and fell to the floor. Mr. Ellis reported Resident A later approached him and apologized for about what happened.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to

	mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	There was enough evidence found to support that Mr. Ellis exposed Resident A to physical and emotional harm. There were consistent reports that Mr. Ellis put his hand on Resident A's neck and pushed him. Mr. Ellis reported he thought he had used a proper blocking technique but was informed by another staff that he put his hand on Resident A's neck. Mr. Ellis reported he might have done this but if he did, it was not intentional. Other staff reported witnessing Mr. Ellis grab other residents and raise his voice at them.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **REFERENCE SIR #2025A1031010 dated 5/30/25, SIR #2023A0579011 dated 12/28/22 and corrective action plan (CAP) dated 1/9/23.**

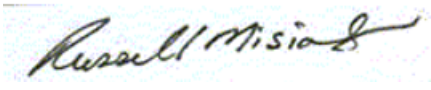
IV. RECOMMENDATION

It is recommended that the current recommendation of revocation be continued.

7/14/25

Kristy Duda Date
Licensing Consultant

Approved By:



7/14/25

Russell B. Misiak Date
Area Manager