GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 17, 2025

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

RE: License #: AS630387842
Investigation #: 2026A0626004
Beacon Home at Dilley

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 (248) 972-9136.

Sincerely,

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630387842
Investigation #:	2026A0626004
Complaint Receipt Date:	11/24/2025
Investigation Initiation Date:	11/24/2025
Report Due Date:	01/23/2026
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:	Ramon Beltran
Name of Facility:	Beacon Home at Dilley
Facility Address:	7570 Dilley Road Davisburg, MI 48350
Facility Telephone #:	(248) 382-5648
Original Issuance Date:	08/13/2018
License **Status:**	REGULAR
Effective Date:	09/10/2025
Expiration Date:	09/09/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Home manager, Bryce Gates, engaged in a physical altercation with Resident A, leaving him with blood on his ear.	Yes
Additional Findings	No

III. METHODOLOGY

11/24/2025	Special Investigation Intake 2026A0626004
11/24/2025	APS Referral Adult Protective Services (APS) referral received.
11/24/2025	Special Investigation Initiated - Telephone I initiated the investigation by completing a telephone interview with Kathleen Garcia from Oakland Community Health Network.
12/01/2025	Contact - Telephone call made I completed a telephone interview with Adult Protective Services investigator, Candid Jamerson.
12/02/2025	Contact - Face to Face I completed an unannounced onsite investigation at Beacon at Dilley. I completed interviews with Jaqueline Wilson, program director, Resident A, and Resident B.
12/02/2025	Contact - Telephone call made I completed phone interviews with the home manager, Bryce Gates, and Resident A's case manager through Saginaw County Community Mental Health, Judy Sausedo.
12/03/2025	Contact - Telephone call made I completed a telephone interview with direct care staff member, Brenda Allen.
12/03/2025	Contact - Telephone call made I completed a telephone interview with Guardian A.

12/04/2025	Contact – Telephone call made I completed a telephone interview with direct care staff member, Margaret Yearby.
12/26/2025	Exit Conference I completed an exit conference, via telephone, with licensee designee, Ramon Beltran. The findings were discussed and he had no additional questions or concerns.

ALLEGATION:

Home manager, Bryce Gates, engaged in a physical altercation with Resident A, leaving him with blood on his ear.

INVESTIGATION:

On 11/24/205, I received a complaint, via email, alleging that the home manager, Bryce Gates, at Beacon at Dilley, physically assaulted Resident A, leaving him with a bloody ear.

On 11/24/2025, I initiated the investigation by completing a telephone interview with Kathleen Garcia, recipient rights specialist with Oakland Community Health Network. Ms. Garcia does not have Resident A in her records. She denied having had any allegations or concerns regarding the home manager, Bryce Gates. She requested I contact her if there are any other issues found involving other residents in the home.

On 12/01/2025, I completed a telephone interview with Adult Protective Services (APS) investigator, Candid Jamerson. Ms. Jamerson went to the home and interviewed Resident A. Resident A did not have any visible injuries when Ms. Jamerson was there. She conducted interviews while there with Resident A and direct care staff member, Brenda Allen. Ms. Allen told her that she was working and heard a commotion. Resident A came into the home and told her he had gotten into it with Mr. Gates after he yelled at Resident A when he asked about denture cream and his allowance money. Mr. Gates "took a swing" at Resident A. The police were notified and came to the home. She has not yet contacted the police but stated it was Oakland County Sheriff who responded, and she has also informed them of the allegations. The program director is filling in for Mr. Gates, and she is still waiting for the incident report.

On 12/02/2025, I completed an unannounced onsite investigation at Beacon at Dilley. I completed an interview with program director, Jacqueline Wilson. Ms. Wilson is filling in while Mr. Gates is suspended, pending further investigation, for the incident with Resident A. She was not there when the incident took place and did not know about it until she was contacted by recipient rights in Saginaw County, then human resources. Resident A reported having been choked by Mr. Gates and staff had to get involved to break it up. She was not there when it happened and did not find out about it until the

following week. Recipient rights specialist, Judy Sausedo contacted her and told her there was a complaint about a resident being choked. She contacted human resources about it and Mr. Gates was suspended, pending investigation. She spoke with a resident who told her he heard furniture being moved and came out to see what was going on. Staff had to get involved and the police were called. The police did not arrest anyone, she stated it was due to there being two different stories and no eyewitnesses. The reports she received from staff, Resident A, and the other resident who was there, are all similar and are all that Mr. Gates was the initial aggressor and Resident A had blood on his ear. Ms. Sausedo told her she had other incidents reported to her regarding Mr. Gates and Resident A and requested suspension. Staff did inform her they had concerns prior to this but did not report them due to fear of retaliation from Mr. Gates. Two staff members told her that if Mr. Gates is brought back, they will request to be transferred to another Beacon Home. She has spoken with Resident A's guardian, who wants a no contact order put into place due to the incident.

Ms. Wilson provided me the incident report for that day. It was written by Brenda Allen. In the incident narrative, it says the following:

> "Staff was in the laundry room and Resident A walked in through the garage door, as he came, he said, "Fuck this, I am out of here". Staff asked what was wrong, Resident A stated that he asked Bryce for his $10 for doing chores and Resident A stated that Bryce told him he was not paying him shit. Bryce then came in through garage door behind Resident A and he was yelling and screaming at Resident A. Staff tried to separate them and put them in different areas of the home. Upon staff stepping outside to make a phone call to our Program Director, staff heard a loud noise and went running back inside, upon entering the kitchen the living room coffee table was knocked over. Staff heard Bryce say to Resident A, "What you going to do now?" Staff had Resident A go towards his bedroom and Bryce outside calm the situation. Staff asked Bryce if he and Resident A were fighting and Bryce stated yes because Resident A hit him first. Staff then went to Resident A's room and asked him if he was ok and he stated that Bryce had choked him. As Resident A turned to walk away staff noticed blood on his clothing and ear and noticed Resident A's left lower ear was bleeding. Staff helped clean Resident A's ear and Resident A called the police. The police talked with staff and Resident A and had Resident A go for a walk to calm down."

Ms. Wilson also provided me with Resident A’s Individual Plan of Service, which includes a behavior plan. The plan indicates he has a history of verbal aggression; his behavior plan states the following:

- “Verbal threats of aggression include yelling, using foul language, threatening and arguing. Resident A has a history of fluctuating moods, when told no or if he doesn't agree with something. Resident A has a history of yelling and using profanity towards others when upset. If Resident A appears to be agitated, begins to yell, or makes vulgar statements, staff will immediately prompt Resident A to stop and ask

what is wrong. Staff should always use a calm and neutral tone when addressing Resident As concerns.

- Staff should encourage Resident A to use deep breathing exercises, listen to music, watch television, color, or engage in a different activity in an attempt to calm himself.
- If Resident A continues the outburst, staff will walk away for a few minutes before resuming to deescalate. Staff will encourage Resident A that he can come and talk with staff when he is calm and ready.
- Once calm for several minutes, staff will remind Resident A, they understand he was upset. Staff will also remind Resident A they want to help but cannot when yelling and making threatening statements. For example, this could include staff saying "Resident A if you are upset or frustrated you should tell me what is wrong. I cannot help or understand when you are yelling."

The behavior plan also states that if Resident A shows signs of becoming angry, which can lead to physical aggression, staff are to ask him if he needs to talk. They are to remind him that there are people who love and care for him. The plan also indicates that staff should be working with him to develop solutions on how to assist him, as well as teaching him more appropriate ways to deal with anger. The intervention plan indicates that if Resident A becomes physically aggressive, staff will firmly prompt him to stop. They are to be firm, but never harsh or scolding.

On 12/02/2025, during my onsite investigation, I completed a private face to face interview with Resident B. He has lived here since September and thinks it's ok. There isn't much to do and he wants to get a job. He feels safe here but has certain feelings about certain people, which he described as nothing specific, just a "feeling". He was home when the incident happened with Resident A and Mr. Gates. He was playing a video game in his room and heard arguing and yelling, then a thud. When he went out to see what was going on, it was already over. He saw Mr. Gates standing up and Resident A on the couch. He believes Resident A was antagonizing Mr. Gates, as he has done before. The police came and no one was arrested, and he did not see any injuries on either man. The day before, he heard direct care staff member, Margarat Yearby, tell Resident A, after a verbal confrontation with Resident A and Mr. Gates, "Don't do it while I am here". He thinks she said that to protect Resident A. He described Mr. Gates as defiant and not ready for the job, as he is dealing with a lot of stuff. Mr. Gates does not allow them to go out as much as they would like, and he does not like that.

On 12/02/2025, during my onsite investigation, I completed a private, face to face interview with Resident A. He feels safe where he is, now that Mr. Gates is gone. He likes having Ms. Wilson there and her presence has made things better. On that day, 11/20/2025, he went outside to ask Mr. Gates for his chore money. Mr. Gates told him, "I don't have to give you shit; this is my house." When they were still outside, Mr. Gates chest bumped him and said, "Shut up, cracker!" When Mr. Gates came into the home, he shoved Resident A down on the couch, told him to respect his elders, and choked him. He is glad Mr. Gates is not there anymore, as he never wanted to do anything for him. While Mr. Gates was choking Resident A, his nail scratched Resident A's ear. His

family came and picked him up that day. Mr. Gates told him that no one respects him in the house. He described Mr. Gates as an "arrogant kid".

On 12/02/2025, I completed a telephone interview with home manager, Bryce Gates. Mr. Gates stated he was outside, talking on the phone, when Resident A came out and started disrespecting him and calling him "out of his name". Resident A wanted his $10 allowance for doing chores. Mr. Gates told him to wait and reminded him that he had not forgotten his money before and he will get it to him. Resident A would not stop, got into his face, and called him the "n word" with a "hard r". He came into the home and Resident A grabbed his hoodie and pushed him over the table. The police came and everyone told them that Resident A was the aggressor, and no one was arrested. After the incident report was completed, he received a call from human resources and was suspended. He insisted Resident A was the aggressor and cusses him out on a regular basis. He believes Resident A has a problem with him because he is significantly younger than Resident A and he doesn't like having him tell him what to do. Resident A has a pattern of aggression and pushed him into the kitchen once because he was upset that his family wasn't picking him up that day.

On 12/02/2025, I completed a telephone interview with Judy Sausedo, recipient rights specialist with Saginaw County Community Mental Health. Mr. Gates has contacted her, asking when he can go back to work. She has interviewed Mr. Gates and direct care staff member, Brenda Allen. There were not any witnesses to the actual physical altercation, Ms. Allen was working, and did not witness the altercation, but when she came into the room, it appeared as though Mr. Gates was on top of Resident A. Mr. Gates told Ms. Sausedo that Resident A was in his face, grabbed his hoodie, and he had to push him hard to get him off of him. Mr. Gates informed her that he had scratches from the altercation. She did not see the scratch on Resident A's ear. She interviewed Resident A and he told her Mr. Gates choked him and hit him. Resident A told her that the table flipped over when Mr. Gates pushed him and that he choked Mr. Gates as Mr. Gates was choking him. Ms. Allen was adamant that the furniture was turned over and with Mr. Gate's position, she believed it happened how Resident A described. She has heard of Mr. Gates and Resident A having issues, she received a complaint before, from other staff members, regarding how Mr. Gates was talking to Resident A. Mr. Gates told Resident A he was going to have him go to jail. She believes staff were intimidated by Mr. Gates and were afraid to come forward, as they were worried about retaliation. Resident A wants to relocate to Saginaw County, to be closer to family.

On 12/03/2025, I completed a telephone interview with direct care staff member, Brenda Allen. Ms. Allen has been working as a direct care staff member for approximately 25 years. Ms. Allen described working with Mr. Gates as walking on eggshells and the fear of retaliation. She was working on the day of the incident. She was in the laundry room and heard Resident A say, "Brenda, fuck this, I am outta hear!" Then, Mr. Gates came in yelling. She told both men to calm down and Resident A walked away. He told her that he asked Mr. Gates for his chore money and Mr. Gates told him, " I don't have to give you shit!" He also told her that he asked Mr. Gates to buy him Fixodent for his

dentures and Mr. Gates told him it was not his responsibility. She went outside to take a call from her daughter and could hear them arguing, then heard a thud. She ran in and saw furniture turned over and heard Mr. Gates ask, "Whatcha gonna do now?" She got them separated and noticed Resident A had blood on his ear. She denied taking a photograph of the injury. Resident A told her, with tears, that Mr. Gates choked him. Resident A called the police; they came and talked to Mr. Gates. Mr. Gates stayed on his shift, and she wrote up an incident report, which Mr. Gates oversaw. She believes Resident A's version of events, due to their positioning when she saw them. She tried to explain that Resident A was near the couch, with his back to it, and Mr. Gates was near the laundry room door. Also, the way the furniture was, made her believe Resident A. She denied ever seeing Resident A angry or aggressive and does not believe he was physical first. She had been told that Mr. Gates had physically attacked residents before, but she did not know details, as she never saw it. She feels Mr. Gates is intimidating and is calling staff to see what is going on, even though he was told not to and staff were told not to talk to him. Mr. Gates is disrespectful to residents and staff, he gets a "tone" with them and speaks in a hostile manner. He would never allow them to take residents on outings and wanted them to just sit in the house all day.

On 12/03/2025, I completed a telephone interview with Guardian A1. She is also a relative of Resident A. Guardian A1 was called by Resident A on 11/14/2025, following the incident with Mr. Gates. She went and picked up Resident A to take him to her home for the weekend, like she frequently does. She picked him up around 6:30pm, and she received the call around 3:30pm. She never received a notice in writing and was not contacted by anyone associated with Beacon until 11/20/2025, when Ms. Wilson called her. She saw the blood on Resident A's ear and did not take photographs. When she picked up Resident A, Mr. Gates was not there. Resident A told her that he went outside to ask Mr. Gates for his chore money and Mr. Gates tackled him to the ground and choked him. Mr. Gates called Resident A a cracker. Resident A didn't say much else about what happened.

On 12/04/2025, I completed a telephone interview with direct care staff member, Margaret Yearby. Ms. Yearby was working the day prior to the alleged incident and is familiar with Mr. Gates and Resident A. She does not like Mr. Gates and does not want to work for him. He is rude to staff and takes it all to his head. He is on a power trip and does not know everything he is supposed to be doing. They are all walking on eggshells with him. Mr. Gates and Resident A have had problems with each other for a while now. She has contacted the I CARE line, run by Beacon Specialized Living, to report issues with Mr. Gates. She loves working for Beacon Specialized Living, but not with Mr. Gates. While she was working the day before the physical altercation, Mr. Gates was “getting into it” with Resident A and she asked Resident A to please not do that while she was there, as she did not want to see them get into it and Resident A respects her.

She did not know what they were arguing about. Mr. Gates has asked Resident A if he “eats booty”. Mr. Gates does not speak to Resident A appropriately and has told him he is not responsible for purchasing his insulin and other medical supplies. Mr. Gates treats Resident A as a problem, but Resident A is cooperative; he just likes to be treated and talked to with respect. Mr. Gates frequently tells Resident A to “respect his elders”, even though Resident A is significantly older than Mr. Gates.

On 12/26/2025, I completed an exit conference, via telephone, with Ramon Beltran, licensee designee. He was informed of the findings and had no additional questions or concerns.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the information gathered during my special investigation, there is sufficient evidence to support the allegations that Resident A did not receive protection and personal care as specified in his assessment plan. Resident A stated that Mr. Gates physically assaulted him after a verbal argument. Ms. Allen stated that, she heard a verbal argument between Mr. Gates and Resident A, intervened, then heard the physical altercation, upon her checking on them, she stated the positioning of their bodies supported the version of events told by Resident A. Ms. Yearby stated there has been other instances of Mr. Gates speaking inappropriately to Resident A and there was a history of them having problems with each other. Mr. Gates stated that Resident A was the physical aggressor. Resident A’s guardian and Ms. Allen both admitted to seeing Resident A’s blood on his ear. These interviews support Resident A’s version of events. Regardless of who started the physical altercation, there are witnesses who stated they heard Mr. Gates arguing with Resident A, which is not consistent with his behavior plan outlined in his individual plan of service.
CONCLUSION:	**VIOLATION ESTABLISHED**

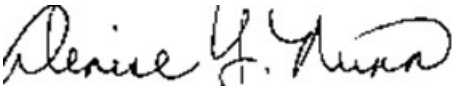
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

12/26/2025

Sara Shaughnessy — Date
Licensing Consultant

Approved By:



02/17/2026

Denise Y. Nunn — Date
Area Manager