GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 27 2026

Nichole VanNiman
DuNord, Inc
Suite 110
890 North 10th Street
Kalamazoo, MI 49009

RE: License #: AM390259947
Investigation #: 2026A0581023
Beacon Home at River Run

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 (517) 335-5985.

Sincerely,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM390259947
Investigation #:	2026A0581023
Complaint Receipt Date:	03/11/2026
Investigation Initiation Date:	03/12/2026
Report Due Date:	05/10/2026
Licensee Name:	DuNord, Inc
Licensee Address:	555 Railroad Street Bangor, MI 49013
Licensee Telephone #:	(269) 344-7972
Administrator:	Aubry Napier
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at River Run
Facility Address:	716 Leenhouts Kalamazoo, MI 49048
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	05/12/2006
License Status:	REGULAR
Effective Date:	01/20/2025
Expiration Date:	01/19/2027
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATIONS

	Violation Established?
Resident A threatened direct care staff, April Smith, with a belt, and April Smith responded by using derogatory language and making threats.	Yes

III. METHODOLOGY

03/11/2026	Special Investigation Intake - 2026A0581023
03/11/2026	Referral - Recipient Rights - ISK received allegations and are investigating.
03/11/2026	Contact - Document Sent - Email correspondence with Integrated Services of Kalamazoo (ISK) Recipient Rights Officer, Suzie Suchyta. I received Incident Reports (IRs)
03/12/2026	Special Investigation Initiated – Telephone - With Complainant
03/13/2026	APS Referral - online referral
03/24/2026	Contact - Face to Face - Interview with Resident A.
03/24/2026	Contact - Face to Face - Interview with direct care staff, Justise Johnson.
03/24/2026	Contact – Telephone call made – Left voicemail with home manager, Cindy Balkema.
03/24/2026	Contact - Telephone call made - Interview with direct care staff, April Smith.
03/24/2026	Inspection Completed On-site - Resident A was at an appointment with direct care staff, April Smith.
03/26/2026	Inspection Completed-BCAL Sub. Compliance
03/27/2026	Exit conference with the licensee designee, Nichole VanNiman.

ALLEGATION: Resident A threatened direct care staff, April Smith, with a belt, and April Smith responded by using derogatory language and making threats.

INVESTIGATION: On 03/11/2026, I received this complaint through the Bureau of Community Health Systems (BHCS) online complaint system. The complaint alleged on or around 02/22/2026, Resident A threatened direct care staff, April Smith, with a belt and a verbal altercation ensued. The complaint alleged April Smith called Resident A derogatory names including “bitch”, “hoe”, “slut”, “psychopath”, and “cunt”. The complaint indicated Integrated Services of Kalamazoo (ISK) Office of Recipient Rights (ORR) also received the allegations and was investigating.

On 03/11/2026, I emailed ISK Recipient Right’s Officer (RRO) Suzie Suchyta, who documented she had already interviewed most of the direct care staff involved and determined the incident occurred. According to Suzie Suchyta, Resident A swung a belt at staff and made threats toward April Smith. She further documented April Smith told Resident A she would contact law enforcement if she was assaulted. Suzie Suchyta documented that April Smith referred to Resident A as a “bitch” while she was talking to the home manager, Cindy Balkema, and while Resident A was within hearing distance. Suzie Suchyta also documented that staff indicated April Smith referred to Resident A as a “sociopath” while April Smith was talking to staff, Justise Johsnon. Suzie Suchyta documented that April Smith denied calling Resident A a “cunt”, but acknowledged she may have made that statement to the home manager, Cindy Balkema, while Resident A was within hearing distance.

Suzie Suchyta also provided two Incident Reports (IRs). The first IR completed by April Smith, dated 02/22/2026 at approximately 8 pm, documented Resident A became increasingly agitated while attempting to speak with staff regarding earlier events. Following medication administration, Resident A escalated behaviorally, including throwing drinks, making threats towards staff, and brandishing a belt in a threatening manner. April Smith documented attempts to verbally redirect Resident, utilize DBT coaching, and encourage her to contact her treatment team support.

The IR further documented that Resident A continued to escalate, making repeated threats and refusing to engage in coping strategies. April Smith documented becoming overwhelmed, and verbal exchanges between her and Resident A became inappropriate, which consisted of her telling Resident A “you are crazy you need to be in a locked down home…” and referring to Resident A as a “psychopath”. The IR documented additional staff support was requested, and supervisory staff responded to assist with de-escalation. The IR documented Resident A was eventually redirected and calmed with continued staff support. The IR noted expectations for staff to follow facility policies, treat residents with dignity and respect, and refrain from raising their voices.

The second IR, which was dated 02/24/2026, and completed by Resident A’s therapist documented that Resident A reported interpersonal conflict with the facility’s staff, April Smith. Resident A reported that April Smith threatened to write

her up and told her that her therapist did not like her and only saw her out of obligation. Resident A further reported that Cindy Balkema told her that staff were quitting because of her and that she was tired of dealing "…with [her] shit". Additionally, Resident A reported that staff called her derogatory names, including "cunt" and "bitch".

On 03/10/2026, Suzie Suchyta and I interviewed the facility's Program Director, Shawn Remynse. Shawn Remynse stated she was not working on the evening of 02/22/2026 and did not recall the specific incident involving Resident A. She stated that the facility's home manager, Cindy Balkema, contacted her regarding the situation and that she later spoke to staff, April Smith. Shawn Remynse stated Cindy Balkema reported Resident A's behaviors had escalated and were difficult to manage, including yelling and swearing at staff. She further stated Cindy Balkema reported that April Smith left the home following the incident. Shawn Remynse stated she contacted April Smith while she was still onsite at the facility.

Shawn Remynse stated she was not aware of all details but stated April Smith indicated she was "done" with Resident A due to her ongoing behaviors. Shawn Remynse recalled speaking with April Smith while April Smith was in her car and providing guidance on de-escalation, including maintaining space between staff and Resident A. She stated staff interactions can contribute to escalation and emphasized the importance of acknowledging resident behavior rather than engaging.

Shawn Remynse stated April Smith acknowledged engaging in a verbal altercation with Resident A and described feeling overwhelmed. Shawn Remynse stated she understood no injuries occurred and did not believe medical intervention was necessary. She stated the interaction involved yelling and use of inappropriate language between both parties.

In a separate discussion, Suzie Suchyta stated she deduced the incident with Resident A occurred in a common area of the facility while April Smith was preparing medications. She stated Resident A made a comment toward April Smith, which led to a verbal exchange. She stated staff, Justise Johnson, attempted to intervene and Cindy Balkema responded to the home. She stated April Smith left the facility prior to completing her shift, but Cindy Balkema remained to provide coverage.

On 03/24/2026, I conducted an unannounced onsite inspection; however, neither April Smith nor Resident A were present in the facility. Other staff informed me April Smith transported Resident A to a therapy appointment.

On 03/24/2026, I interviewed direct care staff, April Smith. She stated Resident A was exhibiting increased behaviors throughout the day and was targeting her, including following her around the home and threatening to hit her with a belt. April Smith stated she attempted to verbally redirect Resident A, encouraged her to utilize

coping strategies, and limited her attention to the behavior; however, these interventions were not effective.

April Smith stated the incident occurred at approximately between 8 pm – 9 pm. She stated she became overwhelmed and “snapped”, though she could not recall the exact statements made at that time. She stated she later apologized to Resident A and felt remorseful. April Smith stated she was working with Justise Johnson and that her supervisor, Cindy Balkema, arrived at the facility during the incident. She stated Cindy Balkema allowed April Smith to step outside to calm down, and April Smith subsequently spoke with Shawn Remynse who provided her with guidance. April Smith stated she returned to work the following morning after taking the night to cool down.

April Smith acknowledged that she referred to Resident A using inappropriate language, stating she called her a derogatory name while speaking to Cindy Balkema, within Resident A’s hearing range. She stated this was said out of frustration and characterized it as venting. April Smith also stated she told Resident A she would contact law enforcement if Resident A physically assaulted her.

April Smith stated that her relationship with Resident A has generally been improving since the incident, noting Resident A has been given increased independence, including additional community access and phone privileges. She stated she received disciplinary action following the incident and discussed expectations with management, including seeking support from coworkers and supervisors when feeling overwhelmed.

On 03/24/2026, I interviewed staff, Justise Johnson. She stated April Smith was administering evening medications at approximately 8 pm when Resident A continued taunting April Smith. Justise Johnson stated Resident A made statements that she would report April Smith to Recipient Rights reporting that she was trying to harm her and April Smith responded that Resident A was threatening her.

Justise Johsnon stated she heard April Smith call Resident A derogatory names, including referring to her as a “bitch” and a “psycho”, and stated these comments were made directly to Resident A. She indicated Cindy Balkema had not yet arrived to the facility at that time. She stated Cindy Balkema was already coming to the facility because she was responding to staffing issues, as night staff had called off. Justise Johnson described the environment as already stressful. She further stated Resident A was also calling April Smith names, making threats toward April and her family, and was holding a belt and snapping it in a threatening manner. She stated Cindy Balkema arrived and staff were able to separate Resident A and April Smith.

Justise Johnson stated she attempted to intervene by using blocking techniques and verbal redirection, including DBT coaching and encouragement. She stated she encouraged April Smith to step outside to de-escalate; however, staffing limitations made it difficult to maintain adequate coverage on the floor. Justise stated April

Smith initially indicated she would not return to work but ultimately returned the following day.

Justise stated that since the incident, interactions between Resident A and staff have improved. She stated staff have a better understanding of allowing space for de-escalation and providing support by rotating staff when situations become heightened.

On 03/24/2026, I interviewed Resident A. She initially stated she did not recall the incident, but later reported that April Smith called her derogatory names, including “slut”, “bitch”, “cunt”, and “hoe”, and stated these comments were made directly to her face. Resident A stated she believed April Smith became upset after she asked her a question. She further stated that Cindy Balkema addressed April Smith regarding use of these statements. Resident A stated that her relationship with April Smith has improved since the incident.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on my investigation, which included interviews with Resident A, direct care staff, April Smith and Justise Johsnon, and the Program Director, Shawn Remynse, review of Incident Reports, and information provided by ISK RRO, Suzie Suchyta, there is sufficient evidence to support that direct care staff, April Smith, did not treat Resident A with dignity and respect on or around 02/22/2026. April used derogatory and demeaning language toward Resident A, including calling her a “bitch” and “psycho”, which was corroborated by multiple sources. Although Resident A’s behavior was escalated, staff are expected to maintain professionalism and use appropriate de-escalation techniques, which did not occur in this instance.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks.** **(iv) Threats.**
ANALYSIS:	Based on interviews, incident reports, and Recipient Right's findings, there is sufficient evidence that direct care staff, April Smith, subjected Resident A to verbal abuse and derogatory remarks when she used offensive and demeaning language toward Resident A during their interaction on 02/22/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 03/27/2026, I attempted to contact the licensee designee, Nichole VanNiman, to conduct my exit conference. I was unable to reach her via telephone; however, I emailed informing her of my findings.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

03/26/2026

Cathy Cushman Date
Licensing Consultant

Approved By:

03/27/2026

Dawn N. Timm Date
Area Manager