STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

April 8, 2026

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

RE: License #: AM800267885
Investigation #: 2026A1030020
Beacon Home at Anchor Point North

Dear Ms. VanNiman:

Attached is the Special Investigation Report for the above-referenced facility.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing, and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,

Nile Khabeiry, LMSW

Nile Khabeiry, 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 #:	2026A1030020
Complaint Receipt Date:	02/26/2026
Investigation Initiation Date:	02/26/2026
Report Due Date:	04/27/2026
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:	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?
A staff member poured ice water on Resident A while he was sleeping on the couch.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/26/2026	Special Investigation Intake 2026A1030020
02/26/2026	Special Investigation Initiated - Telephone Interview with Referral Source
02/26/2026	APS Referral APS referral made
02/27/2026	Contact - Telephone call made Interview with Isreal Baker
03/02/2026	Contact - Face to Face Interview with Resident A
03/02/2026	Contact - Face to Face Interview with DeShawn Lloyd
03/02/2026	Contact - Telephone call made Interview with Alexis Cripps
03/02/2026	Contact - Telephone call made Interview with Ashely Williams
03/13/2026	Contact - Document Received Reviewed SIR # 2025A1030019
03/12/2026	Contact – Document Received Reviewed Settlement Agreement
03/30/2026	Contact – Document Received Reviewed Resident B’s Behavior Treatment Plan
04/06/2026	Contact – Phone call

	Interview with Kelly Green
04/08/2026	Exit conference – Exit conference by phone.

ALLEGATION:

A staff member poured ice water on Resident A while he was sleeping on the couch.

INVESTIGATION:

On 2/26/26, I interviewed the referral source (RS) by phone. The RS reported direct care staff member (DCSM) Ashley Williams was the staff member in question. The RS reported that although Ms. Williams denied dumping a bucket of ice water on Resident A, the incident was witnessed by another DCSM. The RS further reported that the witness indicated that Resident A was lying on the couch in one of the common areas of the facility and Ms. Williams dumped water on him. The RS reported that she also interviewed Resident A who initially denied the incident occurred but later in the conversation she indicated that Ms. Williams encouraged him not to disclose what happened because she may lose her job.

On 2/27/26, I interviewed facility supervisor Isreal Baker by phone. Mr. Baker reported he was aware of the situation involving Resident A and Ms. Williams. Mr. Baker reported he suspended Ms. Williams pending the investigation. Mr. Baker reported he had not spoken with Resident A about the incident but did speak with the DCSM that witnessed the incident and believed that it did occur. Mr. Baker reported he heard from other staff members that Ms. Williams dumped ice water on Resident A as a retaliation for him stealing her submarine sandwich earlier in the shift. Mr. Baker reported he also believed it was premeditated because Ms. Williams waited until all the supervisors left for the day and went to the other side of the building and poured ice water on Resident A while he was lying on the couch. I confirmed with Mr. Baker that Ms. Williams was assigned to an adjoining facility that holds a separate license.

On 3/2/26, I interviewed Resident A at the facility. Resident A reported he stole Ms. Williams' sandwich on 2/23/26 while he was in the staff office. Resident A reported that at the time he and his assigned one to one staff Alexia Cripps were in the medication room. Resident A reported there were other staff members in the office, but no one saw him take the sandwich. Resident A reported later that day at about 6:00 pm he abruptly awoke to Ms. Williams throwing ice water on him. Resident A reported he did not know she was going to do that and that he believes that she did it because he took food from her.

On 3/2/26, I interviewed DCSM DeShawn Lloyd at the facility. Mr. Lloyd reported he worked at the facility for three weeks and was working on 2/23/26 when the incident occurred. Mr. Lloyd reported DCSM Alexis Cripps was on a one-to-one with Resident A and had him in the staff office around lunchtime. Mr. Lloyd reported Resident A took a sandwich off the desk that belonged to DCSM Ashely Williams. Mr. Lloyd reported that he did not witness Resident A taking the sandwich but was informed of the situation by Ms. Cripps who seemed angry at Resident A. Mr. Lloyd reported that later in the shift he was in the common room with Resident A and Ms. Cripps who was still one to one with Resident A. Mr. Lloyd reported that at about 5:45 pm Ms. Williams entered the common room with a pitcher of ice water and poured it on Resident A while he was sleeping on the couch. Mr. Lloyd reported he was very upset by Ms. Williams actions and thought it was very inappropriate. Mr. Lloyd reported he expressed his feelings to Ms. Williams and Ms. Cripps and they both pressured him not to report the incident to management.

On 3/2/26, I interviewed DCSM Alexis Cripps by phone. Ms. Cripps confirmed that she was working on 2/23/26 and was doing a one-on-one with Resident A. Ms. Cripps reported she had Resident A in the staff office and was dealing with some medications although indicated Resident A was in her "line of sight" which is a requirement of the enhanced staffing requirements. Ms. Cripps reported Ms. Willams had a Subway sandwich on the table near where Resident A was standing. Ms. Cripps reported Resident A has a history of stealing food and he took the sandwich and ate it in the bathroom.

Ms. Cripps reported after it was discovered that Resident A took the sandwich she spoke with Resident A about making positive decisions and that he needed to follow his food plan as he was diabetic. Ms. Cripps denied being angry with Resident A and indicated that Ms. Williams did not "seem too upset" about having her sandwich stolen from her. Ms. Cripps reported that Ms. Williams entered the common area where she was supervising Resident A sometime after 6:00pm and poured a pitcher of ice water on Resident A while he was sleeping. Ms. Cripps reported that she was unable to intervene because she did not know what Ms. Williams was going to do and that it happened very quickly.

On 3/2/26, I interviewed DCSM Ashley Williams by phone. Ms. Williams reported she was aware of the investigation and denied throwing a pitcher of water on Resident A. Ms. Williams described the incident as "joking and playing" and indicated she and Resident A were throwing cups of water on each other during the shift. Ms. Williams reported Resident A took her sandwich earlier in the shift but was not angry or upset. Ms. Williams reported she was working on the other side of facility and was on a one to one with Resident B. Ms. Williams reported she and Resident B were in the kitchen making noodles because Resident B had slept through dinner. Ms. Williams reported she could hear Ms. Cripps talking with Resident A in the common room and opened the door threw a small glass of water at him.

On 4/6/26, I reviewed Special Investigation Report #2025A1031019 regarding an investigation due to the death of a resident at the facility in 2025. I noted the facility was cited for administrative rules **R 400.14308 Resident behavior interventions prohibitions** and **R 400.15206 Staffing requirements.** Both violations were repeat violations.

On 4/6/26, I reviewed the Settlement Agreement related to violations cited in SIR Report # 2025A1031019 and noted Beacon Specialized Living Services, Inc. agrees to increase the management presence and oversight at the site to ensure that resident needs and objectives of the agreement are met.

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: (a) Use any form of punishment.
ANALYSIS:	It was alleged that a staff member poured ice water on Resident A while he was sleeping on the couch. Based on interviews this violation was established. On 2/23/26, Resident A stole Ashley Williams' sandwich from the staff office. Approximately six hours later Ms. Williams, while working at another licensed facility that is attached, left her assigned area and poured a pitcher of ice water on Resident A while he was lying on the couch sleeping. Although. Ms. Williams described this incident as joking and playing the two staff members who witnessed the incident denied that this was a playful situation. In addition, Ms. Williams coerced Resident A and Mr. Lloyd not to report what she had done and too which they both initially complied with.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/8/26, I shared the findings of the investigation during an exit conference with licensee designee Nichole VanNiman. Ms. VanNiman agreed with the findings and acknowledged that the facility was cited last year for a similar violation. Ms. VanNiman reported that Ms. Willams employment was terminated.

ADDITIONAL FINDINGS:

INVESTIGATION:

Staff members Deshawn Lloyd and Alexis Cripps reported that at the time of the incident, Ms. Williams was assigned to provide enhanced one-on-one staffing to

Resident B who resided on an attached facility that holds its own license. Both staff members witnessed Ms. Williams pour ice water on Resident A and stated that Resident B was not within her line of sight, which was the requirement of one-on-one staffing procedure.

On 3/30/26, I received and reviewed Resident B's Behavior Treatment Plan (BTP) dated 12/10/25. The BTP read Resident B would be provided one to one staffing for 12 hours per day and staff should be in eyesight of Resident B "at all times." The BTP also read Resident B received enhanced supervision due to a history of verbal aggression, physical aggression, property damage and unsafe lighter use.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement.
ANALYSIS:	During the investigation, it was discovered that Ashely Williams was assigned to provide one-on-one staffing to Resident B per his Behavior Treatment Plan at an attached but separately licensed facility and made the decision to leave that facility to pour ice water on Resident A at this licensed facility. Although, Ms. Williams indicated Resident B was in her line of sight the two staff members who were near Resident A did not see Resident B which would have been the case if he was in Ms. Willims' line of sight.
CONCLUSION:	**REPEAT VIOLATION NOT ESTABLISHED** **Reference Special Investigation Report #20251031019 dated 6/11/25 and Settlement agreement dated 9/30/25**

On 4/8/26, I shared the findings of the investigation during an exit conference with licensee designee Nichole VanNiman. Ms. VanNiman agreed with the findings and acknowledged that the facility was cited last year for a similar violation that resulted in a settlement with the Bureau that required increased supervision and accountability.

INVESTIGATION:

While interviewing DCSM DeShawn Lloyd he reported that Ms. Cripps pressured him not to report the incident after he expressed being very upset after witnessing Resident A treated in such a disrespectful manner.

On 4/6/26, I interviewed lead staff member Kelly Green by phone. Ms. Green reported she was working on 2/23/26 when the incident occurred between Resident A and Ms. Williams. Ms. Green reported she did not know the incident occurred until the next day. Ms. Green reported she was in the staff office working on medications. Ms. Green indicated that as the lead staff member she was responsible for supervising the staff and agreed that the incident should have been reported to her because of the seriousness of the incident. Ms. Green reported DSCM Alexis Cripps told her what happened the following day and informed her that she did not want to tell her because she was afraid that she would get in trouble because she was assigned to Resident A as a one-on-one. Ms. Green also reported she had no idea that Resident A stole Ms. Williams' sandwich earlier that day and that the ice water was in retaliation for the theft.

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:	During the investigation into the behavior of DSCM Ashley Willams related to Resident A, I found additional concerning behavior by DCSM Alexis Cripps. According to Mr. Lloyd and the lead staff member on duty, Ms. Cripps not only fail to report the incident for fear of getting in trouble but actively tried to conceal what occurred by pressuring Mr. Lloyd not to report the incident. Although Ms. Cripps may not have been able to prevent the incident she failed to attend to Resident A's right to be treated with dignity and respect after the incident and acted out of self-preservation rather than attending to Resident A's needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 4/8/26, I shared the findings of the investigation during an exit conference with licensee designee Nichole VanNiman. Ms. VanNiman agreed with the findings and reported that Ms. Cripps' behavior was unacceptable. Ms. VanNiman indicated that Ms. Cripps's supervisor spoke with her after the incident occurred, but she has not received any formal counseling or discipline.

IV. RECOMMENDATION

Based on repeat violations concerning resident care it is recommended that the facility be placed on a 6-month provisional license.

Nile Khabeiry, LMSW

4/7/26

Nile Khabeiry | Date
Licensing Consultant

Approved By:

Russell Misiak

4/8/26

Russell B. Misiak | Date
Area Manager