STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

May 12, 2026

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

RE: License #: AS370413382
Investigation #: 2026A1029033
Beacon Home At Nottawa

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated by the licensee designee.

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. 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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**
**BUREAU OF COMMUNITY AND HEALTH SYSTEMS**
**SPECIAL INVESTIGATION REPORT**

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS370413382 |
| | |
| **Investigation #:** | 2026A1029033 |
| | |
| **Complaint Receipt Date:** | 03/23/2026 |
| | |
| **Investigation Initiation Date:** | 03/24/2026 |
| | |
| **Report Due Date:** | 05/22/2026 |
| | |
| **Licensee Name:** | Beacon Specialized Living Services, Inc. |
| | |
| **Licensee Address:** | 890 N. 10th St. Suite 110, Kalamazoo, MI 49009 |
| | |
| **Licensee Telephone #:** | (269) 427-8400 |
| | |
| **Administrator:** | Nichole VanNiman |
| | |
| **Licensee Designee:** | Nichole VanNiman |
| | |
| **Name of Facility:** | Beacon Home At Nottawa |
| | |
| **Facility Address:** | 7302 S Nottawa Rd, Mount Pleasant, MI 48858 |
| | |
| **Facility Telephone #:** | (269) 427-8400 |
| | |
| **Original Issuance Date:** | 11/14/2022 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 12/21/2024 |
| | |
| **Expiration Date:** | 12/20/2026 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | DEVELOPMENTALLY DISABLED<br>MENTALLY ILL |

ALLEGATION(S)

| Allegation | **Violation Established**? |
|---|---|
| Direct care staff member Johnathan Benton fell asleep on 03/17/2026 during third shift with his head down on the kitchen table. | No |
| Resident A did not receive his medication correctly from the time period of 12/25/2026-3/19/2026 because there was a medication change after he was discharged from the hospital and the direct care staff members did not administer this correctly. | Yes |

## II. METHODOLOGY

| Date | Activity |
|---|---|
| 03/23/2026 | Special Investigation Intake 2026A1029033 |
| 03/24/2026 | Special Investigation Initiated – Letter ORR Keegan Sarker |
| 04/01/2026 | Inspection Completed On-site – Face to face with Lisa Kappler, Brandon Brown, Aaron Guy and Resident A at Beacon Home at Nottawa |
| 04/02/2026 | Contact - Document Received - Email from Ms. Kappler |
| 04/03/2026 | APS Referral made to Centralized Intake |
| 04/10/2026 | Contact - Telephone call received from APS James Helwig |
| 04/15/2026 | Contact - Telephone call made to Katie Hohner, Keegan Sarker, and email to RN Sarah Kiley and James Helwig |
| 04/16/2026 | Contact – Telephone call to Tammy Everest, administrator Roxanne Goldammer, and licensee designee Nichole VanNiman |
| 05/07/2026 | Contact – Telephone call to Jonathan Benton (mailbox full / sent text), CMH RN Sarah Kiley (Left message), Beacon RN Randy Stewart, Roxanne Goldammer, email exchange with Ms. Kappler |
| 05/08/2026 | Contact – Telephone call to Behavioral Health (inpatient care) – Kinross Building (spoke to Behavioral health supervisor, Corinna Haller), CMH case manager, Rebecca Pope, RN Sarah Kiley |
| 05/12/2026 | Exit conference with licensee designee Nichole VanNiman |

**ALLEGATION: Direct care staff member Johnathan Benton fell asleep on 03/17/2026 during third shift with his head down on the kitchen table.**

**INVESTIGATION:**

On 03/23/2026 a complaint was received via Bureau of Community and Health Systems online complaint system with allegations that direct care staff member Jonathan Benton fell asleep during his third-shift shift on 03/17/2026. It was reported that he was found sleeping at the kitchen table, awakened by home manager Lisa Kappler around 7:00 a.m., and later found asleep again a few minutes later.

On 04/01/2026, I interviewed home manager Lisa Kappler. Ms. Kappler confirmed that she observed Mr. Benton asleep at the kitchen table when she arrived at approximately 7:30 a.m. She stated she woke him and advised him to get up. Direct care staff member Tammy Everest was also on duty but was in the living room at the time. Ms. Kappler reported that no residents were awake during the incident. Ms. Kappler stated that Mr. Benton received a written disciplinary action for sleeping on shift. Ms. Kappler also stated she had never previously observed him sleeping and noted that no residents require 1:1 supervision during nighttime hours; Resident A's 1:1 supervision begins at 9:00 a.m.

On 04/01/2026, I interviewed direct care staff members Brandon Brown and Aaron Guy. Both stated they had never observed Mr. Benton sleeping on shift. They confirmed that two staff members are scheduled each night and that no residents require 1:1 supervision overnight. Mr. Brown stated that if a staff member is found sleeping, the procedure is to notify a manager and attempt to wake the staff member.

On 4/02/2026 Ms. Kappler sent me the discipline for Mr. Benton for sleeping on shift. He received verbal counseling for this incident:

*Details of the incident:*
*When CTM arrived for work around 7:30ish am on 03/17/2026 they discovered Mr. Benton sleeping at the dining room table with his head down and appeared to be sleeping. CTM went downstairs to clock in and when returning upstairs he still appeared to be sleeping. CTM tapped him on the back and told him it was time to wake up. He was awake and alert the remainder of his shift.*
*Expectations moving forward:*
*To follow Beacon Specialized Living policy which specifies that there is no sleeping on shift. Each shift is awake to monitor the residents and the home.*

On 4/16/2026 I interviewed direct care staff member Tammy Everest. Ms. Everest stated she has never observed Mr. Benton sleeping while on shift.

On 04/16/2026 I interviewed direct care staff member Roxanne Goldammer. Ms. Goldammer stated she did not have concerns regarding Mr. Benton sleeping. Ms.

Goldammer reported that the program managers continue to conduct two drop ins per month. Ms. Goldammer stated that Ms. Kappler found Mr. Benton asleep on 03/17/2026 and confirmed there are currently no residents who require 1:1 supervision during sleeping hours.

| APPLICABLE RULE | |
|---|---|
| **R 400.629** | **Direct care staff; qualifications and training.** |
| | **(4) Direct care staff shall possess all of the following qualifications before working independently:**<br>**(b) Be capable of appropriately handling emergency situations.** |
| **ANALYSIS:** | Although Mr. Benton did fall asleep while working third shift at Beacon Home at Nottawa, there is no evidence that any of the residents were harmed during this time. None of the residents currently require 1:1 staffing supervision during sleeping hours and there was another direct care staff member Ms. Everest who was awake while he was sleeping to provide supervision for the residents. Ms. Kappler did provide a written discipline for this incident and she reported she has had no further issues. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION: Resident A did not receive his medication correctly from the time period of 12/25/2026-3/19/2026 because there was a medication change after he was discharged from the hospital and the direct care staff members did not administer this correctly.**

**INVESTIGATION:**

On 03/23/2026, a complaint was received via the Bureau of Community and Health Systems online complaint system alleging that Resident A did not receive his medications correctly from 12/25/2025 to 03/19/2026 due to medication changes following a hospital discharge that were not properly administered by direct care staff. Adult Protective Servies (APS) James Helwig was also assigned to investigate these concerns.

On 04/01/2026, I completed an unannounced on-site investigation and interviewed direct care staff member whose role is home manager, Ms. Kappler. Ms. Kappler reported that medication changes made at Resident A's hospital discharge on 12/24/2025 were not entered into the system and were not discovered until his 03/18/2026 appointment at Community Mental Health. Ms. Kappler stated this occurred because the previous home manager, Ms. Kellogg, failed to upload the discharge paperwork. Ms. Kappler stated because Resident A routinely refused follow-up appointments, staff were unaware the medications had not been updated until the 03/18/2026 appointment.

Ms. Kappler stated she began her role in mid-January 2026 and was not aware of the December 2025 medication changes. She did not know which medications had changed and could not provide this information during the on-site investigation and stated that direct care staff member Mr. Guy and former home manager Ms. Kellogg transported Resident A home from the hospital on 12/24/2025. Ms. Kappler also stated the home's registered nurse, Randy Stewart, typically assists with medication concerns, but she did not know whether he had been informed of the changes.

Ms. Kappler explained that direct care staff members are expected to give all appointment paperwork to the home manager to upload and send any new prescriptions to the pharmacy, and it appears this did not occur. Ms. Kappler stated that she has since reviewed all resident medications to ensure that current provider orders are in place and plans to address proper handling of discharge summaries and provider contact forms at the next staff meeting. Ms. Kappler also stated that, in the past, these documents were shredded after uploading, but moving forward they will be kept in a binder for each resident in case they are not properly entered in the system.

On 04/01/2026, I interviewed direct care staff member Brandon Brown. Mr. Brown stated that Resident A was admitted to the mental health unit on 12/09/2025 after an altercation and was discharged on 12/24/2025. He stated that Mr. Guy and Ms. Kellogg transported him home and that he does not know where the discharge summary is because Ms. Kellogg "wasn't good at paperwork," and Mr. Guy only assisted with transport. Mr. Brown stated he was not aware of any December 2025 medication changes until the 03/18/2026 appointment, where he learned that Resident A was supposed to receive Olanzapine 5 mg in the morning, 5 mg in the afternoon, and 10 mg at night, which he believes differed from the December medication orders. Mr. Brown reported the new medications were not properly entered into the MAR system or sent to the pharmacy, but he did not know why, as this is the manager's responsibility. Mr. Brown stated that discharge paperwork is typically uploaded into the Beacon system and becomes part of the MAR. Mr. Brown reported that Resident A had previously been prescribed Olanzapine only in the morning, but it is now scheduled throughout the day.

On 04/01/2026, I interviewed direct care staff member Mr. Guy who confirmed he transported Resident A home with Ms. Kellogg on 12/24/2025. He stated that Ms. Kellogg left the hospital with paperwork, and as home manager she would have been responsible for uploading it, but he recently learned this may not have occurred. Mr. Guy stated he was unsure what medication changes were made but thought Zyprexa may have been involved, although he did not recall Ms. Kellogg mentioning any changes. Mr. Guy stated Ms. Kellogg would have been responsible for notifying the pharmacy or RN Stewart. Mr. Guy located the discharge paperwork from Resident A's inpatient stay and emailed it to me on 04/01/2026.

I reviewed the Discharge Summary from MyMichigan Health – University of Michigan, which showed that Resident A was hospitalized from 12/19/2025 to 12/24/2025. The summary included instructions to discontinue:

• Aripiprazole (Abilify Maintena) 300 mg injection
• Duloxetine (Cymbalta) 60 mg
• Lorazepam (Ativan) 0.5 mg tablet
I reviewed the January–March 2026 MAR, and these three medications were not listed.

The discharge instructions stated: "What's Next: Go to Beacon Nottawa; Go to Rebecca – CMH case manager; Go to Dr. Siedler on 01/05/2026 at 10:45 a.m. at CMH."

I reviewed Resident A's *Assessment Plan for AFC Residents*, which notes that Resident A requires staff to administer and prompt him for medication compliance.

On 04/10/2026, I received a call from APS Investigator Mr. Helwig. He stated that he was assigned to investigate these concerns but that there was confusion regarding which medications had changed in December 2025. He reported that the discharge paperwork indicates instructions to stop three medications but does not include directions to start any new medication. Mr. Helwig stated he would like to receive confirmation from CMH which medications were supposed to be adjusted or changed.

On 04/15/2026, I emailed CMH RN Sarah Kiley to request clarification regarding the medication changes and the errors that occurred. RN Kiley reported that the medication changes were made during Resident A's inpatient hospitalization, but direct care staff members continued administering medications as previously prescribed by Dr. Siedler. According to RN Kiley, the medication errors were as follows:
• Hydroxyzine: Administered as 25 mg PRN; discharge instructions indicated 50 mg PRN.
• Benztropine 1 mg: Administered twice daily PRN; discharge instructions indicated scheduled twice daily.
• Melatonin 3 mg: Administered nightly; discharge instructions listed PRN use only.
• Olanzapine ODT 10 mg: Administered as 10 mg each morning; discharge instructions indicated 5 mg with breakfast and 5 mg with lunch.
• Olanzapine ODT 10 mg: Administered as 20 mg nightly; discharge instructions indicated 10 mg nightly.

RN Kiley further stated Resident A was discharged on 12/24/2025 and should have been seen within 30 days; however, he did not attend scheduled appointments on 01/22/2026 and 02/12/2026. She reported that the CMH case manager contacted the home on 03/17/2026 due to concerns that Resident A was running low on medications. After being notified that Dr. Siedler could not provide refills because the hospital physician was the most recent prescriber, direct care staff members ensured Resident A attended his 03/19/2026 appointment. At that time, nearly three months after discharge it was discovered that the incorrect medication regimen had been administered.

I reviewed the MAR from 03/19/2026–04/30/2026 and confirmed that medications were correct. Resident A was receiving Melatonin 3 mg at bedtime as a scheduled medication. While the inpatient discharge summary listed Melatonin as PRN, Dr. Siedler

changed it to back to a scheduled medication on 03/19/2026. Additionally, Dr. Siedler changed Benztropine 1 mg back to PRN on 03/18/2026, which was reflected in the April MAR.

On 04/16/2026, I interviewed direct care staff member Ms. Everest. She stated that she understood medication changes occurred during Resident A's last hospital stay, but she was not present and had not been informed of them. Ms. Everest stated she believed the home manager was responsible for ensuring medications were correct. Ms. Everest confirmed Resident A refused two follow-up appointments, which is consistent with his history of refusals. Ms. Everest reported no knowledge of medication errors.

On 04/16/2026, I interviewed administrator Roxanne Goldammer. Ms. Goldammer stated Resident A missed two appointments because he refused to get out of bed, which is not uncommon for him. Ms. Goldammer stated that if he misses appointments, he does not receive his injection, leading to increased behaviors. Ms. Goldammer reported uncertainty regarding whether the home received new prescriptions at discharge. Ms. Goldammer stated that some hospitals send prescriptions directly to the pharmacy, while others do not. Ms. Goldammer explained that if the home receives a paper script, staff scan it to the pharmacy, but if they are unaware of medication changes, they cannot complete this step. Ms. Goldammer stated the home manager is responsible for reviewing the discharge summary to ensure it matches the MAR. Ms. Goldammer also stated she did not believe CMH discussed any medication changes for Resident A during monthly meetings in January or February 2026 and identified Rebecca Pope as the CMH case manager for the home.

On 4/22/2026 I interviewed licensee designee Nichole VanNiman. Ms. VanNiman was not aware of the medication concerns or changes for Resident A. Ms. VanNiman stated they recently changed pharmacies but if there were medication changes then the pharmacy would have been aware of this. Ms. VanNiman stated if it was an outside pharmacy then they would not have entered them in. Ms. VanNiman stated there was no follow up from Ms. Kellogg on the changes. Ms. VanNiman stated the Beacon Specialized Living RN Randy Stewart would have also reviewed the discharged paperwork from Ms. Kellogg and confirmed Resident A's medications.

On 5/08/2026 I interviewed supervisor from Inpatient Behavioral Health Kinross, Corinna Haller. Ms. Haller stated she's looking at the after visit summary and they did send the *After Visit Summary* to Beacon and to Ambulatory Care / CMH that he was involved with. The *After Visit Summary* shows what medications Resident A was discharged on. Ms. Haller stated they typically will follow directions from the AFC but sometimes they CMH will do this and sometimes they will go to the AFC and they will forward the new medications on to the pharmacy. Ms. Haller stated current prescriptions were sent to Kalamazoo Long Term Care Pharmacy, and either CMH or AFC staff would have facilitated this by letting them know the correct pharmacy. Ms. Haller confirmed the discharge planner notes show that on 12/23/2025, staff contacted CMH worker Toni Ziegler. Medication review and discharge planning were completed with home manager Ms. Kellogg and with Beacon clinician Adrianna Pantano. Ms. Haller

stated according to the discharge planning documentation, a call was also made to the home manager to confirm preferred pharmacy, and she confirmed that nicotine products were not prescribed at discharge. Ms. Haller stated medication review was reviewed with house manager Ms. Kellogg at this time and the return home was discussed.

On 5/08/2026 I interviewed Beacon Specialized Living RN Randy Stewart who oversees Beacon Home at Nottawa. RN Stewart stated there are times when hospitals will tell them there are no medication changes and then they will be listed on the discharge summaries. RN Stewart stated he believes the former manager Ms. Kellogg handled this discharge. RN Stewart stated the only medication change that he was aware of from that timeframe was Vitamin D12 which ended on 12/23/2025. RN Stewart stated the direct care staff members bring residents to appointments, obtain consult forms and discharge summaries, and then the manager is responsible for reviewing them and coordinating any medication changes. RN Stewart reported he did not receive the December discharge summary and had no emails from Ms. Kellogg indicating otherwise; therefore, he did not make pharmacy updates.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.675** | **Resident medications.** |
| | **(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.** |
| **ANALYSIS:** | Based on interviews and documentation reviewed, there is sufficient evidence to conclude that Resident A did not receive his medications as prescribed following his December 2025 hospitalization. Inpatient Behavioral Health – Kinross supervisor Ms. Haller confirmed they provided updated medication orders at discharge and communicated these changes to the former home manager, Ms. Kellogg, as well as to CMH and sent updated orders to the pharmacy. However, these changes were not communicated from Ms. Kellog to RN Stewart, who is responsible for updating the MAR and coordinating with the pharmacy. As a result, the medication adjustments were not entered into the MAR, and direct care staff continued administering the incorrect medications for approximately three months. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## III. RECOMMENDATION

Upon receipt of a corrective action plan, I recommend no change in the license status.

_ _________5/12/2026________________________
Jennifer Browning                                Date
Licensing Consultant

Approved By:

05/13/2026
________________________________________
Dawn N. Timm                                Date
Area Manager