GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 4, 2026

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

RE: License #: AS630387842
Investigation #: 2026A0626017
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
Cadillac Place
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

I. IDENTIFYING INFORMATION

License #:	AS630387842
Investigation #:	2026A0626017
Complaint Receipt Date:	03/15/2026
Investigation Initiation Date:	03/17/2026
Report Due Date:	05/14/2026
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 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?
Resident A eloped from the home and was found at a neighbor's home, requesting a lighter.	Yes
Additional Findings	No

III. METHODOLOGY

03/15/2026	Special Investigation Intake 2026A0626017
03/17/2026	Special Investigation Initiated - Telephone I initiated the special investigation by completing a telephone interview with the complainant. The complainant sent me a text message containing a video of the resident at her home.
03/17/2026	Contact - Document Sent I sent a copy of the complaint to Oakland Community Health Network (OCHN) office of recipient rights.
03/18/2026	Contact - Face to Face I completed an unannounced, onsite investigation at Beacon at Dilley. I completed interviews with program manager, Jackie Wilson, home manager, Carla Meeks, and direct care staff members, Margaret Yearby and Cortney Edwards.
03/18/2026	APS Referral I submitted a referral to Adult Protective Services via the MIBridgges Mandated Reporter Portal.
03/19/2026	Contact - Telephone call made I attempted phone contact with Washtenaw County Community Mental Health to report the concerns with recipient rights. A message was left requesting a return phone call.

03/20/2026	Contact - Telephone call received I received a phone call from Washtenaw County Community Mental Health. I reported the concerns to Recipient Rights.
03/20/2026	Contact - Document Sent I sent an email to Oakland County Sheriff's Department, requesting reports regarding Resident A.
03/23/2026	Contact - Telephone call received I received a phone call from Detective Sergeant Charles Yon, from Oakland County Sheriff's Office. He informed me that there have been multiple calls to the home regarding Resident A. He agreed to send me the reports via email.
03/23/2026	Contact - Document Received I received an email from Detective Sergeant Charles Yon from the Oakland County Sheriff's Office containing police reports regarding Resident A. He indicated there were two case reports and ten total calls to the home ffor Resident A.
03/24/2026	Contact - Document Received I received a letter, via email, from Adult Protective Services, indicating the complaint was not assigned for investigation.
03/24/2026	Contact - Face to Face I attempted an unannounced face to face interview with Resident A at the home. He was not there.
03/26/2026	Contact - Face to Face I attempted an unannounced face to face interview with Resident A at the home. He was not there.
04/17/2026	Contact - Document Sent I sent an email to licensee designee, Nichole VanNiman, to schedule an exit conference.

04/20/2026	Contact - Telephone call made I attempted phone contact with licensee designee, Nichole VanNiman to complete an exit conference. A message was left requesting a return call.
05/04/2026	Exit conference I completed an exit conference, via telephone, with licensee designee, Nichole VanNiman.

ALLEGATION:

Resident A eloped from the home and was found at a neighbor's home, requesting a lighter.

INVESTIGATION:

On 03/17/202, I received a complaint, via email, alleging Resident A was found at a neighbor's home. He had eloped from Beacon Home at Dilley, and rang the doorbell, requesting a lighter.

On 03/17/2026, I initiated the special investigation by completing a telephone interview with the complainant. She stated that two nights ago, her and her husband were at a neighbor's home, and they received a notification that there was someone at their home. Her husband went to their home to see what was going on. He found a black male at their door, who they had never seen before, saying he was looking for a lighter for his cigarette. He rang the doorbell multiple times. Right after her husband arrived, a police car pulled in, and the officer informed them that they were looking for the male. Her husband showed them the video footage and within minutes, one of the direct care staff members pulled up to get him. This was the first time any of the residents had been at their home, they have seen them walking up and down the road, but never on their property before. She sent me a copy of the footage via text message.

On 03/17/2026, I attempted phone contact with the Springfield Township of the Oakland County Sheriff. I left a message indicating I was requesting information regarding the incident with Resident A.

On 03/17/2026, I contacted Oakland Community Health Network's (OCHN) office of recipient rights. I spoke with Kathleen Garcia. Ms. Garcia stated that some of the residents at Beacon Home are with other community mental health agencies. We did not have the name of the resident at that time; I agreed to contact her after I went out and was able to identify the resident.

On 03/18/2026, I completed an unannounced onsite investigation at Beacon Home at Dilley. Upon my arrival, I completed an interview with district manager, Jackie Wilson, while the new home manager, Carla Meeks, sat in. Ms. Wilson identified the resident for me. He came to the home approximately one week ago and has been eloping every day, sometimes multiple times in one day. He was admitted from a psychiatric in-patient hospitalization in Ann Arbor and is a consumer with Community Mental Health of Washtenaw County. He is his own guardian and while he has community access, they have not been able to obtain any additional information or guidelines regarding that access, as they have been trying to schedule a meeting with his case manager and have been unsuccessful. He will not accept re-direction, and the police have been called approximately 6-7 times within the past week. He will go outside and run off. Staff members will follow him and call police if he leaves their line of sight or refuses to get back into the van. One time, he told staff members he was going to look for drugs and before they could get to him, he hitchhiked and took a ride with someone who provided him with marijuana, then dropped him back at the home. He is not familiar with the area and will leave to go to the store and other places. Ms. Wilson has been having staff members take him out, sometimes multiple times a day, when he says he needs to go somewhere, to try to cut down on his eloping. One day, they took him to the store to buy snacks, then to buy cigarettes, when he wanted to go again, he was told that he would need to wait because staff were taking care of other residents. Resident A was not happy about waiting and he tried to light his cigarette on the stove. He was stopped, then he took off and was found at the neighbor's home, looking for a lighter. She has staff members sitting by each of the doors of the home to try to curb the behavior, but they are limited in what they can do to stop him, as there is no behavior plan yet. Ms. Wilson and Ms. Meeks both denied observing other negative behaviors but stated they had heard that he can be physically and verbally aggressive. Ms. Wilson stated that the clinician came to see Resident A today and told him that he is allowed to leave, as long as he signs out and is back before his night medications are to be administered. Ms. Wilson revealed that they are trying to get Resident A into one of their more secure facilities for his safety.

While I was interviewing them, Ms. Meeks looked out the window and saw Resident A heading down the driveway, she ran out to get him. At the conclusion of my interview, I asked to interview Resident A. Ms. Meeks accompanied me to the dining room and asked the direct care staff members where Resident A was. They stated that he left approximately ten minutes ago. Ms. Meeks instructed direct care staff member, Cortney Edwards, to take the van and try to locate Resident A.

Ms. Wilson shared the following incident reports regarding Resident A:

> 03/12/2026, written by direct care staff member, Brenda Allen. The report indicates that while Ms. Allen was making lunch, Resident A went out to smoke a cigarette. She went to check on him, and he was in the middle of the road, a few houses down. She called him and he came back, informing her that he is 55 years old and can do what he wants.

03/13/2026, written by direct care staff member, Brenda Allen. The report indicates that Resident A told Ms. Allen he wanted to walk to the store. He was informed that he did not have community access and if he did not return within an appropriate time, she would have to contact police and make a report. He indicated he understood and walked off. Ms. Allen got into the van, followed him, and brought him back home.

03/15/2026, written by Cortney Edwards. The report indicates that while Ms. Edwards was cleaning up after lunch, then completed a room check and found out that Resident A was not in his room. She called the police after she couldn't find him outside and within 15 minutes he was back, informing her that he had gone to the store for cigarettes. He informed her that "Jim" picked him up, took him to the store, then brought him back. The police came to the home and spoke with Resident A. Not even ten minutes after the police left, Resident A was gone again. He was seen headed toward the neighbor's home and Ms. Edwards contacted police. Police brought him back and told him he could not go onto the neighbors' property. Resident A told police, "I don't give a fuck". Police redirected him and left. Resident A calmed down and he left again for another neighbor's home. Ms. Edwards followed him and he told her he was trying to get a lighter. He came back and then tried to light a cigarette on the stove. He was stopped and it was explained to him that he could not do that because it was not safe. He ignored her, went outside and smoked. He began to get verbally aggressive and used racial slurs toward staff.

03/15/2026 written by Cortney Edwards. The report indicates Ms. Edwards and another direct care staff member, Mercedes Taylor, were working and smelled marijuana. They walked around the home and realized it came from Resident A. His eyes were lower and red. He was slurring his words and his behavior was not normal.

Ms. Wilson shared Resident A's assessment plan. The assessment plan was not fully completed. It indicates he can move independently in the community. I inquired about an Independent Plan of Service (IPOS) for Resident A and she provided me with a pre-IPOS meeting report. The assessment plan indicates Resident A has had difficulty with aggressive behavior, but there is no information regarding what this looks like, nor are there any instructions regarding what to do when these behaviors are displayed. There is no information in the assessment plan regarding the amount of care and supervision Resident A requires.

On 03/18/2026, during the onsite investigation, I completed an in-person interview with direct care staff member, Margaret Yearby. Ms. Yearby stated they still did not have an individual plan of service (IPOS) for Resident A. He is fixated on going to church and will get upset and leave if they tell him he must wait for them to drive him. They have told him that if he leaves, they have to call the police, but then the social worker told him he could sign out for the day. She stated they are not sure

about what his community access should be, as CMH has not provided enough information. They were provided a court order regarding Resident A, as she stated he was facing criminal sexual assault charges. She provided me with a court order to review. The order is dated 01/29/2026 and it is a request to defer hearing on commitment. He was ordered to a combined hospitalization and outpatient treatment, up to 180 days, with the hospital stay not lasting more than 60 days. It indicated he was to participate in all services recommended by the treatment provider and all medications, including injectables. Ms. Yearby informed me that Resident A receives injections for his paranoid schizophrenia, but she does not believe it is working. She stated that she believes he needs a guardian.

On 03/18/2026, during my onsite investigation, I completed an in-person interview with direct care staff member, Cortney Edwards. Ms. Edwards has worked at the home since January. She was working on the day that Resident A eloped and was found at the neighbor's home. She had been making lunch and Resident A started pacing back and forth, then sat down and told her he needed cigarettes and wanted her to take him to the store. She told him she had to clean first. She cleaned up, then went to perform room checks and he was gone. Another resident told her he saw Resident A run outside, so she ran out there to see if she could stop him, but he was too fast. She called the police and they brought him home; he had gone to the party store to buy cigarettes. He did not have a lighter and told her he needed to go to the store again. She suggested he ask the other residents if they had a lighter, they didn't. Resident A then tried to light his cigarette using the stove, which she stopped him from doing. He started pacing again and left. She contacted the police and he was found at the neighbors' house, trying to get a lighter from them. The police told Resident A that he cannot be going on other people's property. The police worked to calm him down and left, then Resident A took off again, but she was able to get him to come back without involving police. They try to redirect Resident A, but it doesn't work. He does not seem to understand right from wrong and has smoked marijuana in the home, that he got from a man who picked him up while he was hitchhiking. Ms. Edwards could not locate Resident A to bring him back for an interview.

On 03/18/2026, I submitted a referral to Adult Protective Services (APS), via the MiBridges Mandated Reporter Portal, for Resident A, due to the concerns shared about guardianship.

On 03/19/2026, I attempted contact with Washtenaw County Community Mental Health to share the concerns with their recipient rights department. A message was left requesting a return call.

On 03/19/2026, I completed a search of Washtenaw County Probate Court records for Resident A. Resident A was ordered a guardian in 2018 and it was terminated in 2019 due to no response/reports from the guardian. A new guardian was not appointed. There is a case dated 01/28/2026 for a petition for mental health treatment.

On 03/20/2026, I received a return phone call from Washtenaw County Community Mental Health. I informed them of the concerns regarding Resident A.

On 03/20/2026, I sent an email to the Oakland County Sheriff's Department, requesting assistance in obtaining any reports pertaining to Resident A.

On 03/23/2026, I completed a telephone interview with Detective Sergeant Charles Yon from the Oakland County Sheriff's Office. He stated there have been many calls to them regarding Resident A. They are having serious issues with him as a missing person. He relayed that Resident A would leave, smoke cigars, then go back. He received a call from them over the weekend, asking for him to be committed, but due to Resident A not expressing suicidal or homicidal thoughts, they could not. He agreed to email me any reports regarding Resident A.

On 03/23/2026, I received, via email, reports regarding Resident A, sent by Detective Sergeant Charles Yon of the Oakland County Sheriff's Office. The calls for service, from 03/15/2026-03/23/2026, there were calls made on 03/15/2026(3), 03/16/2026 (2), 03/17/2026, 03/18/2026, and 03/19/2026 (3). There was an attached incident report dated 03/15/2026, indicating 911 was called due to a group home resident eloping and the caller could not follow him due to having other residents in the home. The call was made at 12:17pm and he was back at home by 12:54pm. There was a case report dated 03/19/2026, for a mental health call. The report indicates that staff called to request Resident A be taken for mental health treatment and had a petition for commitment written, but he was not taken due to him not making any homicidal or suicidal statements.

On 03/24/2026, I received a letter, via email, from Adult Protective Services, indicating the referral had not been assigned for investigation.

On 03/24/2026, I completed an unannounced, onsite visit at Beacon at Dilley to attempt to interview Resident A. I spoke with Ms. Meeks who informed me that Resident A had left. She stated he has been good about signing in and letting them know when he will be back. She stated that the meeting took place regarding Resident A's behavior. A petition was written to have Resident A hospitalized, but the paramedics would not take him in due to him not being suicidal or homicidal.

On 03/26/2026, I completed an unannounced onsite visit at Beacon at Dilley to attempt to interview Resident A. Ms. Meeks stated he was not there, he left with his bible and told them he is going to church. She stated he has not been following the rules and does not like having women telling him what to do.

On 05/04/2026, I completed an exit conference, via telephone, with licensee designee, Nichole VanNiman. Ms. VanNiman was informed of the findings and agreed with the recommendations. She informed me that Resident A is no longer at

any of the Beacon Homes and is now in a facility better suited for his needs, as he has recently been diagnosed with Parkinson's disease and it is believed it is further affecting his mental state of mind.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(2) Interventions must be specified in the resident's assessment plan and performed in accordance with that plan. Interventions must ensure that the safety, welfare, and rights of the resident are adequately protected. If an intervention is needed to address the unique programmatic needs of a resident, the intervention must be developed in consultation with, or obtained from, a professional or professionals licensed, certified, or registered in that scope of practice.
ANALYSIS:	Based on the information gathered during the special investigation, there is enough evidence to conclude that there were no behavior interventions included in the assessment plan for Resident A. His assessment plan indicates behavioral issues but contains no interventions or guidance on how to handle those behaviors. The direct care staff members did not know how to handle Resident A's elopement, nor did they have instructions for his community access. Due to direct care staff members not having this information, they were left to make multiple contacts with law enforcement and Resident A was placed in potentially dangerous situations.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I do not recommend any changes to the status of the license.

05/04/2026

Sara Shaughnessy Date
Licensing Consultant

Approved By:

For 05/04/2026

Denise Y. Nunn Date
Area Manager