



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2026

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

RE: License #:	AM610305548
Investigation #:	2026A0356035
	Beacon Home at Lakeview

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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in black ink that reads "Elizabeth Elliott". The signature is written in a cursive style with a large initial "E" and a long, sweeping underline.

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM610305548
Investigation #:	2026A0356035
Complaint Receipt Date:	04/14/2026
Investigation Initiation Date:	04/17/2026
Report Due Date:	06/13/2026
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 Lakeview
Facility Address:	403 S. Mears Ave. Whitehall, MI 49461
Facility Telephone #:	(231) 894-0501
Original Issuance Date:	02/08/2013
License Status:	REGULAR
Effective Date:	08/08/2025
Expiration Date:	08/07/2027
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff Breanna Christiansen engaged in a verbal confrontation with Resident A.	Yes

III. METHODOLOGY

04/14/2026	Special Investigation Intake 2026A0356035
04/17/2026	Special Investigation Initiated - Telephone
04/17/2026	APS Referral
04/27/2026	Contact - Document Sent Email with Sarah Watson, Central Michigan CMH.
05/29/2026	Inspection Completed On-site
05/29/2026	Contact - Face to Face Carol Welch, home manager, DCW's Chris Welch, Joanna Kowalkowski, Resident A.
05/29/2026	Contact - Telephone call made Chris Welch, DCW.
05/29/2026	Contact - Document Received Facility documents reviewed.
05/31/2026	Contact-Telephone call made DCW (former) Breanna Christiansen.
06/09/2026	Contact-Document Received. Facility document-staff training.
06/10/2026	Exit conference-Nicole VanNiman, Licensee Designee.

ALLEGATION: Staff Breanna Christiansen engaged in a verbal confrontation with Resident A.

INVESTIGATION: On 04/14/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs-Bureau of Community Health Systems) online complaint. The complainant reported that DCW (Direct Care Worker) Chris Welch contacted Crisis Mobilization and Intervention Team (CMIT) on 04/12/2026 by telephone and

reported that DCW Breanna Christiansen was sent home on 04/12/2026 due to a verbal confrontation with Resident A. Mr. Welch and DCW Joanna Kowalkowski saw Resident A was getting escalated due to Ms. Christiansen being verbally confrontational and aggressive towards Resident A. Mr. Welch reported safety was assured, and Ms. Christiansen was sent home early on 04/12/2026. On 04/13/2026, Carol Welch, home manager, reported that Ms. Christiansen would not provide direct care to Resident A.

On 04/27/2026, I emailed Sarah Watson, Central Michigan Community Mental Health, supports coordinator for Resident A. Ms. Watson is aware of the complaint allegation and received a recipient rights complaint.

On 05/29/2029, I conducted an unannounced inspection at the facility and interviewed home manager, Carol Welch. Ms. Welch stated the information in the allegation is accurate and true. Ms. Welch stated that Ms. Kowalkowski and Mr. C. Welch witnessed the incident, called her, and she directed Ms. Christiansen to leave the facility and go home for the rest of her shift. Ms. Welch stated after that, Ms. Christiansen did not work with Resident A again. Ms. Welch stated Ms. Christiansen no longer works at this facility.

On 05/29/2026, I interviewed DCW Joanna Kowalkowski at the facility. Ms. Kowalkowski stated she worked on 04/12/2026 with Mr. C. Welch and Ms. Christiansen. Ms. Kowalkowski stated she observed and heard Ms. Christiansen yell at Resident A. She described it as “egging him on” and “cussed at him.” Ms. Kowalkowski stated Resident A came out of his room at dinner time and was “moody.” He was being verbal with the other residents and punching the table. Ms. Kowalkowski stated Ms. Christiansen was yelling at Resident A, perpetuating the problem and saying things such as “are you fucking serious” to Resident A and then Resident A would yell back at her.

On 05/29/2026, I interviewed DCW Chris Welch via telephone. Mr. C. Welch stated Ms. Christiansen’s tone with Resident A was “very confrontational” and Resident A does not respond well to harsh tones. Mr. C. Welch stated Resident A was targeting other residents and yelling at them and Ms. Christiansen did not redirect Resident A. She became confrontational with him, yelling at Resident A, which escalated his behavior. Mr. C. Welch stated he got Resident A out of the dining room, Resident A took a walk and came back to the facility but was still upset so Mr. C. Welch called Ms. Welch and Ms. Welch instructed Ms. Christiansen to go home. Mr. C. Welch stated Ms. Christiansen did not work with Resident A anymore after that incident and she no longer works at the facility.

On 05/29/2026, I interviewed Resident A at the facility. Resident A stated he was having a hard time with another resident and Ms. Christiansen tried to intervene and “I said, mind your own business, I can handle this” and she (Ms. Christiansen) “argued with me.” Resident A stated he had just woken up, took his medications and another resident “almost called me the N word.” Resident A stated Ms. Christiansen

told the other resident that he did not need to be around him (Resident A) and Resident A stated he told Ms. Christiansen to “mind her own business, I can handle it,” and Mr. C. Welch told Ms. Christiansen not to raise her voice to him (Resident A). Resident A stated he was so upset that he threw a binder but does not remember punching the table. Resident A stated, “after this day, she never worked with me anymore.” Resident A stated things were better after this.

On 05/29/2026, I reviewed the next step note printout dated 04/12/2026, IR (Incident Report) written by Joanna Kowalkowski, DCW and signed by Carol Welch, home manager. The IR documented the following information, *‘After dinner time, (Resident A) was calling one of his housemates an asshole. One of the staff (Ms. Christiansen) raised their voice at (Resident A) and asked them to stop calling people names. (Resident A) did also call that staff (Ms. Christiansen) an asshole and staff got a bit upset about that. (Resident A) had walked past another resident and called them a fat ass so that certain staff (Ms. Christiansen) got even more upset and started yelling at (Resident A) some more. (Resident A) then got very loud with that staff to the point where (Resident A) was shaking so bad and started punching the table right next to that staff member (Ms. Christiansen) and then threw the staff book. That’s when another staff (Mr. C. Welch) had (Resident A) leave the area and tried to get him to calm down. Later on in the day when that certain staff (Ms. Christiansen) went home, (Resident A) asked me and another staff (Mr. C. Welch) to give him his PRN for agitation so he could calm down some more.’*

On 05/29/2026, I reviewed the Office of Recipient Rights Complaint dated 04/12/2026, written by Christopher Welch, DCW. The ORR complaint documented the following information, *‘(Resident A) was calling another resident a name when Breanna Christiansen asked him (Resident A) to stop. (Resident A) then began insulting another resident. Breanna then shouted at (Resident A) and demanded (Resident A) stop bullying other housemates. (Resident A) started yelling back at Breanna and Breanna continued yelling at him telling him he cannot talk to people any way he pleases. As (Resident A) was walking away he called Breanna an asshole. Breanna appeared angered by this and started shouting very aggressively at him telling him that she was not going to let him talk to her like that. (Resident A) then turned around and approached Breanna and screamed in her face and began slamming his fist on the table in front of her. That is when I approached (Resident A) and convinced him to take a walk with me away from the situation. I was able to calm (Resident A) down and Breanna was sent home for the rest of the day. This was also witnessed by Joanna Kowalkowski.’*

On 05/29/2026, I reviewed the assessment plan for AFC residents dated 02/04/2026 for Resident A. The assessment plan documented that Resident A does not control aggressive behavior and described, *‘does have some history of being aggressive towards others and property destruction. Staff will work with (Resident A) daily on developing and utilizing his coping skills and redirect as needed.’*

On 05/29/2026, I reviewed The Community Mental Health for Central Michigan PCP

(Person Centered Plan) for Resident A, dated 04/08/2026, signed by Alivia Paetz, case manager. The PCP documented, *'(Resident A) has a history of significant anger and aggression, including past arrests for assault and multiple incidents of physical altercations with housemates in residential settings. Although he reports that his current medication regimen helps reduce aggression, he continues to require close monitoring for behavioral escalation, regular assessment of medication effectiveness, and consistent prompting to use coping skills. (Resident A) often struggles to manage frustration, interpret social cues, and de-escalate independently, which increases the likelihood of impulsive or aggressive responses. Ongoing staff support is essential to help him recognize early signs of anger, practice appropriate conflict-resolution strategies, and maintain behavioral safter within the AFC environment.'*

On 05/31/2026, I interviewed (former) DCW Breanna Christiansen via telephone. Ms. Christiansen stated that Resident A was irritated and blaming his "rage" on another resident. He was telling another resident that he was "ugly as fuck," and for the resident to "change his clothes." Ms. Christiansen stated Resident A was not being nice and had his finger in her face. Ms. Christiansen stated Resident A told her that he was going to rape her and kill her and saying things like "show me your boobs" and "you have to show me your boobs because you work for the residents." Ms. Christiansen stated she was left to deal with Resident A herself because Ms. Kowalkowski was upstairs on her phone and would not come down. Ms. Christiansen stated during this incident, Resident A threw a binder and she told Resident A that was not a nice thing to do. On the following day, Ms. Christiansen stated she, Ms. Kowalkowski and Mr. C. Welch worked together, and Resident A came up to her got close to her face and "apparently" her "tone was off" with Resident A. Resident A felt "threatened" and she (Ms. Christiansen) ended up talking to someone from ORR (Office of Recipient Rights). Ms. Christiansen stated she did not raise her voice, she never shouted, and was not rude or mean to any of the residents including Resident A.

On 06/09/2026, I reviewed the certificate of completion for Ms. Christiansen for the Ukeru Training on Trauma-Informed Care. This training documented Ms. Christiansen was trained on 12/04/2025 and attended the full presentation that included blocking techniques, protective skills and releases and how to manage the least resistive approach to crisis management.

On 06/11/2026, I conducted an exit conference with Melissa Williams for Licensee Designee, Nicole VanNiman. Ms. Williams stated she understood the information, analysis, and conclusion of this applicable rule violation and that an acceptable corrective action plan will be submitted.

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:	<p>The complainant reported DCW Breanna Christiansen had a verbal confrontation with Resident A on 04/12/2026. Ms. Christiansen was sent home early and did not provide direct care to Resident A after that date.</p> <p>Based on my investigative findings, there is a preponderance of evidence to indicate that on 04/12/2026, Ms. Christiansen engaged in a verbal confrontation with Resident A causing Resident A to have a behavior. While Ms. Kowalkowski and Mr. C. Walsh intervened, Ms. Christiansen was sent home and did not work with Resident A after that date, a violation of this applicable rule is still established.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



06/11/2026

Elizabeth Elliott
Licensing Consultant

Date

Approved By:



06/11/2026

Jerry Hendrick
Area Manager

Date