GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 8, 2026

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

RE: License #: AM590387878
Investigation #: 2026A1033041
Beacon Home At The Lodge

Dear Ms. VanNiman:

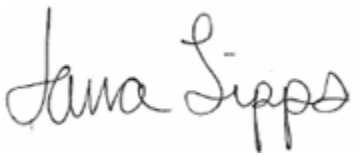
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (517) 335-5985.

Sincerely,



Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM590387878
Investigation #:	2026A1033041
Complaint Receipt Date:	06/08/2026
Investigation Initiation Date:	06/08/2026
Report Due Date:	08/07/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Roxanne Goldhammer
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At The Lodge
Facility Address:	1550 E. Colby Road Stanton, MI 48888
Facility Telephone #:	(989) 831-0626
Original Issuance Date:	04/17/2018
License **Status:**	REGULAR
Effective Date:	10/17/2024
Expiration Date:	10/16/2026
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff, Joe Pruitt, placed Resident A in a headlock because Resident A spit on Mr. Pruitt.	Yes

III. METHODOLOGY

06/08/2026	Special Investigation Intake 2026A1033041
06/08/2026	Contact - Document Sent Email correspondence sent to recipient rights advisor, Sarah Watson, Central Michigan Community Mental Health.
06/08/2026	Special Investigation Initiated - Letter Email correspondence received from Sarah Watson, Recipient Rights Advisor, CMCMH.
06/15/2026	Inspection Completed On-site Interviews conducted with direct care staff/Care Team Manager, April McCreery, and Resident B. Review of Resident A's resident record initiated.
06/16/2026	APS Referral- APS referral made per protocol.
07/07/2026	Exit Conference- Conducted via telephone with licensee designee Nichole VanNiman. Voicemail message left.

ALLEGATION: Direct care staff, Joe Pruitt, placed Resident A in a headlock because Resident A spit on Mr. Pruitt.

INVESTIGATION:

On 6/8/26 I received an online complaint regarding the Beacon Home at the Lodge, adult foster care facility (the facility). The complaint alleged that direct care staff Joe Pruitt, placed Resident A in a headlock because Resident A spit on Mr. Pruitt. The complaint reported that Resident A filed a written complaint with the Community Mental Health (CMH) Office of Recipient Rights, regarding the incident.

On 6/8/26 I had email correspondence with Community Mental Health Central Michigan (CMHCM), Recipient Rights Advisor, Sarah Watson, regarding the allegation. Ms.

Watson provided copies of her interview notes as she is currently investigating the same allegations for CMHCM. I observed the following information in these notes:

- On 6/8/26 Ms. Watson interviewed direct care staff Alyssa Dickinson regarding the allegation. Ms. Dickinson reported to Ms. Watson that she had been working on the date of the alleged incident. She reported that Resident A was experiencing “delusions” and yelling at Mr. Pruitt. She reported that Mr. Pruitt had been sitting on the couch and Resident A spit on Mr. Pruitt. Ms. Dickinson reported that Mr. Pruitt then got up from the couch and put Resident A in what looked like a “choke hold”. Ms. Dickinson reported to Ms. Watson that she then had to separate Mr. Pruitt and Resident A. She reported that Mr. Pruitt then went to the office. Ms. Dickinson reported that Resident B observed the situation.
- On 6/8/26 Ms. Watson interviewed Resident A. Resident A reported that he spit on Mr. Pruitt’s T-shirt and walked away from Mr. Pruitt. He reported to Ms. Watson that Mr. Pruitt came after him and put him in a “choke hold”. Resident A reported that he could breathe during this incident. He reported that he had no further information he wished to provide.
- On 6/8/26 Ms. Watson interviewed Mr. Pruitt regarding the allegation. Mr. Pruitt reported that during the week of the incident Resident A required constant redirection as he had been swearing and yelling at Mr. Pruitt. He reported that the day of the incident, Resident A had been swearing and yelling at him. He reported that he had been sitting on the couch and Resident A came over to him and spit in his face. He reported that he got up from the couch and put his right hand across Resident A’s chest. He reported that he did this to calm Resident A down. Mr. Pruitt reported that Resident A had been walking away, but throughout the shift he would walk away and then come back. He reported that his left hand was on Resident A’s shoulder and he said, “this needs to stop.” Mr. Pruitt reported that he then went to the office to speak with direct care staff/home manager, April McCreery, about the incident. He reported that Resident A followed him to the office. He reported that after Ms. McCreery saw what was happening, she moved Mr. Pruitt to another licensed adult foster care facility on this campus. Mr. Pruitt reported to Ms. Watson that he understood what he did was wrong. He acknowledged that he should not have been aggressive with Resident A.

On 6/15/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. McCreery regarding the allegation. Ms. McCreery reported that the alleged incident occurred on 6/5/26. She reported that she had been working on this date and was in the office when the incident occurred. She reported the office is not attached to the facility but rather is its own independent building on the campus. Ms. McCreery reported that on this date Mr. Pruitt came to the office to explain to her that Resident A had spit on him. She reported that Mr. Pruitt stated he put Resident A in a “loose hold” in response to Resident A’s actions. Ms. McCreery reported that CPI (Nonviolent Crisis Intervention) training is not used at the facility for any of the current residents. She reported that the facility has gone away from the use of CPI and now uses a nonviolent approach known as Ukeru. She reported that the Ukeru training works with using pads to block yourself defensively from a physical threat. She reported

that there is no restraint or hold involved with this training. Ms. McCreery reported that Resident A does not have any directive in his current care plan that would allow for a direct care staff member to put him in any type of hold or lay hands on him in any way. Ms. McCreery reported that on this date Ms. Dickinson had been working with Mr. Pruitt and she and Resident B both observed Mr. Pruitt's actions. Ms. McCreery reported that both Ms. Dickinson and Resident B confirmed that it appeared Mr. Pruitt had Resident A in a headlock type of hold. Ms. McCreery reported that Mr. Pruitt admitted that he should not have put this hold on Resident A and he was frustrated with the fact that Resident A spit in his face. She reported that Mr. Pruitt is currently suspended pending the outcome of the investigation from CMHCM recipient rights.

On 6/15/26 during the unannounced, on-site investigation I interviewed Resident B regarding the allegation. Resident B reported that he had been present at the facility and observed Mr. Pruitt interact with Resident A on 6/5/26. Resident B reported that he was sitting in the kitchen on his laptop. He reported that Mr. Pruitt had been sitting on the couch. He reported that Resident A tends to have more aggressive behaviors after he has been given caffeine and he was acting out on this date. He reported "[Resident A] hocked a loogie in [Mr. Pruitt's] face." Resident B reported, "[Mr. Pruitt] lost it." He reported that he jumped up from the couch and wrapped around Resident A. He reported that Ms. Dickinson came in and prompted Mr. Pruitt twice to let Resident A go. Resident B reported that Mr. Pruitt then let go of Resident A and left the facility. He reported that Mr. Pruitt returned to the facility with Ms. McCreery and the two tried to interview Resident B about what he observed. He reported that Mr. Pruitt was trying to get him to side with him about the incident. He reported that he felt uncomfortable in this interaction. Resident B reported that Mr. Pruitt should not have put hands on Resident A but further stated, "Everyone here needs an ass whooping." Resident B reported that Mr. Pruitt did not injure Resident A.

During the on-site investigation on 6/15/26 I reviewed the following documents:

- *AFC Licensing Division – Incident/Accident Report*, for Resident A, dated 6/5/26, completed by Ms. Dickinson. Under the section, *Explain What Happened/Describe Injury*, it reads, "[Resident A] came out of his room and had walked towards staff yelling at them and accusing that staff of bullying [Resident A's] mother. [Resident A] then repeatedly hit staff phone down trying to knock it out of their hands. [Resident A] then spit on staff and walked away."
- *AFC Licensing Division – Incident/Accident Report*, for Resident A, dated 6/5/26, completed by Ms. Dickinson. Under the section, *Explain What Happened/Describe Injury*, it reads, "[Mr. Pruitt] a staff member had went up behind [Resident A] and it looked to other staff as if he has put [Resident A] in a choke hold." Under the section, *Action Taken by Staff/Treatment Given*, it reads, "Staff let home manager and PD know the situation then immediately called Central Michigan Recipient Rights to report the incident. Staff intervened in the altercation and separated [Mr. Pruitt] from [Resident A]. [Resident A] went and sat on the couch."
- Community Mental Health for Central Michigan, *Functional Behavior Assessment*, for Resident A, dated 8/4/25. This document identifies the following:

    - Resident A is diagnosed with:
        - Unspecified Schizophrenia spectrum and other psychotic disorders.
        - Intellectual disability, Mild
        - Antisocial personality disorder
        - Amphetamine-type substance use disorder, severe
        - Cannabis use disorder, severe
        - Other specified attention-deficit/hyperactivity disorder
        - Tobacco use disorder, moderate
        - Unspecified anxiety disorder
    - On page one, under the section, *Reason for Referral*, it lists:
        - History of elopement
        - Verbal aggression
        - Physical aggression
        - Stealing
        - Property destruction
- Community Mental Health for Central Michigan, *Behavior Treatment Plan*, for Resident A, dated 9/9/24. This plan is noted to have been updated on 8/4/25. This document identifies the following:
    - On page five, under the section, *Behavior Interventions*, subsection, *Proactive Strategies*, paragraph two, reads, “When [Resident A] is delusional, this can impact his relationship and interactions with others so he may prefer to spend time in his room. When establishing a trusting relationship with him, do not reason, argue, or challenge his delusional statements. It may be best to ignore negative delusional statements. Attempting to disprove his delusion may not be helpful and may create mistrust. Please don’t take negative delusional statements he makes toward others personally. Focus on building a trusting relationship with him, rather than the need to control his symptoms and remain clam.”
    - On page seven, paragraph three reads, “Be aware of precursor behaviors and situations which have been associated with target behaviors in the past. For example, he may pace or walk in circles while engaged in delusional statements. Please document delusional statements in Beacon Next Step and related activities and actions to help identify triggers and precursor behaviors to delusions and situations when they are more likely to occur. Staff may be able to identify changes in his body language, tone of voice, word usage, or behaviors that indicate he is anxious and needs support. He may tend to target a specific person. He may escalate his attempts to start a fight with the targeted person (e.g., he may get up in their face). When possible, ignore negative and inappropriate statements.”
    - On page nine, paragraph three reads, “If [Resident A] is targeting a specific staff or is not responding positively to one staff member’s attempt at de-escalation and use of reactive strategies, it may be helpful to have a different staff member swap in if they are available. Sometimes, the switching of staff is enough to help de-escalate and redirect the situation.”

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 upon the interviews conducted, review of Ms. Watson's interview notes, and documentation reviewed during this investigation, it can be determined that there is substantial evidence to identify that Mr. Pruitt did not treat Resident A with dignity and respect and keep him protected and safe. The interviews conducted with eyewitness accounts from Ms. Dickinson, Mr. Pruitt, Resident A, and Resident B identify that Resident A spit in Mr. Pruitt's face and Mr. Pruitt had an immediate physical reaction to this experience, got up from his seated position and placed Resident A in a type of headlock. This information was reported by Resident A and Ms. Dickinson to Ms. Watson, and by Resident B during the interview I conducted on-site on 6/15/26. Mr. Pruitt acknowledged to Ms. McCreery and Ms. Watson that he should not have put hands on Resident A but denies that he had him in anything other than a "loose hold". Resident A's *Behavior Treatment Plan* does not provide for Resident A to be handled in a physical manner while he is experiencing delusional and potentially aggressive behaviors. Instead, the plan outlines, ignoring the delusional thought process, redirecting Resident A, and even potentially switching out the targeted direct care staff member in an effort to calm Resident A's delusions. Based upon the fact that Mr. Pruitt reacted in that moment and immediately put Resident A in a type of headlock, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the current status of the license recommended at this time.

7/7/26

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Jana Lipps Date
Licensing Consultant

Approved By:

07/08/2026

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Dawn N. Timm Date
Area Manager