GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 2, 2026

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

RE: License #: AS390413020
Investigation #: 2026A0581027
Beacon Home At Miller

Dear Nichole 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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS390413020
Investigation #:	2026A0581027
Complaint Receipt Date:	05/26/2026
Investigation Initiation Date:	05/27/2026
Report Due Date:	07/25/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At Miller
Facility Address:	10752 Miller Dr. Galesburg, MI 49053
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/31/2022
License Status:	REGULAR
Effective Date:	04/30/2025
Expiration Date:	04/29/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION

	Violation Established?
On or around 12/21/2025, direct care staff, Virginia Whalen exploited professional boundaries with Resident A by engaging in a personal relationship, communicating with him through social media applications, requesting purchases of alcohol and marijuana, and making romantic advances.	No
Additional Findings	Yes

III. METHODOLOGY

05/26/2026	Special Investigation Intake - 2026A0581027
05/26/2026	APS Referral
05/26/2026	Referral - Recipient Rights - ISK RRO received allegations and investigating
05/27/2026	Special Investigation Initiated - On Site - Interview with residents and staff.
05/27/2026	Referral - Law Enforcement - Kalamazoo Co. Sheriff's Department investigated alleged assault between resident and staff.
05/27/2026	Contact - Document Received - Received police report from Kalamazoo Co. Sheriff's Dept.
05/28/2026	Contact - Telephone call made - Attempted contact with staff, Virgina Whalen.
05/28/2026	Contact - Document Received - Email correspondence with Karrie Guess.
05/29/2026	Contact - Document Received - Email correspondence with Karrie Guess
07/01/2026	Contact – Document Received – Email correspondence with Karrie Guess.
07/01/2026	Contact – Telephone call made – Attempted contact with Viriginia Whalen; however, voicemail box was full and unable to leave message.
07/01/2026	Exit conference with licensee designee, Nichole VanNiman.

ALLEGATION: On or around 12/21/2025, direct care staff, Virginia Whalen, exploited professional boundaries with Resident A by engaging in a personal relationship, communicating with him through social media applications, requesting purchases of alcohol and marijuana, and making romantic advances.

INVESTIGATION: On 05/26/2026, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged that on or around 12/21/2025, direct care staff, Virginia Whalen, took Resident A to her house and asked him to purchase her marijuana and alcohol. The complaint further alleged Virigina Whalen had personal conversations with Resident A via Snapchat and Facebook applications. The complaint alleged Virginia Whalen reported to Resident A that he looked like her deceased boyfriend and made advances at him, but the complaint did not specify the nature of the advances. The complaint alleged Integrated Services of Kalamazoo (ISK) Office of Recipient Rights (ORR) was involved and interviewed Resident A on 05/22/2026. The complaint alleged Resident A confirmed the allegations to ISK Recipient Rights Officer (RRO), Keyanna Ford, on 05/22/2026.

On 05/26/2026, I confirmed with Keyanna Ford that she made an APS referral. She documented Resident A blocked Virgina Whalen on Facebook messenger application. She also documented residents reported to her that Virigina Whalen would smoke vape pens with residents.

On 05/27/2026, I interviewed Keyanna Ford. She stated her original complaint alleged direct care staff were sleeping during the overnight shift. Keyanna Ford stated she received additional concerns that Viriginia Whalen had an inappropriate relationship with Resident A. She stated she interviewed Resident A who reported to her that Viriginia Whalen would message him on Facebook and ask him to buy her alcohol. He reported to Keyanna Ford that he and Viriginia Whalen were friends, but he had since blocked her on Facebook so she could not contact him. Additionally, Keyanna Ford stated Resident A denied the alleged incident between him and Virginia Whalen. Keyanna Ford further stated Virginia Whalen no longer works in the facility for the licensee.

On 05/27/2026, I conducted an unannounced inspection. I interviewed the facility's identified home manager, Karrie Guess, regarding the alleged incident that occurred between Resident A and Virigina Whalen on or around 12/21/2026. Karrie Guess stated Virginia Whalen worked as the only overnight staff in the facility from 7 pm until 7:30 am on 12/20/2025 through 12/21/2025. Karrie Guess stated Virginia Whalen acknowledged to her she fell asleep for approximately 30 minutes in the facility while working before awakening to an alleged incident with Resident A. Karrie Guess confirmed staff are prohibited from sleeping while working overnight, regardless of residents' level of supervision needs, and stated staff would be subject to discipline if found sleeping on duty.

Karrie Guess stated Virginia Whalen had been working for the licensee since approximately April 2025, had been assigned to the overnight shift since approximately October 2025 and was the only staff working the overnight on 12/20/2025 through 12/21/2025. Karrie Guess stated the facility's current residents neither require overnight assistance from staff nor have enhanced supervision requirements. She stated residents are administered evening medications prior to going to bed.

Karrie Guess stated Virginia Whalen regularly transported residents in the community as part of her job. She stated at one point, Virginia Whalen, requested permission to bring residents to her family's gathering; however, Karrie Guess stated this request was denied. Karrie Guess also acknowledged residents occasionally use tobacco or vape products. Karrie Guess stated she was unaware of Virginia Whalen being under the influence of marijuana or alcohol while working or being aware of Viriginia Whalen asking residents to purchase her alcohol or marijuana vapes.

Karrie Guess stated staff are instructed not to have relationships or contact with residents outside of work. She stated she was not aware of Viriginia Whalen interacting, socializing or talking to residents outside of work. She stated Resident A showed her a message between him and Virginia Whalen on Facebook messenger; however, it appeared to her that Resident A sent the message, not Virginia Whalen. She stated the message said "hey" or "hi". She stated she instructed Resident A to block Virginia Whalen from contacting him. Karrie Guess stated it was the licensee's policy not to be friends or interact with residents outside of work.

Karrie Guess stated Virigina Whalen resided close to downtown Augusta, which is near the town's local shops and parks where residents may visit. Karrie Guess stated it was possible Virginia Whalen told residents where she lived due to the proximity of her home. Karrie Guess stated she was not aware of Viriginia Whalen taking any residents into her home and having them visit her home. She stated the residents would verbalize if Virigina Whalen took them to her house.

I interviewed Residents A, B, C, and D during the inspection. I was unable to interview Resident E because he was showering during the inspection.

Resident A stated Virigina Whalen fell asleep while working the overnight shift in the facility on 12/21/2025 when she was the only staff. Resident A stated Virginia Whalen woke up because of an alleged incident involving him. Resident A stated Virginia Whalen routinely slept during overnight shifts after residents went to bed, which was sometimes as early as 9 pm or 11 pm. He further stated there had been an occasion when he needed PRN medication for back pain, but Virginia Whalen was asleep and did not respond to his requests for the medication. He was unable to recall the date or time when this alleged incident occurred.

Resident A stated Virginia Whalen transported residents into the community and would occasionally stop at her residence while residents remained in the vehicle. He stated he had not been inside her home.

Resident A also stated Viriginia Whalen asked him to obtain alcohol and marijuana for her, invited him to spend time with her outside of work and told him she liked him. Resident A stated he could not recall the specific dates of these interactions but believed they occurred around the Christmas timeframe.

Resident A stated Viriginia Whalen communicated with him through the Snapchat and Facebook messenger applications. He stated he no longer had any of the messages between them because she blocked him on all applications. He stated since she blocked him the messages were then deleted. Resident A admitted he would send Virginia Whalen “reels” or short videos on various social media applications but stated she asked him to add her on these social medica applications.

Resident B stated he’d observed Virginia Whalen asleep during overnight shifts on multiple occasions, typically for approximately 30 minutes to one hour. He stated he recalled one instance when he was unable to wake her despite needing assistance. He was unable to recall specific dates or times when he observed her asleep.

Resident B stated Viriginia Whalen transported residents into the community, including trips to local businesses downtown Augusta. He stated that during one outing, she picked up a family member and drove the person to her residence before continuing the resident’s outing. He denied ever going into her home.

Resident B stated Viriginia Whalen asked residents to purchase her nicotine vape products when they walked to the local gas station. He stated she provided them with her debit card for the purchases. He also stated she asked a resident to purchase a THC vape pen for her on one occasion and stated he observed her smoking the THC vape pen outside in the facility’s driveway while working.

Resident B stated he’d observed communication between Virigina Whalen and Resident A on Snapchat or Facebook. He stated he could not recall the nature of these messages and later learned Resident A blocked her from contacting him.

Resident C stated he would be asleep at night; therefore, he had not observed Virigina Whalen sleeping in the facility at night while working. His statement regarding her transporting residents to her house was consistent with Resident B’s statement. He stated she occasionally stopped at her residence with residents in the facility vehicle; however, he stated residents would stay in the vehicle while she went inside for approximately 5-10 minutes. Resident C stated Virigina Whalen did not take residents into marijuana dispensaries. He also denied her asking residents to purchase her alcohol or marijuana. Additionally, he stated he had not observed any inappropriate interactions between Viriginia Whalen and Resident A. He stated he

was not aware if Viriginia Whalen communicated with residents outside of work using her personal phone number or social media applications.

Resident D's statement about observing Virigina Whalen sleeping and staying in the facility vehicle while she stopped at her home was consistent with other resident's statements. He neither identified any issues arising while she slept nor did he identify needing any assistance from her. Resident D stated he was not aware of Virginia Whalen asking any resident to purchase marijuana or alcohol for her. He stated she would transport residents to a local business near a marijuana dispensary and resident would independently walk to the dispensary to purchase marijuana.

I interviewed direct care staff, Donyea White-Anderson. She stated she's worked in the facility since approximately October 2025 as a daytime staff. She stated she never actually worked with Virginia Whalen and therefore could not provide any information regarding her sleeping while working or what she did while she was on outings with residents. She stated if she saw her during shift changes, she did not observe any concerning or inappropriate interactions between Virginia Whalen and Resident A.

I interviewed direct care staff, Jason Muse; however, he stated he had only been working in the facility since February 2026 and had never worked with Virginia Whalen.

On 05/27/2026, I reviewed Kalamazoo County Sheriff's Department police report number # 2025-00045459. According to the report, Virginia Whalen reported to police she was up until 2 am playing Fortnite with Resident A on 12/21/2025. She reported that this was normal activity and not out of her normal routine. Virginia Whalen reported to police that at approximately 2 am, she developed a migraine and she and Resident A stopped playing video games. She reported to police that Resident A then got up and went to his bedroom for the evening. Virginia Whalen reported to police she cleaned the facility before lying down on the couch at approximately 4:50 am. Virginia Whalen contacted 911 at approximately 6:02 am after notifying her home manager of an alleged incident between her and Resident A. Virginia Whalen reported to police she believed she'd been asleep for approximately 30 minutes before waking up. The police also interviewed Resident A; however, Resident A did not report to police how long Virginia Whalen had been asleep. No additional information was in the report regarding how long Virginia Whalen had been asleep and no additional residents were interviewed.

On 05/28/2026, I reviewed Resident A's, B's, C's, D's, and E's, *Assessment Plan for AFC Residents*. None of the assessment plans contained documentation supporting or relating to the allegations investigated, including a need for awake staff, overnight assistance, or increased supervision.

I also reviewed the facility's AFC Licensing Division – Incident / Accident Report (IR), dated 12/21/2025 regarding the alleged incident between Resident A and Virginia

Whalen. According to the IR, Virginia Whalen contacted Karrie Guess at approximately 5:30 am to report she fell asleep and woke up because of an alleged incident with Resident A.

On 05/29/2026, Karrie Guess provided a copy of the licensee's code of conduct and employee handbook, which documented sleeping on duty is strictly prohibited and subject to serious disciplinary action up to and including termination and dual relationships with residents was also strictly prohibited. It further documented that social networking between employees and residents is not allowed and may be grounds for termination.

On 07/01/2026, I reviewed each resident's corresponding Individual Plan of Service (IPOS). The information contained in each IPOS was consistent with each resident's assessment plan.

On 05/28/2026 and 07/01/2026, I attempted to contact Virginia Whalen for an interview; however, she neither answered nor returned my phone calls. I was unable to leave a voicemail due to her voicemail box being full.

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 on my investigation, which included interviews with Residents A, B, C, and D, and direct care staff, Donyea White-Anderson, and home manager, Karrie Guess, there is no supporting evidence direct care staff, Virginia Whalen, exploited professional boundaries with Resident A by engaging in a personal relationship, communicating with him through social media applications, making romantic advances towards him or requesting residents purchase alcohol and marijuana for her.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.621	**Capability.**
	Licensees, staff, volunteers, and members of the household shall be capable of ensuring the welfare of residents.

ANALYSIS:	Based on my investigation, which included interviews with Residents A, B, C, and D, and direct care staff, Donyea White-Anderson, and home manager, Karrie Guess, a review of the facility's Incident Report dated, 12/21/2025, review of Kalamazoo County Sheriff's Department case # 2025-00045459, and Virginia Whalen 's admission to both home manager, Karrie Guess and law enforcement, I established that Viriginia Whalen fell asleep on 12/21/2025 at approximately 4:40 am for approximately 30 minutes when she was the sole staff on duty. Multiple residents also stated they observed Viriginia Whalen asleep during overnight shifts. During the time Virginia Whalen was asleep on 12/21/2025, an alleged incident involving Resident A occurred. Regardless of the outcome of that allegation, Virginia Whalen was unable to actively supervise residents or respond to their needs while asleep. Additionally, the licensee's own policies document sleeping on duty is strictly prohibited. Subsequently, Virginia Whalen was not capable ensuring the health, safety and welfare while responsible for their care.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/01/2026, I conducted an exit conference with the licensee designee, Nichole VanNiman. I explained my findings and allowed an opportunity for questions and feedback. She acknowledged an understanding of the violation and stated the licensee conducts quarterly meetings reminding staff about not sleeping during the overnight shifts. She stated she would respond to the report upon reviewing it.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

Cathy Cushman 07/01/2026

Cathy Cushman Date
Licensing Consultant

Approved By:

Dawn Timm 07/02/2026

Dawn N. Timm Date
Area Manager