GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 9, 2026

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

RE: License #: AS630387840
Investigation #: 2026A0465027
Beacon Home at Lake Orion

Dear Nichole VanNiman:

Attached is the Special Investigation Report for the above-referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. A previous recommendation for revocation was made in SIR #: 2026A0465013, which remains in effect. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Stephanie Gonzalez

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
Cell: 248-308-6012

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630387840
Investigation #:	2026A0465027
Complaint Receipt Date:	05/07/2026
Investigation Initiation Date:	05/11/2026
Report Due Date:	07/06/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Licensee Designee/ Administrator:	Nichole VanNiman
Name of Facility:	Beacon Home at Lake Orion
Facility Address:	175 E. Silverbell Rd. Lake Orion, MI 48360
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/10/2017
License Status:	REGULAR
Effective Date:	08/08/2024
Expiration Date:	08/07/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 4/17/2026, direct care staff, Precious Porter, left the facility, leaving several residents unsupervised while she drove another resident to an appointment.	Yes
Resident D's bedroom is dirty, including trash on the floor and plastic containers filled with urine.	Yes

III. METHODOLOGY

05/07/2026	Special Investigation Intake 2026A0465027
05/07/2026	Special Investigation Initiated – Telephone call I spoke to Complainant via telephone
05/07/2026	Contact – Telephone call made I spoke to Relative D1 via telephone
05/11/2026	APS Referral Adult Protective Services (APS) Referral made; Denied
05/11/2026	Inspection Completed On-Site I conducted an onsite investigation; I completed a walk-through of the facility, observed residents, reviewed files, and interviewed Resident B, Resident D and direct care staff, Don Adams
05/12/2026	Contact - Document Received Documents received via email
05/13/2026	Contact - Document Received Documents received via email
05/13/2026	Contact - Telephone call made I called direct care staff, Precious Porter; No answer; Unable to leave a voice message
06/17/2026	Contact - Telephone call made I called direct care staff, Precious Porter; No answer; Unable to leave a voice message

06/22/2026	Contact - Telephone call made I spoke to direct care staff, Kyle Wilson, via telephone
07/02/2026	Contact - Telephone call made I spoke to direct care staff, Dorothy Burton, via telephone
07/06/2026	Contact - Telephone call made I called direct care staff, Precious Porter; No answer; Unable to leave a voice message
07/07/2026	Contact - Telephone call made I spoke to direct care staff, Precious Porter, via telephone
07/07/2026	Contact - Telephone call made I spoke to ex-direct care staff, Aaron Connor, via telephone
07/07/2026	Exit Conference I conducted an Exit Conference with licensee designee and administrator, Nichole VanNiman, via telephone
07/09/2026	Referral – Recipient Rights Referral submitted via online system

ALLEGATION:

On 4/17/2026, direct care staff, Precious Porter, left the facility, leaving several residents unsupervised while she drove another resident to an appointment.

INVESTIGATION:

On 5/7/2026, a complaint was received, alleging that on 4/17/2026, direct care staff, Precious Porter, left the facility, leaving several residents unsupervised while she drove another resident to an appointment.

On 5/7/2026, I spoke to Complainant via telephone. Complainant stated, “I was at the facility on 4/17/2026 from 12:00pm – 2:30pm. Sometime around 1:30pm or a little before, the staff, Precious, left the home to take a resident to an appointment and it was just me, my husband and all the residents alone at the facility. There was a female in the living room laying on the couch. She was throwing up into a bucket. There were no staff in the home to care for the residents. When we left the facility around 2:30pm, there were still no staff in the home and Precious had not returned yet. I was very worried that when I left, the residents were going to be left alone and that was concerning.” Complainant confirmed the information contained in this complaint is true.

On 5/11/2026, I conducted an unannounced onsite investigation at the facility. At the time of my onsite investigation, there were six residents residing at the facility. I completed a walk-through of the facility, observed residents, reviewed files, and interviewed Resident B, Resident D and direct care staff, Don Adams.

According to the *Staff Schedule*, direct care staff, Precious Porter and Aaron Connor, were scheduled to work at the facility on 4/17/2026. I reviewed the facility file and was unable to locate any documentation related to staffing issues or concerns on 4/17/2026.

I spoke to Resident B, who stated, “It’s good here. Staff are here all the time. There are two staff all the time. If one staff leaves, someone always stays with us.” Resident B denied knowledge of this complaint being true.

I spoke to Resident D, who stated, “Staff are always here. I have never been here alone without staff.” Resident D denied knowledge of this complaint being true.

On 7/7/2026, I spoke to direct care staff, Precious Porter, via telephone. Ms. Porter stated that she has worked at the facility for seven months. Ms. Porter stated, “I recall this day. I remember that my coworker Aaron and I were both working that day and there was no manger on duty. I had to take a resident to a group meeting and Aaron was not feeling too good. She was feeling ill due to a medical condition she has. So, that morning I administered all the medications and I even prepped lunch before I left so she didn’t have to worry about that. I felt bad that I had to leave to take a resident to an appointment but there were only two of us working that day. I did tell management. I told Jacqueline Wilson that Aaron was sick. She told me someone would come to relieve her, but no one ever showed up. I left sometime in the afternoon for an hour. When I got back, Aaron was kind of curled up on the couch. She left for the hospital right after I got back to the facility. She was sick but she was there. The residents were not left alone ever. Aaron was there. She just wasn’t feeling good.”

On 7/7/2026, I spoke to former direct care staff, Aaron Connor, who stated that she worked at the facility from December 2025 through April 2026. Ms. Connor stated, “I am diabetic and that day I was really sick. I had worked the night before and was working a double shift. That morning, I was not feeling well and hadn’t been since the night prior. It was rough. I was throwing up and I didn’t feel well. Every time I would try to stay on my feet and move around, I would throw up. I did as much as I could, but I was really sick. I was lying in the living room, throwing up. The residents felt bad and kept coming to check on me and ask if I was okay. I called Jacqueline Wilson, who was our manager. I told her I was sick and couldn’t work the shift. She told me I was required to stay and find coverage. She told me that I had to stay if I couldn’t find someone to cover my shift. I waited until Precious came back from taking the resident to the appointment, and then I left. I ended up being hospitalized that day. The residents were not left alone, but I was limited in what I could do.”

On 10/17/2025, Adult Foster Care Licensing Consultant, Frodet Dawisha, conducted a special investigation related to insufficient staffing at the facility. Ms. Dawisha's investigation determined that, on 10/18/2025, the staff on-duty left the facility and subsequently left residents unsupervised for an extended period of time. On 11/18/2025 it was recommended that licensee designee and administrator, Ramon Beltran, submit an acceptable corrective action plan. On 12/3/2025, Mr. Beltran submitted a corrective action plan, agreeing to comply with maintaining sufficient staff on duty at all times, including retraining all staff on the attendance policy.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(b) 12 residents for small group and family homes.**
ANALYSIS:	According to Ms. Porter and Ms. Connor, on 4/17/2026, for approximately one hour, Ms. Connor was left alone with the residents, during a time that she was ill and unable to sufficiently provide supervision, personal care and protection to the residents. Ms. Connor was lying on the couch, throwing up, and unable to move around. Visitors to the home were unable to identify that Ms. Connor was staff. Based on the information above, on 4/17/2026, there was insufficient staff on duty to meet the supervision, personal care and protection needs of the residents during the approximately one-hour timeframe that Ms. Connor was left alone with residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report: #2026A0605001 dated 11/18/2025**

ALLEGATION:

Resident D's bedroom is dirty, including trash on the floor and plastic containers filled with urine.

INVESTIGATION:

On 5/7/2026, a complaint was received, alleging that on 4/17/2026, Resident D's bedroom was observed to be dirty, including trash on the floor and plastic containers filled with urine. The complaint stated that on 4/17/2026, Resident D's bedroom was observed to be in bad condition. The complaint stated that there were cigarette butts spread throughout the floor area and there were plastic urinals filled with urine in his closet. The complaint stated that Resident D's bedroom was also very cluttered.

On 5/7/2026, I spoke to Complainant via telephone. Complainant confirmed the information contained in this complaint is true.

On 5/7/2026, I spoke to Relative D1 via telephone. Relative D1 stated, "I visited the facility on 4/17/2026 to see (Resident D). When I went into his bedroom, I was shocked at what I saw. There were cigarette butts everywhere. There were plastic urinals filled with urine in his closet. The room was not clean. There was also a lot of stuff in the room. (Resident D) has some limitations and issues, but I do not believe his room should be in this condition. He is in an adult foster care facility, and staff should be helping him and making sure he is living in a clean and healthy environment."

On 5/11/2026, I conducted an unannounced onsite investigation at the facility. I arrived at the facility at approximately 9:55am. I conducted a walk-through of Resident D's bedroom, and I interviewed Resident D and direct care staff, Don Adams. I also spoke to licensee designee and administrator, Nichole VanNiman, via telephone while onsite at the facility. When I entered Resident D's bedroom, I observed two urinals on the floor. I observed a large puddle of urine surrounding the two urinals. I observed a large area of liquid on the floor of Resident D's closet area that also had a strong odor of urine. I observed several cups on Resident D's dresser that also had a strong odor of urine. I smelled a strong odor of urine within Resident D's bedroom.

I reviewed Resident D's *Face Sheet*, which stated that Resident D moved into the facility on 4/28/2020 and discharged from the facility on 5/12/2026. Resident D has a legal guardian, Guardian D1. The *Health Care Appraisal* listed Resident D's medical diagnosis as Schizoaffective Disorder – Bipolar and Traumatic Brain Injury. The *Assessment Plan for AFC Residents,* dated 3/30/2026, stated that Resident D moves independently in the community, has a history of substance abuse, independently completes self-care tasks, has a prosthetic leg and uses a wheelchair for mobility assistance. The *Individual Plan of Service* (IPOS), dated 1/21/2026, stated that Resident D has a history of verbal and physical aggression, substance

abuse history, disruptive behavior, including urinating on the floor and smoking in his room, and requires verbal prompts and/or physical assistance with personal hygiene, dressing and incontinence care. I was unable to locate any documentation in the assessment plan or IPOS that specified the use and/or protocol for use/maintenance of a urinal in Resident D's bedroom. I reviewed the *Incident/Accident Reports* for March 2026 – June 2026, which documented the following:

3/30/2026 at 11:30am: Completed by Aaron Connor- Staff prompted Resident D to clean his room 3 times. He let staff take some things out of his room but refused to let them clean his room or change his bedding. Staff will monitor for health and behavior. The Corrective Measures Taken to Remedy or Prevent Recurrence section was blank.

5/7/2026 at 9:00pm: Completed by Janelle Coaster- I was informed that during 1st shift today that Resident D refused to let the staff wash his soiled sheets. So, after I passed medications, I went to ask him again to either wash his bedding or let staff do it. He began to yell and was verbally aggressive towards staff. At that time, I tried to talk with him to calm him down, and it only worked to a certain extent. He still refused to wash his bedding and to take a shower. Staff talked to Resident D, and I documented in Nextstep and I also did an ER report. The Corrective Measures Taken to Remedy or Prevent Recurrence section was blank.

I spoke to Resident D, who stated, "I use urinals in my room. Sometimes I spill. I can't clean because I'm in a wheelchair. I can't get on the floor to clean. There is urine on my floor, but staff haven't come in yet to clean it."

I spoke to direct care staff, Don Adams, who stated, "Resident D prefers to use a urinal in his bedroom. He puts the urinals in here. He is in a wheelchair, and he is not always safe at lowering to the ground or using urinals." When I asked Mr. Adams why there was urine on the floor, and how long it has been sitting for, he stated, "They {staff} are going to come in here and clean it up. I just walked into the facility three to five minutes before you did. Let me grab a glove real quick. We are going to replace the floors, and we ordered some new urinals that have lids to help him not have spills. Specialized urinals that we are still waiting to come in."

I spoke to licensee designee and administrator, Nichole VanNiman, via telephone while onsite at the facility. Ms. VanNiman stated, "(Resident D's) room is going to be completely gutted. We are coordinating with his case manager and there is a lot of navigating that is happening to address his behaviors. We ask staff to go into his room after he leaves, to clean the area. We are also getting a spill-proof urinal, but it hasn't arrived yet."

On 6/22/2026, I spoke to direct care staff, Kyle Wilson, via telephone. Mr. Wilson stated, "(Resident D) uses a urinal in his room, and he sometimes gets urine on the floor and other areas in his room. We try to keep his room clean, but sometimes he

won’t notify us when his urinal is full or when it has spilled on the floor. Or sometimes staff weren’t checking like they should have. I saw that happen several times. Unfortunately, we did have a few staff that weren’t cleaning his room. And if (Resident D) told us not to come in his room, we couldn’t go in and clean. Sometimes, we would knock and he would not let us even come into his room to see the condition of the room. He has the right to refuse to allow us into his room. We have to honor his rights. I observed urine splatter around (Resident D’s) urinal at times. He is in a wheelchair, and he would try to aim at the floor and the urinal, but it would get all over the floor too. Our protocol for (Resident D) was the same as the other residents. We checked on them every hour during the daytime and every 30 minutes at night. There was not an additional protocol for (Resident D). If he did not let us in his room to clean, we had to wait until he left the room. It is a requirement from recipient rights that we cannot go in without his permission.”

On 7/2/2026, I spoke to direct care staff, Dorothy Burton, via telephone. Ms. Burton stated that she has worked at the facility for 11 months. Ms. Burton stated, “(Resident D) had urinals in his room and staff had to remind him to dump them. He wasn’t great with not getting urine on the floor. We went in a couple times a day to clean and try and keep the smell down. If he wouldn’t let us in, then we couldn’t go in. We would wait until he came out of his room, and then we could go in.

On 7/7/2026, I spoke to Ms. Porter, via telephone. Ms. Porter stated that she has worked at the facility for seven months. Ms. Porter stated, “(Resident D) used urinals in his room. It was common to find urine on his floor and in his room. We tried to clean his room every day and remove the urinals every day when we could. He would refuse to clean his room, and we had to respect his rights. I found out that we can’t make him do anything if it isn’t in his IPOS. He would pick and choose when he wanted it cleaned. Most times we could get in and clean his room and sometimes he wouldn’t let us in to clean. He has free will. We are supposed to do room checks on him, but all we can really do is knock and there were times he would not let us in to see his room.”

On 10/17/2025, Adult Foster Care Licensing Consultant, Frodet Dawisha, conducted an unannounced special investigation at the facility related to special investigation #2026A0605001. Ms. Dawisha observed Resident B’s bedroom to be unclean, with piles of clothes on the bed and floor areas. On 11/18/2025 it was recommended that licensee designee and administrator, Ramon Beltran, submit an acceptable corrective action plan. On 12/3/2025, Mr. Beltran submitted a corrective action plan, agreeing to comply with maintaining the safety and cleanliness of the home, including retraining all staff on cleaning duties and expectations.

On 2/11/2026, I conducted an unannounced special investigation at the facility related to special investigation #2026A0465013. I observed a large hole in the cabinet beneath the kitchen sink. I observed the residents’ bedrooms to be unclean, with large amounts of dirt, debris, clutter, food crumbs, trash and urine

stains on walls and furnishings. I smelled a strong odor of urine in the resident bedrooms. In Resident C's bedroom, I observed a table lamp with multiple stains that smelled of urine as well as several areas of his bedroom walls that had dried liquid stains that also smelled of urine. I observed feces stains on Resident C's closet floor and his bedroom dresser was missing a drawer. I observed Resident D's bedroom to have a strong odor of urine. I observed two plastic urinals inside the closet, with a large amount of fruit flies sitting on top of, and inside of, the urinals. Resident D's bedroom floors and walls were unclean, and there was a table lamp with large liquid stains with a strong odor of urine. On 3/25/2026, a recommendation of revocation of the license was made.

On 7/7/2026, I conducted an Exit Conference with licensee designee and administrator, Nichole VanNiman, via telephone. Ms. VanNiman stated that she is not in agreement with the recommendation.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	On 5/11/2026, I observed, in Resident D's bedroom, two urinals filled with urine and a large amount of urine surrounding the exterior of the urinals. I also observed liquid on Resident D's closet floor and in cups on his dresser, both of which had a strong odor of urine. According to staff, Mr. Wilson, Ms. Burton, and Ms. Porter, Resident D preferred to urinate into urinals that he kept in his bedroom. Mr. Wilson, Ms. Burton and Ms. Porter stated that it was common for Resident D to urinate on his bedroom floor and refuse to allow it to be cleaned up. Based on the information above, the facility has not properly maintained the home to provide adequately for the health, safety and well-being of the residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2026A0465013 dated 3/25/2026**

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**

	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	On 5/11/2026, I observed, in Resident D's bedroom, two urinals filled with urine and a large amount of urine surrounding the exterior of the urinals. I also observed liquid on Resident D's closet floor and in cups on his dresser, both of which had a strong odor of urine. According to the *Incident/Accident Reports*, on 3/3/2026 and 5/7/2026, direct care staff observed Resident D's bedroom in need of cleaning. On both occasions, direct care staff did not complete the necessary housekeeping tasks due to Resident D's refusal. According to staff, Mr. Wilson, Ms. Burton, and Ms. Porter, Resident D's bedroom frequently had urine on his bedroom floor and urinals filled with urine. Mr. Wilson, Ms. Burton and Ms. Porter stated that they were unable to clean the urine on Resident D's floor until Resident D gave verbal permission and/or left his room. Mr. Wilson, Ms. Burton and Ms. Porter stated that the recipient rights rules prevented them from completing necessary cleaning and housekeeping duties within Resident D's bedroom during the time that he resided at the facility. Based on the information above, direct care staff have failed to provide adequate housekeeping services to maintain a clean and comfortable home environment. Direct care staff are using recipient rights guidelines as the reason for not providing adequate housekeeping standards to provide a comfortable, clean and orderly home for Resident D.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Reports #: 2026A0605001 dated 11/18/2025 and #2026A0465013 dated 3/25/2026**

IV. RECOMMENDATION

A previous recommendation of revocation was made in Special Investigation Report #: 2026A0465013, dated 3/25/2026. The recommendation for revocation remains in effect.

7/8/2026

Stephanie Gonzalez — Date
Licensing Consultant

Approved By:

WOC Area Manager for — 07/09/2026

Denise Y. Nunn — Date
Area Manager