GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 19, 2026
Nichole VanNiman
Beacon Specialized Living Services, Inc.
890 N. 10th St., Suite 110
Kalamazoo, MI 49009

RE: License #: AS130408635
Investigation #: 2026A1030047
Beacon Home at East Ave

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.

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 (616) 356-0100.

Sincerely,

Nile Khabeiry, LMSW

Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130408635
Investigation #:	2026A1030047
Complaint Receipt Date:	07/24/2026
Investigation Initiation Date:	07/27/2026
Report Due Date:	09/22/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubrey Napier
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at East Ave
Facility Address:	20271 East Ave N Battle Creek, MI 49017
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/04/2021
License Status:	REGULAR
Effective Date:	04/04/2026
Expiration Date:	04/03/2028
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was verbally and physically mistreated by a staff member.	Yes
Additional Findings	No

III. METHODOLOGY

07/24/2026	Special Investigation Intake 2026A1030047
07/27/2026	Special Investigation Initiated - Telephone Interview with referral source
07/27/2026	Contact - Document Received Received and reviewed two incident reports
07/28/2026	APS Referral
07/29/2026	Contact - Face to Face Interview with Resident A
07/29/2026	Contact - Face to Face Interview with Heather Martinez
07/31/2026	Contact - Telephone call made Interview with Macy Reschner
08/19/2026	Exit Conference Exit conference by phone

ALLEGATION:

Resident A was verbally and physically mistreated by a staff member.

INVESTIGATION:

On 7/27/26, I interviewed the referral source (RS) by phone. The RS reported she revied two incident reports regarding the situation. The RS reported that in addition to the verbal disrespect alleged it was also alleged that direct care staff member (DCSM) Lorrie Pierce "bragged" to other staff members that she used CPI which is a physical intervention program that the facility stopped using in favor or a non-physical program called Ukuru. The RS reported that Ms. Pierce was suspended pending the investigation.

On 7/27/26, I received and reviewed two incident reports. IR-1, authored by DCSM Emma Shugars indicated that Resident A informed her and staff member Krystle Waterhouse that Ms. Pierce got physical with her by using a CPI technique when she was had self-harming behaviors the night before. IR-1 also indicated that Ms. Pierce pushed Resident A onto the couch at the end of the incident.

IR-2, authored by DCSM Shade Barrios, indicated that Ms. Pierce had been speaking with Ms. Shugars and Ms. Waterhouse and admitted to swearing at Resident A by saying "I'm not fucking playing anymore" and that she "threw Resident A onto the couch." IR-2 also indicated that Ms. Pierce reported that she would justify that she used a CPI technique that is no longer allowed because she had been protecting herself and Resident A.

On 7/29/26, I interviewed Resident A at the facility. Resident A reported that there was an incident with DCSM Lorrie Pierce on 7/19/26 and she was "CPI'ed and threw on the couch. Resident A reported that she was having behavioral problems and tried to grab a fork to harm herself and Ms. Pierce put her in a bear hug and then pushed her onto the couch. Resident A reported that Ms. Pierce also yelled and swore at her.

On 7/29/26, I interviewed facility supervisor, Heather Martinez at the facility. Ms. Martinez reported that she reviewed the incident reports and believed Ms. Pierce acted inappropriately as the facility changed their policy on physical intervention and stopped using CPI several months ago. Ms. Martinez also reported that Resident A often claimed to be suicidal to get attention and was not in jeopardy of injuring herself on 7/19/26. Ms. Martinez indicated that Ms. Pierce "bragged" about the incident the next day to the staff members who completed incident reports as they also believed that Ms. Pierce mistreated Resident A. Ms. Martinez reported that she suspended Ms. Pierce pending the investigation but indicated that Ms. Pierce resigned her position at the facility.

On 7/31/26, I interviewed DCSM Macy Reschner by phone. Ms. Reschner reported that she was aware of the incident between Resident A and Ms. Pierce because she overheard Ms. Pierce talking about it. Ms. Reschner reported that Ms. Pierce had be bragging about using a CPI technique on Resident A even though they are no longer allowed to physically restrain the residents and then pushed Resident A onto the couch. Ms. Pierce reported that Resident A had been having behavioral problems on the day the incident occurred but did not believe that was justification for what occurred and that pushing her onto the couch seemed like something she did out of anger. Ms. Reschner indicated that Ms. Pierce was suspended but quit her job due to the incident.

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:	It was alleged that Resident A was verbally and physically mistreated by a staff member. Based on interviews and documentation, this violation will be established. On 7/19/26, Resident A made self-harming statements and behaviors which were not unusual for Resident A. During this situation DCSM Lorrie Pierce became angry with Resident A and used an inappropriate physical intervention technique, pushed her onto the couch and made disparaging remarks to her.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/19/26, I shared the findings of the investigation with licensee, Nichole VanNiman by phone. Ms. VanNiman acknowledged the findings and agreed to submit a corrective action plan.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the current license status.

Nile Khabeiry, LMSW

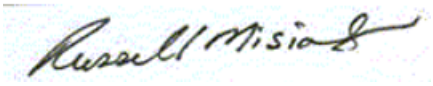
8/19/26

_____

Nile Khabeiry Date

Licensing Consultant

Approved By:



8/19/26

Russell B. Misiak Date
Area Manager