GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 12, 2026

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

RE: License #: AM800299049
Investigation #: 2027A1030001
Beacon Home at Woodland

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 (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 #:	AM800299049
Investigation #:	2027A1030001
Complaint Receipt Date:	10/01/2026
Investigation Initiation Date:	10/01/2026
Report Due Date:	11/30/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Woodland
Facility Address:	56832 48th Avenue Lawrence, MI 49064
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	09/12/2016
License Status:	REGULAR
Effective Date:	03/12/2025
Expiration Date:	03/11/2027
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
A medication error was made by a staff member.	Yes
A staff member threatened to punch Resident A.	No
Additional Findings	No

III. METHODOLOGY

10/01/2026	Special Investigation Intake 2027A1030001
10/01/2026	APS Referral APS referral
10/01/2026	Special Investigation Initiated - Telephone Interview with Danyell Baltazar
10/07/2026	Inspection Completed On-site Interview with Resident A
10/07/2026	Contact - Face to Face Interview with Angie Jackson
10/07/2026	Contact - Face to Face Interview with Resident B
10/07/2026	Contact - Face to Face Interview with Resident C
10/07/2026	Contact - Document Received Received and reviewed incident report
10/09/2026	Contact - Telephone call made Interview with Anita Collins
10/09/2026	Contact - Telephone call made Interview with Pasha Johnson
10/12/2026	Exit Conference Exit conference by phone

ALLEGATION:

A medication error was made by a staff member.

INVESTIGATION:

On 10/7/26, I received a phone call from home manager, Danyell Baltazar who reported a medication error occurred this morning. Ms. Baltazar reported that DCSM Anita Collins administered Klonipin to Resident B instead of Lorazepam and administered Resident C Lorazepam instead of Klonipin. Ms. Baltazar indicated that the error was caught shortly after it occurred.

On 10/7/26, I received and reviewed an Incident Report (IR) related to the medication error that occurred today. The IR indicated during shift change it was discovered that Ms. Collins administered Resident B Klonopin instead of Lorazepam and administered Resident C Lorazepam instead of Klonopin. The IR also indicated that the facility contacted their medical department to report the error and were informed to monitor both residents for health and safety.

On 10/7/26, I interviewed Resident B at the facility. Resident B was informed that she was administered the wrong medications this morning by DCSM Anita Collins. Resident B reported she was unaware that she was given the wrong medication and did not have any adverse reactions.

On 10/7/26, I interviewed Resident C at the facility. Resident C was informed that she was administered the wrong medications this morning by DCSM Anita Collins. Resident C reported she was unaware that she was given the wrong medication and did not have any adverse reactions.

On 10/9/26, I interviewed DCSM Anita Collins by phone. Ms. Collins acknowledged that she made a medication error on 10/7/26. Ms. Collins reported that she realized she made the mistake right away and contacted the facility's medical department, her supervisor and recipient rights.

On 10/9/26, I interviewed DCSM Pasha Johnson. Ms. Johnson reported that she was aware of investigation and denied ever threatening Resident A. Ms. Johnson reported that Resident A tends to be very emotional and will proclaim her love for her and then yell and scream at her.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	It was alleged that a medication error was made by a staff member. Based on documentation and interviews, this violation will be established. On 10/7/26, DCSM Anita Collins administered Resident B a medication that should have been administered to Resident C and administered Resident C a medication that should have been administered to Resident B. Although both medications were in the Benzodiazepine family, they were not the exact same and should not have been administered to the incorrect resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

A staff member threatened to punch Resident A.

INVESTIGATION:

On 10/1/26, I interviewed home manager, Danyell Baltazar by phone. Ms. Baltazar reported that she was not a witness to the incident but does not believe that direct care staff member (DCSM) Pasha Johnson would threaten a resident. Ms. Baltazar reported that Resident A can be very emotional and often makes false allegations when she gets upset.

On 10/7/26, I interviewed Resident A at the facility. Resident A reported that she believed that there was a “miscommunication” between her and Ms. Johnson. Resident A reported that she and Ms. Johnson were having a discussion, and she told Ms. Johnson that she did not like her. Resident A then indicated that she “loves all the staff” including Ms. Johnson. Resident A reported that Ms. Johnson responded by saying that she would punch Resident A if she tried to hug her. Resident A reported that DCSM Angie Jackson heard the conversation between them. Resident A reported that she attempted to contact her Recipient Rights officer several times to cancel the investigation because she did not wish to pursue anything against Ms. Johnson.

On 10/7/26, I interviewed DCSM Angie Jackson at the facility. Ms. Jackson confirmed that she overheard the conversation between Resident A and Ms. Johnson. Ms.

Jackson reported that Resident A became upset with Ms. Johnson and threatened to punch her, however Ms. Johnson did not threaten to punch Resident A. Ms. Johnson indicated that Ms. Jackson said, “how are you going to punch me when you give me hugs.”

On 10/9/26, I interviewed DCSM Pasha Johnson. Ms. Johnson reported that she was aware of investigation and denied ever threatening Resident A. Ms. Johnson reported that Resident A tends to be very emotional and will proclaim her love for her and then yell and scream at her. Ms. Johnson reported that she tries very hard to be a positive influence on all the residents and would never threaten to harm Resident A.

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 a staff member threatened to punch Resident A. Based on interviews this violation will not be established. Although Resident A accused Pasha Johnson of threatening to punch her there was no evidence of this alleged threat.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 0/12/26, I shared the findings of the investigation with licensee designee, Nichole VanNiman. Ms. VanNiman acknowledged the findings and agreed to submit a corrective action plan.

IV. RECOMMENDATION

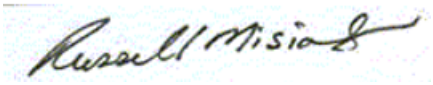
Contingent upon the submission of an acceptable corrective action plan, I recommend no change to the current license status.

Nile Khabeiry, LMSW

_____

Nile Khabeiry Date
Licensing Consultant

Approved By:



10/15/26

_____

Russell B. Misiak Date
Area Manager