GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 9, 2025

Carson Dyer
Ryder Specialized Care, LLC
P.O Box 44
Battle Creek, MI 49016

RE: License #: AS130418240
Investigation #: 2025A1034042
Ryder 1

Dear Mr. Dyer:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Kevin L. Sellers

Kevin Sellers, Licensing Consultant
Department of Licensing and Regulatory Affairs
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(517) 230-3704
SellersK1@michigan.gov
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130418240
Investigation #:	2025A1034042
Complaint Receipt Date:	09/09/2025
Investigation Initiation Date:	09/09/2025
Report Due Date:	11/08/2025
Licensee Name:	Ryder Specialized Care, LLC
LicenseeAddress:	P.O Box 44 Battle Creek, MI 49016
Licensee Telephone #:	(269) 425-6288
Administrator:	Carson Dyer
Licensee Designee:	Carson Dyer
Name of Facility:	Ryder 1
Facility Address:	34 Byron St Battle Creek, MI 49017
Facility Telephone #:	(269) 966-7459
Original Issuance Date:	03/11/2024
License Status:	REGULAR
Effective Date:	09/11/2024
Expiration Date:	09/10/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
AFC has no licensee designee	Yes
Residents were not protected	Yes
DCW Brianna Beaudrie verbally mistreated Resident B	Yes
Residents were not served meals	No

III. METHODOLOGY

09/09/2025	Special Investigation Intake 2025A1034042
09/09/2025	APS Referral- Made
09/09/2025	Contact - Telephone Contact Made
09/09/2025	Special Investigation Initiated – Telephone Contact
09/10/2025	Contact - Telephone Contact Received
09/10/2025	Contact - Telephone Contact Made
09/11/2025	Inspection Completed On-site
09/11/2025	Contact - Telephone Contact Made
09/11/2025	Contact - Telephone Contact Received
09/12/2025	Contact - Telephone Contact Made
09/12/2025	Contact - Telephone Contact Received
09/12/2025	Contact - Telephone Contact Made
09/14/2025	Contact - Document Received
09/15/2025	Contact - Telephone Contact Made
09/17/2025	Contact - Telephone Contact Made

09/17/2025	Contact - Telephone Contact Made
09/17/2025	Contact - Telephone Contact Made
09/17/2025	Contact - Telephone Contact Received
09/17/2025	Contact - Telephone Contact Made
09/18/2025	Inspection Completed On-site
09/18/2025	Contact - Document Received
09/23/2025	Contact - Document Sent
09/23/2025	Contact - Telephone Contact Received
09/24/2025	Contact - Telephone Contact Made
09/24/2025	Contact - Telephone Contact Made
10/07/2025	Contact - Telephone Contact Made
10/08/2025	Contact - Telephone Contact Made
10/09/2025	Contact - Telephone Contact Made
10/09/2025	Exit Conference

ALLEGATION:

AFC has no licensee designee

INVESTIGATION:

On 9/9/25, I received a complaint through LARA-BCHS complaint alleged five months ago licensee designee James Ruoff and administrator Carson Dyer parted ways in the business. The complaint alleged James Ruoff's position was left vacant and Carson Dyer did not follow the appropriate steps per adult foster care (AFC) licensing requirements.

On 9/9/25, I interviewed Complainant via telephone who verified accuracy of the information in the complaint.

On 9/10/25, I interviewed Emmet County Office of Recipient Rights (ORR) Specialist Brandy Marvin via telephone. Ms. Marvin reported investigating concerns of management issues at the facility. Ms. Marvin reported licensee designee (LD) James Ruoff had vacated this position five months ago. Ms. Marvin reported administrator Carson Dyer remained as administrator.

On 9/11/25, I conducted an unannounced onsite investigation and interviewed DCW Brianna Beaudrie at the facility. DCW Beaudrie reported the last time observing LD James Ruoff working at the facility was proximally five months ago. DCW Beaudrie reported due to Mr. Ruoff's departure DCWs reported directly to administrator Carson Dyer.

On 9/11/25 and 9/18/25, I interviewed Residents A, B, C and D at the facility. Residents A, B, C and D reported last observation of James Ruoff working was proximally five months ago.

On 9/12/25, I interviewed administrator Carson Dyer via telephone. Mr. Dyer reported proximally late April 2025 or early May 2025 LD James Ruoff parted ways from the business. Mr. Dyer reported after having a conversation with Mr. Ruoff he made the decision of no longer wanting to be LD on the license. Mr. Dyer reported continuing to operate the facility as the administrator. Mr. Dyer denied knowing he was required to report Mr. Ruoff resigning his position. Mr. Dyer reported he was willing to take steps remediating this situation.

On 9/17/25 and 9/24/25, I interviewed DCWs Kayla Dunlap, Jacob Tappenden and Mike Hammer via telephone. DCWs Dunlap, Tappenden and Hammer's statements coincided with those of DCW Beaudrie and Mr. Dyer.

On 9/24/25, I followed up with ORR Specialist Brandy Marvin who reported substantiating her investigation due to contract requirements Mr. Ruoff and Mr. Dyer have with office of recipient rights.

APPLICABLE RULE	
R 400.14103	**Licenses; required information; fee; effect of failure to cooperate with inspection or investigation; posting of license; reporting of changes in information.**
	(5) An applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for a license, including any changes in the household and in personnel-related information, within 5 business days after the change occurs.

ANALYSIS:	Based on interviews with Mr. Dyer, DCWs Beaudrie, Hammer, Dunlap and Tappenden, Residents A, B, C and D, ORR Specialist Marvin. It was evident James Ruoff parted ways leaving the LD position vacant proximally late April 2025. Mr. Dyer continued his role as administrator operating functions within the facility. Mr. Dyer admitted not being aware when Mr. Ruoff vacated his position as LD his role as administrator was to inform the department of the changes.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents were not protected

INVESTIGATION:

The complaint alleged DCW Hammer removed light bulbs from light sockets inside the facility causing safety concerns for residents. The complaint then alleged DCW Hammer rudely grabbed an unlit cigarette out of Resident B's mouth.

Ms. Marvin reported investigating concerns of DCW Hammer removing light bulbs within the facility along with a physical altercation between DCW Hammer and Resident B.

DCW Hammer reported working third shift when residents were sleeping. DCW Hammer denied ever removing light bulbs from their light sockets located in the second floor hallway. DCW Hammer admitted he has removed the light bulb from the socket located at the bottom of the stairs in the facility. DCW Hammer reported first removing the light bulb due to the broken light cover. DCW Hammer reported returning the bulb back into the light socket even though the cover was broken. DCW Hammer reported without the light cover the bulb gave off a glaring effect. DCW Hammer reported only removing the bulb once or twice but denied removing the bulb more times. DCW Hammer reported he remembered telling Carson Dyer about the broken light cover. DCW Hammer reported remembering engaging into a physical altercation with Resident B about three months ago. DCW Hammer reported on the day of the incident being very frustrated when he observed Resident B with an unlit cigarette in his mouth. DCW Hammer reported his frustrations stemmed from prior incidents catching Resident B smoking cigarettes inside his bedroom. DCW Hammer shared about addressing these prior incidents with Resident B with Carson Dyer and having to file numerous incident reports. DCW Hammer reported even after filing incident reports and repeatedly informing Resident B this was unacceptable behaviors, Resident B continued smoking in his bedroom. DCW Hammer shared when he observed the unlit cigarette in Resident B's mouth he lost it. DCW Hammer admitted grabbing the unit cigarette out of Resident B's mouth and engaging into a physical scuffle on the living room floor with

Resident B. DCW Hammer reported Resident B pulled away from him and then ran outside of the facility walking down the street. DCW Hammer admitted his actions were wrong especially engaging into a physical altercation with Resident B.

DCWs Beaudrie, Dunlap and Tappenden reported working first and second shifts. DCWs Beaudrie, Dunlap and Tappenden reported their work shifts sometimes overlap into DCW Hammer's third shift. DCWs Beaudrie, Dunlap and Tappenden denied observing DCW Hammer remove light bulbs from light sockets or engage into a physical altercation with Resident B. DCWs Dunlap and Tappenden reported only hearing about the removal of light bulbs or DCW Hammer engaging into a physical altercation with Resident B due to conversations they had with residents living in the facility. DCW Dunlap shared about one incident she experienced relating to the light bulb concern. DCW Dunlap shared starting her work shift proximally three weeks ago and observing light bulbs laying on the office desk. DCW Dunlap reported asking DCW Hammer why there were light bulbs on the desk. DCW Dunlap reported DCW Hammer provided the following statement "This was Carson's house and when light bulbs were left turned on this adds to the electric bill." DCWs Dunlap and Tappenden shared their reasons why DCW Hammer removed the light bulb at the bottom of the stairs due to the bright glaring effect from the bulb. DCWs Dunlap and Tappenden both shared of the safety concerns with residents movement if light bulbs were removed. DCW Tappenden reported having a conversation with Resident D three weeks ago. DCW Tappenden reported Resident D told him how he observed with Hammer continuing to remove the light bulb at the bottom of the stairs. DCW Tappenden reported Resident D told him he unscrewed the bulb and put "lock tight" glue on the end of the bulb returning the bulb back into the light socket. DCW Tappenden stated Resident D told him he did so to ensure DCW Hammer would stop removing the bulb. DCW Tappenden reported he believed Resident D told the truth due to remembering during a work shift observing remanence of a broken light bulb in the light socket.

Residents A, C and D reported observing DCW Hammer remove the light bulb from the socket at the bottom of the stairs. Resident B denied having any knowledge of DCW Hammer removing light bulbs from their light sockets. Resident D shared not wanting DCW Hammer to remove the bulb again so he placed "lock tight" glue on the end of the bulb and then placed the bulb back into the socket. Resident D reported later observing that the light bulb was broken inside of the socket. Resident D reported telling administrator Dyer about DCW Hammer removing the bulb. Resident A denied witnessing a physical altercation between DCW Hammer and Resident B three months ago but learned of the incident afterwards. Resident C and D reported witnessing the physical altercation between DCW Hammer and Resident B three months ago. Residents C and D reported Resident B was walking through the facility with an unlit cigarette in his mouth. Residents C and D reported DCW Hammer grabbed the unlit cigarette out of Resident B's mouth. Residents C and D reported observing DCW Hammer grab the cigarette and then both of them engaged into a physical scuffle on the living room floor. Residents C and D reported they were both on top of each other on the floor as Resident B was attempting to push away

from DCW Hammer. Residents C and D stated Resident B was able to distance himself from DCW Hammer and then exited out through the front door of the facility. During my interview with Resident B, he was observed quiet and hesitant on answering questions about the physical altercation between him and DCW Hammer. Resident B made the following statement “I do not know anything about this”. Pictures taken of the light bulb at the bottom of the stairs showing no light cover.

Mr. Dyer reported being aware of the broken light cover for the light at the bottom of the stairs. Mr. Dyer reported DCW Hammer informed him of removing the light bulb due to the broken cover. Mr. Dyer denied DCW Hammer has removed light bulbs since addressing the issue. Mr. Dyer reported he was aware of the incident between DCW Hammer and Resident B three months ago. Mr. Dyer reported addressing the situation after learning what happened. Mr. Dyer reported he was unaware if an incident report was filed due to the incident.

Ms. Marvin reported substantiating her investigation against DCW Hammer due to residents safety of removing the light bulb and physical altercation with Resident B.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on interviews with Mr. Dyer, DCWs Beaudrie, Dunlap, Tappenden and Hammer, Residents A, B, C and D and ORR Specialist Marvin. I found evidence DCW Hammer removed the light bulb located at the bottom of the stairs along with a physical altercation with Resident B. DCW Hammer provided disclosures of removing the light bulb along with engaging into a physical altercation with Resident B. Information gathered through other interviews coincided with DCW Hammer and his actions clearly demonstrated concerns with resident safety and protections.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

DCW Brianna Beaudrie verbally mistreated Resident B

INVESTIGATION:

The complaint alleged DCWs Brianna Beaudrie made the following statements to Resident B "You fucking smell like shit", "Pick your fucking cups up...pick them the fuck up" and then “You smell like shit because your room smells like shit."

Ms. Marvin reported concerns DCW Beaudrie made inappropriate statements to Resident B.

DCW Beaudrie denied ever making inappropriate statements "You fucking smell like shit", "Pick your fucking cups up...pick them the fuck up" and then “You smell like shit because your room smells like shit." towards Resident A.

DCWs Tappenden and Hammer’s statements coincided with those of DCW Beaudrie.

DCW Dunlap reported witnessing DCW Beaudrie make inappropriate statements to Resident B several weeks ago. DCW Dunlap reported hearing the following statements "You fucking smell like shit", "Pick your fucking cups up...pick them the fuck up" and then “You smell like shit because your room smells like shit." DCW Dunlap reported DCW Beaudrie’s statements were inappropriate and why she addressed it with administrator Carson Dyer.

Resident A denied witnessing DCW Beaudrie make inappropriate statements to Resident B. Residents C and D reported witnessing DCW Beaudrie making the following statements to Resident B "You fucking smell like shit", "Pick your fucking cups up...pick them the fuck up" and then “You smell like shit because your room smells like shit." Residents C and D reported the statements were inappropriate and DCW Beaudrie should have never made them. During my interview with Resident B, he denied DCW Beaudrie making the inappropriate statements but he was observed being hesitant on answering question.

Mr. Dyer reported being aware of DCW Beaudrie’s statements made towards Resident B after being informed by DCW Dunlap. Mr. Dyer reported addressing that situation privately with DCW Beaudrie.

Ms. Marvin reported substantiating her investigation against DCW Beaudrie due to substantiated evidence.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of

	the licensee, employees, or any person who lives in the home shall not do any of the following: **(f) Subject a resident to any of the following:** **(iii) Derogatory remarks about the resident or members of his or her family.**
ANALYSIS:	Based on interviews with Mr. Dyer, DCWs Beaudrie, Dunlap, Tappenden and Hammer, Residents A, B, C and D and ORR Specialist Marvin. I found evidence protections for Resident B was not adhered to and DCW Beaudrie made inappropriate statements to Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents were not served meals

INVESTIGATION:

The complaint alleged DCWs only prepare dinners requiring residents to prepare their own breakfast and lunch. The complaint alleged residents were not allowed or having access to snacks. Additionally, the complaint alleged no posted food menus at facility.

Mr. Dyer denied residents were not served at least three meals daily with beverage and snack options. Mr. Dyer reported residents have access to snacks daily located in a bowl on the dining room table. Mr. Dyer reported extra snacks were located in a locked cabinet in the facility office. Mr. Dyer denied DCWs were only preparing dinner meals for residents. Mr. Dyer reported in the past DCWs prepared breakfast, lunch and dinner for residents. Mr. Dyer reported due to residents either not awake or not wanting to eat breakfast or lunch the meals went into the trash. Mr. Dyer reported making the decision in reducing food waste at breakfast and lunch. Mr. Dyer reported instructing DCWs to ask residents if they want breakfast or lunch prepared or if residents wanted to prepare their own meal. Mr. Dyer shared this change better helps resident independence. Mr. Dyer reported dinner meals for residents were still prepared by DCWs.

DCWs Beaudrie, Dunlap, Tappenden and Hammer’s statements coincided with those of Mr. Dyer.

Residents A, B, C and D who all denied they have gone without meals while living at the facility. Residents A, B, C and D reported eating three meals daily and having access to snacks as needed. Residents A, B, C and D reported having independence preparing their own breakfast or lunch. Residents A, B, C and D shared they might eat breakfast or lunch at different times. Residents A, B, C and D

stated they have the ability to prepare their own meals or get assistance from DCWs.

I reviewed Ryder 1 Menus for 8/25/25 through 9/28/25 determining the facility provided nutritious meals for breakfast, lunch, and dinner. There were a variety of food items served during those mealtimes. I observed refrigerator, kitchen cupboards and snack cabinet finding ample supplies of food and snacks at the facility for residents.

Ms. Marvin reported denying the allegations due to lack of evidence.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on interviews with Mr. Dyer, DCWs Beaudrie, Dunlap, Tappenden and Hammer, Residents A, B, C and D, Ms. Marvin long with reviewing menus and inspecting food storage areas. I found no evidence residents were not provided with three nutritious meals daily and having access to snacks. Observations of the facility showed ample food supplies for residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/9/25, I conducted an exit conference with licensee designee Carson Dyer who agreed with the findings of the special investigation.

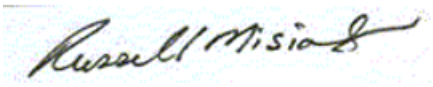
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in license is recommended.

Kevin L. Sellers 10/9/25

Kevin Sellers Date
Licensing Consultant

Approved By:



10/16/25

_____

Russell B. Misiak Date
Area Manager