



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 11, 2026

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

RE: License #: AS390405404  
Investigation #: 2026A0581015  
Beacon Home at Schoolcraft North

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,

A handwritten signature in black ink that reads "Cathy Cushman". The signature is written in a cursive, flowing style.

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  
 THIS REPORT CONTAINS QUOTED PROFANITY**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS390405404
<b>Investigation #:</b>	2026A0581015
<b>Complaint Receipt Date:</b>	01/20/2026
<b>Investigation Initiation Date:</b>	01/20/2026
<b>Report Due Date:</b>	03/21/2026
<b>Licensee Name:</b>	Beacon Specialized Living Services, Inc.
<b>Licensee Address:</b>	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
<b>Licensee Telephone #:</b>	(269) 427-8400
<b>Administrator:</b>	Aubry Napier
<b>Licensee Designee:</b>	Nichole VanNiman
<b>Name of Facility:</b>	Beacon Home at Schoolcraft North
<b>Facility Address:</b>	10713 S. 12th Street Portage, MI 49087
<b>Facility Telephone #:</b>	(269) 372-4820
<b>Original Issuance Date:</b>	09/01/2021
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/01/2024
<b>Expiration Date:</b>	02/28/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	DEVELOPMENTALLY DISABLED MENTALLY ILL



## II. ALLEGATIONS

	<b>Violation Established?</b>
Diabetic snacks are not available.	No
Meals on the menu are not being followed.	Yes
Residents are not being treated with dignity and respect when home manager, Brandon Root, curses and yells at them.	No
Between 01/10/2026 through 01/17/2026, Brandon Root threw his eyeglasses at Resident A.	No

## III. METHODOLOGY

01/20/2026	Special Investigation Intake - 2026A0581015
01/20/2026	Referral - Recipient Rights – Integrated Services of Kalamazoo (ISK) investigating.
01/20/2026	Special Investigation Initiated – Letter - Email with Complainant
01/20/2026	Contact - Document Sent - Email with Suzie Suchyta, ISK RRO
01/21/2026	APS Referral - APS referral unnecessary; no allegations of neglect or abuse
01/21/2026	Contact - Document Received - Email correspondence with Suzie Suchyta
01/22/2026	Contact - Telephone call made Interview with direct care staff, Tyler Reeves and Hannah Enos, via MiTeams.
01/26/2026	Contact - Telephone call made - Interview with direct care staff, LaShawn Daniel and home manager, Brandon Root.
01/29/2026	Inspection Completed On-site - Interviewed residents and direct care staff, Addie Maston.
02/12/2026	Contact - Face to Face - Interview with Program Director, Terrance Brunn
03/09/2026	Inspection Completed-BCAL Sub. Compliance
03/10/2026	Contact – Document Received Email from Program Director, Terrance Brunn.
03/10/2026	Exit conference with the licensee designee, Nichole VanNiman.

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**ALLEGATION: Diabetic snacks are not available.**

**INVESTIGATION:** On 01/20/2026, I received this complaint from the Bureau of Community Health Systems (BCHS) online complaint system alleging the facility does not have diabetic snacks available. The complaint did not include additional details.

On 01/21/2026, I confirmed with Integrated Services of Kalamazoo (ISK) Recipient Rights Officer (RRO), Suzie Suchyta, that she had also received the allegation and was conducting an investigation. In an email to me, she documented that she interviewed Residents A, B, C, and D; however, none of them reported any concerns related to food or diabetic snacks. She documented she also interviewed direct care staff, Maryah Vasquez and Addie Mastron, who also did not report any concerns regarding diabetic snacks not being available.

On 01/22/2026, Suzie Suchyta and I interviewed direct care staff, Tyler Reeves and Hannah Enos. Both staff identified Residents A, D, and E as having diabetes. Though they both stated there were limited items specifically labeled as diabetic snacks, they stated the facility had snack options available that could be provided to diabetic residents including fresh fruit (such as apples and bananas), peanut butter, popcorn, cereal (Frosted Wheats or Cheerios), granola bars, gingersnap cookies, sugar free cookies, and leftovers food items from meals. Both Tyler Reeves and Hannah Enos stated that if residents purchase his or her own snacks then staff cannot prevent the resident from consuming those items.

On 01/26/2026, Suzie Suchyta and I interviewed direct care staff, LaShawn Daniel and Brandon Root. Both of their statements to Suzie Suchyta and I were consistent with Tyler Reeves' and Hannah Enos' statements. LaShawn Daniel stated she did not experience any difficulty locating or providing appropriate snack options for residents with diabetes.

On 01/29/2026, I conducted an unannounced inspection at the facility. I interviewed Addie Maston whose statement was consistent with other direct care staff interviews. She identified additional snack items available to residents including rice cakes, apple sauce, and animal crackers. I also observed the facility's pantry and refrigerator, which contained snack items such as fresh oranges, kiwi, and apples, fruit cups in fruit juice, animal crackers, apple sauce, and rice cakes.

I interviewed Resident B, C, and E. None of the residents identified any concerns related to food in the facility. All three residents confirmed snacks are available and identified items such as popcorn and fruit.

I reviewed Resident A's, B's, C's, D's, and E's *Health Care Appraisals* (HCA). The HCAs confirmed Resident A and Resident E are prescribed diabetic diets. Resident

D's HCA documented a regular mechanical soft diet and did not identify a prescribed diabetic diet, despite documentation of a Type II diabetes diagnosis.

<b>APPLICABLE RULE</b>	
<b>R 400.663</b>	<b>Nutrition; adoption by reference.</b>
	<b>(5) A resident who has a prescribed diet by an appropriately licensed health care professional shall be provided that diet.</b>
<b>ANALYSIS:</b>	Based on my investigation, which included interviews with multiple direct care staff and residents, and observation of the facility's pantry and refrigerator, snack items including fresh fruit, applesauce, fruit cups, rice cakes, and animal crackers were available. Therefore, there is insufficient evidence to support that residents with prescribed diabetic diets are not provided appropriate snack options.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION: Meals on the menu are not being followed.**

**INVESTIGATION:** The complaint alleged the facility's home manager, Brandon Root, is not completing the facility's grocery shopping; therefore, the facility does not have the necessary ingredients to prepare meals listed on the menu. The complaint further alleged on 01/14 and 01/15 the facility did not have cheese to prepare macaroni and cheese, which was listed on the menu and did not have bread to make sandwiches.

ISK RRO, Suzie Suchyta, documented in an email to me that she interviewed Residents A, B, C, and D; however, none of the residents reported any concerns related to food at the facility. She documented direct care staff, Maryah Vasquez and Addie Mastron, both reported that staff sometimes have difficulty preparing menu items when all ingredients are not available. Suzie Suchyta further documented she recently visited the facility during a meal time and observed that staff did not have all the ingredients to prepare the meal listed on the menu and instead improvised the meal.

Direct care staff, Tyler Reeves, Hannah Enos, and LaShawn Daniel all stated the facility's food inventory is monitored by staff who notify Brandon Root when items are running low, and he is responsible for ordering and picking up food. All three staff stated the refrigerator and freezer may occasionally run low on food every few weeks; however, they all agreed staff ensure nutritious meals are still served to residents. They also stated that although a menu is posted on the refrigerator, it is not updated when menu changes occur due to unavailable ingredients or when staff

must improvise a meal. LaShawn Daniel stated that when meals are improvised younger or less experienced staff may have more difficulty making substitutions.

The facility's home manager, Brandon Root, confirmed he orders all the food in the facility. He stated the facility's meal planning is completed through a system called "My25", which he described as a subscription based program that provides customized weekly menus, grocery lists, and recipes. He stated he places grocery orders weekly from Walmart and either he or another staff picks up the order. Brandon Root stated that although the My25 system generates the menus, some meals listed on the menu are not preferred by the residents; therefore, he does not always order all the ingredients needed for those meals. As a result, he stated staff may prepare alternative meals based on residents' preferences. Brandon Root also stated staff do not always update the menu to reflect what is actually served.

Brandon Root further stated he regularly purchases staple food items such as cheese, bread and milk. He stated staff typically notify him when items are running low or are out so they can be replenished. He also stated there is a whiteboard in the kitchen where staff can write items that are low or out. He stated he typically obtains those items by the following day.

I conducted my inspection at the facility during lunch while staff, Addie Maston, was preparing the meal. I observed the facility's weekly menu on the refrigerator. According to the menu, lunch consisted of sauteed rice, meat of choice, California blend of vegetables, graham crackers, and a vegetable of choice as a snack. Addie Maston stated she was serving ham with the rice, which I observed, and showed me the frozen vegetables that would be prepared. Addie Maston stated that during the current week staff have recently begun updating the posted menu to reflect any substitutions when meals differ from the original menu. She stated staff are able to serve balanced meals that include fruit, vegetables, and protein.

I interviewed Resident B, C, and E. None of the residents identified any concerns related to food in the facility.

<b>APPLICABLE RULE</b>	
<b>R 400.663</b>	<b>Nutrition; adoption by reference.</b>
	<b>(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented.</b>

<b>ANALYSIS:</b>	Based on my investigation, which included interviews with multiple direct care staff and residents, and my own observations, menus are being written at least one in week in advance and posted. Although staff stated food items may run low and substitutions are made, multiple staff stated the posted menu was not being updated to reflect the meals actually served to residents. Therefore, substitutions to the menu were not consistently documented, as required.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

- **Residents are not being treated with dignity and respect when home manager, Brandon Root, curses and yells at them.**
- **Between 01/10/2026 through 01/17/2026, Brandon Root threw his eyeglasses at Resident A.**

**INVESTIGATION:** The complaint alleged the home manager, Brandon Root, often becomes frustrated and overwhelmed with residents and curses in their presence. It was further alleged that during the week of 01/10/2026 through 01/17/2026, Brandon Root became upset and threw his eyeglasses at a kitchen wall, which then struck Resident A. The complaint alleged direct care staff, Maryah Vasquez and Addie Maston, were present when the incident occurred.

Suzie Suchyta documented in an email to me that she interviewed Residents A, B, C, and D; however, Resident E declined to speak with her. She documented that Resident A reported to her that Brandon Root yells at him to calm down, but he did not report Brandon Root throwing his eyeglasses at him. She further documented Resident B denied the allegations while Resident C and Resident D both reported Brandon Root yells at them.

Suzie Suchyta also documented that she interviewed Maryah Vasquez and Addie Mastron. She documented both staff reported that Brandon Root yells and curses in the facility when he becomes frustrated. She further documented that Maryah Vasquez reported witnessing Brandon Root throw his eyeglasses, which struck Resident A.

Tyler Reeves stated he has observed Brandon Root become agitated with residents and raise his voice. He stated Brandon Root can be short with residents and tell them they “need to give [him] a minute”. Tyler Reeves stated he has not observed Brandon Root curse directly at residents; however, he has heard him use profanity in the vicinity of residents while working on his computer in the dining room. He stated residents were within earshot when Brandon Root used language such as “fuck” and “son of a bitch”. He further stated he has never observed Brandon Root become

physically aggressive towards residents or throw objects at them. Tyler Reeves stated residents have not reported concerns to him, although he believes some residents may be reluctant to report concerns in general.

Hannah Enos' statement was consistent with Tyler Reeves' statement to me. Hannah Enos stated Brandon Root may tell residents in a raised voice, "not right now dude, I'm getting my work done". She stated she is not aware of any residents displaying behaviors as a result of Brandon Root's interactions with them and stated residents typically walk away. She further stated Resident A has become agitated at times; however, staff are able to calm him by redirecting him to activities such as word searches or looking up magic tricks.

Lashawn Daniel statement was consistent with the statements provided by Tyler Reeves and Hannah Enos. She stated Brandon Root's loud cursing has startled residents and that his tone can sometimes sound agitated. She further stated she had never witnessed Brandon Root throw anything at any residents.

Brandon Root stated he works approximately 50-60 hours per week at the facility and described feeling distressed when working day and overnight shifts consecutively. He stated staff also contact him at home, which contributes to his stress. Brandon Root acknowledged it was possible he has sworn or cursed around residents. He denied becoming frustrated with residents when they ask for assistance, but acknowledged he may have told residents to wait or hold on before assisting them. He denied yelling at residents, but stated it was possible he has raised his voice. He also denied telling residents to leave him alone and stated he may have said, "dude, just give me a minute – I'll help you in one second".

Brandon Root initially stated he did not recall recently throwing anything in Resident A's direction; however, later during the interview he stated there may have been a recent incident in which he threw his eyeglasses at a wall and may have inadvertently struck Resident A. Brandon Root could not recall why he threw the eyeglasses or what occurred immediately afterward. He stated he believed he spoke with Resident A after the incident and ensured he was ok. He stated he did not recall Resident A sustaining any injuries and that staff may have been present when the incident occurred.

Addie Maston's statement was consistent with other staff's statements. She stated Brandon Root appears to get frustrated while completing work on his computer. She stated while she was working when the incident where Brandon Root threw his eyeglasses and struck Resident A, she stated Maryah Vasquez reported to her that the eyeglasses hit Resident A in the shoulder or head area.

I interviewed Residents B, C, and E. All three residents denied Brandon Root yells or swears at them. Resident C and Resident E stated they had never observed Brandon Root throw anything at any residents. Resident B stated he recalled a time when Brandon Root's glasses fell off his head, but he was unable to provide

additional details. Resident B, C, and E all stated they feel safe around Brandon Root.

Resident A was not in the facility at the time of my inspection; therefore, I was unable to interview him.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>
<b>ANALYSIS:</b>	<p>Based on my investigation, which included interviews with the home manager, Brandon Root, multiple direct care staff and residents, information indicates Brandon Root may raise his voice and use profanity in the vicinity of residents when frustrated; however, the information obtained did not support that the language was directed at residents or resulted in significant resident distress or behavioral concerns.</p> <p>Information obtained during the investigation also indicated Brandon Root threw his eyeglasses at a wall on one occasion and inadvertently struck a resident; however, the evidence did not indicate the action was intentional or directed toward the resident.</p> <p>In contrast, the residents interviewed denied Brandon Root yells or curses at them, and they reported they feel safe in his presence.</p> <p>Therefore, there is insufficient evidence to support the home manager, Brandon Root, fails to treat residents with dignity and respect or fails to provide protection and safety as required.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

On 03/10/2026, I conducted my exit conference with the licensee designee, Nichole VanNiman. She acknowledged the findings. She stated the facility's Program Director, Terrance Brunn, conducted a training with home managers addressing the importance of following facility menus and updating them to reflect any changes to meals served. I provided consultation to Nichole VanNiman regarding Brandon Root's behavior in front of residents. She stated both she and Terrance Brunn have addressed this with Brandon Root and discussed appropriate coping strategies.

**IV. RECOMMENDATION**

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

*Cathy Cushman*

03/11/2026

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Cathy Cushman  
Licensing Consultant

Date

Approved By:

*Dawn Timm*

03/11/2026

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Dawn N. Timm  
Area Manager

Date