



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 26, 2026

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

RE: License #: AM390418976
Investigation #: 2026A0581035
Beacon Home At River Run

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 script is cursive and fluid, with the first name "Cathy" and last name "Cushman" clearly legible.

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**

I. IDENTIFYING INFORMATION

License #:	AM390418976
Investigation #:	2026A0581035
Complaint Receipt Date:	07/04/2026
Investigation Initiation Date:	07/07/2026
Report Due Date:	09/02/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Aubry Napier
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home At River Run
Facility Address:	716 Leenhouts St Kalamazoo, MI 49048
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	07/02/2026
License Status:	TEMPORARY
Effective Date:	07/02/2026
Expiration Date:	01/01/2027
Capacity:	12
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION

		Violation Established
Resident A ingested a chemical cleaner that had been left unsecured by the facility's direct care staff.		Yes

III. METHODOLOGY

07/04/2026	Special Investigation Intake - 2026A0581035
07/06/2026	APS Referral - APS received the allegations, but denied investigating.
07/06/2026	Referral - Recipient Rights - Referred to ISK ORR
07/07/2026	Special Investigation Initiated – Letter - Received IR and Resident A's ISK IPOS and treatment plan.
07/08/2026	Contact - Document Received - Email correspondence with Suzie Suchyta.
07/10/2026	Inspection Completed On-site - Interviews with direct care staff.
07/15/2026	Contact - Document Received - Email correspondence from Kerri Ruelas, facility's Care Team Manager.
08/12/2026	Contact - Face to Face - Interview with Kerri Ruelas.
08/18/2026	Inspection Completed-BCAL Sub. Compliance
08/18/2026	Contact – Document Sent – Email correspondence with Suzie Suchyta.
08/19/2026	Contact – Document Received – Email correspondence with Suzie Suchyta.
08/19/2026	Exit conference with licensee designee, Nichole VanNiman. Left message.
08/19/2026	Contact – Telephone call made – Interview and exit conference with Administrator, Aubry Napier.

ALLEGATION: Resident A ingested a chemical cleaner that had been left unsecured by the facility's direct care staff.

INVESTIGATION: On 07/04/2026, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged Resident A unintentionally ingested a chemical cleaner that had been left unsecured by the facility's direct care staff. The complaint alleged that staff placed the chemical cleaner in a pitcher and subsequently poured it into a cup. The complaint alleged Resident A reportedly believed the substance was lemonade and consumed it. The complaint further alleged that following ingestion, Resident A experienced abdominal and possible chest pain and was transported to the local hospital for medical evaluation. The complaint also alleged the facility maintains a locked chemical closet for the storage of cleaning products.

The complaint documented Adult Protective Services (APS) also received the allegations, but denied investigating.

On 07/07/2026, I made a referral to Integrated Services of Kalamazoo (ISK) Office of Recipient Rights (ORR). I was informed the agency had also received the allegations and Suzie Suchyta was identified as the Recipient Rights Officer investigating.

On 07/08/2026, Suzie Suchyta provided the Incident Report (IR) pertaining to Resident A's ingestion of chemical cleaner. I reviewed the IR, dated 07/04/2026, which was completed by staff, Latoya Harris. The IR documented at approximately 12:30 pm on 07/04, a pitcher was left on the counter with chemicals in it and Resident A accidentally took a drink of it. The IR documented the staff obtained Resident A's vital signs, contacted the facility's home manager and poison control while Resident A contacted Emergency Medical Services (EMS). The IR further documented the corrective measures to be taken would be that staff not use anything other than the approved containers for cleaning chemicals, that staff not leave any cleaning chemicals left out without supervision and that staff complete a training acknowledgement on proper cleaning methods.

Suzie Suchyta also provided me with Resident A's *ISK Behavior Support Plan* (BSP), effective 06/18/2026, and *Individual Plan of Service (IPOS)*, effective 11/13/2025. I reviewed Resident A's BSP, which identified Resident A as having a moderate intellectual disability and documented significant safety concerns, including suicidal behaviors, major self-injurious behaviors, elopement, and property destruction as Resident A's target behaviors. I reviewed Resident A's IPOS, which documented Resident A experienced recent increases in suicidal ideation, self-injurious behaviors, property destruction, and medication related behaviors.

On 07/10/2026, I conducted an unannounced onsite inspection, in conjunction with ISK RRO, Suzie Suchyta. I was unable to interview Resident A due to her experiencing significant behavior at the beginning of the investigation and was

observed walking away from the facility. I attempted to interview her at the conclusion of the investigation; however, she was sleeping and unable to be awakened.

During the investigation, I interviewed multiple direct care staff, including Brianna Rudly, Latoya Harris, Lily Baalman, and Jakayla Locke.

Direct care staff, Brianna Rudly, stated she worked the overnight shift from 07/03 at 7 pm until 07/04 at 7:30 am. She stated she worked with staff, Lily Baalman, who was in training.

Brianna Rudly stated that approximately 4 am on 07/04, she began cleaning the facility. She stated Resident A was asleep at the time she was cleaning, but stated Resident A typically wakes between 5 am and 6 am. Brianna Rudly stated she used a pitcher of hot water and added a green mopping solution to it, which she obtained from the closet where the facility's chemicals are kept locked. Brianna Rudly was unable to report how much of the chemical solution she added to the hot water because she stated she measured by sight rather than using a measuring instrument. Brianna Rudly stated she poured water onto the facility's floor and then used a dry Swiffer to clean the floor. She stated the whole cleaning process took approximately one hour and she believed she used approximately one half of the pitcher for cleaning.

Brianna Rudly stated she stated she felt rushed when she was getting ready to leave and forgot to dispose of the remaining pitcher with cleaning solution. She stated it was left on the kitchen counter prior to leaving the facility. She stated that after leaving work, day shift staff, Jakayla Locke, texted her and told her Resident A had consumed some of the liquid from the pitcher and was taken to the hospital.

Brianna Rudly stated the facility's Care Team Manager, Kerri Ruelas, removed the facility's industrial mop bucket after coming to the facility, and staff had not been instructed what they should use instead. Brianna Rudly stated she had previously asked day shift staff what she should use but she was not provided with suggestions and she stated she did not ask Kerri Ruelas what equipment should be used.

Direct care staff, Latoya Harris, stated when she arrived for her shift on 07/04, she checked on the residents, prepared medications in the medication room, and then started preparing breakfast. She stated Resident A was still sleeping when she arrived at work at approximately 7 am.

Latoya Harris stated Resident A came to her at approximately 8 am requesting MiraLAX. Latoya Harris stated she instructed Resident A that she should take MiraLAX with a lighter colored liquid, such as water, lemonade, or apple juice, rather than milk. She stated Resident A came back to her and reported she had lemonade in her cup. Latoya Harris stated she looked in Resident A's cup, and it appeared to be lemonade based on the color of the liquid. Latoya Harris stated Resident A then drank the lemonade.

Latoya Harris stated at approximately noon, Resident A approached her near the medication room and told her there was something in the pitcher of lemonade that she was not supposed to drink. Latoya Harris stated Resident A did not indicate how much of the liquid she consumed.

Latoya Harris described the liquid in the pitcher as yellow-green in color, similar in appearance to lemonade or juice. She stated the pitcher had been left on the kitchen counter by overnight staff and it did not have a lid on it. Latoya Harris stated she emptied the pitcher and washed it twice. She stated the facility has approximately two or three similar pitchers and it is common for the pitchers to be on the kitchen counter.

Latoya Harris stated Resident A called 911 herself while another staff contacted the facility on call medical provider and home manager while Latoya Harris spoke to the paramedic. Latoya Harris stated the paramedic was unable to locate information regarding the ingredients of the chemical and according to Latoya Harris, the paramedics transported Resident A to the hospital because the information was not available.

Latoya Harris stated the facility's mop bucket and brooms are stored near lockers within the kitchen area and are out in the open. She stated the facility previously had an industrial style yellow mop bucket, but it was recently discarded and replaced with a black and red mop bucket. She stated the facility's locked closet contained chemicals that are used in cleaning.

Direct care staff, Lily Baalman's statement was consistent with Brianna Rudly's statement. She stated hot water was boiled on the stove, a chemical cleaning solution from the closet was then added to the pot and then this mixture was transferred into a pitcher to make it easier to pour onto the floor for cleaning. She stated Brianna Rudly then used a Swiffer to clean the floors by spreading the liquid around. Lily Baalman stated while Brianna Rudly cleaned the facility's floors she completed shift notes. She stated she did not see the pitcher again after cleaning was completed. Lily Baalman stated she was not aware of and did not ask about using a mop bucket rather than a pitcher to disperse the cleaning solution. She stated during her previous shadow shifts she only swept the floor.

Direct care staff, Jakayla Locke's statement was consistent with Latoya Harris' statement. She stated when she arrived to work she immediately began preparing breakfast and made a pitcher of apple juice, which she stated she placed in the refrigerator. Jakayla Locke stated Resident A awoke at approximately 7:50 am and later asked Jakayla Locke to do her hair. Jakayla Locke stated while doing Resident A's hair at approximately 8:30 am -9 am, Resident A had a cup containing a liquid that appeared to be lemonade. She stated Resident A was acting normally and she did not appear ill.

Jakayla Locke stated that at approximately 11 am, Resident A came into the kitchen and asked what was in the pitcher on the countertop because she had consumed some of it. Jakayla Locke stated the liquid in the pitcher appeared to be similar to lemonade or orange juice. Jakayla Locke stated she did not recall seeing the pitcher on the counter earlier that morning but acknowledged it could have been there.

Jakayla Locke stated Resident A contacted 911 while she contacted the facility's home manager. Jakayla Locke stated she was familiar with the facility's mop bucket and normally placed hot water and cleaning chemicals directly into the mop bucket rather than using a pitcher, which is used for human consumption.

During the inspection, I observed a red and black mop bucket, with mop and a sprayer mop near the lockers in the kitchen. I also observed multiple beverage pitchers in the kitchen cabinets.

I inspected the secured closet containing cleaning products. Staff identified Array Concentrated Neutral Floor Cleaner as the product used to clean the floor on 07/04/2026. A Safety Data Sheet for the product was not available for review during the inspection.

On 07/15/2026, I reviewed Resident A's Emergency Department (ED) Discharge Instructions, dated 07/04/2026. The discharge instructions documented Resident A was evaluated in the ED for ingestion of a substance and was instructed to follow up with her primary care physician within 2-3 days. The discharge instructions contained no additional information regarding the substance ingested or treatment provided, other than educational materials.

I confirmed Resident A was seen by her primary care physician on 07/08/2026. I reviewed the *After Visit Summary* from this appointment, which did not contain any information relevant to this investigation.

On 08/12/2026, I interviewed the facility's home manager, Kerri Ruelas. She stated she had been working in the facility since mid May 2026. She stated staff were supposed to use spray mops to clean the facility's floor to prevent the floors from being saturated and damaged by using too much water. She stated when she began working at the facility, she discarded the old mop and bucket and purchased two new spray mops, which were stored next to the facility's refrigerator. Kerrie Ruelas stated staff were informed about using the new spray mops.

Kerrie Ruelas stated she was not aware of the cleaning method described by Brianna Rudly and Lily Baalman. Kerrie Ruelas stated as a result of the investigation, staff meetings were held on 07/30 and 07/29, and it was believed cleaning procedures were addressed at both meetings.

On 08/19/2026, Suzie Suchyta documented she interviewed Resident A. Suzie Suchyta documented the content of her interview with Resident A who reported to

her seeing a Kool-Aid pitcher on the counter and believed it contained Kool-Aid. Resident A reported to Suzie Suchyta that she poured some of the liquid into a cup and drank it before realizing it contained a cleaning chemical. Resident A reported to Suzie Suchyta that 911 was contacted and she was transported to the hospital, where she was treated and released the same day. Resident A reported to Suzie Suchyta that she experienced an upset or “bubbly” stomach following the incident and identified no additional concerns.

APPLICABLE RULE	
R 400.645	Environmental health.
	(7) Poisons, caustics, and other dangerous materials must be stored and safeguarded in nonresident, non-food preparation areas, and storage areas.
	Based on my investigation, which included interviews with direct care staff, Brianna Rudly, Lily Baalman, Latoya Harris, and Jakayla Locke, and home manager, Kerri Ruelas, and my review of the Resident A’s After Visit Summary, dated 07/04/2026, and the facility’s Incident Report, dated 07/04/2026, staff, Brianna Rudly and Lily Baalman, both acknowledged preparing a cleaning solution during the overnight shift on 07/04/2026. The solution was placed in a beverage pitcher and Brianna Rudly acknowledged leaving the pitcher containing the solution on the kitchen counter after cleaning. Although it could not be confirmed that Resident A ingested the solution, the cleaning solution was left unsecured and accessible to residents; therefore, the cleaning solution was not properly stored and safeguarded, as required.
CONCLUSION:	VIOLATION ESTABLISHED

On 08/19/2026, I attempted to conduct the exit conference with the licensee designee, Nichole VanNiman, but was unable to reach her and left a voicemail. I subsequently conducted the exit conference with Administrator, Aubry Napier. Aubry Napier stated staff have been educated not to use food or beverage containers for cleaning purposes and to use only designated cleaning equipment. She stated staff were also instructed that cleaning products transferred into another container, such as a spray bottle, must be properly labeled. Aubry Napier further stated that Brianna Rudly’s employment had been terminated.

IV. RECOMMENDATION

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

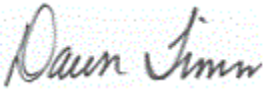


08/19/2026

Cathy Cushman
Licensing Consultant

Date

Approved By:



08/26/2026

Dawn N. Timm
Area Manager

Date