



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

December 23, 2025

Erin Gust  
Dignitas, Incorporated  
P.O. Box 3460  
Farmington Hills, MI 48333

RE: License #: AS630349201  
Investigation #: 2026A0611007  
Dignitas Inc./Orchard Lake House 3

Dear Ms. Gust:

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 (248) 972-9136.

Sincerely,

A handwritten signature in grey ink that reads "Sheena Worthy". The signature is fluid and cursive, with a large loop at the beginning of the first name.

Sheena Worthy, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Place  
3026 W. Grand Blvd, Suite 9-100  
Detroit, MI 48202

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS630349201
<b>Investigation #:</b>	2026A0611007
<b>Complaint Receipt Date:</b>	12/10/2025
<b>Investigation Initiation Date:</b>	12/10/2025
<b>Report Due Date:</b>	02/08/2026
<b>LicenseeName:</b>	Dignitas, Incorporated
<b>Licensee Address:</b>	24505 Orchard Lake Road Farmington Hills, MI 48336
<b>Licensee Telephone #:</b>	(586) 201-7873
<b>Administrator:</b>	Erin Gust
<b>Licensee Designee:</b>	Erin Gust
<b>Name of Facility:</b>	Dignitas Inc./Orchard Lake House 3
<b>Facility Address:</b>	24467 Orchard Lake Road Farmington Hills, MI 48336
<b>Facility Telephone #:</b>	(248) 442-1170
<b>Original Issuance Date:</b>	03/06/2015
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/12/2024
<b>Expiration Date:</b>	04/11/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
There was a fire at Dignitas Orchard Lake on 12/08/2025. The fire department arrived and found combustible materials in the resident's room where the fire originated and also in other resident's rooms.	Yes

**III. METHODOLOGY**

12/10/2025	Special Investigation Intake 2026A0611007
12/10/2025	Special Investigation Initiated - Letter I received a copy of the police report regarding the allegations.
12/17/2025	Inspection Completed On-site I completed an unannounced onsite. I interviewed the administrator director Stephanie Guzak, Resident C, and Resident B. I observed the residents bedrooms that contained a stove in them.
12/18/2025	Contact - Telephone call made I left a voice message for staff member Charron Hardges requesting a call back.
12/18/2025	Contact - Telephone call received I received a return phone call from staff member Charron Hardges. The allegations were discussed.
12/23/2025	Contact – Document Received I received pictures verifying that all the stoves in the residents bedrooms have been disconnected and the outlets have been capped.
12/23/2025	Exit Conference I completed an exit conference with Stephanie Guzak as the licensee designee Erin Gust is out of the country.

## **ALLEGATION:**

**There was a fire at Dignitas Orchard Lake on 12/08/2025. The fire department arrived and found combustible materials in the resident's room where the fire originated and also in other residents' rooms.**

## **INVESTIGATION:**

On 12/10/25, complaint was received and assigned for investigation alleging that there was a fire inside the AFC group home. The fire department arrived and found combustible materials in the resident's room where the fire originated and also in other residents' rooms.

On 12/10/25, I received a copy of the police report from the Farmington Hills police department dated 12/08/25. A copy of the police report is below:

*"All call was dispatched to flames coming from an oven. FD arrived on scene and command was established. FD found paper towel rack and other combustible items were on the stove that had gotten turned on. Resident applied extinguisher to items and had fire out prior to FD arrival. 360 was performed. FD light water extinguisher was used for minor smoldering. FD removed burning items and ventilated the house. Residents were being evacuated as FD arrived. Residence had working smoke alarms. FD used gas monitor and returned to normal readings before occupants were allowed back in. Fire was extinguished, home was ventilated, and residents returned back inside. FD returned in service".*

*"FD made contact with the resident, employee, and manager of the group home where this incident took place. The following is the information that was gathered. Charron Hardges who is the employee at this group home stated, that Resident C, who was the resident in the room, turned on his electric stove top. He had unused groceries stored in combustible boxes and a paper towel holder on top of the unit while the heat had been turned on. Mrs. Hardges stated he then left his room and went to the common area because he forgot he turned on the stove top. The smoke alarms went off, and smoke was coming from the room, so Mrs. Hardges called 911 and began to evacuate the residents. At this time, another resident went into the room and put out the fire with an extinguisher. He had also turned off the stove at this time. The fire was confined to the stove top and there was not any damage to the drywall or the cabinets. Staff was educated on proper fire safety on all stove tops. Other rooms had similar issues and FD removed combustible items to prevent this from happening again. The cause of this fire was combustible items that caught fire from an electric stove top. Mary Smith who is the manager of this property was also notified".*

The fire department report also included pictures of the fire damage to Resident C's stove including the paper towel holder that was on top of Resident C's stove, along with several boxes of food next to the stove.

On 12/17/25, I completed an unannounced onsite. I interviewed the administrator director Stephanie Guzak, Resident C, and Resident B. I observed the resident's bedrooms that contained a stove in them.

On 12/17/25, I interviewed the administrator director Stephanie Guzak. Regarding the allegations, Ms. Guzak stated the incident occurred on 12/8/25 after dinner time which was around 7:00pm. There are six residents in the AFC group home and every resident has their own bedroom. There are two residents who are in wheelchairs and Resident C also uses a wheelchair but he is also ambulatory. There are four bedrooms that have a stove inside the bedroom. Ms. Guzak stated prior to the fire, it was her understanding that all of the stoves were disconnected from the electrical socket. Ms. Guzak was informed by the home manager Mary Smith that all of the stoves were disconnected prior to the incident. However, following the incident Ms. Guzak became aware that Ms. Smith did not ensure Resident C's stove was disconnected as she assumed it was since he never uses it and always orders food.

Ms. Guzak stated on the day in question, Resident C inadvertently bumped the burner on the stove in his bedroom which turned the burner on. Resident C was not trying to cook. Resident C did have boxes on his counter top and on top of the stove. The box on top of the stove caught fire. Ms. Guzak stated Resident C's countertop and bedroom is normally cluttered with several items. Ms. Guzak stated there is a fire extinguisher in every bedroom that has a stove. Ms. Guzak thinks Resident C was in his bedroom when the fire started. The staff member that was on duty was Charron Hardges. While Ms. Hardges was trying to evacuate the residents, Resident B grabbed a fire extinguisher and put out the fire in Resident C's bedroom. Resident C did not want to evacuate the AFC group home and the staff could only get him to go onto the front porch. Ms. Guzak stated the fire department could not get Resident C or Resident B to leave the front porch and join the other residents in the AFC group home next door as it was cold outside.

Ms. Guzak stated there has never been a fire in the AFC group home before. Ms. Guzak stated following this incident, all of the stoves in the bedrooms were checked to ensure they were all disconnected. Ms. Guzak was advised and agreed to unscrewing the electrical cords from all the stoves in the residents bedrooms and install a cap over the wall outlet to ensure none of the stoves can be plugged back in.

I observed each bedroom that contained a stove. The first bedroom I observed is considered the Southwest bedroom. This bedroom was recently vacated as the previous resident was discharged. The stove located in the Southwest bedroom was observed to be plugged into the wall and in working order. I observed Ms. Guzak unplug the stove. I observed Resident C's bedroom and saw the fire damage to his stove. I also saw that the stove was unplugged. There is a new fire extinguisher in Resident C's bedroom. I observed the other two bedrooms that have stoves in them and; both stoves were unplugged. Every bedroom containing a stove had a fire extinguisher and a full-

size refrigerator. I did not observe any items and/or combustible items on any of the stoves.

On 12/17/25, I interviewed Resident C. Regarding the allegations, Resident C stated he was watching TV in his bedroom and when he looked over to his stove he saw that his paper towel holder was on fire. Resident C stated he never turned on his stove and he has no idea how the fire started. Resident C stated he never does any cooking in his bedroom and he only uses his microwave. Resident C admitted to having his paper towel holder and boxes of food on top of his stove. Resident C stated there was no fire extinguisher in his bedroom prior to the fire. Resident C stated Resident B used a fire extinguisher from a different location to put out the fire in his bedroom.

Resident C stated that he does participate in the fire drills conducted in the AFC group home. Resident C is aware that during a fire drill you are supposed to evacuate far away from the AFC group home. However, during this incident Resident C did not want to follow procedure because the fire had been put out.

On 12/17/25, I interviewed Resident B. Regarding the allegations, Resident B stated he was using the bathroom in his bedroom when he heard the fire alarm go off. Resident B came out of his bedroom and saw the staff member trying to put the wheelchair bound residents into their wheelchairs to evacuate them. Resident B saw the fire in Resident C's bedroom and he proceeded to grab the fire extinguisher in his bedroom and put out the fire. Resident B does not know if there was a fire extinguisher in Resident C's bedroom but, he knew he had one in his bedroom. Resident B saw the paper towel dispenser on top of Resident C's stove. Resident C also had boxes of food on top of his stove. Resident B turned off the burner, turned on the stoves ventilation system, and opened up a window. Resident B wheeled Resident C to the front door and; then the fire department arrived and escorted Resident C onto the front porch.

On 12/18/25, I received a return phone call from staff member Charron Hardges. Regarding the allegations, Ms. Hardges stated she was sitting in the common area along with two other residents, while the other residents were in their bedrooms. Ms. Hardges stated she smelled smoke and then the fire alarm went off. Ms. Hardges started looking for the fire and opened up Resident C's bedroom door and saw the fire. Resident C was inside his bedroom looking at the fire. Ms. Hardges told Resident C that he had to evacuate the building but he refused to do so. Ms. Hardges left Resident C's bedroom and grabbed the emergency bag and evacuated the rest of the residents. Ms. Hardges stated when she entered back into the building she saw that Resident B used a fire extinguisher to put out the fire. Ms. Hardges received assistance from the staff members next door with moving the residents inside of Orchard Lake House #2. Ms. Hardges stated she does not know how Resident C's stove got turned on as Resident C would not answer any questions as he would only use profanity and tell her he will not leave the home.

On 12/23/25, I received pictures from all four bedrooms verifying that all the stoves in the resident's bedrooms have been disconnected as the cords have been unscrewed from behind the stove and; the outlets on the wall behind the stove have been capped.

On 12/23/25, I completed an exit conference via telephone with Stephanie Guzak as the licensee designee Erin Gust is out of the country. Ms. Guzak was informed that the allegations will be substantiated and a corrective action plan will be required.

<b>APPLICABLE RULE</b>	
<b>R 400.731</b>	<b>Flame-producing equipment; enclosures.</b>
	<b>(4) Combustible materials must not be stored in rooms that contain heating equipment, water heater, incinerator, or other flame-producing equipment.</b>
<b>ANALYSIS:</b>	Based on the information gathered, there is sufficient evidence to support the allegations. It was confirmed that Resident C did have combustible materials such as a paper towel holder and boxes on and/or near his stove inside his bedroom which caused the fire.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

<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>	There is sufficient information to support this allegation. According to the Farmington Hills fire department report, the cause of the fire was combustible items that caught fire from an electric stove top inside of Resident C's bedroom. The fire department observed the other bedrooms and saw similar issues. The fire department removed combustible items from the other bedrooms to prevent another fire from happening again. Ms. Guzak confirmed that Resident C's bedroom is normally cluttered including his countertop located near his stove.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

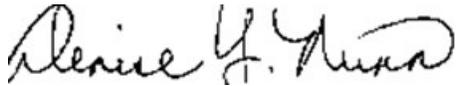
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.



Sheena Worthy  
Licensing Consultant

12/23/25  
Date

Approved By:



12/23/2025

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Denise Y. Nunn  
Area Manager

Date