GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 1, 2026

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

RE: License #: AS630387842
Investigation #: 2026A0605023
Beacon Home at Dilley

Dear Nichole VanNiman:

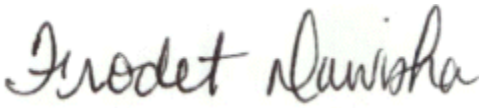
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 972-9136.

Sincerely,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 W. Grand Blvd.
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Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630387842
Investigation #:	2026A0605023
Complaint Receipt Date:	05/28/2026
Investigation Initiation Date:	05/28/2026
Report Due Date:	07/27/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St. Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator/Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Dilley
Facility Address:	7570 Dilley Road Davisburg, MI 48350
Facility Telephone #:	(248) 382-5648
Original Issuance Date:	08/13/2018
License Status:	REGULAR
Effective Date:	09/10/2025
Expiration Date:	09/09/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED/MENTALLY ILL AGED/TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
A resident at Beacon Home at Dilley reported being sexually assaulted by another resident, and staff allegedly failed to report the incident for five days after being informed.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/28/2026	Special Investigation Intake 2026A0605023
05/28/2026	APS Referral Adult Protective Services (APS) made referral. APS worker Heather Stickel was assigned this investigation
05/28/2026	Special Investigation Initiated - Telephone Left messages for APS worker Heather Stickel and Oakland County Office of Recipient Rights (ORR) worker Katie Garcia
05/28/2026	Contact - Telephone call received ORR Katie Garcia will not be investigating these allegations unless it is determined that direct care staff (DCS) did not follow standard of care regarding Resident A
05/28/2026	Contact - Document Received Text message from APS Heather Stickel
05/28/2026	Contact - Telephone call received Discussed allegations with APS Heather Stickel
06/01/2026	Inspection Completed On-site Conducted unannounced on-site investigation
06/15/2026	Contact - Telephone call made Discussed allegations with direct care staff (DCS) and assistant home manager Don Adams. I also interviewed Saginaw County ORR Rhonda Nelson and spoke with Detective Bohn with Oakland County Sheriff's Department (OCSD)
06/23/2026	Contact - Telephone call made Follow up with Detective Bohn with OCSD

06/24/2026	Contact - Telephone call made Left message for DCS
06/25/2026	Contact – Telephone call received Discussed allegations with Resident A's mother
06/30/2026	Exit Conference Attempted to leave message for licensee designee Nichole VanNiman, to conduct the exit conference but the phone cut off. Emailed her my findings.

ALLEGATION:

A resident at Beacon Home at Dilley reported being sexually assaulted by another resident, and staff allegedly failed to report the incident for five days after being informed.

INVESTIGATION:

On 05/28/2026, intake #210809 was received from Adult Protective Services (APS) who is investigating these allegations. The assigned APS worker is Heather Stickel.

On 05/28/2026, I received a telephone call from Oakland County Office of Recipient Rights (ORR) Katie Garcia and APS worker Heather Stickel. Ms. Garcia stated that she will not investigate these allegations as Oakland County ORR does not have jurisdiction over this group home. In addition, ORR does not investigate allegations of "resident on resident," however, if it was determined that staff failed to follow procedure regarding supervision or standard of care, the ORR will investigate. Ms. Stickel is investigating these allegations regarding Resident E assaulting Resident A at Beacon Home at Dilley when Resident E resided there for about two weeks. Ms. Stickel is also investigating allegations regarding Resident E assaulting other residents at Beacon Home at Lake Orion, where he was and is currently residing. The allegations related to Beacon Home at Lake Orion are being investigated by licensing consultant Stephanie Gonzalez. There was a water main break that impacted Lake Orion, so three residents, including Resident E, were moved into Beacon Home at Dilley from 05/11/2026-05/26/2026. Resident A disclosed to Ms. Stickel that Resident E "raped him," while direct care staff (DCS) Brian Britt was out in the living room, with his headphones on, and could not hear Resident A "yelling for help." Ms. Stickel spoke with acting home manager, Don Adams, who advised Ms. Stickel that Resident E's individual plan of service (IPOS) has "sexual deviant behaviors," however, due to no incidents since 2021, this information was never told to DCS at Beacon Home at Dilley unless staff "read the IPOS." After these allegations were made, Resident E now has one-to-one staffing at Beacon Home at Lake Orion.

On 06/01/2026, I conducted an unannounced on-site investigation. Present were the home manager Jordan Eldridge, lead staff Cortney Edwards, DCS Ja'Kobee Hardy, and

Resident A, Resident B, Resident C, and Resident D. I interviewed the home manager, Jordan Eldridge, regarding the allegations. Jordan has been working for this corporation since 05/11/2026 and her first full day as home manager was on 05/28/2026. She is still learning her role at this home. APS worker Heather Stickel was at Dilley on 05/28/2026 with Jordan and Don Adams advising them that Resident A disclosed that Resident E "put his private area in Resident A's mouth." There was a water main break near Lake Orion's group home, so all the residents were moved. Resident E along with two other residents moved into Dilley on 05/11/2026 and moved back to Lake Orion on 05/26/2026. Jordan stated she did not observe anything between Resident A and Resident E during her time at Dilley while she was training. She had no additional information to offer.

Lead staff, Cortney Edwards, was interviewed regarding the allegations. She has been working for this corporation for four years but has been at Dilley since 01/2026. She works 7:00AM-7:30PM. Resident A moved into Dilley on 02/19/2026. He has a history of "being manipulative," and "lying." He is also, "hospital seeking," and "has sexual deviant behaviors." On 05/26/2026, Resident A asked to speak with Cortney in the office. He told Cortney, "On midnight, Resident E came into my room and asked me for oral. I told him no, but Resident E locked the bedroom door and forced me to do it or he wouldn't leave. I did it but I did not want to." Resident A told Cortney that he reported this incident to DCS Janeen Rondo who told Resident A that "she will inform everyone via text message." Resident A told Cortney this alleged incident occurred on 05/21/2026. Cortney stated that no text message was sent by any DCS. The first time she heard about this incident was on 05/26/2026. After speaking with Resident A, Cortney contacted Don Adams, completed an incident report (IR), and forwarded the IR to Saginaw County ORR. She also sent emails to Resident A's guardian and mother. Cortney stated she does not know if what Resident A reported to her is true or not. Soon after Resident A moved into Dilley, another resident moved into Dilley and Resident A made similar allegations against that resident, which were unfounded. Ms. Edwards stated that Resident A also reported these allegations to DCS Margaret Yearby, who immediately made a report to Oakland County Sheriff's Department. Margaret wanted Resident A to be seen at the hospital, but Resident A refused. The police came to Dilley, took Resident A's statement, and offered to take Resident A to the hospital, but again, he refused. Resident A changed his story when he was providing his statement to police. Resident A told the officer that Resident E "raped him, anally," and that it was not "oral." Resident A has his own bedroom. When Resident E was residing at Dilley, Resident E shared a bedroom with Resident D, who had also come from Lake Orion. Cortney stated she never observed Resident E going into any residents' bedrooms including Resident A's room. She stated that it was always other residents going into Resident D and Resident E's bedroom. When Resident E moved in, the only concerns reported were that Resident E was "drug seeking," and required "supervision for drugs." She was never informed that Resident E had "sexual seeking behaviors." Cortney reviewed Resident E's IPOS and stated there is no mention of sexual deviant behaviors in his IPOS; therefore, no DCS at Dilley would have known unless they were told by staff at Lake Orion. However, Cortney stated that Margaret had mentioned after Resident A disclosed that "it is known that Resident E has done this at

Lake Orion," but Margaret never reported this as direct knowledge. Cortney stated that no other residents at Dilley have disclosed that they were inappropriately touched or sexually assaulted by Resident E. Cortney was not informed by Resident A that DCS Brian Britt was working when he was assaulted. Resident A specifically stated it was when Janeen was working, not Brian.

On 06/01/2026, I interviewed Resident A regarding the allegations. Resident A stated he knew why I was there to speak with him. He reported that the incident occurred on 05/19/2026 by a "black male 6'4"- (Resident E)." He said, "I don't know his name, but around 10PM my door was locked and he figured out a way to open the door. He just raped me. He put his penis in my ass. I yelled, 'get out of my room,' but he didn't leave. He forced himself upon me. I grabbed him by his throat and threw him against the wall and said, 'if you do that again, I will beat you up." Resident A stated that a male was working during the incident and that male was in the living room with headphones on "playing video games on his PlayStation." He does not know the male staff's name. Resident A knows this male was playing video games because, "he cusses a lot when he's playing video games." All the other residents were sleeping during this incident. Resident E was living here but has moved back to Lake Orion. Resident A stated, "he (Resident E) told me he did this to other clients at Lake Orion house." Resident A stated, "I was scared to tell anyone until (Resident E) moved out of the home." He told DCS Janeen "two days after what happened." He refused to go to the hospital and said that the police came to Dilley, and he told them what happened. Resident A was unable to provide any further information regarding the incident.

On 06/01/2026, I interviewed Resident B regarding the allegations. Resident B has been residing at Dilley for five months. Resident A told Resident B, "I got raped by (Resident E)." Resident B stated, "that's not true. I know (Resident E) and he would not do that to him. Our bedroom doors are locked at night, and I never heard anyone yell or say stop." Resident B is unsure if Resident A told anyone else what happened. Resident B has never observed anything inappropriate by Resident E within the time he moved into Dilley. However, Resident B confirmed that DCS Brian Britt "plays video games every night." He stated, "I see him setting it up when we get ready for bed."

On 06/01/2026, Resident C and Resident D refused to be interviewed. Cortney stated that Resident C told her, "I don't want to be triggered," so he declined to answer any questions. I observed both residents. Resident C was lying in his bedroom. Resident D is an amputee who was sitting in a wheelchair. He moved to Dilley from Lake Orion and decided he did not want to move back to Lake Orion.

On 06/01/2026, I interviewed DCS Ja'Kobee Hardy regarding the allegations. Ja'Kobee has been working for this corporation for two years. He works first shift from 7:00AM-7:30PM but has worked two midnight shifts from 7:00PM-7:30AM. Resident E moved into Dilley on 05/11/2026 from Lake Orion due to a water main break. He was informed that Resident E is "drug seeking," but no information was ever disclosed about Resident E's "sexual deviant behaviors." He was not aware of any "extra supervision." Resident A is described as "likes attention," sometimes "he says things that are untrue," and "tries

to manipulate people." Last week, Resident A told lead shift Cortney Edwards and DCS Margaret Yearby, "something sexual happened Thursday night with (Resident E)." Ja'Kobee currently does not work the midnight shift, so he was not aware of any incident. During Ja'Kobee's shift when Resident E was at Dilley, Ja'Kobee never observed anything inappropriate between Resident E and Resident A, nor did any resident, including Resident A, report anything inappropriate. However, during his shifts he did observe Resident E in Resident A's bedroom watching TV. Resident E was standing at the door, which was wide open, watching TV. He never observed Resident E in Resident A's bedroom with the door closed. Resident E was sharing a room with Resident D who also moved into Dilley from Lake Orion, but Resident D decided to remain living in Dilley. Resident E moved out of Dilley and back to Lake Orion on 05/26/2026. Ja'Kobee stated, "I believe (Resident A) because the allegations are so serious, I hope no one would lie about this." Ja'Kobee has never worked with DCS Brian Britt and has never heard that Brian plays video games during the midnight shift. He had no other information regarding the allegations.

On 06/15/2026, I interviewed Saginaw County ORR worker Rhonda Nelson regarding the allegations. Ms. Nelson stated that she spoke with DCS Janeen Rondo who denied that Resident A disclosed anything to her regarding Resident E sexually assaulting Resident A. Janeen told Ms. Nelson if Resident A had disclosed to her, she would have made a report. Ms. Nelson stated that initially Resident A said the sexual assault was "oral," but then he changed his story to "anal." Also, Resident A refused all medical treatment. Ms. Nelson stated that Resident A has sexual deviant behavior and requires supervision while in the community because he is "at risk of sexual thoughts and urges towards females." Ms. Nelson will not be investigating the allegations because they are regarding "resident on resident," and she does not have enough information to say that staff failed to protect Resident A.

On 06/15/2026, I interviewed DCS Janeen Rondo regarding the allegations. Janeen has been working for this corporation for two years. She works from 7:00PM-7:30AM Thursdays, Fridays, and Saturdays. Resident E moved into Dilley from Lake Orion from 05/11/2026-05/26/2026 due to a water main break. Janeen worked from 05/14/2026-05/16/2026. During these days, she observed Resident A asking Resident E for a cigarette. Janeen told Resident E "don't give Resident A a cigarette," because "Resident A doesn't smoke." She stated other than this, nothing happened during her shift. All the residents were in their bedrooms and no residents, including Resident E, woke up nor went into Resident A's bedroom. She stated, 90% of the time, Resident E was in his bedroom. The only time he came out was to eat, go to the bathroom, and take his medication. Janeen then worked from 05/21/2026-05/23/2026 and stated again that nothing at all happened between Resident A and Resident E during her shift. However, on 05/23/2026, when she arrived at her shift the police were called out to Dilley. Resident A was sitting on the couch, and the house phone was in Resident D's bedroom. The police spoke with Resident A and then left. Janeen stated she did not witness anything inappropriate between Resident A and Resident E and she denied that Resident A told her that Resident E "assaulted him." I asked her, "what would you do if he had told you he was sexually assaulted?" She said, "I probably would have told

management and written an IR, but he never told me anything because it never happened." Janeen stated, "neither Resident A nor Resident E left their bedrooms during my shift on any of the days I worked." She stated, "Resident E does have sexual behaviors but he's not going to force himself on anyone." Janeen stated that no other resident at Dilley reported anything inappropriate to her regarding Resident E.

On 06/15/2026, I interviewed DCS Margaret Yearby regarding the allegations. Margaret has been working for this corporation for over one year. She works first shift from 7:00AM-7:30PM, and sometimes she picks up second shift from 7:30PM-7:00AM. Resident E along with Resident D and another resident moved into Dilley from Lake Orion either on 05/11/2026 or 05/12/2026. Margaret worked from 05/14/2026-05/17/2026 and then on 05/20/2026 and 05/22/2026, which is the day Resident E along with the other resident moved back to Lake Orion. Resident D decided to remain living at Dilley. On 05/22/2026, Resident A asked to speak to her and lead shift staff Cortney Edwards after Resident E was taken back to Lake Orion by staff. Resident A told Margaret that during midnight shift Resident E came into his room and forced him to do oral sex. Resident A was lying in bed watching TV when Resident E came into his bedroom and locked the door. Resident A told Resident E to leave, but Resident E refused, saying unless you perforce oral sex, then I'll leave, so Resident A did it and then Resident E left. Margaret contacted Saginaw County ORR who advised her that they would not be investigating because it was "resident on resident," but will open a case since Resident A told Margaret that he reported it to the staff on shift, but that staff did not do anything. Margaret also called Resident A's guardian and filed a police report. Margaret stated that a police officer from OCSD showed up and it was the same police officer that had been at the home a couple of days prior. Margaret heard the officer say to Resident A, "why didn't you report this to me when I saw you two days ago?" and Resident A responded, "I was scared of (Resident E)." Margaret also heard Resident A tell the officer that he was anally assaulted too, so the officer advised him to go to the hospital to get checked out but Resident A refused. Margaret also advised Resident A he should go to the hospital to get checked out, but again he refused. She completed an IR and added that Resident A stated he was assaulted anally because of the information he disclosed to the officer. Margaret stated that according to Resident A's IPOS, there is information stating that, "(Resident A) does have sex with males and gets embarrassed and says things like these allegations to go to the hospital to get the nurses to touch him to get him aroused." Resident A has an extensive sexual past. Margaret denied that anything inappropriate occurred between Resident A and Resident E during her shifts. She stated, "(Resident E) did not have much contact with any resident. He stays in his bedroom and comes out only to eat, smoke cigarettes, and take his meds. Other than that, he is always in his bedroom." She stated, "if something happened, it's probably during the other shift." Margaret also stated that there is nothing in Resident E's IPOS regarding any sexual deviant behaviors. However, at Lake Orion, Resident E had his own bedroom, but when he moved into Dilley, he had to share a room with Resident D. Margaret also encouraged all the residents at Dilley to go to the doctor to get checked for any sexually transmitted diseases (STD), but they all declined. Resident B said, "that faggot didn't touch me so 'F-in' no I'm not going to get tested for STDs." Resident D said, "one-time (Resident E) said something to me (didn't tell

Margaret what was said) but I shut it down, so I'm not going to get tested." Margaret stated that Janeen is a non-confrontational staff so instead of her redirecting residents, she will give them cigarettes when they ask for it and energy drinks just to avoid any conflict. Now that she has been suspended pending this investigation, Margaret has observed behaviors from the residents because they are being redirected and not given what they ask for. Margaret described DCS Brian Britt as a "good worker," and has not heard anything about him playing video games.

On 06/15/2026, I interviewed interim home manager Don Adams regarding the allegations. Resident E's behavioral treatment plan does reference incidents of sexual behavior; however, these behaviors occurred from 2020-2022. When Resident E moved into Lake Orion, he required one-to-one staffing, but then the one-to-one was removed and the focus became his substance abuse, which did not require the one-to-one staffing. On 05/12/2026, there was a water main break, so Resident E moved from Lake Orion to Dilley. All staff at Dilley were trained on Resident E's IPOS; however, sexual deviant behaviors were not in his IPOS, but in his behavioral treatment plan. Resident A disclosed to staff at Dilley that "Resident E had intercourse and he was bleeding from the rectum." Resident A initially reported that he performed oral sex on Resident E, but then that changed to anal sex. He initially said it was consensual, but then he said it was not consensual. Detective Bohn with OCSD will be coming to Dilley to interview Resident A regarding the allegations. Resident A's mother was informed and does not believe these allegations. Resident E was discharged from Beacon Home at Lake Orion on 06/08/2026.

On 06/15/2026, I contacted Detective Bohn with OCSD. He is going to Dilley tomorrow to interview Resident A. Based on that interview, he will either move forward with his investigation and interview Resident E or close his case if there is no disclosure. He will call me tomorrow to provide an update after the interview.

On 06/18/2026, I contacted licensing consultant Stephanie Gonzalez who was investigating allegations regarding Resident E assaulting residents at Lake Orion. Ms. Gonzalez attempted to interview Resident E, but Resident E told Ms. Gonzalez that he was advised by his grandmother not to speak to anyone without an attorney present. Therefore, she was unable to interview him regarding the allegations.

On 06/23/2026, I contacted Detective Bohn with OCSD requesting an update. Resident A disclosed lots of information to Detective Bohn; however, Resident A stated that the "oral and anal sex, were consensual," between Resident A and Resident E. Initially, Resident A stated he was raped by Resident E, but then when asked questions about the rape, Resident A stated that Resident E came into Resident A's bedroom while Resident A was masturbating so both began masturbating which then led to oral and anal sex. Due to Resident A reporting it was consensual, Detective Bohn is closing out his case.

Note: I reviewed IRs from Lake Orion pertaining to Resident E to determine if there were any sexual behaviors after 2022 and found the following:

- 06/08/2023 at 1:00AM, Resident E asked to speak with staff saying, he was “sexually frustrated,” and that “I have been in the system for so long that it has been about four years since I have had a man.” Resident E then said, “I will be up all night if you’d like to come to my room and watch TV. I will get up for you.”
- 06/01/2025 at 10:00PM, Resident E was acting out of character. He was really wound up and was overheard by staff making sexual advances towards another resident leading to a verbal altercation between himself and other residents. While staff were trying to deescalate the situation, Resident E called the police saying that the other residents tried to jump him. Resident E was under the influence.
- 06/07/2025 at 5:30PM, A 911 call was made, and police arrived at the home. It was later brought to light that Resident E has been making sexual comments towards another resident. The police talked with Resident E and advised him to keep his comments to himself and to leave the other resident alone.
- 02/28/2026 at 5:20PM, Staff went to do a resident check and discovered an unknown visitor in Resident E’s room. When staff approached the door, Resident E opened it and did not have a shirt on. Due to the suspicious nature of the visit, staff redirected the unknown male to sign in and move into the common area during the visit. The unknown visitor left out the side door without showing his ID or signing in. Staff believe that Resident E may have snuck the visitor in either through the far side door or his window as he was not seen coming in the home by residents or staff.

I reviewed Resident E’s Easterseals behavioral assessment completed on 01/10/2025. The behavioral assessment identified Resident E’s inappropriate sexual behaviors in 2021, but there is no documentation of any inappropriate sexual behaviors that I have identified above regarding the IRs. The reactive strategy according to the behavioral assessment is for staff to verbally redirect once. If it continues, then staff should not respond, just walk away and do not engage. If he engages in inappropriate interactions with peers, staff should offer to play a game, watch a movie, or take a walk. Staff should document any inappropriate interactions on the provided data sheet. I reviewed Resident A’s Easterseals IPOS dated 03/20/2026 that mentions Resident A is “at risk of sexual thoughts and urges towards females.” No other information was provided regarding his sexual behavior.

On 06/24/2026, I emailed Resident A’s mother requesting a call back to discuss the allegations. She did not have a contact number on Resident A’s face sheet, just her email address.

On 06/24/2026, I emailed Don Adams requesting to know the dates Resident E moved in and out of Dilley as I was getting several different dates from different staff. Don stated Resident E moved in on 05/12/2026 and moved back to Lake Orion on 05/26/2026.

On 06/24/2026, I followed up with APS worker Heather Stickel. Ms. Stickel, along with Detective Bohn with OCSD, conducted a forensic interview with Resident A at Dilley

with a Care House representative. Resident A disclosed that he and Resident E had both consensual and non-consensual oral and anal sex with staff present at Dilley. Based on this information, Ms. Stickel will be substantiating staff, as both Resident A and Resident E were not supervised properly during this consensual/non-consensual incident.

On 06/25/2026, I received a return call from Resident A's mother regarding the allegations. Resident A's mother spoke with Resident A and staff about the incident between Resident A and Resident E. Resident A's mother stated, "(Resident A) has gone both ways, men and women," regarding sexual encounters. She stated that Resident A is also a compulsive liar; however, she believes something sexual happened between Resident A and Resident E. She is unsure if the encounter was consensual or not but believes something occurred between the two at the group home in Resident A's bedroom while staff were at the home. Resident A's mother heard that Resident E "is known to have sexually assaulted other residents too." She was told by a female staff that "staff were outside conducting business on the phone." Resident A told his mother that staff on duty was a male. Resident A's mother expressed dissatisfaction regarding the level of supervision being provided to Resident A at this group home. She stated, "I thought specialized care meant better, more attention to my son, but I feel that staff don't care."

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:	Based on my investigation and information gathered, Resident A was not protected and safe during an alleged sexual incident that occurred sometime between 05/11/2026-05/26/2026 when Resident E was living at Beacon Home at Dilley. Resident E resided at Beacon Home at Lake Orion, but due to a water main break, he moved into Dilley. Resident E has a history of sexual deviant behaviors that involve inappropriateness towards other residents. Resident A disclosed to APS, licensing, and to law enforcement that he and Resident E had both consensual and non-consensual oral and anal intercourse at Dilley while staff were in the home. Staff denied these allegations; however, Resident A's story was consistent regarding something occurring between him and Resident E when Resident E stayed at Dilley. Therefore, Resident E was not supervised properly, leaving Resident A unprotected. Resident E was discharged from Beacon Specialized Living Services.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/01/2026, during the unannounced on-site investigation, I requested to see Resident A's bedroom since Resident A reported that he "threw (Resident E)," a 6'4" male into the wall, and if there was damage. I observed Resident A's walls and there was no damage. However, Resident A did not have sheets on his bed nor a pillowcase. The home manager Jordan stated that Resident A "does not want sheets or a pillowcase," but that this was not in his assessment plan. I then observed Resident C's bedroom which was across from Resident A's bedroom. Resident C was sleeping in bed with the door wide open. There was cigarette tobacco on the floor along with debris. I then observed Resident D's bedroom that he had shared with Resident E. There were no sheets or pillowcases on either bed. There were two urinal containers laying on the floor, full of urine, and a puddle of urine on the floor between the two beds. Jordan advised that Resident D does not want sheets on his bed or a pillowcase on his pillow, but it was not in his assessment plan either. She stated that the urinal containers had lids to prevent the urine from spilling on the floor even though there was a puddle of urine on the floor.

On 06/15/2026, I discussed these allegations with Don Adams. Resident D had the same concerns regarding urinating on the floors at Lake Orion. Don stated that the urinal containers with lids were purchased to prevent the urine from spilling onto the floor. I advised Don that during my on-site visit on 06/11/2026, the lids on the urinal were not working because both urinals were full of urine, laying on the floor with a puddle of urine between the two beds. Don stated that staff are told to go into Resident D's bedroom every 30 minutes to check on the containers and empty them, and that Don himself has gone to Dilley and this was done by staff. I advised Don that I was at the group home and this is not being done by staff, because both urinal containers were full sitting on the bedroom floor. He continued to state that the lids were added to the containers to prevent the spills even though I advised him there was a puddle of urine on the floor.

On 06/30/2026, I attempted to leave message for licensee designee, Nichole VanNiman, to conduct the exit conference but the phone cut off. I emailed Ms. VanNiman my findings. Ms. VanNiman emailed back acknowledging my findings and stated that she will submit a corrective action plan in a timely manner.

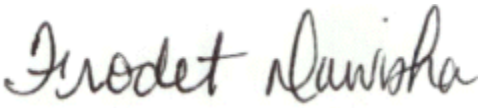
APPLICABLE RULE	
R 400.645	**Environmental health.**
	(10) When a resident is discharged, the resident's room and its contents must be thoroughly cleaned, and blankets and linens sanitized.
ANALYSIS:	During the on-site investigation on 06/01/2026, the bedroom that Resident E was staying in from 05/11/2026-05/26/2026 was not thoroughly cleaned. There were urine containers near the bed, and the bed did not have any sheets, blankets, nor pillowcases.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	During the on-site inspection on 06/01/2026, Resident C and Resident D’s bedrooms were not kept in a clean and orderly appearance. I observed cigarette tobacco and debris on the floor in Resident C’s bedroom and a puddle of urine on Resident D’s floor, along with two full containers of urine sitting between the beds.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.669	**Linens.**
	(1) A licensee shall provide all of the following: **(a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.**
ANALYSIS:	During the on-site inspection on 06/01/2026, I observed no fitted sheet, top sheet, or pillowcases on Resident A, Resident D, and Resident E’s beds.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

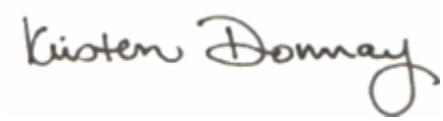
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



06/30/2026

Frodet Dawisha — Date
Licensing Consultant

Approved By:



WOC Area Manager for — 07/01/2026

Denise Y. Nunn — Date
Area Manager