GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 10, 2026

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

RE: License #: AS630387840
Investigation #: 2026A0465031
Beacon Home at Lake Orion

Dear Nichole VanNiman:

Attached is the Special Investigation Report for the above-referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. Previous recommendations for revocation were made in SIR #: 2026A0465013 and 2026A0465027, which remain in effect. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Stephanie Gonzalez

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202

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

License #:	AS630387840
Investigation #:	2026A0465031
Complaint Receipt Date:	05/28/2026
Investigation Initiation Date:	05/29/2026
Report Due Date:	07/27/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	Suite 110 890 N. 10th St. Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Licensee Designee/Administrator:	Nichole VanNiman
Name of Facility:	Beacon Home at Lake Orion
Facility Address:	175 E. Silverbell Rd. Lake Orion, MI 48360
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/10/2017
License Status:	REGULAR
Effective Date:	08/08/2024
Expiration Date:	08/07/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED/TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident C is being sexually assaulted by Resident E. It is unknown if Resident E is sexually abusing other residents in the home.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/28/2026	Special Investigation Intake 2026A0465031
05/28/2026	APS Referral Adult Protective Services (APS) Referral assigned to Heather Stickel for investigation
05/29/2026	Contact – Telephone call received I received a call from licensee designee/administrator, Nichole VanNiman
05/29/2026	Special Investigation Initiated - Letter Email exchange with Ms. Stickel
06/01/2026	Comment Intake #210835 added to this investigation as additional information received
06/01/2026	Contact - Document Received Email exchange with Ms. Stickel
06/01/2026	Contact - Document Received Discharge Notice received from licensee designee and administrator, Nichole VanNiman
06/04/2026	Inspection Completed On-site I conducted an unannounced onsite investigation at the facility. I completed a walk-through of the home, observed residents, reviewed facility files and interviewed Resident A, Resident B, Resident C, Resident E, Resident F and direct care staff, Don Adams and Dorothy Burton
06/04/2026	Contact - Telephone call made I spoke to Easter Seals Behavioral Specialist, Mark Lakier, via telephone

06/05/2026	Contact - Document Received Facility documents received via email
06/05/2026	Contact - Document Received Email exchange with Ms. Stickel
06/13/2026	Contact - Document Received Email exchange with Ms. Stickel
06/25/2026	Contact - Document Received Email exchange with Ms. Stickel
07/02/2026	Contact - Face to Face Facetime with Ms. Stickel at the facility; Interviewed Resident A, Resident B, Resident F and direct care staff, Don Adams
07/02/2026	Contact - Telephone call received Telephone call with Ms. Stickel
07/02/2026	Contact - Telephone call made I spoke to direct care staff, Dorothy Burton, via telephone
07/03/2026	Contact - Document Received Facility documents received via email
07/06/2026	Contact - Document Received Email exchange with Easter Seals Behavioral Specialist, Mark Lakier; Documents received
07/06/2026	Contact - Telephone call made I spoke to direct care staff, Carla Meeks, via telephone
07/06/2026	Contact - Telephone call made I spoke to direct care staff Kyle Wilson, via telephone
07/07/2026	Contact - Document Received Facility documents received via email
07/07/2026	Contact - Telephone call made I spoke to Precious Porter via telephone
07/08/2026	Contact - Document Received Facility documents received via email
07/10/2026	Referral – Recipient Rights Referral submitted via email

07/10/2026	Exit Conference I conducted an Exit Conference with licensee designee and administrator, Nichole VanNiman, via telephone

ALLEGATION:

Resident C is being sexually assaulted by Resident E. It is unknown if Resident E is sexually abusing other residents in the home.

INVESTIGATION:

On 5/28/2026, a complaint was received, alleging that Resident C is being sexually assaulted by Resident E. The complaint stated that it is unknown if Resident E is sexually abusing other residents in the home. The complaint stated that Resident E gets high on unknown substances and sexually abuses Resident C. The complaint stated that Resident E bullies Resident C into performing oral sex on him and engaging in anal sex. The complaint stated that Resident C did not disclose this information due to being afraid of Resident E. It is unknown when the abuse began and how long it has been occurring for. On 6/1/2026, a secondary complaint was received, which stated that Resident B has also been sexually assaulted by Resident E. The complaint stated that Resident E forced Resident B to perform oral sex on him. The complaint stated that Resident B disclosed this information to the prior home manager, Amanda Rondo, but she did not do anything.

On 5/29/2026, 6/1/2026, 6/5/2026, 6/13/2026 and 6/25/2026, I spoke to Adult Protective Services Specialist, Heather Stickel, via email exchange. Ms. Stickel stated that her investigation is still ongoing at this time.

On 5/29/2026, I received a telephone call from licensee designee and administrator, Nichole VanNiman. Ms. VanNiman notified me that there is an active police investigation related to a complaint that Resident E sexually assaulted other residents in the facility. Ms. VanNiman stated that the Oakland County Sheriff's Office is investigating this complaint.

On 6/4/2026, I conducted an unannounced onsite investigation at the facility. At the time of my onsite investigation, there were five residents residing at the facility. I completed a walk-through of the home, observed residents, reviewed facility files and interviewed Resident A, Resident B, Resident C, Resident E, Resident F and direct care staff, Don Adams, and Dorothy Burton. During my onsite investigation, Resident E was in his bedroom, with the door closed, unsupervised and without 1:1 enhanced staffing. I did not observe staff inside Resident E's bedroom nor outside of his bedroom door during the time that I was at the facility.

I reviewed Resident E's record. The *Face Sheet* stated that Resident E moved into the facility on 4/3/2023 and has a legal guardian, Guardian E1. The *Health Care Appraisal* listed Resident E's medical diagnosis as Anxiety and Type 2 Diabetes. The *Assessment Plan for AFC Residents,* dated 3/30/2026, stated that Resident E moves independently in the community, controls sexual behavior, has a history of alcohol/drug use, independently completes self-care tasks, and does not require use of assistive devices. The *Easterseals Michigan – Behavioral Assessment*, dated, 1/25/2025, 3/18/2026 and 6/1/2026, which stated, in part, the following:

> Resident E is diagnosed with Bipolar I Disorder and Antisocial Personality Disorder, has a history of substance use and has a history of being sexually inappropriate toward staff and peers, which seems to present when he is under the influence. If staff have suspicion that Resident E is in possession of, or has used substances, staff will complete a room search. Resident E will be notified prior to the room search and may be present during any search. When performing a room search, two staff will need to be present during the entirety of the search. In the event that Resident E engages in substance use, entering establishments that sell sleeping aids during independent community access or elopement (not returning within 15 - minutes of his return time, or not communicating with his staff that he is running late) while in the community, his titration will go back to the previous phase. In an event where Resident E engages in a significant behavior of aggression or elopement Beacon and Easterseals MORC treatment teams will evaluate the safety concerns with the ability to reset to a previous stage including the Initial stage (no independent community access. Update on 6/1/2026: Since the last review, specifically in the last few days, there have been reports of significant increase in substance use and inappropriate sexual behavior. A recent report indicated that three separate home peers reported that Resident E was having nonconsensual relations with them. One individual reported that Resident E tied him up and engaged in sexual relations with him. In addition, following the report Beacon staff indicated that on several occasions there were concerns of him using/being under the influence of substances over the past 6 weeks. Due to these concerns Resident E will be moving to a new home with Mentors of Michigan. Enhanced 1:1 staffing is required at this time to maintain his safety and the safety of others in the home. Resident E will reset to the baseline phase of independent community access. Resident E will be provided with 1:1 staffing for 24 hours daily. 1:1 staffing is to be in eyesight of him at all times and within 20 feet of Resident E (including when he is in his room). Resident E is allowed to use the bathroom with the door closed. Staff should remain outside the door with ability to listen for concerning behaviors. While he is sleeping, either the door must be open, or staff must be in the room. Once Resident E awakes, he should be in eyesight of staff.

I reviewed the *Incident/Accident Reports* for the last six months, which documented the following:

2/4/2026 at 7:10am; Completed by Precious Porter: Resident E was spotted sneaking out the far side door. Staff witnessed Resident E walking to the gas station. The owners of this particular establishment did forewarn the CTM and staff that if he returned to the store police would be called. Staff did prompt him twice to return to the home. Action taken by staff: IR written, CTM {Care Team Manager} was notified. Corrective measure: Resident E will continue to be encouraged to not go to that gas station as the store has expressed in the past that they do not want him up there due to him harassing
other customers for money. Also to follow his BTP (behavior treatment plan) as this store has a wide range of over-the-counter substances readily accessible.

2/23/2026 at 12:00pm; Completed by Zoe Leach: Another resident informed staff that Resident E was pressuring him to give Resident E his medication. The other resident alleged that Resident E offered him cigarettes in exchange for his Ativan this morning. Action taken by staff: Staff have been observant during medication pass times; Staff also reminded all residents that the expectation is for them to take their medication as prescribed. Corrective measures: All residents have been reminded of the importance of taking medication as prescribed. The residents are encouraged to take all medication in front of the DMA {Designated Medication Aide} at the medication window during assigned times.

2/28/2026 at 5:20pm; Completed by Dorothy Burton: 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 id or signing in. Staff believe 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. Action taken by staff: Hm notified and event report done. Corrective measures: Resident E will be encouraged to let staff know when he is having a visitor and have them sign in according to policy.

3/17/2026 at 9:10pm; Completed by Precious Porter: Resident E was observed by his housemates leaving the home. He left out the front door and told staff he just was stepping on the porch for some fresh air. He was observed walking up towards the store and later observed standing outside the store asking random people for money. While staff was encouraging him to return, the police were called by someone in the community. They were able to convince him to return to the home. Action taken by staff: CTM was contacted and Guardians were informed. Documentation was completed. Corrective measures: Resident E will be encouraged to follow his plan as written and not leave off the property without staff or his guardians. Resident E will be encouraged not to return to the gas station as they've expressed him being banned due to past behaviors

3/19/2026 at 4:00pm; Completed by Aaron Connor: Staff followed Resident E up to the gas station. Staff was able to encourage Resident E to return to the home. Later

staff noticed Resident E to be acting off. He was talking fast and more social than normal. Staff also observed Resident E to have dilated pupils. Staff reached out to non-emergency EMS to evaluate Resident E's condition as staff had suspected he may have taken something. Resident E told the EMS he was fine and that he had not taken anything and didn't want to go to the hospital. EMS took some vitals and left after evaluating him. Action taken by staff: Staff followed Resident E when he left the property and was able to encourage him to return home. Staff reached out to have his condition evaluated. His guardian was contacted and home manager was informed. Corrective Measures: Resident E will be encouraged to follow his BTP and not use over the counter substances and not just take off and leave the property.

4/5/2026 at 6:00pm; Completed by Aaron Connor: Resident A, Resident B, and Resident D all came to meet with staff around 6pm. Resident D had a complaint that Resident E has been pressuring him to give him his medications when it is time for medication passes. He has been participating in drug seeking behavior with his fellow residents, and Resident A and Resident B have been witnesses to these actions by Resident E. Action taken by staff: Advised Resident D to continue to say no to giving over his medications and event report as well. Misc. notes have been filed. Staff separated the residents to provide time to de-escalate and decompress. Corrective Measures: Advised residents to come staff to notify of what was going on so that staff can notify home manager

I reviewed the *Intent to Discharge Notice*, dated 5/29/2026, which stated, in part, the following:

> Recent allegations involving inappropriate sexual contact between individuals in Beacon's care, who do have guardians and therefore cannot legally make decisions on their own behalf, have created serious safety concerns within the home environment. These allegations (against Resident E) have resulted in regulatory agency involvement, including the police, APS, Recipient Rights and LARA. Given the seriousness of the reports received, Beacon staff, including clinical support and leadership, have taken immediate action to protect all the parties involved. Beacon continues to partner with the regulatory agencies, guardians, and its staff on protecting those in our care. Due to the seriousness of the allegations and the vulnerability of the individuals involved, the situation presents concerns regarding the health, safety, and welfare of individuals residing within the home. While this matter is being reviewed, Beacon has implemented additional measures through increased safety checks to protect individuals in our care. We have been in contact with the case management group that oversees the BTP and they have confirmed not only their awareness, but the need to ensure safety for all in the home. A temporary leave of absence for Resident E has been arranged with the co-guardian through Tuesday, June 2nd, to allow for the completion of the police investigation. Moreover, Beacon is exploring the option of a twenty-four-hour discharge as a potential solution to further protect those in the home. Current clinical recommendations remain focused on maintaining resident safety, preventing further incidents, providing

trauma-informed support to affected individuals, and ensuring a stable living environment while investigations and reviews are ongoing.

I spoke to Resident A, who stated, “(Resident E) talks sexual to me. He told me he wanted to suck me off. I just ignored him. He hasn’t hurt me. I didn’t see him hurt anyone. (Resident C) told me that (Resident E) raped him. I didn’t tell anyone anything. When he uses drugs, it’s bad. I have told staff that he is using drugs.”

I spoke to Resident B, who stated, “I don’t really want to talk about this. (Resident C) told me that (Resident E) did something to him, but that’s all I know. (Resident E) uses drugs. He takes Tylenol PM. Every staff here knows he does it. He isn’t allowed to go out by himself anymore. He is a really good guy when he is not high. He only says bad stuff when he is high. He says bad things to us. He needs help. We tell staff and ask them to get him help.”

I spoke to Resident C, who stated, “All I can say is that (Resident E) raped me. It really upsets me to talk about it. It happened in (Resident E’s) room. He told me to go to his room so he could give me a cigarette. When I got to his room, he shut the door and locked it. He took my clothes off me and then he raped me. It happened weeks ago. After it happened, I was scared to tell. I thought (Resident E) would hate me forever. I don’t think he has hurt anyone else. At night shift, we have to keep staff Kyle {Wilson} safe because (Resident E) told us he wants to rape him. There is just a lot going on here. Too much going on. I told Kyle Wilson that (Resident E) wants to rape him. (Resident E) takes pills to get high. He steals pills from the stores and gas stations. Sometimes he asks us {residents} to steal Tylenol PM from the store for him. When he is high, he will ask me if he can suck my dick. He keeps pills in a baggie in his room, and he will buy weed gummies and pills from the store. It’s the drugs that make him mean. Staff know he is going to the store and getting pills.”

I spoke to Resident E, who stated, “I do not want to talk. I have nothing to say. My granny told me not to talk to anyone without my guardian or lawyer. I have to protect myself.”

I spoke to Resident F, who stated, “I don’t have any concerns. Nothing has happened to me. No one has hurt me. I don’t know anything.”

I spoke to direct care staff/home manager, Don Adams, who stated, “I am aware of the allegations regarding (Resident E) and the other residents. I was not aware of any concerns prior to now. After we found out, we issued a discharge notice to (Resident E). (Resident E) was supposed to be discharged this past weekend. Originally, (Guardian E1) agreed to pick him up from the facility last Friday and take him home. However, (Guardian E1) never came to pick him up. He changed his mind and told us he was not going to pick him up. So, this past Saturday, we implemented 1:1 staffing 24/7 for (Resident E). But, if he is in his room sleeping, or in the bathroom, there is no 1:1 to respect his privacy. There is an open police investigation, but none of the residents have been interviewed yet. Interviews are

scheduled for 6/10/2026 and 6/11/2026. (Resident E) had community access up until this past Saturday."

On 6/4/2026, I spoke to Easter Seals Behavioral Specialist, Mark Lakier, via telephone. Mr. Lakier stated, "I am (Resident E's) behavioral specialist. I am aware of the allegations against (Resident E). (Resident E) has a history of inappropriate sexual behavior, which is triggered by drug use. (Resident E) does have community access, but it also is clearly outlined in his behavioral plan that his community access is based on no incidents of drug use. In the plan, it specifies that if staff suspect he is under the influence of substances, they are required to complete a room sweep. I have not received any calls from the facility about concerns of drug use or inappropriate sexual behavior. If I had been aware of these issues, his community access would have been restricted." I informed Mr. Lakier that I was at the facility earlier today and did not observe 1:1 staffing being provided to Resident E while he was awake and in his bedroom with the door shut. Mr. Lakier stated, "(Resident E) has been receiving 1:1 enhanced staffing since 6/1/2026, and staff are supposed to be within line of sight at all times, including when he is in bedroom. His bedroom door is supposed to remain open. Staff are supposed to remain directly outside of his bedroom door when he is actively sleeping as well. I am concerned that the 1:1 enhanced staffing is not being provided."

On 6/5/2026, Ms. Stickel forwarded an email she received from Mr. Lakier, which he sent to Ms. VanNiman and Mr. Adams, in addition to other Beacon corporate staff. In the email, Mr. Lakier vocalized the following concerns related to his unannounced onsite visit to the facility on 6/4/2026:

> I am writing to formally report several serious concerns regarding staff supervision and compliance with (Resident E)'s Behavior Treatment Plan (BTP) during my visit to the Lake Orion home today. During this visit, I observed multiple lapses in supervision, safety protocol implementation, and staff understanding of (Resident E)'s support requirements. These observations raise significant concerns regarding the effectiveness of current staff training and the consistent implementation of the BTP.
>
> While at the home, I observed staff taking several residents, including (Resident E), to a smoke shop. One staff member remained at the home while a single staff member transported (Resident E) and multiple other residents to the store. (Resident E) is currently required to have 1:1 staffing, requiring staff to remain within 20 feet and maintain line-of-sight supervision at all times. The only exceptions are when (Resident E) is using the bathroom or actively sleeping, during which time staff are required to remain immediately outside the door and be able to hear when he awakens or if other concerning behaviors occur. Given these supervision requirements, I am concerned that staffing expectations during community outings may not have been fully understood or implemented. While in the home, I observed a staff member seated at the end of the hallway wearing headphones. From her location, she was unable to maintain the required line-of-

sight supervision of (Resident E). I attempted to engage the staff member in conversation; however, she continued wearing her headphones throughout the interaction. I am unsure whether she was listening to anything during our discussion. During the conversation, I asked how she had been trained on (Resident E)'s BTP and supervision requirements. She was unable to describe the expectations of the plan or explain the supervision protocols necessary to ensure (Resident E)'s safety. I reviewed the supervision requirements outlined in the BTP and provided coaching regarding the expectation for continuous line-of-sight supervision. Despite this discussion, as I was leaving the home, the staff member remained outside of line-of-sight supervision and did not demonstrate implementation of the guidance that had been provided.

Additionally, I was informed that Cassidy had provided training and coaching to staff earlier in the day regarding (Resident E)'s Behavior Treatment Plan, supervision requirements, and expectations for maintaining line-of-sight supervision. Despite receiving this training and direction, staff continued to demonstrate a lack of understanding of the plan and did not consistently implement the supervision requirements. The concerns observed during my visit occurred after staff had already received coaching and instruction, raising significant concerns regarding the effectiveness of training efforts and staff compliance with established supervision and support requirements. These observations raise serious concerns regarding staff competency, training effectiveness, and adherence to (Resident E)'s approved Behavior Treatment Plan. Given the potential risks associated with inadequate supervision, I am requesting clarification on how Easterseals MORC can better support the Beacon staff and provide safety for (Resident E) and the other housemates.

On 7/2/2026, I spoke to direct care staff, Dorothy Burton, via telephone. Ms. Burton stated she has worked at the facility since August 2025. Ms. Burton stated, “I was not aware of any concerns regarding sexual behavior by (Resident E). No residents ever came and told me anything was going on. I didn’t see anything that was concerning. (Resident E) has a drug problem, and he was trying to go to the store to steal medicine. There were times when I suspected (Resident E) was high, but I could not confirm it. I never did check his room or do a room sweep. When we suspected him of using drugs, we weren’t able to search his room. I never saw any other staff do a room sweep either. We were always told to call management and 911 if needed, so that’s what I did. I don’t know about (Resident E)’s community access, but I think he can sign out for 15 minutes. He now has a 1:1 but only when he is not in his room or the bathroom.”

On 7/2/2026, I received an email and phone call from Ms. Stickel. Ms. Stickel stated, “I received a call from (Resident E) today. He stated that he did have sex with (Resident A), (Resident B), and (Resident C). He stated the sex was consensual. (Resident E) also stated he has sex with direct care staff, Kyle Wilson. (Resident E) sent me two pictures of a male’s buttocks, which he stated are of Mr. Wilson.” Ms. Stickel forwarded these pictures to me. I reviewed the two photos, which were of a

white male's buttocks, wearing underwear in what appeared to be an outdoor setting. I was unable to see a face or any additional identifying information in the photos.

On 7/2/2026, Ms. Stickel conducted a follow-up onsite investigation at the facility, and I was present via Facetime video. We interviewed Resident A, Resident B and Resident F. At the time of our onsite investigation, Resident C was inpatient at the hospital and Resident D was no longer residing at the facility.

Resident A stated, "No" to every question. He stated, "Kyle Wilson is cool and nice." Resident A's interview was short. He stated he wanted to go back to sleep.

Resident B stated, "No one is doing that shit. Kyle Wilson would never do that. No, that's a lie. He is a nice staff." Kyle stated that the only thing he knows regarding Kyle Wilson is that Resident E threatened Kyle Wilson and said he wanted to have sex with him.

Resident F stated, "Wilson is a good guy. On a good day, everyone likes Kyle Wilson. He can be nice and sometimes he can be serious. I've never seen him do anything bad."

On 7/6/2026, I spoke to direct care staff, Carla Meeks, via telephone. Ms. Meeks stated that she has worked at the facility for three months. Ms. Meeks stated, "I know about the complaint. When it came out, I was shocked. I never observed (Resident E) being inappropriate with me or anyone else. The other residents did come to me several different times and tell me that (Resident E) was high, but I couldn't tell if he was high. I did look around his room and I didn't see anything. I didn't know what else I could do. I searched his room by myself. I have never seen him be inappropriate towards residents."

On 7/6/2026, I spoke to direct care staff Kyle Wilson, via telephone. Mr. Wilson stated, "(Resident E) definitely would make sexual comments to residents. We made sure they were safe and we called 911 as needed. I never suspected or thought he did anything sexual to anyone. No one vocalized any concerns to me and I didn't see anything. (Resident E) was drug-seeking and always wanted to go to the corner store to meet people. He had no community access and needed a 1:1 in the community, but he would sneak out. We called the police each time and we notified the manager and completed an incident report. If we suspected drug use, we weren't allowed to search his room without his guardian or the police present. There were times when I suspected he was using drugs and I couldn't check his room. I wanted to check, but he has his rights. I have never had sex or done anything inappropriate with any resident. This is definitely not true. (Resident E) has said comments to me, and other residents have told me he has a crush on me, but that's it." Mr. Wilson stated that he did not complete room sweeps of Resident E's bedroom.

On 7/7/2026, I spoke to Precious Porter via telephone. Ms. Porter stated, “Honestly, this complaint was frightening to hear. All the residents get along so well. I was really confused when I heard about this. I never saw any signs of concern. I have had residents tell me they thought he was under the influence. They would tell me he was high. That has definitely been vocalized to me. I thought he was under the influence too. We are supposed to call the manager and document it on an IR. We would try to approach the situation, but he would go into his room. We did not search his room, but I would ask him if he was using or had anything in his room. Because of his rights, we can’t search his room. He has a 1:1 staff. We have a chair outside his room to sit in.” Ms. Porter denied knowledge of any staff engaging in inappropriate sexual behavior with a resident.

On 7/9/2026, I conducted an Exit Conference with licensee designee and administrator, Nichole VanNiman, via telephone. Ms. VanNiman is not in agreement with the findings of this investigation.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(3) Staff responsible for implementing a resident's assessment plan must be trained in the applicable behavior intervention techniques and onsite at the facility during each shift.
ANALYSIS:	According to Resident E’s *Easterseals Michigan – Behavioral Assessment*, if there is suspicion of substance use, a room search will be completed by two direct care staff. It also stated that, in the event that Resident E engages in substance use, his independent community access would be restricted and/or eliminated. Effective 6/1/2026, direct care staff were to provide 1:1 enhanced staffing 24 hours daily, including remaining within eyesight of him at all times, within 20 feet at all times, and within his bedroom or directly outside, with the door open unless staff are directly inside his room. According to the *Incident/Accident Reports*, between February 2026 and June 2026, Resident E has eloped from the facility twice and was observed under the influence of drugs two additional times in the last four months. The IR’s did not indicate that room searches were conducted. According to Resident A, Resident B and Resident C, they have informed direct care staff that Resident E when Resident E is under the influence of drugs on several occasions.

	According to Ms. Burton, Mr. Wilson and Ms. Porter, when they observed and/or suspected Resident E was under the influence of drugs, they did not complete room checks of his bedroom with two staff, as specified in Resident E's *Easterseals Michigan – Behavioral Assessment.* According to Mr. Adams and Ms. Burton, 1:1 enhanced staffing does not need to be provided when Resident E is in his bedroom or in the bathroom. On 6/1/2026, Resident E was assigned 1:1 enhanced staffing, to be provided 24 hours daily. On 6/4/2026, at different times in the day, both the Easterseals behavioral specialist, Mr. Lakier, and myself conducted unannounced investigations at the facility, and observed Resident E unsupervised by staff, with 1:1 staffing not being provided as outlined in his behavioral plan. Mr. Lakier expressed concern that staff were not appropriately trained regarding Resident E's behavior treatment plan, as the staff on shift was unable to describe the expectations of the plan or explain the supervision protocols necessary to ensure Resident E's safety Based on the information above, direct care staff are not properly trained in and adhering to the behavior interventions specified in Resident E's behavioral plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	According to Resident E's *Easterseals Michigan – Behavioral Assessment Plan,* Resident E has a history of inappropriate sexual behavior that presents when he is under the influence of drugs. It also stated that, in the event that Resident E engages in substance use, his independent community access would be restricted and/or eliminated. According to the *Incident/Accident Reports*, between February 2026 and June 2026, Resident E eloped from the facility twice and was observed under the influence of drugs two additional times in the last four months. No additional safety measures were implemented, and community access was not restricted until 6/1/2026.

	According to Resident A, Resident B and Resident C, they have informed direct care staff that Resident E is under the influence of drugs on several occasions. According to Resident A and Resident B, Resident E has made sexual advances to them. According to Resident C, he was raped by Resident E during the month of May 2026. Based on the information above, direct care staff' did not properly follow Resident E's behavioral plan, failing to provide adequate safety and protection, therefore placing all residents at risk of harm.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed Resident C's *Incident/Accident Reports* for the months of March 2026 – June 2026, which documented the following:

3/30/2026 at 9:31pm; Completed by Janelle Coaster: Other residents were complaining of Resident C's hygiene while they were all sitting in the living room watching TV. After that I started prompting the residence to take their medications. Resident C came to the med room door, and I also smelled the odor. I asked Resident C if he would get in the shower after he took his meds and he got extremely angry and walked away while yelling profanities at staff. I prompted him 3 more times to take his medications and he said "no" to all prompts. So, at this time, I put it in as a medication refusal.

4/28/2026 at 9:10pm; Completed by Dorothy Burton: Staff prompted Resident C to assist with cleaning he refused and while he laid on the couch in common area. Staff did observe empty packages of lunch meat, especially around Resident C's bed. Staff did thoroughly clean around his bed area and the bed itself. Staff also disinfected the entire area and removed dirty dishes, soiled laundry, and trash that accumulated overnight. Staff also tried to prompt Resident C to shower when he was fully awake and he refused. Action taken by staff: Event report submitted /manager will be notified before end of shift of this concern.

5/4/2026 at 8:00am; Completed by Dorothy Burton: This morning staff had asked Resident C to please bring me his dirty bedding due to him having an accident in the bed. Resident C brought out a couple clothes items to be washed. Staff then noticed nothing from the bed was in the laundry. Resident C stated the blanket was clean and he put a brand-new pillowcase on his brand-new pillow. Once staff realized

nothing was there, she went to check to find that he defected and urinated on himself and the bedding was balled up and threw in a corner and hid it under his clean clothes. Staff encouraged and reminded Resident C to make sure he tells us so we can wash it right away he said yeah but I be forgetting. Action taken by staff: Gathered the dirty items up and went and started washing them. Resident C also has not been showering, and his body odor is increasing. Staff will continue to encourage and prompt. I also have contacted my program director.

5/8/2026 at 8:00pm; Completed by Janelle Coaster: I was doing the med pass, and Resident C refused his medications. I waited about 15 minutes before he was asked again, and he still refused. After asking him over 3 times within an hour he refused all attempts to pass his medications. He was also yelling and calling me bad names. He also refused to take a shower as well. There is a really bad smell coming from his room, and he said he does not want staff in his room. Action taken by staff: I informed my superiors and I am also writing an IR report about this issue.

6/6/2026 at 6:00pm; Completed by Precious Porter: Resident C got up off the couch and staff observed feces on the couch. Staff cleaned the couch and talked to Resident C about the situation. He let staff know that he is aware that he has feces in his shorts and he refused to shower or change his clothes. Action taken by staff: Staff prompted Resident C to change his clothes and shower. He refused

6/6/2026 at 10:00pm; Completed by Janelle Coaster: Another resident informed me that Resident C defecated and urinated on himself and it was all over the couches and in the bathroom on a shower chair. I asked Resident C about it and when I was standing near him, I smelled the urine and the defecation. I asked him to clean up after himself and to take a shower. He then started to get angry and said that he had already taken a shower that morning. I informed him that if he uses the bathroom on himself {and} he {needed} another shower. He then started to get even angrier and told me that he was not doing it and that he was not cleaning up after himself. Action taken by staff: I cleaned the couches and the shower chair inside the bathroom, and I made an incident report. I will also inform my superiors.

6/9/2026 at 3:30pm; Completed by Precious Porter: Staff prompted Resident C to take a shower after finding feces and urine on the couch where he was sitting. Resident C said he took a shower during the morning and neither staff witnessed this. Resident C did not shower and did do any of his other ADLs (activities of daily living). Action taken by staff: prompting and promoting good hygiene.

On 7/6/2026, I spoke to Ms. Meeks, via telephone. Ms. Meeks stated, “(Resident C) had issues with incontinence. He would urinate and defecate on himself. I would ask him to shower and change his clothes, but he would refuse. We had to prompt him all day to clean himself. He would refuse to shower. He never really showered with soap and water. He would tell us that he was showering but he really wouldn’t take a shower. He always had a strong body odor even after he came out of the bathroom

from taking a shower. I don't think he ever took a real shower when he was at the facility.

On 7/6/2026, I spoke to Mr. Wilson, via telephone. Mr. Wilson stated, "(Resident C) was incontinent. He would refuse to use the bathroom. He would refuse to take showers. We would encourage and prompt him to shower but it was his right to refuse. There was one time that I witnessed him lose control of bowel and he defecated on the couch. We cleaned the couch and mopped around it. He would shower maybe once every two weeks. But it was a fake shower. He would only get his feet wet and did not wash his entire body with soap and water. He did smell and it was an issue because all of the other residents would complain about him. But it was his right to refuse to shower. Management did know. Amanda Rondo and Don Adams were aware of the issue, and they said they would look into it but nothing changed.

On 7/7/2026, I spoke to Precious Porter via telephone. Ms. Porter stated, "(Resident C) refused to shower and there would be fecal matter everywhere. He would go to the bathroom and not properly wipe, and the feces would stay on him, and it would end up on the couches. He didn't shower properly and he smelled. Even when he took a shower I don't think he was properly washing a lot of the time. I'm not sure he would use soap. Every morning we would find urine and fecal matter in his bedroom. The smells in his room were really bad. He didn't want us to clean his room so we would have to wait for him to come out to take his meds or eat breakfast before we could go in there and change his sheets and clean up the room we would clean but it had to be on his time. We waited until he left the room to clean. He was showering once a week maybe, but it was very hard to ever get him to do this. I documented every time he refused. The other residents complained about the fecal matter on the toilet in the bathroom. I tried to encourage him to the best of my ability, but he would refuse to complete hygiene."

On 2/11/2026, I conducted an unannounced special investigation at the facility related to special investigation #2026A0465013. I observed a large hole in the cabinet beneath the kitchen sink. I observed the residents' bedrooms to be unclean, with large amounts of dirt, debris, clutter, food crumbs, trash and urine stains on walls and furnishings. I smelled a strong odor of urine in the resident bedrooms. In Resident C's bedroom, I observed a table lamp with multiple stains that smelled of urine as well as several areas of his bedroom walls that had dried liquid stains that also smelled of urine. I observed feces stains on Resident C's closet floor and his bedroom dresser was missing a drawer. I observed Resident D's bedroom to have a strong odor of urine. I observed two plastic urinals inside the closet, with a large amount of fruit flies sitting on top of, and inside of, the urinals. Resident D's bedroom floors and walls were unclean, and there was a table lamp with large liquid stains with a strong odor of urine. On 3/25/2026, a recommendation of revocation of the license was made. On 5/11/2026, I conducted an unannounced special investigation at the facility related to special investigation #2026A0465027. In Resident D's bedroom, I observed two urinals filled with urine and a large amount of

urine surrounding the exterior of the urinals. I also observed liquid on Resident D's closet floor and in cups on his dresser, both of which had a strong odor of urine. The previous recommendation of revocation remains in effect.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	According to the *Incident/Accident Reports,* as well as interviews with Ms. Meeks, Mr. Wilson and Ms. Porter, there have been ongoing concerns regarding Resident C's lack of adequate hygiene and access to the common areas, including defecating on the toilet seat and living room couches. According to Mr. Wilson and Ms. Porter, the other residents in the home also vocalized concerns related to their exposure to fecal matter in the common areas. Based on the information above, the facility is not properly maintaining the home to provide adequately for the health, safety and well-being of the residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2026A0465013 dated 3/25/2026 and 2026A0465027 dated 7/9/2026**

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(2) A licensee shall ensure the resident receives or has access to all of the following: **(a) Bathing at least weekly.** **(b) Toileting as needed.** **(c) Assistance with resident hygiene as needed.**
ANALYSIS:	According to the *Incident/Accident Reports* as well as interviews with Ms. Meeks, Mr. Wilson and Ms. Porter, Resident C has had ongoing issues with incontinence and refusal to properly shower or complete necessary hygiene tasks. Ms. Meeks, Mr. Wilson and Ms. Porter acknowledged that there are significant concerns related to the unhealthy hygiene practices of Resident C and his refusal to complete and/or accept help with personal care/hygiene needs.

	Based on the information above, Resident C is not receiving bathing at least weekly, toileting as needed, or assistance with hygiene as needed..
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2026A0465013 dated 3/25/2026**

IV. RECOMMENDATION

A previous recommendation of revocation was made in Special Investigation Reports #: 2026A0465013 dated 3/25/2026 and 2026A0465027 dated 7/9/2026. The recommendation for revocation remains in effect.

Stephanie Gonzalez 7/10/2026

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Kristen Domay

WOC Area Manager for 07/10/2026

Denise Y. Nunn Date
Area Manager