GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 23, 2025

Carl Byerly
Byerly Enterprises II
4759 Owasco Ct
Clarkston, MI 48348

RE: License #: AS630417869
Investigation #: 2025A0991019
Eastlawn Manor

Dear Carl Byerly:

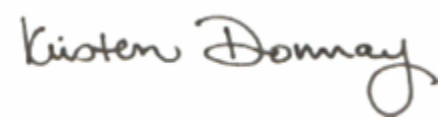
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630417869
Investigation #:	2025A0991019
Complaint Receipt Date:	06/09/2025
Investigation Initiation Date:	06/09/2025
Report Due Date:	08/08/2025
Licensee Name:	Byerly Enterprises II
Licensee Address:	4759 Owasco Ct Clarkston, MI 48348
Licensee Telephone #:	(810) 691-6400
Licensee Designee:	Carl Byerly
Name of Facility:	Eastlawn Manor
Facility Address:	6490 Eastlawn Ave Clarkston, MI 48346
Facility Telephone #:	(810) 691-6400
Original Issuance Date:	03/22/2024
License Status:	REGULAR
Effective Date:	09/22/2024
Expiration Date:	09/21/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 03/13/25, Resident A was observed to have a large handprint shaped bruise on his left arm, bruising on his right arm, and a large abrasion on the left side of his neck. He also had an abrasion on his back. It is believed the injuries were caused by staff using excessive force and improper techniques while physically restraining Resident A.	Yes

III. METHODOLOGY

06/09/2025	Special Investigation Intake 2025A0991019
06/09/2025	Special Investigation Initiated - Telephone Call to Adult Protective Services (APS) worker, Carmen Smith
06/09/2025	APS Referral Received from Adult Protective Services (APS)
06/09/2025	Referral - Recipient Rights Investigated by Newaygo County Office of Recipient Rights (ORR)
06/09/2025	Contact - Document Received Photographs of bruising on Resident A
06/12/2025	Contact - Telephone call made To Office of Recipient Rights (ORR) worker, Jill McKay
06/12/2025	Contact - Document Received Incident report, plan of service, ORR report
06/12/2025	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and observed Resident A
06/27/2025	Contact - Telephone call made To home manager, Jennifer Stancroff
06/27/2025	Contact - Telephone call made Left message for staff, Luke Alexander

07/01/2025	Contact - Document Received Verification of nonviolent crisis intervention training for staff
07/23/2025	Exit Conference Via telephone with licensee designee, Carl Byerly

ALLEGATION:

On 03/13/25, Resident A was observed to have a large handprint shaped bruise on his left arm, bruising on his right arm, and a large abrasion on the left side of his neck. He also had an abrasion on his back. It is believed the injuries were caused by staff using excessive force and improper techniques while physically restraining Resident A.

INVESTIGATION:

On 06/09/25, I received a complaint from Adult Protective Services (APS) alleging that on 03/13/25, Resident A was observed to have a large handprint shaped bruise on his left arm, bruising on his right arm, and a large abrasion on the left side of his neck. He also had an abrasion on his back. The complaint noted that Resident A has limited verbal communication and was not able to communicate how he received these injuries. Resident A's group home reported that an incident occurred on 03/12/25, where group home staff responded to aggressive behavior from Resident A. Staff blocked Resident A's hitting and then physically restrained him. They reported using a seated high-level restraint. The complaint stated that the bruising on Resident A was not consistent with appropriate or safe restraint, and it appears that excessive force was used.

I initiated my investigation on 06/09/25, by contacting the assigned APS worker, Carmen Smith. Ms. Smith stated that she completed her investigation and substantiated physical abuse due to the inappropriate use of physical restraint. Ms. Smith stated that it was initially believed that Resident A was residing in an unlicensed setting, so the referral was not sent to licensing when the intake was first received in March. She stated that the Office of Recipient Rights (ORR) in Newaygo County also investigated the allegations. Ms. Smith forwarded photographs of Resident A's injuries, which were dated 03/14/2025. The photographs show several round fingerprint shaped bruises on the upper inner area of Resident A's right arm as well as a large, dark, handprint shaped, bruise on the upper inner area of his left arm.

On 06/12/25, I contacted the assigned ORR worker, Jill McKay. Ms. McKay stated that she also substantiated the allegations, as it was determined that staff used an improper technique while implementing a two-person seated hold restraint on Resident A on 03/12/25. This resulted in Resident A having bruises on his left and right arms, as well as abrasions on his neck and back. Ms. McKay stated that a CPI (Crisis Prevention Institute) trainer will be going out to the home within the next month to recertify the staff and review proper techniques for using physical restraint. She stated that staff were

previously trained in CPI techniques and are allowed to use physical restraint when necessary, but they were not using the proper techniques. Ms. McKay stated that Resident A does not have a crisis or behavior plan in place.

I received and reviewed a copy of an incident report dated 03/12/25, completed by the home manager, Jennifer Stancroff. The incident report notes that Resident A returned home from school at 2:30pm, put his belongings in his room, then came out to the common area and asked the home manager for chips. Chips were given upon request. Resident A put the chips back into the pantry and then walked up to staff, Sherry McLean, and pinched both of her arms. Both Resident A and Sherry McLean backed away from each other. Resident A then charged after Ms. McLean with “hitting” arms/hands. Ms. McLean put her arms up in the blocking position and kept moving backwards. While the home manager was redirecting other residents into their rooms for safety, another staff, Luke Alexander, intervened with blocking pads to assist Ms. McLean. Ms. Mclean and Mr. Alexander were able to block Resident A from leaving the dining area while the home manager, Jennifer Stancroff, directed the other residents into their rooms. Resident A hit the left side of his body on the wall while violently moving his head and body from side to side. The home manager opened the medication closet to get a PRN for Resident A. Resident A was able to get away from the other staff. He grabbed the home manager’s hair and pushed her into the medication cabinet. The home manager used the “push/pull hair” technique to remove herself from Resident A’s grip. Staff used the blocking pads to guide Resident A to the couch. Ms. McLean and Mr. Alexander used the seated high-level restraint on Resident A. The home manager was able to give Resident A his PRN while staff restrained him. Staff counted with Resident A to twenty and waited for signs of calmness. Ms. McLean and the home manager switched spots.

After a ten-minute hold, the home manager and Mr. Alexander released Resident A from the hold and walked with him to the bathroom to take a shower. Resident A attempted to enter another resident’s room and was blocked by staff, Luke Alexander, while the home manager closed the resident’s door. Staff, Luke Alexander, was head butted in the chin during the process. The home manager told Resident A to sit down. Resident A sat down in the hallway on the floor and finally laid down. Staff counted with Resident A again and sat with him until he was calm enough to take a shower. After his shower, Resident A was close to baseline and staff monitored him until he was safe. The incident report also included a skin integrity form, which notes that Resident A had a ¼ inch abrasion on his left ear, as well as a 2-inch abrasion and a ½ inch abrasion on the left side of his neck. He had a 3 x 4 inch round bruise on his left arm, and an abrasion on his back left side. His forehead was also noted to be red from headbutting.

On 06/12/25, I conducted an unannounced onsite inspection at Eastlawn Manor. I attempted to interview Resident A, but he was unable to engage in the interview process due to limited verbal and cognitive abilities. Resident A mimics and repeats what is said to him. I did not observe any marks or bruises on Resident A.

On 06/12/25, I interviewed direct care worker, Sherry McLean. Ms. McLean stated that on 03/12/25, Resident A came home from school, got undressed, and asked for snacks. He was given two bags of chips, but then he put them in the cupboard, walked over to Ms. McLean and pinched both of her arms. Ms. McLean stated that she stepped back, but Resident A went after her. He started to hit her and was headbutting. Another staff, Luke Alexander, intervened by using blocking pads to block Resident A. They ended up in the dining room. At one point, the blocking pads dropped, and Mr. Alexander was using his hands to hold Resident A back. Ms. McLean stated that they eventually got Resident A onto the couch with the blocking pads. Ms. McLean stated that she physically restrained Resident A with Mr. Alexander. She was on one side, and Mr. Alexander was on the other side. She got tired and the home manager, Jennifer Stancroff had to swap places with her. Ms. McLean stated that they were not holding Resident A's arms with their hands, but rather their arms were hooked through his arms. She stated that the staff are all trained in physical restraint through CPI training, and they just had a refresher course in May. Ms. McLean stated that they needed to start with a high-level restraint, because Resident A escalated quickly. She did not feel that they could have started with a lower-level restraint or by trying to redirect him. She stated that the home manager was able to give him a PRN medication while he was on the couch, but he also went after the home manager, grabbing her and slamming her into the medication closet when she was trying to get the PRN. Ms. McLean stated that Resident A eventually calmed down and they got him into the shower. She stated that there was nothing they could have or would have done differently during the incident. She stated that Resident A has not had any other behavioral issues since this incident occurred in March.

On 06/27/25, I interviewed the home manager, Jennifer Stancroff, via telephone. Ms. Stancroff stated that on 03/12/25, Resident A came to her and asked her for chips. She gave them to him, but then he put them back in the pantry and something set him off. Resident A went up to staff, Sherry McLean, and pinched her. He then went after all three staff. He grabbed Ms. Stancroff's hair and shoved her into the closet while she was trying to get a PRN medication for him. Sherry McLean and Luke Alexader were blocking Resident A and trying to direct him to the couch, while Ms. Stancroff was closing the other resident's bedroom doors and getting the PRN. Ms. McLean and Mr. Alexander got Resident A to the couch. They were holding him in a seated position on the couch and were trying to breathe and count with him. Ms. Stancroff was able to administer the PRN medication to Resident A. Ms. McLean got tired while restraining Resident A, so Ms. Stancroff switched positions with her. She had Ms. McLean go outside, because it seemed as though Resident A was hyper focused on her.

Ms. Stancroff stated that while she and Mr. Alexander were restraining Resident A, they were in a seated position on the couch. She was on Resident A's right side and Luke Alexander was on his left side. She had her arm under Resident A's arm and was holding his hand. Her other hand was on top of Resident A's arm to prevent him from moving it. Mr. Alexander had his arm under Resident A's arm and was holding Resident A on the bicep with his other arm. Ms. Stancroff stated that Resident A eventually began

to calm down. They were trying to get him to go take a shower, when Resident A tried to go into another resident's room. Mr. Alexander was trying to block Resident A, and Resident A went after him. They told Resident A to sit down, so he sat on the floor until he eventually decided that he was ready to shower. Ms. Stancroff stated that Resident A never had a behavior plan in place. She stated that they had talked to his case manager about a behavior plan at his previous placement, but Resident A needed to have a certain number of behaviors within a one-month timeframe in order to initiate the process, and he never met the threshold. Resident A's behavior improved when he moved to Eastlawn Manor in June 2024, as he was in the home by himself for a few months. He has not had any behavioral issues since the incident in March. Ms. Stancroff stated that all staff were retrained in physical restraint techniques in May 2025.

I received and reviewed a copy of Resident A's individual plan of service (IPOS) / treatment plan from Newaygo County Mental Health dated 09/06/2024. The plan notes that his caseworker started the process to request a functional behavioral assessment and to look at potentially obtaining behavioral guidelines. It indicates that Resident A has not had any physical aggression since moving over to Eastlawn Manor. The plan notes that Resident A has a goal of decreasing physical aggression in the home and at school to one or fewer episodes per month for six consecutive months. The interventions for this goal note that home staff will monitor for signs that Resident A is getting frustrated or upset. If signs appear, they will offer Resident A distraction or redirection to another activity (He prefers a snack or shower). If the environment is too stimulating, they will offer Resident A the opportunity to go to an area where he feels safe, such as his room. They are to allow Resident A time in the safe area to calm himself and offer praise when Resident A is able to calm himself or accept the alternative activity. Staff are to document incidents as they occur and provide ABC (antecedent-behavior-consequence) data regarding the incident. The plan notes that if Resident A is involved in any type of physically aggressive activity or self-harm that may have incurred injury, it is requested that he be taken either to urgent care or the emergency room for a medical evaluation to ensure no significant injury. This was requested by adult foster care licensing. As a precautionary measure, to ensure knowledge of any visible injury and where it may have stemmed from, particularly as bruising may appear the next day, staff will document all incidents and parts of body that may be impacted. They will do a daily check for any bruising on his body and will document any that is observed. The plan notes that indications that Resident A is frustrated or agitated include shaking, clenching teeth, facial grimacing, balling his fists, heavy breathing, holding his ears tight to his head, and yelping.

I received and reviewed copies of CPI training cards for Jennifer Stancroff, Sherry McLean, and Luke Alexander, which show they completed Non-Violent Crisis Intervention, 3rd Edition Training. Ms. Stancroff completed eight hours of training on modules 1-8 on 5/4/24. Ms. McLean completed eight hours of training on modules 1-8 on 5/4/24. Mr. Alexander completed twelve hours of training on modules 1-10 on 6/7/24. All three staff completed a refresher training course which consisted of four hours of training on modules 1-8 on 05/15/25.

I received and reviewed documentation from the assigned ORR worker, Jill McKay, regarding her meeting with Resident A's case manager, Pamela Baron, on 03/14/25. Ms. Baron is also the CPI instructor who trained the staff at Eastlawn Manor on nonviolent crisis intervention. Ms. McKay met with Ms. Baron in person on 3/14/25. She inquired about CPI techniques, specifically the high-level seated hold that the Eastlawn staff used with Resident A on 3/12/25. ORR asked if one would typically perform a high-level seated hold without first trying a low or medium level hold. Ms. Baron stated, "It would depend on what the person is demonstrating and what the level of risk is. Staff would have to assess the level of aggression that is being presented and the level of risk where the person is a potential for harm to themselves or others." When asked if there is a time limit on how long a hold can be performed, Ms. Baron stated, "A hold can be performed up to ten minutes at a time." Ms. McKay asked if the swapping of staff on one side would be considered a break between holds. Ms. Baron responded, "A break only counts if both sides disengage from the hold." Ms. McKay asked Ms. Baron, as Resident A's case manager, if she is aware of him having a history of bruising easily. Ms. Baron stated, "He does have a history of bruising easily, (pictures of the bruising on Resident A's arms were reviewed with Ms. Baron) but that heavy of a bruise does bother me." Ms. Baron stated that she would follow up with the CPI consultant regarding the bruising on Resident A.

Ms. Baron sent a follow-up email to Ms. McKay on 03/18/25. She indicated that the CPI consultant stated that it may be reasonable to expect some marks given that Resident A did not have a shirt on (so no padding), he is fair skinned, he was combative and very strong, and staff did two high level holds. She stated that the home manager clarified that she switched positions with staff when they had released Resident A, feeling he might be calm enough to de-escalate. Resident A re-escalated and tried to attack staff, so they did the second hold. The time frame for both holds was estimated to be about ten minutes. Ms. Baron indicated in her email that the CPI consultant stated that staff likely grabbed too firm/hard due to the staff's level of anxiety and trying to keep everybody safe. She stated that the CPI consultant did not commit to saying they did the hold incorrectly.

I received and reviewed a copy of the guidelines for a high-level restriction seated hold from the Non-Violent Crisis Intervention Training Participant Workbook. It notes the following guidelines:

- Begin in the medium level of restriction.
- Sit close. Use your leg furthest from the person to remain balanced and stable.
- Apply the Inside principle by using your closest hand to hold the person's wrist.
- Keeping your hands on the person's wrist and elbow, guide their arm back so their wrist is beneath their shoulder.
- Apply the Outside principle by removing your hand from the person's elbow and replacing it with your body.
- Place the palm of your furthest hand on the person's fist. Cup your hand to avoid squeezing.

- Use your body to maintain contact at their shoulder, hip and thigh.
- Keep upright. Avoid leaning or bending the person forward.

The illustrations that accompany the instructions show that staff are not using their hands to hold any part of the upper arm.

On 07/23/25, I conducted an exit conference via telephone with the licensee designee, Carl Byerly. I reviewed my findings and Carl Byerly agreed to submit a corrective action plan to address the violations.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not ensure Resident A's safety and protection when they physically restrained him on 03/12/25. The home manager, Jennifer Stancroff, and staff, Luke Alexander and Sherry McLean, used a high-level seated hold to restrain Resident A on the couch when he demonstrated physically aggressive behavior. While staff completed CPI non-violent crisis intervention training, they did not utilize the proper techniques for the hold, causing significant bruising and abrasions to Resident A's arms and body. Staff, Sherry McLean, also stated that the pads dropped while blocking Resident A prior to putting him in the hold. Staff Luke Alexander was using his hands to hold back Resident A, which could have also contributed to the bruising. The home manager, Jennifer Stancroff, also administered a PRN medication to Resident A while he was restrained in a seated hold, putting him at additional risk of harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14307	**Resident behavior interventions generally.**
	(2) Interventions to address unacceptable behavior shall be specified in the written assessment plan and employed in accordance with that plan. Interventions to address unacceptable behavior shall also ensure that the safety, welfare,

	and rights of the resident are adequately protected. If a specialized intervention is needed to address the unique programmatic needs of a resident, the specialized intervention shall be developed in consultation with, or obtained from, professionals who are licensed or certified in that scope of practice.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident A's individual plan of service did not contain information that staff can use physical restraint as a form of intervention for unacceptable behaviors. While the staff in the home are trained in CPI nonviolent crisis intervention techniques, Resident A's plan does not specify that staff can utilize these techniques to address his behaviors. Resident A's plan dated 09/06/2024 indicates that home staff will monitor for signs that Resident A is getting frustrated or upset. If signs appear, they will offer Resident A distraction or redirection to another activity, such as a snack or shower. If the environment is too stimulating, they will offer Resident A the opportunity to go to an area where he feels safe, such as his room. Resident A's plan notes that his caseworker started the process to request a functional behavioral assessment and to look at potentially obtaining behavioral guidelines; however, the home manager stated that a behavior plan was never put in place, as Resident A did not meet the threshold for the number of behaviors needed to warrant a behavior plan. On 03/12/25, staff used physical intervention techniques to manage Resident A's behavior. The interventions were not properly implemented and did not ensure Resident A's safety, resulting in bruising and abrasions on his arms and body.
CONCLUSION:	**VIOLATION ESTABLISHED**

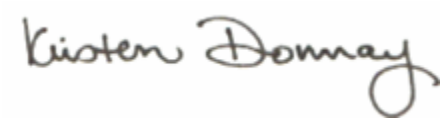
APPLICABLE RULE	
R 400.14309	**Crisis intervention.**
	(3) Crisis intervention shall be used to the minimum extent and the minimum duration necessary and shall be used only after less restrictive means of protection have failed.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not attempt to use less restrictive means of protection prior to engaging Resident A in a high-level seated hold on 03/12/25 when Resident A started to become physically aggressive towards staff by pinching Sherry McLean. Resident A's treatment plan notes that if Resident A shows signs of anger or frustration, staff should offer him a distraction or redirection to another activity, such as a snack or shower. If the environment is too stimulating, they should offer Resident A the opportunity to go to an area where he feels safe, such as his room. Staff did not attempt to redirect Resident A to another activity prior to utilizing blocking pads and restraining him in a high-level hold on the couch. In addition, they did not attempt to use a low or medium level hold prior to using the high-level seated hold.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14309	**Crisis intervention.**
	(4) Crisis intervention shall be employed to allow the resident the greatest possible comfort and to avoid physical injury and mental distress.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not employ crisis intervention techniques in a manner to avoid physical injury to Resident A. On 03/12/25, the home manager, Jennifer Stancroff, and staff Luke Alexander and Sherry McLean, used a used a high-level seated restriction to restrain Resident A when he was exhibiting physically aggressive behavior. Staff did not use the proper technique for this hold, as Resident A had bruising that resembled hand and fingerprints on his upper arms. The Non-Violent CPI Training Workbook illustrates that in a high-level seated hold, staff do not physically have their hands holding the resident's arms. Staff are to hold the resident's fist with their furthest hand and then cup their hand to avoid squeezing. Their body is then used to maintain contact at the shoulder, hip, and thigh. The home manager, Jennifer Stancroff, also administered a PRN medication to Resident A while he was restrained in a seated hold, putting him at additional risk of harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

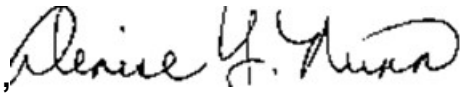
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



07/23/2025

Kristen Donnay Date
Licensing Consultant

Approved By:



07/23/2025

Denise Y. Nunn Date
Area Manager