GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 21, 2026

Dawn Martin-Speese
Falco Corporation
Suite 101
5228 Lovers Lane
Portage, MI 49002

RE: License #: AM800015739
Investigation #: 2026A1031009
Allegan Enrichment Center #3

Dear Mrs. Martin-Speese:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0100.

Sincerely,

KDuda

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM800015739
Investigation #:	2026A1031009
Complaint Receipt Date:	11/12/2025
Investigation Initiation Date:	11/14/2025
Report Due Date:	01/11/2026
Licensee Name:	Falco Corporation
Licensee Address:	Suite 101 5228 Lovers Lane Portage, MI 49002
Licensee Telephone #:	(269) 342-8766
Licensee Designee/Administrator:	Dawn Martin-Speese
Name of Facility:	Allegan Enrichment Center #3
Facility Address:	122 E. Delaware Street Decatur, MI 49045
Facility Telephone #:	(269) 423-7892
Original Issuance Date:	06/01/1994
License Status:	REGULAR
Effective Date:	09/01/2025
Expiration Date:	08/31/2027
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was sexually abused by another resident.	No
Resident B was not provided with prescribed medications.	No

III. METHODOLOGY

11/12/2025	Special Investigation Intake 2026A1031009
11/12/2025	APS Referral
11/14/2025	Special Investigation Initiated - Letter Email exchange with Mike Hartman.
11/14/2025	Contact - Document Received Email exchange with Mike Hartman.
11/14/2025	Contact - Document Received Police Report
11/21/2025	Contact - Document Received Email exchange with Mike Hartman.
11/21/2025	Contact - Document Received Police report and incident report.
12/02/2025	Inspection Completed On-site
12/02/2025	Inspection Completed-BCAL Full Compliance
12/02/2025	Contact - Document Received - Assessment Plans and Medication Records.

ALLEGATION:

Resident A was sexually abused by another resident.

INVESTIGATION:

On 11/12/25, I received an online complaint that Resident A was sexually abused by another resident in the facility as there was redness around his rectal area.

On 11/14/25, I exchanged emails with adult protective services (APS) worker Mike Hartman. Mr. Hartman provided a copy of a police report dated 11/7/25. I reviewed the police report, and it read that Resident A denied being sexually assaulted by another resident in the facility. The police closed the investigation as “unfounded”. Mr. Hartman reported he completed his investigation and there was not a preponderance of evidence found to support that Resident A was neglected by staff.

On 12/2/25, I conducted an unannounced visit to the facility and interviewed Resident A and facility manager Hannah Huizenga.

Resident A reported he was sharing a room with Resident B, and he did not like it when he was naked in their room. Resident A reported Resident B never touched him inappropriately. Resident A reported Resident B has only touched his arm, but this did not make him uncomfortable.

Ms. Huizenga reported she was aware of the allegations, however, Resident A never disclosed any sexual abuse to her. Ms. Huizenga reported he was having issues with constipation that could have contributed to redness around his rectal area. Ms. Huizenga provided medical documentation while I was at the facility showing Resident A received treatment for bowel issues related to constipation.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	There was no evidence found to support that Resident A was not provided with appropriate supervision and protection. Resident A reported he was not sexually abused by Resident B and the police investigation along with an investigation completed by APS was closed with no findings.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B was not provided with prescribed medications.

INVESTIGATION:

On 11/21/25, I exchanged emails with Mr. Hartman regarding allegations received that the facility did not provide Resident C with prescribed medications. Mr. Hartman provided a copy of a police report due to Resident C making threats towards others at the facility. The police closed their investigation as Resident C was admitted for psychiatric treatment and transported to a psychiatric facility on the east side of Michigan. Mr. Hartman provided an incident report dated 11/15/25 that I reviewed. The incident report read that on 11/15/25, Resident C was upset with staff assigned to transport residents to an outing. Resident C made multiple threats towards staff and said she would "beat" and "kill" staff. Resident C threatened to have staff fired and staff attempted to verbally redirect her. At 5pm, Resident C refused to take her prescribed medications and when prompted again, she eloped from the facility and went to a nearby store. Staff followed Resident C to the store and Resident C purchased pills from the store although staff encouraged her not to do so as it could be unsafe due to her prescribed medications. When Resident C returned to the facility with staff, staff was instructed to call the police and emergency services due to concerns for her safety and well-being. When staff made the call to police and EMS, Resident C eloped again. The police located Resident C and transported her to the hospital for evaluation. Mr. Hartman reported there was a preponderance evidence found to support that Resident C neglected herself as she was having suicidal ideations. There was not a preponderance of evidence found to support that Resident C was neglected by staff or that she was not provided with her prescribed medications.

On 12/2/25, I conducted an unannounced visit to the facility. Ms. Huizen reported Resident C had an incident where she became upset with staff and eloped from the facility. Ms. Huizen reported the police were contacted and she was located and transported to the hospital for a psychiatric evaluation. Resident C was then transferred to a hospital on the east side of Michigan and remains in the hospital to receive treatment. Ms. Huizen reported Resident C often refused her medications and provided multiple documents stating Resident C had refused her medication.

During the inspection, I reviewed Resident C's medication administration records for the last three months. The facility provided Resident C with her medication, however, there were many days that documented a refusal.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based on interviews and the review of documentation, there was no evidence found to support that facility did not provide or offer Resident C her medications. Resident C has a history of refusing her medications and receiving psychiatric treatment.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

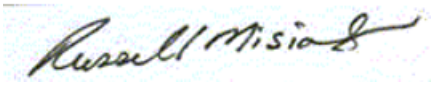
IV. RECOMMENDATION

It is recommended that the status of the license remain unchanged.

12/23/25

Kristy Duda Date
Licensing Consultant

Approved By:



1/21/26

Russell B. Misiak Date
Area Manager