GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2026

Virginia Nobles
13060 Shaffer Rd
Davisburg, MI 48350

RE: License #: AS630093379
Investigation #: 2026A0612023
Nobles Living

Dear Ms. Nobles:

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 (248) 972-9136.

Sincerely,

Johnna Cade

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630093379
Investigation #:	2026A0612023
Complaint Receipt Date:	04/20/2026
Investigation Initiation Date:	04/20/2026
Report Due Date:	06/19/2026
Licensee Name:	Virginia Nobles
Licensee Address:	13060 Shaffer Rd Davisburg, MI 48350
Licensee Telephone #:	(248) 634-3326
Administrator:	Datanyen Myers
Name of Facility:	Nobles Living
Facility Address:	786 Second St Pontiac, MI 48340
Facility Telephone #:	(248) 333-2787
Original Issuance Date:	08/08/2000
License Status:	REGULAR
Effective Date:	12/04/2025
Expiration Date:	12/03/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On an unknown date, Resident A and direct care staff Darryl Pettiford got into a tussle.	No

III. METHODOLOGY

04/20/2026	Special Investigation Intake 2026A0612023
04/20/2026	APS Referral Referral received from Adult Protective Services (APS). APS denied the referral for investigation.
04/20/2026	Special Investigation Initiated - Letter I made a referral to Oakland Community Health Network - Office of Recipient Rights via email.
04/23/2026	Contact - Telephone call received Telephone interview completed with Recipient Rights Specialist Alanna Honkanen.
04/23/2026	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed Resident A, Resident B, direct care staff Darryl Pettiford, and administrator Datanyen Myers.
04/23/2026	Contact - Telephone call received Telephone interview completed with licensee Virginia Nobles.
04/23/2026	Contact - Document Received Incident Reports and Resident A's Easterseals MORC Individual Plan of Service received via email from Recipient Rights Specialist Alanna Honkanen.
04/23/2026	Exit Conference Exit conference completed with licensee Virginia Noble via telephone.

ALLEGATION:

On an unknown date, Resident A and direct care staff Darryl Pettiford got into a tussle.

INVESTIGATION:

On 04/20/26, I received a referral from Adult Protective Services (APS). APS denied the referral for investigation. In summary, the referral indicates Resident A resides at Nobles Living AFC. Resident A is diagnosed with intellectual disability (mild), epilepsy, unspecified disruptive impulse control and conduct disorder, and anxiety disorder (not otherwise specified). Resident A's parents are her guardians. On an unknown date, Resident A and direct care staff Darryl Pettiford got into a tussle. The exact date/time of the incident is unknown. Mr. Pettiford reported Resident A attacked/punched him. Resident A did not obtain any injuries.

On 04/20/26, I initiated my investigation by making a referral to Oakland Community Health Network – Office of Recipient Rights via email. I was advised that the investigation was assigned to Recipient Rights Specialist Alanna Honkanen. On 04/23/26, I received a telephone call from Ms. Honkanen. Ms. Honkanen stated when interviewed, Resident A denied that she and Mr. Pettiford got into a tussle. Resident A stated that she hit Mr. Pettiford then he blocked the doorway of her bedroom, preventing her from leaving. Ms. Honkanen stated she did not establish a preponderance of evidence that indicated this occurred. Ms. Honkanen stated she also interviewed Resident A's guardian who said that she went to the home following the incident and spent time with Resident A. Resident A's guardian reported no concerns that Resident A and Mr. Pettiford had engaged in a tussle. Ms. Honkanen stated she is not substantiating her investigation.

On 04/23/26, I completed an unscheduled onsite investigation. I interviewed Resident A, Resident B, direct care staff Darryl Pettiford, and administrator Datanyen Myers. While onsite I also interviewed licensee Virginia Nobles via telephone.

On 04/23/26, I interviewed Resident A. Resident A stated on an unknown date she wanted to put on her coat to go to the doctors, but direct care staff Darryl Pettiford told her that it was not her turn to go to the doctors. Resident A stated she got upset when Mr. Pettiford asked her to take her coat off. Resident A stated she hit Mr. Pettiford. Resident A became tearful and remarked "it won't happen again." Resident A stated this is a nice home and she likes living here. Resident A denied that Mr. Pettiford used any form of physical force against her and further denied that the two were engaged in a tussle. Resident A denied that Mr. Pettiford blocked the doorway, not allowing her to

leave her room. Resident A stated she understands it is important to tell the truth and she has since apologized to Mr. Pettiford.

On 04/23/26, I interviewed Resident B. Resident B stated he has lived in this home for 20 years. Resident B stated this is a nice home, the staff treat him well and he has no issues or concerns.

On 04/23/26, I interviewed direct care staff Darryl Pettiford. Mr. Pettiford stated the incident occurred on 04/01/26, although he documented 04/05/26, in the incident report he wrote that was not the correct date. Mr. Pettiford stated Resident A put on her coat because she wanted to go to a doctor's appointment with her housemates. He explained to Resident A that it was not her appointment and told Resident A that he would put her coat away. Mr. Pettiford stated when he turned to exit Resident A's bedroom, she hit him with a closed fist six times on the back and the side of his head, then she shoved him. Then, Resident A said that she was going to run away. Mr. Pettiford stated he acknowledged Resident A and said, "okay." Mr. Pettiford stated he made a FaceTime call to licensee Virginia Nobles immediately following the incident to explain what happened and report Resident A's aggression. Mr. Pettiford denied harming, hitting, pushing, and/or engaging in a tussle with Resident A. Mr. Pettiford denied blocking the doorway and not allowing Resident A to leave the room.

On 04/23/26, I interviewed administrator Datanyen Myers. Mr. Myers stated following the incident Mr. Pettiford called him but he did not answer, therefore Mr. Pettiford called licensee Virginia Nobles. Mr. Myers stated he learned of the incident a few days after it occurred. Mr. Myers stated Resident A has lived in this home for 23 years, she has a history of aggression. Following the incident a staff meeting was held to address the incident and further address necessary documentation including incident reports. Mr. Myers stated Mr. Pettiford has worked with Resident A for many years. They have a close relationship, and he does not suspect that he engaged in a tussle with Resident A.

On 04/23/26, while onsite I interviewed licensee Virginia Nobles via telephone. Ms. Nobles stated following the incident she received a FaceTime call from Mr. Pettiford; he was on the floor and Resident A was standing with her fist balled up. Mr. Pettiford kept repeating "all I wanted her to do was put away her coat." Mr. Pettiford was shaken up. Ms. Nobles advised Resident A to sit on her bed and told Mr. Pettiford to exit the room. Ms. Nobles stated she was taking Resident A's housemate to the doctor's office and Resident A put on her coat because she thought she was going to the doctors too. When Mr. Pettiford told her that she was not going to the doctor's she became upset. Ms. Nobles stated Resident A has been in her care for 23 years, she has a history of aggression, and they continue to work with her family and her treatment team to address this behavior.

On 04/23/26, I reviewed the following documentation:

Incident Report (IR) written by Brittany Williams Easter Seals MORC care coordinator. The incident report was written on 04/17/26. The date of the incident is unknown. The IR in summary indicates Resident A reported that she and a staff member got into a tussle. The staff was present and reported that Resident A attacked (punched) him. The date and time of the incident is unclear.

Incident Report (IR) written by direct care staff Darryl Pettiford. Date of the incident is 04/05/26. In summary, the IR indicates I asked Resident A for her coat to put it away when I turned to leave the room she physically struck me six times to the back of the head.

Resident A's Easterseals MORC Individual Plan of Service (IPOS) effective 04/01/26. Resident A's IPOS indicates "(Resident A) continues to show displays of aggression (physical or verbal) with housemates and staff. She tends to lie and steal from her home as well. (Resident A) will try to create an event and blame other housemates. Provider has been aware of these behaviors for years and (Resident A) continues to have conversations with her parents about this as well."

On 04/23/26, I completed an exit conference with licensee Virginia Noble via telephone and reviewed my findings. Ms. Nobles was advised that there was no substantial rule violations found. Ms. Noble acknowledged and agreed.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(b) Use any form of restraint without an order from an appropriately licensed heath care professional or physical force, other than physical restraint for crisis intervention.**
ANALYSIS:	Based upon the information gathered during this investigation there is insufficient information to conclude that on an unknown date Resident A and direct care staff Darryl Pettiford engaged in a tussle whereby Mr. Pettiford used any form of physical force against Resident A. Resident A and Mr. Pettiford consistently reported that Resident A hit/punched Mr. Pettiford. Mr. Pettiford reported he was struck six times with a closed fist to the back and side of his head. Resident A denied that Mr. Pettiford used any form of physical force against her and further denied that the two were engaged in a tussle.

	Resident A's Easterseals MORC Individual Plan of Service documents that Resident A continues to display aggression with housemates and staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend that this special investigation be closed with no change to the status of the license.

04/24/26

Johnna Cade — Date
Licensing Consultant

Approved By:

For 04/24/2026

Denise Y. Nunn — Date
Area Manager