GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 10, 2026

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

RE: License #: AS630393369
Investigation #: 2026A0626029
Beacon Home at Clarkston

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. 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,

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(248) 320-3721

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 #:	AS630393369
Investigation #:	2026A0626029
Complaint Receipt Date:	07/08/2026
Investigation Initiation Date:	07/08/2026
Report Due Date:	08/07/2026
Licensee Name:	Beacon Specialized Living Services, Inc.
Licensee Address:	890 N. 10th St. Suite 110 Kalamazoo, MI 49009
Licensee Telephone #:	(269) 427-8400
Administrator:	Nichole VanNiman,
Licensee Designee:	Nichole VanNiman
Name of Facility:	Beacon Home at Clarkston
Facility Address:	10358 Horseshoe Circle Clarkston, MI 48348
Facility Telephone #:	(269) 427-8400
Original Issuance Date:	10/16/2018
License Status:	1ST PROVISIONAL
Effective Date:	01/14/2026
Expiration Date:	07/13/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Direct care staff member, Victory (Tory) Phifer, was sleeping while Resident C had a seizure and was calling out for help. Additionally, she left residents alone in the van while out.	Yes
Direct care staff member, Victory (Tory) Phifer, was demeaning to Resident B and treats other residents disrespectfully.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/08/2026	Special Investigation Intake 2026A0626029
07/08/2026	Special Investigation Initiated - Letter I initiated the special investigation by forwarding the complaint to recipient rights specialist, Sarah Rupkus.
07/10/2026	Contact - Face to Face I completed an unannounced onsite investigation at Beacon Home at Clarkston. I completed interviews with program director, Brooke Landis and Resident A, Resident B, and Resident C.
07/20/2026	Contact - Telephone call made I completed a telephone interview with recipient rights specialist from Livingston County, Molly Myska.
07/24/2026	Contact - Document Received I received, via email, call logs for the home from Oakland County 911 Dispatch.
07/24/2026	Contact - Document Sent I sent an email to licensee designee, Nicole VanNiman, requesting any incident reports from 02/27/2026 and 04/26/2026.
07/31/2026	Contact - Document Received I received an email from Beacon Specialized Services compliance data analyst, Matthew Jenner, containing an incident report for 04/26/2026. The email indicated that there is no incident report for 02/27/2026.

07/31/2026	Contact - Telephone call made I completed telephone interviews with direct care staff members, Janaya Dantzler, Jaime Brazelton, and Onika Walton.
08/03/2026	Contact - Telephone call made I completed telephone interviews with former home manager, Damise Young, Resident C's support coordinator from Saginaw County Community Mental Health, Shermica Chandler, Relative C1, and direct care staff member, Dori'Asia Miller.
08/04/2026	Contact - Telephone call made I completed a telephone interview with recipient rights specialist, Ronda Nelson, from Saginaw County Community Mental Health.
08/05/2026	APS Referral A referral was made via the MI Bridges Mandated Reporter Portal.
08/06/2026	Contact – Telephone call received I received a phone call from APS investigator, Heather Stickel. Ms. Stickel was assigned to the investigation regarding Resident C's seizures.
08/07/2026	Exit Conference I completed an exit conference with licensee designee, Nichole VanNiman, via telephone. The findings and recommendations were discussed.

ALLEGATION:

Direct care staff member, Victory (Tory) Phifer, was sleeping while Resident C had a seizure and was calling out for help. Additionally, she left residents alone in the van while out.

INVESTIGATION:

On 07/08/2026, I received a complaint, via email, indicating residents were not being treated well and that residents were being left home alone.

On 07/08/2026, I initiated the investigation by forwarding the allegations to Office of Recipient Rights (ORR) specialist with Oakland Community Health Network, Sarah Rupkus. Ms. Rupkus informed me that they do not have any residents in the home.

On 07/10/2026, I completed an unannounced onsite investigation at Beacon Home at Clarkston. I completed a private in person interview with Resident A. Resident A

stated there is a lot of "bullshit" going on here. She does not like how the staff treat the residents. She stated one time, approximately one to two months ago, Tory was sleeping and another resident, Resident C, was having a seizure. Resident C screamed for help for half an hour before Tory responded. She did not know if 911 was called or not. There was another resident, who is now gone, who would elope and Resident A is the one who would go after her and bring her back. She has been left in charge of residents in the van. The last time this happened was approximately three months ago.

On 07/10/2026, I completed a private, in person interview with Resident C. Resident C stated she last had a seizure around three months ago, while living at Beacon Home at Clarkston. She was shaking and called for help, but she didn't get any help because Tory was sleeping in the chair. Tory finally woke up and called an ambulance. She stated the ambulance came and the paramedics checked her out and asked her if she wanted to go to the hospital. She told them she did not. She stated the staff are not always nice and she wants to leave here. She stated Tory is not respectful. She stated staff tried to kill her once while she was sleeping. She woke up gasping for air and tried to call for help, then whoever it was ran to the bathroom. Resident C stated she has been left alone with Resident A, but she doesn't think that is a big deal because she isn't like the others and it is ok for her to stay alone in the van.

On 07/10/2026, I completed an in-person interview with program director, Brooke Landis. Resident A recently told her about being left alone in the van. She knows nothing about staff sleeping on duty, as it is against their policy, but was contacted about it recently by recipient rights. Resident A also told her about Resident C having a seizure and falling out of bed while Victory Phifer was in the living room. She has not spoken to Resident C about that yet. She stated there are no incident reports regarding a seizure, nor has she been told about one. She stated, as far as she knows, Resident C has not had any seizures since coming here in January. She does not know if there is any truth to the allegations. She stated Resident A might embellish or exaggerate, but she doesn't lie.

On 07/20/2026, I completed a telephone interview with ORR specialist Rhonda Nelson from Saginaw County Community Mental Health. She stated she has not yet interviewed anyone regarding the allegations but will be reaching out to schedule interviews.

On 07/21/2026, I completed a telephone interview with ORR specialist Molly Myska from Livingston County Community Mental Health. She stated she is currently working on an investigation involving allegations brought to her by Resident A. She indicated that Resident A told her about staff being rude to her and disrespectful. She stated Resident A also told her about the seizure. She agreed to send me a copy of Resident A's individual plan of service (IPOS) and stated Resident A does not require someone to be with her 24/7 and would be okay to be left alone for a short period of time.

On 07/24/2026, I received heavily redacted 911 call logs from the Oakland County Sheriff's Department. There were two logs that raise concern. On 02/27/2026, a call was made by staff Victory, reporting a resident ingested a substance and Poison Control recommended the resident get to the hospital. It was listed as accidental poisoning. The other one was on 04/26/2026. The caller was Victory Phifer. The log indicates a resident was having a headache, trouble breathing, and was throwing up. The log indicates the resident was alert and was behaving normally. The call was made at 4:21 am.

On 07/24/2026, I sent an email to licensee designee, Nicole VanNiman, requesting any incident reports from 02/27/2026 and 04/26/2026.

On 07/31/2026, I received an incident report, via email, from Matthew Jenner, compliance data analyst at Beacon. The report was completed by Victory Phifer and indicates that on 04/26/2026, Resident C came into the living room, crying, telling her she had a seizure and a headache. Staff provided her Tylenol. She took vitals and monitored Resident C; there is no mention of calling 911. Mr. Jenner informed me that there is no incident report dated 02/27/2026.

On 07/31/2026, I complete a telephone interview with direct care staff member, Janaya Dantzler. Ms. Dantzler stated she has worked at Beacon of Clarkston for around three months. She has worked with Victory Phifer and was "kind of" close with her. She stated Ms. Phifer quit working for Beacon after she took a week off for mental health reasons. She denied ever hearing about Resident C having a seizure. She stated when Resident C has a seizure, they are supposed to call 911, but she admitted not knowing Resident C’s seizure protocol.

On 07/31/2026, I completed a telephone interview with direct care staff member, Jaime Brazelton. Ms. Brazelton left employment at Beacon Home at Clarkston four weeks ago. She started working there in the beginning of March. She stated there were so many issues there and she tried resolving them, but it was “horrible.” She has worked with Victory Phifer and stated she did not like how she treated the residents. She witnessed Ms. Phifer sleeping while on duty multiple times and went to Ms. Young about it, but it never changed. She was informed of the seizure Resident C had by Resident C. Resident C told her that she was screaming for Ms. Phifer and had to crawl out of her bedroom, to get to the living room, to wake her up. Ms. Brazelton stated that she came on duty that morning and Resident C was sleeping in her feces, because Ms. Phifer just put her to bed after her seizure and would not help her. She heard about two other staff members sleeping on duty, but she never witnessed it and could not remember their names.

On 07/31/2026, I completed a telephone interview with direct care staff member, Onika Walton. Ms. Walton is no longer working at Beacon Home at Clarkston. She stated it was a mutual decision. She stated they need to “get it together” and they do

not care about their employees. She denied knowing anything about Resident C having a seizure or Ms. Phifer sleeping on shift.

On 08/03/2026, I completed a telephone interview with former home manager, Damise Young. Ms. Young stated she recently left her employment with Beacon Home at Clarkston due to staffing issues. When she started, she was told the home was fully staffed and it was not. She stated they were also not doing what they should have been doing to retain staff. She did not have concerns regarding Ms. Phifer and described her as "okay". She never witnessed Ms. Phifer treating residents poorly, but she did hear some things. She stated there was never any evidence and most of the allegations came when there were disagreements with others. She denied ever hearing about her sleeping on shift. She was told by the program director, Ms. Landis, that Resident A told her about being left in the car by Ms. Phifer, but when Resident A told Ms. Landis, she was mad at Ms. Phifer. She denied knowing anything about Resident C's seizure. She stated no one told her about it. She explained that when an incident report is completed, it is done in their system and is then sent to her and the program director, Ms. Landis. She stated she would have seen an incident report if it had been completed at the time.

On 08/03/2026, I attempted telephone contact with direct care staff member, Victory Phifer. Ms. Phifer sent me a text message stating her phone was off and she wanted to text. Due to confidentiality concerns, I only asked her if she remembered completing an incident report in April regarding a seizure. She stated she was not sure if she completed the incident report, but she did inform me that others had documented it as well. She wrote that she left the job because it was too much for her emotionally.

On 08/03/2026, I completed a telephone interview with Resident C's support coordinator from Saginaw County Community Mental Health, Shermica Chandler. Ms. Chandler stated her concern with the home is the high turnover rate. Whenever she wants to schedule an appointment with Resident C, she must contact someone new because the person she was contacting is gone. She visits the home every three months and has monthly video appointments. When she has been to the home, it has been clean and with appropriate staffing. She has not been informed of Resident C having a seizure, nor has she received an incident report regarding a seizure. She explained that they are supposed to send her an incident report for something like that. She said that there definitely should have been some kind of follow-up with her doctor if Resident C had a seizure. She stated that she had an appointment with Resident C on 04/29/2026, and there was no mention of a seizure. I inquired about the appropriateness of Resident C being left unattended in a vehicle and she stated that was not appropriate and should never happen. She did explain that Resident C has delusions and will often tell her that she has a husband, when she doesn't, and that he has bought her a house for them to move into. She confirmed that Resident C does not have a guardian. After the phone interview, Ms. Chandler called me back and informed me she had just spoken with Don Adams, from Beacon Specialized Services. Mr. Adams called her last week and she returned

his call. He asked her about Resident C's seizure diagnosis and if there was any documentation regarding it.

On 08/03/2026, I reviewed each resident's IPOS. Resident C's IPOS, dated 04/28/2026, indicates that Resident C has delusions. The IPOS indicates, per self-report, that Resident C has high cholesterol, swelling, weakness from standing too long, asthma, high blood pressure, and a history of epilepsy. Under the section regarding current diagnoses, it states the diagnoses are epilepsy, unspecified (refers to recurrent, unprovoked seizures where the exact epilepsy type is not determined), not intractable (manageable or responsive to treatment), without status epilepticus (prolonged or repeated seizures without recovery), Type II diabetes mellitus without complications, and mild intermittent asthma, uncomplicated. It does not indicate when the diagnosis was made or who made it. Resident C's IPOS does not address unsupervised community access, but there are multiple concerns noted, due to her delusions. I then reviewed Resident C's resident information documents I was provided with. The document indicates a diagnosis of epilepsy, effective 02/17/2020.

Resident A's IPOS, dated 09/12/2025, indicates Resident A has freedom to access the community as she chooses, with or without supports.

Resident B's IPOS, dated 06/11/2026, indicates she has a history of aggressive behavior and that staff must maintain close supervision. She has engaged in self-harm and property damage. It also indicates that she has trauma history, dissociation, and occasional child-like presentation during stress, and to prevent the risk of exploitation, staff need to maintain supervision.

Resident D's IPOS, dated 04/10/2026, indicates she has community access and needs to let staff know where she is going and when she will return.

On 08/03/2026, I completed a telephone interview with Relative C1. Relative C1 has frequent contact with Resident C. She received a phone call from Resident C, approximately two months ago, telling her they took Resident C off of her seizure medications. Relative C1 informed me that Resident C has had seizures since she was a child. She has two types, one where she has convulsions and one where she just stares. She stated her daughter and Resident C were close as children and her daughter would run and tell her when Resident C was having seizures. She does not know if Resident C has ever been hospitalized for just the seizures, but she has had brain tumors, and it was assumed the seizures were due to those. She stated Resident C's seizures are manageable if she is on medications. She has witnessed the seizures herself, and Resident C used to see a neurologist for them, but she does not know who it was. Resident C has not told her about having any seizures lately. The home cannot tell her anything because Resident C is her own guardian and needs to give them permission to talk to her. Resident C has not told her anything of concern regarding staff or how she is treated in the home.

On 08/04/2026, I completed a telephone interview with ORR specialist, Ronda Nelson, from Saginaw County Community Mental Health. Ms. Nelson is planning an unannounced visit to the home. She interviewed Resident C over the telephone and stated Resident C told her that she had a seizure and had to crawl to the living room for help because Ms. Phifer was sleeping. She also informed Ms. Nelson that an ambulance came and did not take her to the hospital because she did not want to go. She stated she had a copy of the incident report regarding the seizure, which was received 04/28/2026 and was lacking any additional information.

On 08/04/2026, I completed a telephone interview with direct care staff member, Cheyenne Herrington. Ms. Herrington does not normally work at the Clarkston home but is filling in where needed. She does not have concerns regarding the daily care of the residents.

On 08/04/2026, I completed a telephone interview with direct care staff member, Carla Meeks. Ms. Meeks is assigned to the Dilley home but has been filling in at Clarkston. She denied hearing about any residents being mistreated, seeing any residents being mistreated or disrespected, and anyone sleeping on shift. She knew nothing about Resident C's seizures.

On 08/04/2026, I completed a telephone interview with direct care staff member, Margaret Yearby. Ms. Yearby is assigned to Beacon at Dilley but has been picking up shifts at Clarkston due to them not having any assigned staff there, except for Dori'Asia Miller. She stated they do not even have a home manager there. She has worked three shifts at Clarkston. Her first shift, she was there to work with Ms. Miller. She arrived around 7pm and Ms. Miller was wrapped up in a blanket with her head on the table, she was awake though. She stated Ms. Miller went to her car and stated she was not clocking out until 10pm. She stated Ms. Miller went to her car to sleep. After 10pm, Ms. Yearby went out to have a cigarette and Ms. Miller was still in her car, sleeping. She has not heard anything about staff mistreating residents. She does not know anything about Resident C's seizures.

On 08/05/2026, I completed a referral to Adult Protective Services (APS) due to concerns regarding Resident C’s seizures and the care she was provided.

On 08/06/2026, I received a phone call from APS investigator, Heather Stickel. Ms. Stickel was assigned to the investigation and will be going to the home to complete an unannounced visit.

On 08/06/2026, I completed a telephone interview with Guardian AB1. Guardian AB1 is the guardian to Resident A and Resident B. She just saw Resident B on Saturday, and everything seemed fine. Resident B’s main concern is obtaining her birth certificate to get her identification. She did receive an incident report regarding a verbal altercation between Resident B and another resident, but it was not physical. She stated Resident B would not be safe to be left alone in a van. As for Resident A, she has trouble getting to see her due to Resident A working and having

a boyfriend. Resident A is gone as much as possible. There have been concerns with some of her behaviors since obtaining a boyfriend.

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:	Based on the information obtained during the special investigation, there is sufficient evidence to support that residents were not receiving supervision, protection, and personal care, as specified in their assessment plans. Resident A, Resident C, and direct care staff member, Jaime Brazelton, all stated that direct care staff member, Victory Phifer, was sleeping while Resident C had a seizure. Furthermore, at least two other staff members stated they saw Ms. Phifer sleeping while working. Resident A and Resident C both stated they were left alone in the vehicle. These incidents pose a substantial risk to residents, as they are supposed to be supervised. Resident C could have serious complications due to the seizure and any of the residents could elope from an unattended vehicle, hurt themselves, or others.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference Special Investigation Report #: 2025A0626015 dated: 06/05/2025, CAP dated: 06/09/2025.**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(11) A licensee shall contact a resident's health care professional for instructions as to the care of the resident if the resident requires the care of a health care professional. The licensee shall record in the resident's record any instructions for the care of the resident.
ANALYSIS:	Based on the information obtained during the special investigation, there is sufficient evidence to support that

	Resident C's health care professional has not been contacted for instructions as to the care of Resident C. Resident C's resident information documents and IPOS dated 04/28/2026, both list epilepsy as a diagnosis for Resident C. Resident C stated she had a seizure three months ago. Staff who were interviewed stated they did not know what they were supposed to do if she had a seizure. There was no follow-up with Resident C's physician regarding her seizure, neither to report it nor to inquire about whether she should be seen, or if there should be any adjustment to her medications. This poses a substantial risk to the health and wellbeing of Resident C, as no one has the information required to ensure she is safe from seizures.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care staff member, Victory (Tory) Phifer, was demeaning to Resident B and treats other residents disrespectfully.

INVESTIGATION:

On 07/10/2026, I completed an unannounced onsite investigation at Beacon Home at Clarkston. I completed a private in person interview with Resident A. Resident A stated there is a lot of "bullshit" going on here. She does not like how the staff treat the residents. She went to Walmart with Tory and Resident B. Resident B wanted to buy a pair of shorts. The shorts were stretchy and Resident B made sure they fit. Tory started fat shaming her; telling Resident B that her hips were too big for those shorts and Resident B cried. She has called recipient rights, and she knows that staff are not supposed to retaliate when they make a complaint, but Tory started ignoring her after she read the report.

On 07/10/2026, I completed a private, in-person interview with Resident B. Resident B stated she is happy here and feels safe. There are a couple of residents who are mean and sometimes staff are mean. She is okay with Tory, but she did tell her she couldn't fit in her shorts because they weren't her size. Resident B insisted they were her size and Tory told her, "You're too big for those shorts. You can't get them."

On 07/10/2026, I completed a private, in person interview with Resident C. She stated the staff are not always nice and she wants to leave here. She stated Tory is not respectful.

On 07/10/2026, I completed an in-person interview with program director, Brooke Landis. Ms. Landis stated she heard about the body shaming allegations. She was

told by their chief of compliance, who was told by Resident B. Recipient rights was called and she had not heard anything else. She stated she was told that direct care staff member Victory (Tory) Phifer took Resident B to Walmart and told Resident B that she was too big for the shorts she wanted and that she needed to lose weight.

On 07/31/2026, I complete a telephone interview with direct care staff member, Janaya Dantzler. Ms. Dantzler denied ever seeing Ms. Phifer treating any residents in a bad way, her tone can get "high" but nothing disrespectful.

On 07/31/2026, I completed a telephone interview with direct care staff member, Jaime Brazelton. Ms. Brazelton stated she has worked with Victory Phifer, and she did not like how she treated the residents. She saw Ms. Phifer scream at and put down residents. She stated Ms. Phifer was so mean to Resident B that she became suicidal. She brought the concern to the home manager, Damise Young, and Ms. Young told her that she did not believe the resident. She stated that residents were talked to "sternly" about reporting to recipient rights and Ms. Phifer screamed in a resident's face for calling in a complaint against her. She did not like how Ms. Phifer was with Resident C. She would feed into her delusions and it became scary. She did not provide examples.

On 08/03/2026, I completed a telephone interview with former home manager, Damise Young. Ms. Young did not have concerns regarding Ms. Phifer and described her as "okay." She never witnessed Ms. Phifer treating residents poorly, but she did hear some things. She stated there was never any evidence and most of the allegations came when there were disagreements with others.

On 08/04/2026, I completed a telephone interview with direct care staff member, Carla Meeks. Ms. Meeks denied hearing about any residents being mistreated, seeing any residents being mistreated or disrespected, and denied having knowledge of anyone sleeping on shift.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the information gathered during the special investigation, there is sufficient evidence to support that residents were not treated with dignity and respect. Resident A and Resident B both stated Victory Phifer was rude to Resident B about her weight. Direct care staff members shared concerns with the way Ms. Phifer was talking to residents, including an incident where she berated a resident so badly that she stated she was suicidal. Furthermore, Resident A stated Ms. Phifer

	would yell at the residents if she found out they reported her to recipient rights.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 07/31/2026, I received contact information for the direct care staff members who made 911 calls, Onika Walton, Jaime Brazelton, and Victory Phifer. Onika Walton is not in the Workforce Background Check System as having had a completed background check.

On 08/04/2026, I received the staff schedule for Beacon Home at Clarkston for the last 90 days from Mr. Jenner. I completed a search of the Workforce Background Check System and found that the following employees had no completed background checks for any Beacon Specialized Services homes:

- Makayla Spinner
- Emily Fairris
- Nancy De Leon

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt

	under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on the information gathered during the special investigation, there is sufficient evidence to support that employees without completed background checks had direct access to residents. Upon receipt of the staff schedule, I completed checks of the Workforce Background Check System and four employees who worked with residents did not have completed background checks. This creates a risk for residents due to not knowing if the staff members have convictions and are a danger to residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to the facility currently being on a provisional license and the intervening quality of care violations, I recommend revocation of the license.

08/10/2026

Sara Shaughnessy Date
Licensing Consultant

Approved By:

WOC Area Manager for 08/10/2026

Denise Y. Nunn Date
Area Manager