GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 16, 2026

Byerly Enterprises II
4759 Owasco Ct
Clarkston, MI 48348

RE: License #: AS630417869
Investigation #: 2026A0626030
Eastlawn Manor

Dear Mr. Byerly:

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,

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

I. IDENTIFYING INFORMATION

License #:	AS630417869
Investigation #:	2026A0626030
Complaint Receipt Date:	07/21/2026
Investigation Initiation Date:	07/21/2026
Report Due Date:	09/19/2026
Licensee Name:	Byerly Enterprises II
Licensee Address:	4759 Owasco Ct Clarkston, MI 48348
Licensee Telephone #:	(810) 691-6400
Administrator:	N/A
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?
The home is supposed to have three staff members on duty and are not always fully staffed.	No
Direct care staff members have been observed threatening and mistreating residents, including pushing one of them. They are also exploiting residents, financially, and sexually by stealing food and water and a staff member having a sexual obsession with a resident.	No

III. METHODOLOGY

07/21/2026	Special Investigation Intake 2026A0626030
07/21/2026	APS Referral A referral was not made to Adult Protective Services due to the complaint being sent by them, after they denied it for investigation.
07/21/2026	Special Investigation Initiated - Letter I initiated the special investigation by requesting the contact information of the referral source from Adult Protective Services, via email. A response was received, indicating it was anonymous.
07/21/2026	Contact - Document Sent I forwarded the complaint to office of recipient rights specialist, Sarah Rupkus.
07/22/2026	Contact - Face to Face I completed an unannounced onsite investigation at Eastlawn Manor. I completed interviews with direct care staff members, Amier Hatcher, Jalen Ellis, and Sam Kreiman. I completed a private interview with Resident A and attempted interviews with Resident B, Resident C, Resident D, and Resident E.
07/28/2026	Contact - Document Sent I emailed a request for documents to licensee, Carl Byerly.

07/29/2026	Contact - Telephone call received I received a telephone call from licensee, Carl Byerly, inquiring about the investigation.
08/12/2026	Contact - Document Received I received each resident's IPOS from licensee, Carl Byerly, along with incident reports for Resident B.
08/27/2026	Contact - Telephone call made I completed a telephone interview with Relative B1 and Relative B2. I also completed telephone interviews with Mr. Byerly, direct care staff members, Steven Redmond, Kiyana Harrison, and Resident A's public guardian, Tammy Dykstra.
08/31/2026	Contact - Telephone call made I completed a telephone interview with direct care staff member, Sherry McLean.
09/03/2026	Exit conference I completed an exit conference, via telephone, with licensee, Carl Byerly. The findings were discussed.

ALLEGATION:

The home is supposed to have three staff members on duty and are not always fully staffed.

INVESTIGATION:

On 07/21/2026, I received a complaint, via email, alleging the home was not staffed properly. There were also allegations stating residents were being mistreated. The allegations stated an elderly man in a wheelchair has been threatened by staff members and they are rude to him due to having a communicable disease. Another resident, who is nonverbal, has been pushed down by a worker named Steven. They alleged that there is a staff member who is believed to be sexually obsessed with a resident.

On 07/21/2026, I emailed the complaint to Sarah Rupkus, office of recipient rights investigator with Oakland Community Health Network. She informed me that they are not providing any services for any residents at Eastlawn Manor.

On 07/22/2026, I completed an unannounced onsite investigation at Eastlawn Manor. I observed three staff members on duty. I first interviewed direct care staff member, Amier Hatcher. Mr. Hatcher has been employed at Eastlawn Manor for 4-5 months. He stated there are usually three staff members on duty at all times and denied that any of the residents are 1:1.

On 07/22/2026, during the onsite investigation, I completed an in-person interview with direct care staff member, Jalen Ellis. Mr. Ellis has worked at the home for approximately 5-6 months. He stated there are usually three staff members on duty, sometimes two.

On 07/22/2026, during the onsite investigation, I completed a telephone interview with direct care staff member, Sam Kreiman. He worked at the home for approximately one year. He stated there are usually three staff members on duty.

During the onsite investigation, I requested the IPOS of each resident in the home, the staff members indicated they were kept in the office and the office was locked. They recommended I contact the licensee for the information.

On 07/28/2026, I sent an email to licensee Carl Byerly, requesting the documents I had requested during the onsite investigation.

On 07/29/2026, I received a phone call from licensee, Carl Byerly. He stated he was not aware of the investigation or my request for the documents. He assured me he would get them to me. I informed him of the allegations, and he denied hearing anything regarding any of them. He informed me that he did recently terminate an employee, so he believes this might have something to do with the allegations.

On 08/12/2026, I began reviewing each resident's IPOS to find which community mental health office they are receiving services through. I contacted Northern Lakes Community Mental Health Authority (Resident B), via telephone, and was informed that the complaint had been received and a message was left requesting the assigned investigator to call me. I contacted Pathways Community Mental Health and left a voicemail, requesting a phone call. I contacted Washtenaw County Community Mental Health and left a voicemail; I received a return call and was informed they would not be investigating. I sent an email with the allegations, via email, to Newaygo Community Mental Health. I received a call from Northern Lakes Community Mental Health Authority, the allegations were discussed and I was informed they would not be investigated. Newaygo Community Mental Health contacted me, via telephone, and indicated they would be looking into the allegations.

Resident A's IPOS, dated 04/13/2026, indicates that Resident A is very impulsive and knows how to manipulate systems and social situations to work for him to achieve his desired outcomes. He needs staff to be present to provide ongoing monitoring to support his health and safety needs. He only requires one on one supervision while in the community.

Resident B's IPOS, dated 03/05/2026, indicates that Resident B is a 1:1 while in the community.

Resident C's IPOS, dated 07/18/2026, was reviewed and it indicates that Resident C has a history of assaultive behaviors. There is nothing indicating that he has 1:1 staff.

Resident D's IPOS dated 02/16/2026 does not indicate he needs a 1:1 staff member.

Resident E's IPOS dated 08/29/2026 was reviewed and there is nothing indicating he is a 1:1. He does have a history of causing harm to himself, including bruising.

Resident F's IPOS dated 09/11/2025 contains nothing indicating he requires a 1:1.

I reviewed the staff schedule for Eastlawn Manor for the month of July 2026. Every first shift had 2-3 staff members scheduled to work. Every second shift had three staff members scheduled to work. Every third shift had two staff members scheduled to work. The schedule appeared to have been updated when changes regarding which staff were working.

APPLICABLE RULE	
R 400.671	**Resident care.**
	Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	Based on the information obtained during the special investigation, it has been determined that there is not sufficient evidence to support the fact that there is insufficient staffing. Staff members who were interviewed stated there are always 2-3 staff members on duty. Upon reviewing the staff schedule, the home never has fewer than two people on duty. A review of each resident's IPOS was completed and only Resident B has a 1:1, when he is in the community.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Direct care staff members have been observed threatening and mistreating residents, including pushing one of them. They are also exploiting residents, financially, and sexually by stealing food and water and a staff member having a sexual obsession with a resident.

INVESTIGATION:

On 07/22/2026, I completed an unannounced onsite investigation at Eastlawn Manor. I observed three staff members on duty. I first interviewed direct care staff member, Amier Hatcher. Mr. Hatcher has been employed at Eastlawn Manor for 4-5 months. He informed me that there is one resident in a wheelchair, and that is Resident A. Resident A is verbal and he was home. He denied knowing if any of the residents required a one

on one, as he did not know about their individual plans of service (IPOS). He shared that Resident A has Methicillin-resistant Staphylococcus aureus (MRSA) and is on antibiotics. They have been instructed to keep him in his room as much as possible, to use gloves when going into his room or while providing care for him, and to clean as much as possible. He stated that the other resident is Resident B and he confirmed that he is nonverbal. He denied ever hearing of anyone pushing anyone and shared that "Steven" was not working today. He denied ever hearing about any sexual obsessions, anyone being rude, or anyone being mean to any of the residents.

On 07/22/2026, during the onsite investigation, I completed an in-person interview with direct care staff member, Jalen Ellis. Mr. Ellis has worked at the home for approximately 5-6 months. Mr. Ellis denied seeing anyone being mean to any of the residents. He denied knowing anything about "Steven" pushing anyone and added that he has worked with Steven and he is a good worker. He denied ever seeing any staff members mad at anyone. He denied seeing anyone being rude. He informed me that everyone here helps each other out.

On 07/22/2026, during the onsite investigation, I completed a telephone interview with direct care staff member, Sam Kreiman. He worked at the home for approximately one year. He denied seeing or hearing of anyone being rude, mean, or physical with any residents. He stated it is a nice and relaxed home.

During the onsite investigation, I completed a private in person interview with Resident A. Resident A has lived at the home for approximately three years. He likes it here and feels safe. He denied seeing any residents assaulted by staff members, then shared that there was a staff member who gave a resident a black eye. When I asked which resident and which staff member, he stated he was too scared to tell, out of fear it would happen to him, and since he is the only resident who is verbal, they will know it was him. He shared that the resident still has a black eye. He then shared that "Steven" once hit him in the head with a packet of Kool-Aid. It didn't hurt and he stated "Steven" did it because he was mad. When I asked more about him being mistreated, he replied, "I am fine. You have bad information".

During the onsite investigation, I attempted a private interview with Resident B. Resident B is mostly non-verbal but can answer simple yes or no questions. He nodded his head "yes" when I asked him if he felt safe in the home, likes it here, if someone hurt him, and that it was a staff member. He then started saying, "I sorry", over and over, then he walked about of the room. I did not observe a black eye on him, but I did observe some marks on his neck that appeared to look like scratches. I took photographs and asked Mr. Kreiman about. He stated that Resident B has seizures, and he believes it happened during a seizure.

During the onsite investigation, I attempted a private interview with Resident C. He is nonverbal. I did not see any visible marks or bruises on his face.

During the onsite investigation, I attempted a private interview with Resident D. He is nonverbal. I asked him if he likes it there and he did not answer. I did not observe any visible marks or bruises on his face or exposed skin.

During the onsite investigation, I attempted a private interview with Resident E. He is nonverbal. I asked him if he liked it there and he shook his head "no". He also shook his head for "no" when I asked if the staff was nice and if he was scared. I did not observe any visible marks or bruises on his face or exposed skin.

Before I left the home, I was informed by Mr. Kreiman that he had contacted his boss to request them to send over the documents I requested.

On 07/28/2026, I sent an email to licensee Carl Byerly, requesting the documents I had requested during the onsite investigation.

On 07/29/2026, I received a phone call from licensee, Carl Byerly. He stated he was not aware of the investigation or my request for the documents. He assured me he would get them to me. I informed him of the allegations, and he denied hearing anything regarding any of them. He stated they always have at least two staff members on duty. He informed me that he did recently terminate an employee, so he believes this might have something to do with the allegations.

On 08/12/2026, I began reviewing each resident's IPOS to find which community mental health office they are receiving services through. I contacted Northern Lakes Community Mental Health Authority (Resident B), via telephone, and was informed that the complaint had been received and a message was left requesting the assigned investigator to call me. I contacted Pathways Community Mental Health (Resident D) and left a voicemail, requesting a phone call. I contacted Washtenaw County Community Mental Health (Resident A) and left a voicemail; I received a return call and was informed they would not be investigating. I sent an email with the allegations, via email, to Newaygo Community Mental Health (Resident C and Resident E). I received a return call from Northern Lakes Community Mental Health Authority, the allegations were discussed and I was informed they would not be investigated. Newaygo Community Mental Health contacted me, via telephone, and indicated they would be looking into the allegations.

Resident A's IPOS, dated 04/13/2026, indicates that Resident A is very impulsive and knows how to manipulate systems and social situations to work for him to achieve his desired outcomes. He needs staff to be present to provide ongoing monitoring to support his health and safety needs. He only requires one on one supervision while in the community.

Resident B's IPOS, dated 03/05/2026, indicates that Resident B is a 1:1 while in the community. He is diagnosed with autism spectrum disorder, unspecified intellectual disability, intermittent explosive disorder, unspecified anxiety disorder, and has a history of obsessive-compulsive disorder. He has a history of physical aggression towards

others, and he has caused injuries to others, he resorts to it to communicate his needs. He responds to staff who are calm, caring, and confident. He likes to be alone, and only around people on his terms. He also has a history of hurting himself in different body parts.

I also reviewed an incident report dated 07/16/2026, regarding Resident B, it was written by Jennifer Stancroff and states the following:

> "Staff and Resident B were in the laundry room. Resident B slumped to the floor and staff called out to management. Resident B started to have a seizure. Management laid Resident B on his side with a pillow under his head and asked one staff to time the seizure and the other to call 911. Seizure lasted from start to finish, 2 minutes."

The incident report indicates that Resident B was taken to the emergency department and a follow-up appointment was made with his primary care physician and his neurologist. The discharge papers from McLaren Clarkston dated 07/16/2026, were included with the incident report.

I reviewed another incident report, dated 07/20/2026, regarding Resident B, written by Jennifer Stancroff. It reads:

> "While staff was giving Resident B his meds, the staff noticed a bruise on his forehead, an abrasion on his neck, and a bite mark on his tongue. Management checked his logs and followed up with previous staff. No incident was observed prior to bedtime. Staff is now required to do 30-minute checks instead of every hour and sign off as a precaution due to seizures."

On 08/27/2026, I completed a telephone interview with Relative B1 and Relative B2. They stated they have concerns regarding the lack of communication from the home. Resident B was in a psychiatric hospital in Kalamazoo, then went to Caro Psychiatric Hospital. They had a difficult time finding a home willing to admit him due to his behavior. They did not visit the home for the first year he was there, they explained that they wanted to give him time to adjust. They have been there twice. They want him somewhere closer to them; they live in Traverse City but could not find anywhere closer who would accept him. They informed me that Resident B is non-verbal, and they do not think he understands when people ask him yes or no questions. They stated if he told me he was sorry, it means that he probably did something wrong. They received an incident report on 07/20/2026, indicating staff members thought Resident B had a seizure because he had a bump on his head and a scratch on his neck. He has an appointment with the neurologist tomorrow for testing because the seizures are a fairly new development. Resident B can sometimes become violent, and they would not be surprised if someone were pushing him, he has been abused previously while in the hospital.

On 08/27/2026, I completed a telephone interview with licensee designee, Carl Byerly. Mr. Byerly informed me that he spoke to all staff members, and no one knew anything about food or water going missing and he has not noticed a jump in groceries being bought. He stated that none of the staff members informed him of any concerns. He stated Sherry McLean has worked for him 4-5 years and Kiyana Harrison has worked there for four years. Neither woman has had any complaints made against them and they have been solid employees. Mr. Byerly shared that Resident A will distort stories but has never said anything to him about anyone being mean. He stated Steven Redmond had worked for him for five years and he has never had anyone complain about him.

On 08/27/2026, I completed a telephone interview with direct care staff member, Steven Redmond. Mr. Redmond is aware of the investigation. He denied ever pushing any of the residents. He stated Resident B will target him when he is upset and will come after him; when this happens, he will usually go outside and wait for him to calm down. He denied threatening any residents or hearing anyone else threaten any residents. Mr. Redmond admitted to hitting Resident A with a Kool-Aid packet and stated Resident A was demanding the packet and he tossed it to him. The packet hit his lap, and he started yelling that he threw it at him and hit him on purpose. He denied punching any residents and seeing any residents with a black eye. He knows nothing about any staff member stealing food or water from the home and has not noticed food going missing. He stated there is a Resident who is sexually inappropriate, mostly to Sherry McLean. He stated it is Resident C and he has pulled down his pants in front of the female staff members, he has also touched them on the head and they redirect him. He shared that Ms. McLean seems to be a bit scared of Resident C and walks away when he starts getting inappropriate.

On 08/27/2026, I completed a telephone interview with direct care staff member, Kiyana Harrison. Ms. Harrison denied all allegations regarding residents being mistreated. She stated she has been in this field for 27 years and has never mistreated or disrespected a resident. She denied knowing anything about Ms. McLean taking food and water. She denied hearing of anyone pushing, hitting, or being disrespectful to residents. She stated Mr. Byerly is "on it" when they bring concerns to him. She stated Ms. McLean told her about Resident C, grabbing her hand and placing it on his crotch, she knows nothing else about it. She shared that she is often stern with Resident A because he will steal any chance he gets. If he is caught and someone says something, he accuses them of being mean and yelling at him.

On 08/27/2026, I completed a telephone interview with Resident A's public guardian, Tammy Dykstra. Ms. Dykstra stated that Resident A is extremely difficult, delusional and extremely money focused. He will steal and blame other people if he can. He does not allow staff to clean his wounds and will smoke in the house if no one is watching. He has had MRSA for a long time, so she is doubtful they are picking on him for it. She stated Resident A is a bully and doesn't care about what others think of him. Resident A is not afraid of being hit because he is usually the one doing the hitting. Resident A lies a lot. Ms. Dykstra has never heard of anything inappropriate or concerning at the

home from Resident A, she said he calls her frequently, but it is always about money. She has had Resident A for quite a few years, and it was difficult to find a home that would take him due to his level of difficult behavior. He has been discharged from many group homes.

On 08/31/2026, I completed a telephone interview with direct care staff member, Sherry McLean. Ms. McLean has worked at the home for more than four years. She denied seeing any pushing, picking on, or threatening any residents. She stated she lives in the City of Flint, and she does not trust the water due to the water crisis, so she does take empty water jugs to the home with her, and she fills them with tap water so she can have safe water to drink. She vehemently denied ever taking food from the home.

She stated Resident C does not have a sexual obsession with her, but he is touchier with her than others. She explained that she had been one of the staff members who first picked up Resident C to bring him to the home and that residents will often develop an attachment to the first staff members they meet. She stated he will often touch the top of her head and she did not think much of it, then he started exhibiting sexually inappropriate behavior such as exposing himself, and she started to discourage him from touching her and will tell him to keep his hands to himself and will walk away if he tries to touch her. She denied seeing any residents with a black eye. She stated they recently terminated two employees, and she believes this is where this is coming from. She stated Mr. Byerly is always good at addressing any issues they bring to him.

On 09/03/2026, I completed an exit interview with licensee, Carl Byerly, via telephone. The findings were discussed. I informed Mr. Byerly that while there is not enough evidence to support licensing rule violations, there are concerns. Mr. Byerly stated he is going to have an in-service training with all of his direct care staff members regarding the proper care and treatment of residents.

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 obtained during the special investigation, it has been determined that there is not sufficient evidence to support that the residents are not being treated with dignity and respect, free from exploitation, and protected and safe. Resident A denied being mistreated, he stated that another resident had been punched in the eye but could not tell me which resident or which direct care staff member were involved. Resident A had stated that the resident who was hit still had the blackeye; I saw all residents and did not see any with a black eye or any other bruising or injuries. None of the

	other residents are verbal and could not tell me what has happened. Six direct care staff members were interviewed and each one denied having witnessed any maltreatment of any residents. Resident A's guardian stated that he has been discharged from many group homes due to his behavior; he has delusions and will often bully others. Direct care staff member, Sherry McLean, admitted to taking water from the home, but she was filling her own water jugs with tap water from the home, not any purchased bottled water for residents and she denied stealing any food. None of the other staff members interviewed admitted to seeing anyone take any food or water. Furthermore, Ms. McLean denied that Resident C has a sexual obsession with her and that she has one with him, explaining he touches her head and did expose himself to her, but she has been proactive at redirecting his behavior and walking away from him when the redirection is not effective. Licensee, Carl Byerly denied noticing any increases in grocery costs and hearing anything about any of the other allegations.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

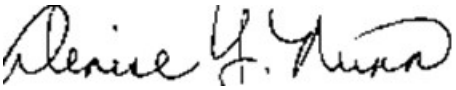
I recommend no changes be made to the status of the license and for the special investigation to be closed.



09/09/2026

Sara Shaughnessy — Date
Licensing Consultant

Approved By:



09/16/2026

Denise Y. Nunn — Date
Area Manager