

STATE OF MICHIGAN
DEPARTMENT OF LIFELONG EDUCATION, ADVANCEMENT, AND POTENTIAL
CHILD CARE LICENSING BUREAU

In the matter of

PBA Royal LLC

License #: DC820407576

SIR #: SI-00141402

SI-00141460

SI-00141971

SI-00142262

SI-00142660

SI-00144586

ORDER OF SUMMARY SUSPENSION
AND NOTICE OF INTENT TO REVOKE LICENSE

The Michigan Department of Lifelong Education, Advancement, and Potential, by Division Director Erika Bigelow and Bureau Director Courtney Adams, Child Care Licensing Bureau, hereafter referred to as “the Bureau,” orders the summary suspension and provides notice of the intent to revoke the license of Licensee, PBA Royal LLC, to operate a child care center pursuant to the authority of the Child Care Organizations Act, 1973 PA 116, as amended, MCL 722.111 et seq., for the following reasons:

1. On or about January 12, 2022, Licensee was issued a license to operate child care center, New Beginnings Child Care and Academy, with a licensed capacity of 137 at 15340 Southfield Freeway, Detroit, Michigan 48223. Pageant Atterberry and Vanecia Ayers are both licensee designees for this center.
2. Prior to the issuance of the license, and during subsequent modifications of the statutes and rules, Licensee received copies of the Child Care Organizations Act,

the licensing rule book for child care centers, and the Child Protection Law.

These rules and statutes are posted and available for download at

www.michigan.gov/mileap.

Previous Licensing Violations

3. On February 17, 2023, Licensing Consultant Essence Hickman initiated *Special Investigation #2023D0350009* after the Bureau received a licensing-related complaint and cited Licensee for failing to provide appropriate care and supervision of children at all times, as required by Rule 400.8125(1). [Effective May 7, 2025, this conduct is regulated under Rule 400.8213(1)(a).] A child, age 4 years, was found alone in a hallway without supervision. On June 7, 2023, Licensee submitted a written corrective action plan to the Bureau that addressed the violation.
4. On February 20, 2024, Licensing Consultant Selika Johnson initiated *Special Investigation #SI-00119141* after the Bureau received a licensing-related complaint and cited Licensee for failing to provide appropriate care and supervision of children at all times, as required by Rule 400.8125(1). [Effective May 7, 2025, this conduct is regulated under Rule 400.8213(1)(a).] On February 15, 2024, a child care staff member pulled a child, age 1 year, by the arm causing nursemaid's elbow. The child needed medical attention to have the elbow put back in place. On July 10, 2024, Licensee submitted a written corrective action plan to the Bureau that addressed the violation.
5. On October 28, 2024, Licensing Consultant Brandon Robinson initiated *Special Investigation #SI-00132163* after the Bureau received a licensing-related

complaint and cited Licensee for failing to provide appropriate care and supervision of children at all times, as required by Rule 400.8125(1). [Effective May 7, 2025, this conduct is regulated under Rule 400.8213(1)(a).] During the investigation on October 28, 2024, Brandon Robinson observed a child care staff member sleeping with her head on a desk and snoring. There were five children present in the room with only a sleeping child care staff member present. Licensee submitted a written corrective action plan to the Bureau that addressed the violation.

6. On May 7, 2025, Licensing Consultant Laura Piacentini initiated *Special Investigation #SI-00137940* after the Bureau received a licensing-related complaint and cited Licensee for failing to provide appropriate care and supervision of children at all times, as required by Rule 400.8125(1). [Effective May 7, 2025, this conduct is regulated under Rule 400.8213(1)(a).] Multiple children were left unsupervised in the center. On May 12, 2025, Licensee submitted a written corrective action plan to the Bureau that addressed the violation.

Current Violations

7. Licensee failed to provide appropriate care and supervision of children at all times as demonstrated by the following:
 - a. In September or October 2024, Child D, age 5 years, got out of the center and was found in the parking lot by a teacher.
 - b. In or around May 2025, Child D's Mother arrived at the center to pick up Child D, and she was not in the classroom. She observed children in the

classroom without a teacher present. Child D's Mother went to the lunchroom to look at the cameras so she could find Child D. Child D's Mother eventually heard Child D upstairs. As Child D's Mother was walking upstairs, she overheard LT 3 stating that "she could have gotten to the freeway." However, LT 3 later stated that she was talking about another child, not Child D.

- c. During the afternoon of July 11, 2025, Teacher 8 transported approximately 20 children to a nearby park for outdoor play. While they were there, three boys who did not attend the child care center jumped on Child B, age 11 years, and stole money from his backpack. Child B suffered scrapes and bruises from the incident. The only staff person present was Teacher 8, and he did not intervene.
- d. On July 11, 2025, while on the bus back to the center, Child E, age unknown, choked Child B. Teacher 8 was the only staff person present, and he was driving the bus. There were no additional child care staff members present to care for and supervise the children.
- e. On July 11, 2025, when the bus arrived back at the center, Child B got off the bus and started walking home. Teacher 8 did not call out to Child B or do anything to prevent him from leaving the center. Child B walked home unsupervised. According to Google Maps, Child B's home is .9 miles and a 19-minute walk from the center. The area is near an entrance to a freeway and is heavily trafficked.

- f. On July 11, 2025, the center called Child A, B, and C's Mother approximately one hour after Child B left the center. Staff informed Child B's Mother that Child B left the center and asked her for her home address. When Child A, B, and C's Mother arrived at her home, she observed Teacher 8 in the driveway. Child A, B, and C's Mother found Child B in the backyard under a tree. Child A, B, and C's Mother took him back to the center.
- g. On July 18, 2025, Child A, B, and C's Mother arrived at the center to pick up Child C, age 2 years. Child C was sleeping on a cot. When staff woke him, his mouth was full of hamburger meat, and Child A, B, and C's Mother had to pull it from his throat.
- h. On July 29, 2025, at approximately 7:15 a.m., Child A, age 8 years, arrived at the child care center. Child A has autism, Down Syndrome, and is non-verbal.
- i. On July 29, 2025, sometime around 8:00 a.m., Child A left the center barefoot and without supervision. At 8:09 a.m., Child A ran across Fenkell Street and Southfield Freeway. As Child A was crossing Fenkell Street, Witness 1 was in his vehicle waiting for the light to change. When he saw Child A, Witness 1 pulled his truck into the intersection to block traffic to prevent Child A from being hit by a car. Witness 1 ran after Child A and grabbed her to prevent her from crossing Grand River Avenue. Witness 1 walked Child A over to a nearby gas station and left Child A with Witness 2 while he moved his vehicle out of the road. Witness 2 tried to

communicate with Child A, but she was unable to respond to Witness 2's questions. Witness 1 called 911 at approximately 8:11 a.m.

- j. On July 29, 2025, at or around 8:16 a.m., Detroit Police officers arrived on scene. At approximately 8:22 a.m., a child care staff member arrived at the gas station and stated that Child A was in care at the center. The child care staff member arrived on foot, was walking casually, and did not appear to be frantic or rushed.
- k. On July 29, 2025, at approximately 8:33 a.m., Licensee Designee Pageant Atterberry, Acting Program Administrator (PA) 1, and Teacher 1 arrived at the gas station. At 8:44 a.m., Child A was taken to Sinai Grace Hospital for a wellness check. No trauma and/or injuries were found.
- l. The distance from the child care center to where Child A was found is approximately 423 feet. The area is near an entrance to a freeway and is heavily trafficked.
- m. On August 7, 2025, Child A's front tooth was knocked out while she was in care at the center. Acting Program Administrator told Child A, B, and C's Mother that Child A was running around and she ran into her arm/wrist causing the tooth to come out.
- n. On August 7, 2025, after picking up Child A from the center, Child A, B, and C's Mother took Child A to the hospital. Medical staff informed Child A, B, and C's Mother that Child A had likely hit something hard, like a table or similar object. Medical staff expressed doubt that the injury could be

caused by a child running into someone's arm. The root of the tooth was still in Child A's gums.

- o. On August 8, 2025, at approximately 5:13 p.m., Child B went into a closet area to collect his backpack. When he went to leave, the closet door was locked. He shouted and pounded on the door for someone to let him out, but no one came.
- p. On August 8, 2025, at approximately 5:30 p.m., Child A, B, and C's Mother arrived at the center to pick up her children but could not locate Child B. Teacher 4 told Child B's Mother that he was in the restroom, but he was not there. Teacher 4 sent other children in care to find Child B. Child A, B, and C's Mother and other children spent approximately 30 minutes looking for him. Eventually, someone checked the closet, and Child B exited. He was crying and sweating all over.
- q. On October 2, 2025, Child L, age 3 ½ years and non-verbal, was in the cafeteria with Teacher 4. At some point, Child L suffered a cut to the back of his head. According to her statement provided to police, Lead Teacher (LT) 5 entered the cafeteria and observed Child L lying on the floor near the entrance, and Teacher 4 sitting at a table working on a tablet. LT 5 asked Teacher 4 why Child L was lying on the floor and observed blood on the floor. After observing the injury, Teacher 4 called 911 for an ambulance at 4:34 p.m.
- r. On October 2, 2025, at 4:37 p.m., Detroit Police Officers Ebbin and Harvey were dispatched to the center. Upon arrival, Officer Harvey

observed blood on the floor in the cafeteria. Child L was screaming and crying, and there was blood coming from the back of his head. There was a large amount of blood all over the back of Child L's shirt. Shortly after the police arrived, Child L's Mother arrived at the center, and she transported Child L to Children's Hospital for treatment.

- s. On October 2, 2025, while on scene, police asked child care staff to view the video footage to determine how Child L received the injury. Staff told police that they were unable to view the video footage because the system needed to be reset. Child care staff provided differing accounts regarding Child L's injury to police, Child L's Mother, and to the Bureau. No one could state for certain how Child L's injury occurred despite the center having security cameras.
8. Licensee failed to cooperate with the Bureau during an investigation, failed to provide accurate and truthful information to the Bureau, and does not have the administrative capability to operate the center in order to provide the services and facilities that are conducive to the welfare of children. Specifically:

Investigation Involving Child A Leaving the Center on July 29, 2025

- a. On July 30, 2025, Acting PA submitted an incident report to the Bureau regarding Child A leaving the center. In the report, Acting PA claimed that she was right behind Child A as she exited the center and followed her to where Witness 2 was located. However, video footage from outside the center shows that Acting PA was not right behind Child A and did not show up to the scene for several minutes.

- b. On August 26, 2025, Selika Johnson called Pageant Atterberry regarding the incident. Pageant Atterberry was unable to confirm the number of children enrolled in the autism spectrum classroom. Pageant Atterberry hung up on Selika Johnson during the call.
- c. During the investigation, Selika Johnson made two requests to view the video footage from July 29, 2025. Licensee did not provide the video footage or an opportunity to view the footage at the center. Pageant Atterberry told Selika Johnson that she did not watch the video footage, and it was no longer available for viewing.
- d. During the investigation, Selika Johnson sent three emails to Pageant Atterberry requesting an interview before Pageant Atterberry finally agreed to an interview on September 10, 2025. During the interview, Pageant Atterberry told Selika Johnson that Child A was never unsupervised while she walked away from the center. However, outside video footage shows that Child A was without supervision for several minutes before child care staff arrived at the gas station.
- e. On July 29, 2025, Pageant Atterberry showed up at the gas station while police were present with Child A. However, during the investigation, Pageant Atterberry did not disclose to Selika Johnson that she was on scene at the gas station or that she had direct knowledge of the incident.

Investigation Involving Child B on July 11, 2025, and Child C

- f. During the investigation, Acting PA told Selika Johnson that Teacher 9 and Teacher 10 accompanied the children to the park on July 11, 2025.

However, Child B stated that Teacher 8 was the only child care staff member present during the outing.

- g. Selika Johnson asked Acting PA about Teacher 8. She denied having any staff working at the center with the same name as Teacher 8. However, Teacher 8 was with Child B at the park, and he went to Child B's home to find him.
- h. Pageant Atterberry told Selika Johnson that the center did not have buses and did not provide any form of transportation for children. However, on July 30, 2025, Selika Johnson observed a bus and a 15-passenger van arriving at the center and dropping off children. Both bus and van had signage on the front and the back with the name of the center. Licensing rules prohibit the use of 15-passenger vans to transport children. Pageant Atterberry stated that either parents provide transportation or they use an outside contract company that provides transportation for the children in care. However, Pageant Atterberry was unable to provide the name of the company that she used to transport children.
- i. During the investigation, Selika Johnson asked Pageant Atterberry for Child E's child information card. She never provided it to the Bureau.
- j. On September 10, 2025, Selika Johnson asked Pageant Atterberry about the incident with Child C falling asleep with hamburger in her mouth. Pageant Atterberry denied the incident ever took place.
- k. Licensee failed to ensure that all child care staff are fingerprinted prior to caring for children. On July 11, 2025, Teacher 8, Teacher 9, and Teacher

10 were all present at the center and providing care for children. None had completed criminal background checks.

Investigation Involving Child B on August 8, 2025

- I. On August 11, 2025, Child B's Mother asked Acting PA to allow her to view the video footage so she could see what happened to Child B. Acting PA and Licensee Designee Vanecia Ayers refused to provide it, stating that the footage gets deleted every 24 hours.
- m. During the investigation, Selika Johnson asked Pageant Atterberry about Child B being locked in the closet. Pageant Atterberry denied that incident ever took place.
- n. During the investigation, Selika Johnson asked Licensee for the information cards for the children that were present on August 8, 2025. Licensee never provided the information cards.
- o. During one of the investigations, Acting PA sent text messages to several teachers telling them not to speak to licensing consultants when they were at the center for an investigation.

Investigation Incident Involving Child L on October 2, 2025

- p. On October 7, 2025, during an on-site investigation, Selika Johnson asked Licensee Designee Vanecia Ayers and Acting Program Administrator (PA) to view the security footage from October 2, 2025. Acting PA told Selika Johnson that the footage was only available for 72 hours before it was deleted.

COUNT I

The conduct of Licensee, as set forth in paragraphs 7(a) through 7(s) above, evidences a willful and substantial violation of:

R 400.8213

- (1) All staff and volunteers present at the center shall:
 - (a) Provide appropriate care and supervision of children at all times.

[**NOTE:** By this reference, paragraphs 3 through 6 is incorporated into this Count for the purpose of demonstrating willful and substantial violation of the above rule.]

COUNT II

The conduct of Licensee, as set forth in paragraphs 8(a) through 8(p) above, evidences a willful and substantial violation of:

MCL 722.120

- (1) The department may investigate, inspect, and examine conditions of a child care organization and may investigate and examine the books and records of the licensee. The licensee shall cooperate with the department's investigation, inspection, and examination by doing all of the following:
 - (a) Admitting members of the department into the child care organization and furnishing all reasonable facilities for thorough examination of its books, records, and reports.

COUNT III

The conduct of Licensee, as set forth in paragraphs 8(a) through 8(p) above, evidences a willful and substantial violation of:

MCL 722.120

(1) The department may investigate, inspect, and examine conditions of a child care organization and may investigate and examine the books and records of the licensee. The licensee shall cooperate with the department's investigation, inspection, and examination by doing all of the following:

(c) Providing accurate and truthful information to the department, and encouraging witnesses, such as staff and household members, to provide accurate and truthful information to the department.

COUNT IV

The conduct of Licensee, as set forth in paragraphs 8(a) through 8(p) above, evidences a willful and substantial violation of:

R 400.8110

(2) The applicant, licensee, and licensee designee shall have the administrative capability to operate the center in order to provide the services and facilities that are conducive to the welfare of children.

DUE TO THE serious nature of the above violations and the potential risk it represents to vulnerable children in Licensee's care, emergency action is required. Therefore, the provision of MCL 24.292 of the Administrative Procedures Act of 1969, as amended, is invoked. Licensee is hereby notified that the license to operate a child care center is summarily suspended.

EFFECTIVE 6:00 p.m., on November 17, 2025, Licensee is ordered not to operate a child care center a child care center at 15340 Southfield Freeway, Detroit,


Michigan 48223. Licensee is not to receive children for care after that time or date.
Licensee is responsible for informing parents or guardians of children in care that the license has been suspended and that Licensee can no longer provide care.

HOWEVER, BECAUSE THE Department has summarily suspended Licensee's license, an administrative hearing will be promptly scheduled before an administrative law judge. Unless Licensee waives their right to an administrative hearing, the Department will submit a request for hearing packet to the Michigan Office of Administrative Hearings and Rules (MOAHR) on Licensee's behalf. If Licensee has questions regarding the administrative hearing or no longer wishes to continue the appeal process, Licensee should contact MOAHR:

Michigan Office of Administrative Hearings and Rules
611 West Ottawa Street, 2nd Floor
P.O. Box 30639
Lansing, Michigan 48909-2484
Phone: 517-335-7519
FAX: 517-763-0155
MOAHR-BSD-Support@michigan.gov

MCL 24.272 of the Administrative Procedures Act of 1969 permits the Department to proceed with the administrative hearing even if Licensee does not appear. Licensee may be represented by an attorney at the administrative hearing.

DATED: 11/17/2025


Erika Bigelow, Division Director
Child Care Licensing Bureau

DATED: 11/17/2025

A handwritten signature in black ink, appearing to read 'Courtney Adams', written in a cursive style.

Courtney Adams, Bureau Director
Child Care Licensing Bureau

This is the last and final page of the ORDER OF SUMMARY SUSPENSION AND NOTICE OF INTENT in the matter of PBA Royal LLC, DC820407576, consisting of 15 pages, this page included.

JEK