GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 3, 2026

CheKeela Walker
Preserve Independence Management, LLC dba Abound Rehabilitation Services Lincoln Park, LLC.
1962 Lietch Street
Ferndale, MI 48220

RE: License #: AS820415601
Investigation #: 2026A0116012
Abound Rehabilitation Services-Lincoln Park

Dear Ms. Walker:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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 (313) 456-0439.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820415601
Investigation #:	2026A0116012
Complaint Receipt Date:	12/30/2025
Investigation Initiation Date:	12/30/2025
Report Due Date:	02/28/2026
Licensee Name:	Preserve Independence Management, LLC dba Abound Rehabilitation Services Lincoln Park, LLC.
Licensee Address:	1962 Lietch Street Ferndale, MI 48220
Licensee Telephone #:	(586) 872-5759
Administrator:	CheKeela Walker
Licensee Designee:	CheKeela Walker
Name of Facility:	Abound Rehabilitation Services-Lincoln Park
Facility Address:	1374 Chandler St Lincoln Park, MI 48146
Facility Telephone #:	(248) 997-7635
Original Issuance Date:	10/18/2023
License Status:	REGULAR
Effective Date:	10/18/2024
Expiration Date:	10/17/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A became agitated over medication as she wanted her medication sooner than prescribed. Resident A became physically aggressive toward staff, Kiara Smith and Resident B. Resident A used racial slurs, and purposely fell twice hitting her head, resulting in her bleeding. The concern is that staff failed to seek immediate medical treatment.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/30/2025	Special Investigation Intake 2026A0116012
12/30/2025	Special Investigation Initiated - Telephone Guardian A1. Telephone number provided was not accurate.
12/30/2025	Contact - Telephone call made Community Living Services, Suzanne Norman.
12/30/2025	Referral - Recipient Rights Received.
12/31/2025	APS Referral Made
01/06/2026	Inspection Completed On-site Staff, Kyrisha Baldwin, Marrianne Herron, home manager Michelle Seaborn, Residents A-C.
01/14/2026	Contact - Telephone call made Staff, Kiara Smith.
01/14/2026	Inspection Completed On-site Reviewed Residents A, D and E's individual plan of service (IPOSs) Resident A's hospital discharge paperwork. Reviewed staff schedule and interviewed staff, Kiara Smith and home manager, Michelle Seaborn.
01/15/2026	Contact - Telephone call made Guardian A1, left a message requesting a return call.

01/15/2026	Contact - Telephone call made Resident A's case manager, Jackie Johnson. Left a message requesting a return call.
01/15/2026	Contact - Telephone call received Guardian A1.
01/15/2026	Contact - Telephone call made Resident D's case manager, Shariel Spencer.
01/15/2026	Contact - Telephone call received Resident A's case manager, Jackie Johnson.
01/15/2026	Contact - Telephone call made Home manager, Michelle Seaborn.
01/15/2026	Contact - Telephone call made Staff, Lisa Tate.
01/15/2026	Contact - Telephone call made Licensee designee, CheKeela Walker.
01/15/2026	Contact - Telephone call made Recipient rights investigator, Phoenicia Jackson, left a message requesting a return call.
01/15/2026	Inspection Completed-BCAL Sub. Compliance
02/02/2026	Exit Conference Licensee designee, CheKeela Walker.
02/02/2026	Exit Conference Chief Executive Officer and board member, David Ellis.

ALLEGATION:

Resident A became agitated over medication as she wanted her medication sooner than prescribed. Resident A became physically aggressive toward staff, Kiara Smith and Resident B. Resident A used racial slurs, and purposely fell twice hitting her head, resulting in her bleeding. The concern is that staff failed to seek immediate medical treatment.

INVESTIGATION:

On 12/30/25, Consultant, Denasha Walker, interviewed Suzanne Noman, with Community Living Services. Ms. Norman reported that she is responsible for reviewing and entering critical incident reports into their system. Upon review it was determined that Resident A did not receive medical treatment in a timely manner. Resident A's head was bleeding and the staff on shift only monitored her and allowed her to go to sleep. She did not receive medical treatment until the following day.

On 01/06/26, I conducted an unscheduled onsite inspection and interviewed staff, Kyrisha Baldwin, Marrianne Herron, home manager, Michelle Seaborn, and Residents A-C. Ms. Baldwin and Ms. Herron reported that neither of them was present in the home when the incident occurred. Ms. Baldwin reported this incident happened on 11/04/25. Ms. Baldwin reported that a similar incident happened during her shift on 12/20/25, with Resident A purposely falling, hitting her head. Ms. Baldwin reported she called 911 immediately and Resident A was evaluated and released the same day. Ms. Baldwin and Ms. Herron both reported that Resident A exhibits self-injurious behaviors and usually does a "death drop" which means that Resident A will simply fall to floor causing her to hit her head either on the floor or on whatever may be near her at the time of her fall. Ms. Herron added that Resident A requires 1:1 staffing and reported that since her guardian has had her taken off her monthly Haldol injection, her behaviors have escalated and become more severe.

I interviewed home manager, Michelle Seaborn, and she reported that she was not on shift at the time of the incident, however, reported she received a call from staff, Kiara Smith, on the evening of 11/04/25 at about 6:15 p.m.-6:30 p.m. informing her that Resident A was having behaviors and fell hitting her head. Ms. Seaborn reported that she instructed Ms. Smith to provide first aid to Resident A and complete an incident report. Ms. Seaborn reported that about an hour later Ms. Smith called her again and informed her that Resident A was acting aggressive toward staff and Resident B and had purposely fell again, resulting in some bleeding from the back of head. Ms. Seaborn reported that Ms. Smith reported to her that she cleaned up the area of her head that was bleeding and a few hours later she went to the home and transported Resident A to the hospital. Ms. Seaborn reported that Resident A required four stitches in the back of her head and was released. Ms. Seaborn reported that there was not a delay in seeking medical treatment.

Ms. Seaborn reported that Resident A is supposed to wear a helmet, however, she purposely broke it. Ms. Seaborn reported that Resident A's case manager, Jackie Johnson, is aware and is working on having a customized helmet made for her. Ms. Seaborn reported that it is not likely that Resident A will wear it, however it still

needs to be available in the home for her. I agreed and recommended that she follow up with Ms. Johnson regarding the status of the helmet.

I attempted to interview Resident A. Resident A refused to answer my questions.

I interviewed Resident B and she reported that Resident A always purposely falls on the floor, she bangs her head on walls, curses and calls staff and residents nasty names. Resident B reported that in the past Resident A has bitten her and she is just out of control.

I interviewed Resident C and she reported that Resident A does not bother or mess with her but reported she attacks and curses at the staff. Resident C reported that Resident A falls on purpose all the time and hits the floor hard. She reported that Resident A will bang her head on anything she sees.

On 01/14/26, I interviewed staff, Kiara Smith, and she reported she was the staff assigned as the 1:1 for Resident A on 11/04/25. Ms. Smith reported that Resident A has had escalating behaviors since her guardian requested that her doctor take her off her monthly Haldol injection. Ms. Smith reported that Resident A is attacking staff, is verbally abusive to staff and residents and is exhibiting more self-injurious behaviors. Ms. Smith reported on 11/04/25 Resident A wanted her 8:00 p.m. medications early. Ms. Smith reported that she informed Resident A that she could not have her medications as it was only 6:00 p.m. Ms. Smith reported Resident A got upset and did a “death drop” hitting her head on the floor in the living room area. Ms. Smith reported that she checked Resident A from head to toe and she appeared fine and was not bleeding. Ms. Smith reported that around 7:00 p.m. Resident A purposely fell again this time resulting in the back of her head bleeding. Ms. Smith reported that she cleaned the blood from the back of Resident A’s head and monitored her. She reported that she also called her home manager, Michelle Seaborn, and informed her of what had occurred. Ms. Smith reported Ms. Seaborn informed her that she would come in to take Resident A to the hospital. Ms. Smith reported that when she left at midnight Ms. Seaborn had not arrived. Ms. Smith reported that Resident A was still awake when she left and appeared to be okay. Ms. Smith reported the bleeding had subsided.

Ms. Smith reported that she did not call 911 because Resident A’s guardian complains to the staff and management about the bills she receives from the hospital and she wants to be contacted before sending Resident A out. I informed Ms. Smith that the guardian does not make that decision as they are the trained staff in the home and are responsible for the care of Resident A. I also informed Ms. Smith that the licensing rules require that staff seek immediate medical attention for a resident when there has been an accident or sudden adverse change in a residents health condition. Ms. Smith reported an understanding and reported that

moving forward she will seek immediate medical attention for Resident A and any other resident when the situation requires it.

On 01/14/26, I conducted an unscheduled onsite and reviewed Resident A's discharge paperwork from 11/05/25 and 12/20/25 and reviewed Residents A, D and E's IPOS. Resident A's discharge paperwork is dated 11/05/25 and the discharge instructions were printed at 10:47 a.m. This information confirms that Resident A did not receive medical treatment until the following day, hours after she fell and sustained an injury to the back of her head. Resident A's IPOS effective 10/06/25 confirmed that she requires 1:1 staffing and she has a history of attention-seeking behaviors (intentional falls/drops) self-injurious behaviors (head banging and biting), and physical aggression (slapping/spitting/property destruction).

On 01/15/26, I interviewed Guardian A1 and she reported that Resident A is a challenge and reported being aware of the incident where Resident A fell and required stitches in the back of head. Guardian A1 reported the incident happened early November 2025 and she does not remember who called and informed her of the incident. Guardian A1 reported that Resident A falls all the time and reported that the case manager is working to get Resident A fitted for a custom helmet as she broke her other one. Guadian A1 reported she is not aware of how long the staff waited to seek medical attention. Guardian A1 reported that she did not tell the staff not to seek medical attention for Resident A but did inform them that they should be ensuring that it is necessary to call 911 as she has received numerous bills after Resident A has been transported by ambulance to the hospital. Guardian A1 reported that overall, she is satisfied with the care the staff provide.

On 01/15/26, I interviewed Resident A's case manager, Jackie Johnson, and she reported that she has been Resident A's case manager for a short time, and the staff at the home have been very helpful providing information as they are well aware of her needs, wants and behaviors. Ms. Johnson reported that home manager, Michelle Seaborn, informed her of the incident on 11/04/25 pertaining to Resident A. Ms. Johnson reported that when she reviewed the incident report, she had questions as to why 911 wasn't called or why Resident A was not transported to the hospital immediately. Ms. Johnson reported staff are not medical professionals and Resident A could have had a concussion, internal bleeding or a number of other serious injuries. Ms. Johnson further reported that she has been to the home since the incident and has reiterated to the staff that they are to err on the side of caution and seek immediate medical attention for Resident A when she falls, especially when she has hit her head. Ms. Johnson confirmed that she is working on getting the authorizations for Resident A to have a custom fitted helmet with the hope that she will keep it on and not destroy it. Ms. Johnson reported that there has been some delays as there were insurance issues that were recently rectified.

On 01/15/26, I spoke with home manager, Michelle Seaborn, to clarify the statements she made to me on 01/06/26 while onsite. Ms. Seaborn initially reported that she came to the home a few hours after Resident A fell on 11/04/25 and

transported her to the hospital. However, during the course of my investigation, I discovered that Resident A was transported to the hospital in the early hours of 11/05/25 via ambulance. When I brought this to Ms. Seaborn's attention, she reported that she had mixed the incidents up as Resident A fell on 12/20/25 also. I reminded Ms. Seaborn that Resident A was also transported by ambulance after purposely falling on 12/20/25. Ms. Seaborn did not have a response.

On 01/15/26, I interviewed staff, Lisa Tate, and she reported that she worked the midnight shift 12:00 a.m.-8:00 a.m. on 11/05/25. Ms. Tate reported that when she arrived at midnight, staff, Kiara Smith, had informed her that Resident A had 2 falls during her shift, but was doing okay. Ms. Tate reported Resident A was still awake when she arrived, so she looked her over and noticed that the back of head was swollen and still bleeding. Ms. Tate reported that she called her manager, Ms. Seaborn, and informed her that Resident A needed to go to the hospital. Ms. Tate reported that Ms. Seaborn informed her that she would come to the home and take Resident A to the hospital. Ms. Shaw reported that some time elapsed and she decided to call 911. Ms. Tate reported when the ambulance arrived, Ms. Seaborn was pulling up and she followed the ambulance to the hospital and stayed with Resident A.

On 01/15/26, I interviewed licensee designee, CheKeela Walker. Ms. Walker reported that she was not aware of the incident until she received a call from recipient rights about a week ago. Ms. Walker reported that staff know that they are to seek immediate medical care for any resident in any instance where they have hit their head. Ms. Walker reported that staff normally keep her abreast of things going on.

On 02/02/26, I conducted the exit conference with licensee designee, CheKeela Walker, and informed her of the findings of the investigation and the specific rule cited. Ms. Walker reported an understanding.

On 02/02/26, I also conducted an exit conference with CEO and board member, David Ellis. I informed Mr. Ellis of the findings of the investigation and the specific rule cited. Mr. Ellis reported an understanding and reiterated that staff is aware and will be seeking medical attention immediately moving forward.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

She ANALYSIS:	Based on the findings of the investigation, which included interviews with staff, Kiarra Smith, home manager, Michelle Seaborn, case manager, Jackie Johnson, and staff, Lisa Tate, there is a preponderance of evidence to substantiate that the staff did not seek immediate medical care for Resident A after she fell and hit her head resulting in swelling and bleeding. Resident A fell at around 7:00 p.m. on 11/04/25 and she did not receive medical treatment until the early morning hours of 11/05/25. The fall resulted in Resident A requiring four stitches in the back of her head. I reviewed Resident A's discharge paperwork from the hospital that shows that she was discharged on 11/05/25 around 10:47 a.m.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/14/26, I conducted an unscheduled onsite inspection and reviewed Resident A, C and E IPOSs and confirmed that each of them requires 1:1 staffing. Resident's A and C plans document that they both require 1:1 staffing. Resident E's plan documenst that she requires 1:1 staffing 24-hours per day. There are a total of six residents living in the home. Residents B, D and F do not require 1:1 staffing.

I interviewed staff, Kiara Smith, and she reported that there are three staff per shift and reported that she believes that there are only three staff per shift because Resident D only requires 1:1 staffing 16 hours per day. Ms. Smith believed that Resident D does not require 1:1 staffing during sleeping hours. Ms. Smith confirmed that she works mostly day and afternoon shifts, and during those shifts there are only three staff on shift.

I interviewed home manager, Michelle Seaborn, and she reported that they have begun staffing the home with four staff per shift. Ms. Seaborn reported that she was told that Resident D only required 16 hours of 1:1 staffing per day. I asked Ms. Seaborn to show me that in Resident D's IPOS. We reviewed Resident D's IPOS together. The IPOS effective date is 09/09/25. Throughout the IPOS it documents that Resident D requires 1:1 staffing and nowhere was there mention of 1:1 staffing for only 16 hours per day. I advised Ms. Seaborn to contact Resident D's case manager to discuss and if Resident D only requires 16 hours of 1:1 staffing per day then the case manager should complete an addendum so that the plan reflects that.

I reiterated to Ms. Seaborn that based on the current needs of the residents the home requires four staff per shift. Three staff assigned to the three residents who require 1:1 staffing and one staff for the other three residents.

I reviewed the staff schedule for the week of 01/10/26-01/16/26 and observed that on Saturday 01/10/26 there were only three staff per shift. On Sunday 01/11/26 there were only three staff on day and afternoon shift. On Monday 01/12/26, Tuesday 01/13/26 and Wednesday 01/14/26 there were only three staff on the midnight shift.

On 01/15/26, I interviewed Resident D's case manager, Shariel Spencer, and she reported that Resident D requires 1:1 staffing. Ms. Spencer reported that she was going to contact Resident D's therapist and Detroit Wayne Integrated Health Network to confirm the number of hours Resident D requires 1:1 staffing. Ms. Spencer reported not being aware of where the staff got the 16 1:1 hours from but reported she would get this rectified and the plan updated so that the staff is clear on how to properly staff the home.

On 01/15/26, I interviewed Resident A's case manager, Jackie Johnson, and she confirmed that Resident A requires 1:1 staffing 24 hours per day. Ms. Johnson reported that the plan has a blanket statement that Resident A requires 1:1 staffing and normally if there is a certain number of hours less than the 24 hours the plan would state that. Ms. Johnson reported that she will update the plan so that everyone is clear that Resident A requires 1:1 staffing 24 hours per day.

On 01/15/26, I interviewed staff, Lisa Tate, and she reported that she works the midnight shift and that there is never more than three staff on shift. She reported to her knowledge there are three staff on each shift. Ms. Tate reported that she is aware that three of the six residents require 1:1 staffing, however reported she does not make the schedules she just comes to work and does her job.

On 02/02/26, I conducted the exit conference with licensee designee, CheKeela Walker, and informed her of the findings of the investigation and the specific rule cited. Ms. Walker reported an understanding and reported that the staffing levels will be adjusted to ensure the home is properly staffed.

On 02/02/26, I conducted the exit conference with Chief Executive Officer and board member, David Ellis, and informed him of the findings of the investigation and the specific rule cited. Mr. Ellis reported his belief that the staffing shortage was only on the midnight shift, and he was not aware of there not being adequate staffing during other shifts. Mr. Ellis reported that the case managers have been contacted and are updating the plan to clearly reflect the number of hours each resident requires 1:1 staffing.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) 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 findings of the investigation, which included interviews of staff, Kiara Smith, home manager, Michelle Seaborn, staff, Lisa Tate, and my review of Resident's A, C and E's IPOS, and the staff schedule, there is a preponderance of evidence to substantiate that the homes staffing levels are not sufficient to meet the needs of the residents in accordance with their IPOSs. Residents A, C and E's IPOS document that they require 1:1 staffing. There are also three other residents who reside in the home. Based on the aforementioned the home requires four staff per shift. Presently the home is not consistently staffing the home based on the needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

02/03/26

Pandrea Robinson
Licensing Consultant

Date

Approved By:

02/03/26

_____

Ardra Hunter
Area Manager

Date