GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 17, 2026

Thomas Quakenbush
Community Homes Inc
3925 Rochester Rd.
Royal Oak, MI 48073

RE: License #: AS630012406
Investigation #: 2026A0626007
Community Homes Inc AFC Home

Dear Mr. Quakenbush:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On 01/22/2026, you submitted acceptable documentation of corrections.

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 E Shaughnessy

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
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 #:	AS630012406
Investigation #:	2026A0626007
Complaint Receipt Date:	12/15/2025
Investigation Initiation Date:	12/15/2025
Report Due Date:	02/13/2026
Licensee Name:	Community Homes Inc
Licensee Address:	3925 Rochester Rd. Royal Oak, MI 48073
Licensee Telephone #:	(248) 336-0007
Administrator:	Thomas Quakenbush
Licensee Designee:	Thomas Quakenbush
Name of Facility:	Community Homes Inc AFC Home
Facility Address:	2503 W 14 Mile Road Royal Oak, MI 48073
Facility Telephone #:	(248) 549-3928
Original Issuance Date:	N/A
License Status:	REGULAR
Effective Date:	10/12/2025
Expiration Date:	10/11/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Direct care staff member who was not trained in medication administration, administered medications.	Yes
Direct care staff member put resident medications in a cup prior and left for another direct care staff member to administer.	Yes
Additional Findings	No

III. METHODOLOGY

12/15/2025	Special Investigation Intake 2026A0626007
12/15/2025	APS Referral A referral was not made to Adult Protective Services due to the alleged violation not being a matter they will investigate.
12/15/2025	Special Investigation Initiated - Letter I initiated the special investigation by sending the referral to Oakland Community Health Network recipient rights worker, Heather Shepherd.
12/18/2025	Contact - Face to Face I completed an unannounced onsite investigation at Community Homes Inc AFC Home. I completed interviews with home manager, Michael Harris and assistant manager, Catrina Lee.
01/09/2026	Contact - Telephone call made I completed a telephone interview with direct care staff member, Lashawna White.
01/20/2026	Contact - Telephone call made I completed a telephone interview with direct care staff member, Kimberly Jones.
01/21/2026	Exit conference I completed an exit conference, via telephone, with licensee designee, Thomas Quakenbush. Mr. Quakenbush agreed to send me the documentation regarding the actions taken upon discovering the errors.

01/22/2026	Contact- Document received I received documentation, via email, regarding the actions taken upon discovering the errors.

ALLEGATION:

- **Direct care staff member who was not trained in medication administration, administered medications.**
- **Direct care staff member put resident medications in a cup prior and left for another direct care staff member to administer.**

INVESTIGATION:

On 12/15/2025, I received a complaint, via email, alleging a direct care staff member who was not trained in the administration of medication had administered medication and that the medication had been placed into unmarked cups by another direct care staff member prior to her leaving.

On 12/15/2025, I initiated the special investigation by sending the referral to Heather Shepherd, the recipient rights specialist, from Oakland Community Health Network.

On 12/16/2025, I received an email from Ms. Shepherd indicating the direct care staff member who administered the medications has since resigned from the home and that the area manager has completed a medication training with all direct care staff members in the home.

On 12/18/2025, I completed an unannounced onsite investigation at Thomas Home. I completed an interview with Michael Harris, the home manager and assistant home manager, Catrina Lee. On 12/04/2025, Ms. Lee took the morning off. They had a newer staff member, Lashawna White, working. Ms. White had not yet completed her medication training, so he asked the night shift to pass morning medications prior to leaving. Kim Jones was working the night shift and instead of passing the medications, she got them ready, left, and told the next staff to pass them out. Ms. White contacted Mr. Harris that morning and woke him up. Mr. Harris was still half asleep, and Ms. White asked him what to do. He was not thinking clearly and told her to pass them. He then woke up more and was contacted by Ms. Lee after she was contacted by the staff member who passed them, Lashawna White, she asked him what had happened, he realized what he had told Ms. White, then called her back to tell her not to pass them, but she had already done it. He contacted the physicians for the residents and told them about what had happened, and they informed him that if anyone had gotten the wrong medication, they would have known by then. He stated no one had any abnormal symptoms, so they all received the correct medication. He handed out corrective actions to the employees involved and conducted a medication administration training on 12/10/2025 for all direct care staff members. Ms. Lee stated she had received a phone call from Ms. White after she had administered the medications, and she contacted Mr. Harris to ask him about it. She normally works morning shift but took that day off.

Mr. Harris agreed to send me the documentation regarding the corrective actions and the medication training.

During the onsite investigation, there was only one resident home. He sat at the table while I interviewed Mr. Harris. I attempted to have a conversation with him, to gauge whether he would be able to participate in an interview. He could not answer my questions in a manner I could understand; he was not interviewed.

On 01/09/2026, I completed a telephone interview with direct care staff member, Lashawna White. Ms. White is the direct care staff member that came on shift the morning of 12/04/2025. Ms. White did not work there very long. On 12/03/2025, there was a discussion between Ms. White, Mr. Harris, and direct care staff member, Kim Jones. They were all aware that the assistant home manager would not be working on 12/04/2025, and the plan was for Ms. Jones to pass the morning medications prior to her leaving the next morning. She came in and one of the residents started asking her about his pill, stating he had to take his pill. He was becoming angry with her, and she told him he should have already gotten his medications, and he told her he did not. Not long after that, another resident started asking her where his medication was. She stated she was in a hurry because she had to get the residents to work and all the residents needed to go with her. She called Mr. Harris, and he told her that the medications were set up and she should pass them. She told him she did not want to pass them because she had not been trained and he insisted she pass them. The medications were in cups in each resident's medication basket and she passed them. She contacted Ms. Lee and she called Mr. Harris because she was mad that he told her to do that. She did not sign off on the MAR, Ms. Jones did. She did not feel good about it and called the main office. Mr. Harris then called Ms. Jones to come back and act like she had passed the medications. She denied having concerns with the care the residents receive at home, especially with Ms. Lee there.

On 01/20/2026, I completed a telephone interview with Kim (Kimberly) Jones. Ms. Jones was the direct care staff member who prepared the medication for Ms. White. Ms. Jones works the night shift and on the morning of 12/04/2025, she received a phone call from the assistant manager asking her to pass medications. She prepared the medications and proceeded to wake the residents and start getting them ready for the day. She was assisting residents with their hygiene, getting them dressed, and feeding them breakfast. When Ms. White came in, she started talking negatively about the company to her. She did not want to hear the negativity, nor did she want the residents to hear it, as she does not want it around them. The negativity threw her off and she hurried out of there. Administering the medication slipped her mind. She got home around 7:45 am and received a phone call from Ms. Lee inquiring about the medications. She rushed back home and arrived around 8:10 am. She went in and was going to administer the medications, but they had already been administered. She has not done anything like this before and feels bad about what happened because she cares greatly for her residents and would never do anything to hurt them.

On 01/21/2026, I completed an exit conference, via telephone, with licensee designee, Thomas Quakenbush. Mr. Quakenbush agreed to send me the documentation regarding the actions taken upon discovering the errors. I received these documents on 01/22/2026, they included the following:

1. Documentation of an in-service meeting taking place. The notes indicate all employees arrived at the home on 12/09/2025, and verbally reviewed the eight rules of passing medications, dispensing medications, policies and procedures, and documenting the health care chronology. The document was signed by Kimberly Jones, Denise Humphrey, Sandra Cochran, Michael Harris, Catrina Lee, and Tanya Washburn.

2. A document containing notes from an emergency meeting at the home on 12/09/2025. The notes indicate the meeting was held due to a rights violation and report. The notes indicate that they were watching residents for health and safety.

3. Documents regarding policies regarding medication administration and documenting the health care chronology. All staff members signed the documents regarding the policies and procedures.

4. Corrective action record for Michael Harris. The document indicates on 12/04/2025, Mr. Harris gave permission for Lashawna White to pass medication that was pre-dispensed into several unmarked cups by Ms. Jones and left out unpassed. Ms. White was not trained in medication administration. It indicates that all of the primary care physicians were contacted to ensure that the medications passed did not have side effects or interactions with previous medications, just in case anyone received the incorrect medication.

5. Corrective action record for Kimberly Jones. It indicates Ms. Jones pre-dispensed six individuals' medication at one time, breaking the 8 rights of medication administration. Ms. Jones then left to go home, leaving unmarked cups with medications. As a result, a new and untrained staff member passed medications to residents. The document indicates that Ms. Jones refused to sign her corrective action.

6. Corrective action record for Lashawna White. It indicates that Ms. White arrived on shift and passed medication, while untrained, that was left pre-dispensed by Kimberly Jones. Ms. White failed to report the error and called the team leader to ask about passing the medications. The team leader instructed her to pass the medication, and she passed unknown medication to residents. It indicates that she was instructed to not pass medication until fully trained and complete three medication observations. She was instructed to report medication errors and complete incident reports when loose medication, or pre-dispensed medications are found.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Based on the information gathered during my special investigation, there is sufficient evidence to support the allegation that an untrained direct care staff member administered medication. The home manager, assistant manager, and two direct care staff members have confirmed that a new staff member administered medications prior to being trained in medication administration.
CONCLUSION:	**VIOLATION ESTABLISHED (BUT CORRECTED)**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	Based on the information obtained during the special investigation, there is sufficient evidence to support that medications were not kept in their original containers. Mr. Harris, Ms. Lee, and Ms. White stated Ms. Jones had put residents' medications into cups, then into their baskets, prior to leaving. Ms. Jones admitted to having put the medications in the cups prior to leaving for the day.
CONCLUSION:	**VIOLATION ESTABLISHED (BUT CORRECTED)**

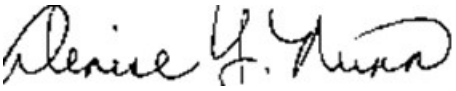
IV. RECOMMENDATION

An acceptable corrective action plan was received on 01/22/2026. It is recommended that the status of the license remains unchanged.

01/22/2026

Sara Shaughnessy — Date
Licensing Consultant

Approved By:



02/17/2026

Denise Y. Nunn — Date
Area Manager