



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 8, 2026

David Ellis
Abound Rehabilitation Service, INC.
1962 Leitch Road
Ferndale, MI 48220

RE: License #: AS630419680
Investigation #: 2026A0612017
Abound Rehabilitation Services - Aberdeen Home

Dear Mr. Ellis:

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,

A handwritten signature in cursive script that reads "Johnna Cade".

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630419680
Investigation #:	2026A0612017
Complaint Receipt Date:	02/25/2026
Investigation Initiation Date:	02/25/2026
Report Due Date:	04/26/2026
Licensee Name:	Abound Rehabilitation Service, INC.
Licensee Address:	1962 Leitch Road Ferndale, MI 48220
Licensee Telephone #:	(248) 416-2768
Administrator:	David Ellis
Licensee Designee:	David Ellis
Name of Facility:	Abound Rehabilitation Services - Aberdeen Home
Facility Address:	28537 Aberdeen St. Southfield, MI 48076
Facility Telephone #:	(248) 997-7372
Original Issuance Date:	07/24/2025
License Status:	1ST PROVISIONAL
Effective Date:	12/08/2025
Expiration Date:	06/07/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
On 02/17/26, Resident A jumped out of a moving vehicle and hit the back of his head. He did not receive medical attention.	Yes
Resident A is paid to work at the Murray Crescent home, which is another home owned/operated by this provider.	Yes
Resident B has green stool he was denied medical treatment.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/25/2026	Special Investigation Intake 2026A0612017
02/25/2026	APS Referral Referral received from Adult Protected Services (APS) assigned APS worker Kanati-Owl Davenport.
02/25/2026	Special Investigation Initiated - Letter Referral made to Oakland Community Health Network - Office of Recipient Rights.
02/25/2026	Contact - Telephone call made Telephone call with APS worker Kanati- Owl Davenport.
03/02/2026	Contact - Document Received Additional allegations received from APS.
03/02/2026	Contact - Document Received Resident B's Easter Seals MORC Individual Plan of Service received via email from Recipient Rights Specialist Amber Oliver.
03/03/2026	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed Resident A and home manager Santecia Dobbs. I obtained a copy of Resident B's Corewell Health William Beaumont University Hospital After Visit Summary dated 02/28/26.

03/04/2026	Contact - Document Received Emails exchanged with APS worker Kanati- Owl Davenport and Recipient Rights Specialist Amber Oliver.
03/04/2026	Contact - Telephone call made Interview completed with Resident B.
03/18/2026	Contact - Document Received Resident A's Easter Seals MORC Individual Plan of Service received via email from Recipient Rights Specialist Amber Oliver.
03/20/2026	Contact - Telephone call made Telephone call with Recipient Rights Specialist Amber Oliver.
03/23/2026	Contact - Telephone call made Telephone interview completed with team lead Shakyna Taylor.
03/24/2026	Contact - Telephone call made Telephone interview completed with HR manager Amyra Burks. Second telephone interview completed with home manager Santecia Dobbs.
03/24/2026	Contact - Document Received Copy of Incident Report received via email.
03/25/2026	Exit Conference I placed a telephone call to licensee designee David Ellis to conduct an exit conference.
03/26/2026	Contact - Document Received Email received from HR manger Amyra Burks on behalf of licensee designee David Ellis requesting to provide additional documentation regarding this investigation. Request granted, documentation requested by end of day Monday, 03/30/26.
03/30/2026	Contact - Document Received Email received from HR manger Amyra Burks requesting an extension to submit documentation. Request granted, documentation requested by end of day Tuesday, 03/31/26.
03/31/2026	Contact - Document Received Facility documentation received via email.
04/01/2026	Contact – Documentation Sent Email sent to Mr. Ellis acknowledging review of the additional documentation provided and the recommendation of revocation.

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ALLEGATION:

On 02/17/26, Resident A jumped out of a moving vehicle and hit the back of his head. He did not receive medical attention.

INVESTIGATION:

On 02/25/26, I received a referral from Adult Protective Services (APS) that indicated, Resident A has Autism, he lives at Abound Rehabilitation Services - Aberdeen Home, he has a legal guardian. On an unknown day last week, Resident A was having suicidal ideations and asked a direct care staff to take him to the emergency room. On the way to the emergency room Resident A was debating whether to go or not. The direct care staff said that they did not have to go and headed back to the home, when Resident A jumped out of the moving vehicle. Resident A hit the back of his head when he jumped out of the car. Resident A believed he was fine and got back into the car. The direct care staff reported the incident to home manager Santecia Dobbs and drove Resident A to the home manager, who was getting her nails done. Resident A's guardian was out of town at the time; however, he was informed. Resident A told everyone that he was fine although he had a bump on his head. No medical treatment was sought. On Wednesday, 02/18/26, Resident A still had a bump on the top left side of his head. Resident A has not reported any symptoms related to the incident/injury. There are concerns that nobody made the decision to have Resident A medically examined after the incident. The APS referral further indicates when APS met with Resident A on call it was discovered that Resident A is paid to work at the Murray Crescent home, which is another home owned/operated by this provider. Resident A further indicated that he is expected to do administrative duties as if staff at the Aberdeen Home.

On 03/02/26, I received an additional referral from APS. In summary, the allegations indicate Resident B has a diagnosis of cognitive impairment, anxiety and depression. Resident B resides at Abound Rehabilitation Services - Aberdeen Home. Resident B has a legal guardian. Resident B has been having issues with his stool, and it is green. Resident B informed the staff, and they have been denying him medical treatment. Resident B's symptoms got worse and on 02/25/26, he went to Corewell Health William Beaumont University Hospital – Royal Oak emergency room. While Resident B was in the waiting room, home manager Santecia Dobbs and HR manager Amyra Burks arrived at the emergency room, removed Resident B and took him back home. Resident B was told that an appointment would be scheduled for the following day and they still have not made an appointment. Resident B's guardian was also notified and refused medical treatment for Resident B.

On 02/25/26, I initiated my investigation by making a referral to Oakland Community Health Network (OCHN) – Office of Recipient Rights (ORR) via email. Recipient Rights Specialist Amber Oliver indicated that she is aware of the allegations. On 02/24/26, Ms.

Oliver conducted an onsite inspection with APS worker Kanati – Owl Davenport. They interviewed Resident A and team lead Shakyna Taylor. Ms. Oliver stated home manager Santecia Dobbs said that Resident A is working with the maintenance man as Resident A wanted something to do during the day and he wanted to learn things. Resident A is learning basic maintenance skills. Ms. Dobbs did not say that Resident A is being paid. Ms. Oliver stated she did not observe any injuries to Resident A's head, and he declined to answer if he jumped out of the van, he further declined that he needed medical care recently.

On 02/25/26, I interviewed APS worker Kanati – Owl Davenport she stated she completed an onsite inspection with Recipient Rights Specialist Amber Oliver on 02/24/26, Resident A declined to answer interview questions.

On 03/03/26, I completed an unannounced onsite investigation. I interviewed Resident A and home manager Santecia Dobbs.

On 03/03/26, I interviewed Resident A. Resident A stated, "since living in this home I have tried to kill myself more times than when I was younger." Resident A stated he was having suicidal thoughts, and he asked to go to the emergency room. He got into the car with direct care staff Quitman Slack and while the car was moving, he opened the door and jumped out. Resident A stated the car was going about 18 mph, they were on a side street. Resident A stated when he jumped out of the car he hit his head on the road. He also hit his shoulder and his butt. Resident A stated he jumped out of the car as an attempt to kill himself. Resident A remarked, "this place is driving me nuts." Resident A said that he told Mr. Slack that he did not want to go to the hospital after jumping out of the car. Resident A further stated that when interviewed by Recipient Rights and APS he refused to talk and told them that nothing happened. At the time of this interview Resident A had no visible injuries.

On 03/03/26, I interviewed home manager Santecia Dobbs. Ms. Dobbs stated she received a telephone call from team lead Shakyna Taylor who informed her that Resident A was walking down the street and direct care staff Quitman Slack was following him in the van while she was following on foot. Ms. Dobbs stated Mr. Slack was able to get Resident A back into the van and was taking him for a ride. Ms. Dobbs stated Resident A told her that he did not jump out of the car, that he got out of the car. Ms. Dobbs was on the phone and was able to encourage him to get back in the car. Ms. Dobbs stated she told Resident A if he wanted to go to the hospital she would take him. Resident A declined and allowed Mr. Slack to drive him to her, at a nail shop, as she was off work. Ms. Dobbs stated she spoke to Resident A, and he explained how he felt that he did not have a purpose. Ms. Dobbs remarked that this is how Resident A feels at his baseline. Ms. Dobbs stated she took Resident A to eat. Then, HR manager Amyra Burks met up with them. Ms. Dobbs and Ms. Burks checked Resident A over for injuries, none were observed. Resident A said that he did not require medical attention.

On 03/04/26, in collaboration with Recipient Rights Specialist Amber Oliver and APS worker Kanati-Owl Davenport I placed a telephone call to direct care staff Quitman Slack. There was no answer. A voicemail was left requesting a return call. Mr. Slack returned the phone call to Ms. Oliver. I received an email from Ms. Oliver saying that she interviewed Mr. Slack. In summary, he reported the following:

Quitman Slack is a direct care worker, has been working with Abound for a little over a month. The day in question, he worked second shift from 4:00 pm - midnight. He reported that Resident A was having "an episode" and eloped from the home around 6:00 - 7:00 pm (still daylight but starting to fade). Resident A eloped and Mr. Slack went after him on foot, then it was cold, so he went back and retrieved the company van. He told team lead Shakyna Taylor that he was taking the van to get him and left. He caught back up to Resident A on a side street and convinced him to get into the van. Once Resident A was in the van, Mr. Slack called Ms. Taylor to let her know that Resident A was safe in the van. Resident A was still mentioning self-harm and suicidal thoughts. Ms. Taylor told him to drive Resident A around for a minute to calm him down, so they proceeded out of the neighborhood and onto 12-mile road. During this time Resident A was agitated, upset, and ended up balling his fist at Mr. Slack and was threatening to hit him, Mr. Slack told Resident A to calm down and relax. Resident A then looked at Mr. Slack and asked him, "what if I called you the N word?" Mr. Slack responded in a laugh and told him it would be alright if he needed to get it out. Resident A then balled his fist and took off his seatbelt. At this time, they were on 12-mile road going the speed limit (40-45mph) and closest to the median. Resident A then opened the door and jumped out of the van. Mr. Slack remarked, "It was weird as he fell on his back, not forward like I thought he would." Mr. Slack stopped the van immediately (heart pounding thinking he ran him over) and saw Resident A get up and run off. Mr. Slack got back in the van and went after him. He called home manager Ms. Dobbs. Resident A was back in a neighborhood road when he caught back up, after hearing Ms. Dobbs voice on speaker phone Resident A approached the van and agreed to get back in, not to go to the hospital, but to go to Ms. Dobbs. Mr. Slack mentioned that at this point, he was just trying to get Resident A calmed down and back somewhere safe. He was not thinking about injuries or anything else with the adrenaline going.

Once Resident A got back in the van to go to Ms. Dobbs, Mr. Slack noticed he had some scrapes on his arms (no blood), and he was holding his head. Mr. Slack drove Resident A to 7 mile and VanDyke where Ms. Dobbs was at a store and dropped Resident A off to Ms. Dobbs. Mr. Slack then went back to the group home for his shift. Mr. Slack did not fill out an Incident Report, but team lead Shakyna Taylor did. Mr. Slack admitted he did not look Resident A over for injuries but asked Resident A "if he was good." Resident A replied with "I am alright, I just want to go to Ms. Dobbs." Mr. Slack stated, "I didn't want him to spaz out again, I was just trying to get him to Ms. Dobbs safely."

When Resident A came home, he went straight to his room and laid down. Mr. Slack stated, "I didn't want to bother him or agitate him anymore." Mr. Slack stated he checked on him twice before the end of his shift and Resident A kept saying "I'm ok." The last time he checked on him, Resident A stated his stomach was hurting, Mr. Slack asked him if he was hungry or took his meds, Resident A stated it wasn't from that. Mr. Slack said, "Do you need to go to the hospital?" and Resident A declined. After that he left at midnight and was off the next day.

At the end of the interview Mr. Slack added "he may have not felt the pain that day due to the adrenaline, but he had to of felt it the next day, he jumped out the van!" Mr. Slack claims he called in the next day to check on Resident A and the staff on shift told him he was fine.

On 03/20/26, I spoke to Recipient Rights Specialist Amber Oliver. Ms. Oliver stated on 03/20/26, she interviewed Resident A's guardian via telephone. Resident A's guardian was out of town from 02/15/26 – 02/20/26. Resident A's guardian said that Aberdeen staff claim that they called him, however, they did not leave a voicemail. Resident A's guardian stated the staff turnover is high, he has saved numbers for staff, but a random number called and did not leave a message. His wife is also guardian. They did not contact her either. Resident A's guardian said he learned about the incident from Resident A that night or the next day. Resident A told him that he was in the van and he jumped out. Resident A mentioned that he hurt his backside, and someone said he hit his head on the pavement. Resident A's guardian spoke to Santecia Dobbs, and she said they offered to take Resident A to the emergency room, and he refused so they took him back to the house. Resident A's guardian stated a few days later, he received something from Corewell health stating the next day Resident A went in with a headache, they gave him Tylenol sent him home. Resident A has not mentioned anything since. Resident A's guardian stated Resident A said he did not get hurt from jumping out of the van and if he declined medical treatment, he is okay with the staff not taking Resident A to the hospital if they did not feel he was in any serious condition.

On 03/23/26, I interviewed team lead Shakyna Taylor. Ms. Taylor stated Resident A was having a difficult day, he refused to do his chores and his hygiene. Around 5:45 pm, he stormed out of his bedroom and went outside, direct care staff Quitman Slack followed him to deescalate. Resident A was screaming that he wanted to die. There was a car driving slowly down the street and Resident A walked out in front of it. The car stopped; there was no incident or impact. Ms. Taylor stated Mr. Slack got into the van to follow Resident A down the street. After about five minutes Resident A agreed to get into the car. Ms. Taylor advised Mr. Slack to drive around with Resident A and let him calm down. While driving Resident A unbuckled and jumped out of the car going 15 – 20 mph. Mr. Slack then called Ms. Dobbs and checked Resident A over for injuries. Mr. Slack took Resident A to Ms. Dobbs, who was at the Murray Crecent home. Ms. Taylor stated Resident A return home around 8:00 pm, she looked him over for injuries, none were observed. Resident A denied the need for medical attention. Resident A went to bed for the evening.

On 03/24/26, I interviewed HR manager Amyra Burks via telephone. Ms. Burks stated she was on the phone with home manager Ms. Dobbs when Ms. Dobbs received a telephone call from Mr. Slack, the calls were merged. Ms. Burks stated while on the phone she could hear Mr. Slack stop at a stop sign on a side street, in the Aberdeen neighborhood. Resident A opened the car door and got out of the car. Resident A did not jump out of the car. Resident A did not fall into the road and/or injury himself. Ms. Burks stated she could hear Mr. Slack verbally encouraging Resident A to get back into the car. Once he agreed to get in the car Resident A was taken to Ms. Dobbs who was off work, on a personal errand. Ms. Burks stated she met Ms. Dobbs and Resident A at

Coney Island, and they all ate dinner together. Ms. Burks stated she is a safe space for Resident A, and she was able to provide de-escalation and talk to him about what was bothering him. Ms. Burks stated she asked Resident A if he wanted to go to the hospital for a mental health evaluation and he declined stating he was fine. Ms. Burks stated while at Coney Island she called Resident A's guardian and spoke to him regarding what occurred that day. Ms. Burks stated she did not do a physical assessment of Resident A's body, but he was wearing a T-shirt, and she did not observe any injuries to him. Ms. Burks remarked that there was no reason to complete a physical assessment of Resident A's body as there was never an accident or an injury. Ms. Burks stated Resident A never mentioned hitting his head or his body. She was never informed by any staff that Resident A hit his head or his body. Ms. Burks stated after eating Ms. Dobbs took Resident A back to the Aberdeen home where he went to bed. Ms. Burks stated Mr. Slack and Resident A were the only two people present in the vehicle so they would be able to provide the most accurate report of what happened as she was only present via telephone. Ms. Burks remarked the Incident Report that was completed regarding this incident was inaccurate and did not accurately represent what occurred as Resident A did not jump out of the moving car.

On 03/24/26, I reviewed an Incident Report (IR) written by team lead Shakyna Taylor and signed off on by HR manager Amyra Burks, date of incident 02/17/26, in summary, the IR is consistent with Ms. Taylor's verbal testimony. In relevant portions the IR states, "while the vehicle was in motion at a low speed, the client unbuckled his seatbelt without permission and abruptly opened the vehicle door, jumping out of the moving car. Staff immediately stopped the vehicle to ensure safety. The client did not appear to sustain visible injury but remained highly agitated."

On 03/18/26, I reviewed Resident A's Easter Seals MORC Individual Plan of Service (IPOS). Resident A's IPOS documents that he has a history of depression, suicidal thoughts, and self-harm.

On 03/26/26, following the exit conference, I received an email from HR manager Amyra Burks on behalf of licensee designee David Ellis requesting to provide additional documentation regarding this investigation. On 03/31/26, additional documentation was received via email.

I reviewed the following documentation provided by Abound Rehabilitation Services (ARS): Table of Contents, ARS Behavioral Summary regarding Resident A, Resident A's IPOS Training Record, an email request sent to Resident A's Easter Seals MORC psychologist on 03/17/26 requesting 16 hours of 1:1 staffing for Resident A, written statement from Amyra Burks, written statement from David Ellis, written statement from Santecia Dobbs, a collaborative written statement from Mr. Ellis, Ms. Taylor, and Ms. Dobbs regarding the inaccuracies of Mr. Slack's testimony when interviewed due to him being distracted, a text message sent to Resident A's guardian from an unknown sender on an unknown date in summary indicating Resident A has been keeping busy cooking with the chef and doing maintenance work, text messages and photo documentation included before and after the incident involving Resident A, Resident A's

progress notes, Resident A's IPOS & Crisis Plan, Resident A's Corewell Health After visit Summary dated 03/06/26, for a psychiatric evaluation, Resident A's ARS Incident Report (IR) Tracker, and varies IR's regarding Resident A.

Resident B's IPOS and Crisis Plan Training Records, Resident B's daily progress notes dated 02/23/26-02/28/26, ARS Appointment Record for First Choice Urgent Care dated 02/24/26 which indicates follow up with primary care physician in 1 – 2 days, Resident B's ARS Appointment Record with primary care physician dated 03/26/26 (appointment record not signed by doctor), Resident B's ARS Incident Report tracker, Resident B's Corewell Health after visit summary dated 03/07/26, portions of Resident B's IPOS, and varies IR's regarding Resident B.

I also reviewed ARS Suicide Risk Response and Active Rescue Procedures Policy, and ARS Neglect and Abuse Prevention & Reporting Policy.

Upon review of the information provided I noted the following information relevant to this allegation:

Resident A's IPOS Training Record (IPOS dated 09/01/25) does not indicate that Amyra Burks has been in-serviced on Resident A's IPOS. Quitman Slack's name is written on the training record, however, it is not signed or dated, and there is no presenter name/ date indicated as is documented for the other staff who are listed as trained. It should be noted that Mr. Slack's last name is spelled incorrectly on the training record.

The written statement provided by Amyra Burks indicates "Mr. Slack reported that he was transporting (Resident A) to assist with de-escalation. He indicated he was traveling at or near the posted speed limit on 12 Mile Road; at no time was excessive speed reported by involved parties."

APPLICABLE RULE	
R 400.629	Direct care staff; qualifications and training.
	<p>(4) Direct care staff shall possess all of the following qualifications before working independently:</p> <p>(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.</p> <p>(b) Be capable of appropriately handling emergency situations.</p>
ANALYSIS:	Based upon the information gathered during this investigation there is sufficient information to conclude direct care staff Quitman Slack, home manager Santecia Dobbs, team lead Shakyna Taylor, and HR manager Amyra Burks are not capable of meeting Resident A's physical and emotional needs and are

	<p>further not capable of appropriately handling an emergency situation.</p> <p>The staff's actions demonstrated a consistent failure to recognize risk, follow proper safety precautions, and respond appropriately to a mental health crisis. The staff were aware that Resident A had expressed suicidal ideations. The staff failed to seek medical intervention or ensure Resident A was in a safe, supervised environment. Direct care staff Quitman Slack followed guidance from team lead Shakyna Taylor to drive Resident A around in an attempt to calm him, rather than escalating the situation to emergency services. This created the opportunity for Resident A who was in crisis to open the door and jump out of a vehicle moving 40–45 mph.</p> <p>After Resident A sustained a potentially serious fall from jumping out of the vehicle and hitting his head, shoulder, and body staff did not seek medical treatment. Instead, home manager Santecia Dobbs instructed that Resident A be brought to her while she was off duty at a public location. She then took Resident A out to eat, where she and HR manager Amyra Burks conducted only a visual check for injuries. Despite Resident A hitting his head and having visible scrapes, no medical professionals were contacted.</p> <p>Staff relying solely on Resident A denying the need for medical care after a suicide attempt and a head injury reflects poor judgment and a failure to meet Resident A's physical and emotional health needs.</p>
CONCLUSION:	VIOLATION ESTABLISHED

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 upon the information gathered during this investigation there is sufficient information to conclude Resident A was not protected and kept safe. Resident A jumped out of a moving vehicle and hit the back of his head. Resident A's Easter Seals MORC Individual Plan of Service documents that he has a history of depression, suicidal thoughts, and self-harming behaviors. After jumping out of a moving vehicle on 12-mile road, going 40-45mph, in what Resident A reported was a suicide attempt, Resident A did not receive mental health or physical health intervention.
CONCLUSION:	VIOLATION ESTABLISHED

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.
ANALYSIS:	<p>Based upon the information gathered during this investigation there is sufficient information to conclude that Resident A jumped out of a moving vehicle, hit the back of his head, and he did not receive medical attention for mental and/or physical health needs.</p> <p>It was consistently reported by Resident A, direct care staff Quitman Slack, home manager Santecia Dobbs, and team lead Shakyna Taylor that Resident A reported suicidal ideations. He eloped from the home and Mr. Slack caught up with him in the company van. Mr. Slack stated he was advised by team lead Shakyna Taylor to drive Resident A around to calm him down. While driving on 12-mile road, going 40-45mph, Resident A opened the door and jumped out of the van. Resident A stated when he jumped out of the car he hit his head on the road. He also hit his shoulder and his butt. Resident A stated he jumped out of the car as an attempt to kill himself. Mr. Slack reported Resident A had scrapes on his arms and he was holding his head. Resident A denied needing medical attention.</p> <p>Mr. Slack was advised by home manager Santecia Dobbs to bring Resident A to Ms. Dobbs who was off shift at a store/nail salon. Ms. Dobbs reported she took Resident A out to eat. Then, HR manager Amyra Burks met up with them. Ms. Dobbs and Ms. Burks checked Resident A over for injuries, none were</p>

	observed. Resident A said that he did not require medical attention. Resident A returned home and went straight to his room and laid down.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A is paid to work at the Murray Crescent home, which is another home owned/operated by this provider.

INVESTIGATION:

On 02/25/26, I received a referral from APS that indicates, when APS met with Resident A on call it was discovered that Resident A is paid to work at the Murray Crescent home, which is another home owned/operated by this provider. Resident A further indicated that he is expected to do administrative duties as if staff at the Aberdeen Home.

On 03/03/26, I completed an unscheduled onsite investigation. I interviewed Resident A and home manager Santecia Dobbs.

On 03/03/26, I interviewed Resident A. Resident A stated getting a job is goal of his. Recently, he has been working with the maintenance man, “Mr. Tez,” later determined to be direct care staff Santez Halthon, doing work at the Murray Crescent home. He gets paid to help change light bulbs, plasters, and fix the washing machine. He received \$35 the first week he worked, and his next payment was \$60. Resident A stated he works from 11:00 am – 1:00 pm. Resident A stated while working he has access to tools needed to do the repair, but the tools do not remain in his possession when he is not working. Resident A denied that he is expected to do administrative duties as if staff at the Aberdeen Home.

On 03/03/26, I interviewed home manager Santecia Dobbs. Ms. Dobbs stated they wanted to find a way to keep Resident A busy so they contacted maintenance and they agreed that Resident A could do maintenance work with the maintenance man, Santez Halthon who is Ms. Dobbs brother. Mr. Halthon also works as a direct care staff at another home in the providers’ networks. Resident A works daily, for three hours a day starting at 11:00 am. Ms. Dobbs stated Resident A is paid weekly. His first payment was \$40, and his second payment was \$60. His payment is not based on hours worked or jobs completed, there was no agreement upon payment structure. Ms. Dobbs stated Resident A works with tools while performing maintenance tasks. These tools are locked up and not accessible to Resident A when he is not working.

On 03/23/26, I interviewed team lead Shakyna Taylor. Ms. Taylor stated Resident A works in a volunteer maintenance program. Ms. Taylor stated she believes Resident A is paid for the work that he does but she does not know any details regarding the

payment he receives. Ms. Taylor stated Resident A's guardians are aware that he is doing maintenance work, however, she does not know if his Easter Seals MORC case manager has been made aware.

On 03/24/26, I interviewed HR manager Amyra Burks via telephone. Ms. Burks stated Resident A's guardians requested that Resident A have something to do outside of the home. They had a meeting with home manager Ms. Dobbs, and it was decided that Resident A would do volunteer maintenance work. Ms. Burks discussed with Resident A and his guardian a schedule for when Resident A would volunteer. They arranged for him to go a few hours a day. However, Resident A has not stuck to the schedule that was created. He goes whenever he wants to go. Ms. Burks stated Resident A does not receive payment, this is a volunteer program which allows him to learn how to complete different maintenance tasks. Ms. Burks stated Resident A always has a direct care staff with him when he is participating in maintenance projects and he only uses items that are safe such as a paintbrush or a screwdriver. Ms. Burks stated Resident A has his own tools that are kept secure and are separate from his maintenance volunteer work. Ms. Burks stated she is unaware if Resident A's Easter Seals MORC case manager has been notified of the volunteer maintenance work he is doing.

On 03/18/26, I reviewed Resident A's Easter Seals MORC Individual Plan of Service (IPOS). Resident A's IPOS does not indicate that he is doing maintenance work for Abound Rehabilitation Services. Resident A's IPOS further documents that he has a history of depression, suicidal thoughts, and self-harm. It does not provide directives on whether it is safe for Resident A to work with tools, caustics and other equipment used in maintenance work.

On 03/26/26, following the exit conference, I received an email from HR manger Amyra Burks on behalf of licensee designee David Ellis requesting to provide additional documentation regarding this investigation. On 03/31/26, additional documentation was received via email. Upon review of the information provided I noted the following information relevant to this allegation:

A screen shot of a text message sent to Resident A's guardian from an unknown sender on an unknown date in summary indicates Resident A has been keeping busy cooking with the chef and doing maintenance work. The text included a photo of Resident A smiling.

Resident A's ARS Behavioral Summary indicates, "(Resident A) initially participated in volunteering with ARS maintenance crew when they have work orders but declined participation due to maintenance staff smoking tobacco products" and that "the resident often declines group outings and in-home activities, expressing the feeling that no one likes him."

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.

	(2) Work that is performed by a resident must be in accordance with the resident’s assessment plan.
ANALYSIS:	Based upon the information gathered during this investigation there is sufficient information to conclude that Resident A’s Easter Seals MORC Individual Plan of Service (IPOS) does not indicate that he is doing maintenance work for Abound Rehabilitation Services. Resident A’s IPOS documents that he has a history of depression, suicidal thoughts, and self-harm. It does not provide directives on whether it is safe for Resident A to work with tools, caustics, and other equipment used in maintenance work. Additionally, it was reported by Ms. Dobbs and Resident A that Resident A has received compensation for the work that he has completed, however, there is no formal agreed upon rate of compensation.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident B has green stool he was denied medical treatment.

INVESTIGATION:

On 03/02/26, I received additional allegations from APS. In summary, the allegations indicate Resident B has a diagnosis of cognitive impairment, anxiety and depression. Resident B resides at Abound Rehabilitation Services - Aberdeen Home. Resident B has a legal guardian. Resident B has been having issues with his stool, and it is green. Resident B informed the staff, and they have been denying him medical treatment. Resident B’s symptoms got worse and on 02/25/226, he went to Corewell Health William Beaumont University Hospital – Royal Oak Emergency Room. While Resident B was in the waiting room, home manager Santecia Dobbs and HR manager Amyra Burks arrived at the emergency room, removed Resident B and took him back home. Resident B was told that an appointment would be scheduled for the following day and they still have not made an appointment. Resident B’s guardian was also notified and refused medical treatment for Resident B.

On 03/03/26, I completed an unscheduled onsite investigation. I interviewed Resident A and home manager Santecia Dobbs.

On 03/03/26, I interviewed Resident A. Resident A stated Resident B called EMS and said that he had diarrhea, but his stool was green, he did not have diarrhea. Resident A said he knew this because he saw it in the toilet. Resident A stated Resident B is not sick, he eats fried foods and drinks pop and that is why his stool is green.

On 03/03/26, I interviewed home manager Santecia Dobbs. Ms. Dobbs stated Resident B contacted her and said his stool was green and it burned when he urinated. She instructed direct care staff Quitman Slack to take Resident B to urgent care and call her with an update. Ms. Dobbs stated the urgent care had no findings and they advised that Resident B follow up with his doctor the next day. HR manager Amyra Burks contacted Resident B's doctor, and they recommended he follow up with a specialist. Once home from the urgent care without notifying staff Resident B called EMS. EMS transported Resident B to the emergency room. HR manager Amyra Burks went to the emergency room and explained to Resident B that this is not an emergency and Resident B agreed to go home. Ms. Dobbs stated the next day Resident B called the police and said that he was neglected. He was taken to the hospital. When assessed he reported to hospital staff that he fell. Ms. Dobbs stated they were unaware that Resident B fell. Ms. Dobbs denied that she went to the emergency room with Ms. Burks to remove Resident B. Ms. Dobbs stated she was unaware if a follow-up appointment had been made for Resident B with a specialist to address his stool, she further reported that Ms. Burks was going to schedule the appointment.

On 03/03/26, while onsite I obtained a copy of Resident B's Corewell Health William Beaumont University Hospital After Visit Summary dated 02/28/26. In summary, the paperwork indicates Resident B was seen for abdominal pain and a fall. It is recommended that he follow up with his primary care doctor within a week (around 03/07/26).

On 03/04/26, I exchanged emails with APS worker Kanati – Owl Davenport. Ms. Davenport indicated that she interviewed Resident B's guardian. Resident B's guardian reported that she had not been notified by the house that Resident B had gone to the emergency room within the past week. She stated that Resident B requires one-on-one staffing and the home receives a per-diem rate to provide the care. She reported that Resident B frequently wants to go to the emergency room or the urgent care, and she has never told the home not to send him but has told them that she needs to be notified. She stated that this home provides great care to Resident B and that if he could not remain in this home, he would end up in jail. She stated he is on probation and not allowed to be anywhere near schools and there are not many homes willing to take on this responsibility. She stated she has been Resident B's guardian for about five months. APS told her that what she is reporting contradicts what APS had been told. APS had been told that the guardian told them that she needs to be called first Resident B wants to go to the hospital and that they cannot just send him there. The guardian stated that was not correct. The guardian is also concerned that Resident B was sent to the ER without staff and that when someone from the company arrived, Resident B left without being seen.

On 03/04/26, in collaboration with APS worker Ms. Davenport and Recipient Rights Specialist Ms. Oliver, I interviewed Resident B. Ms. Davenport and Ms. Oliver were onsite, I was present via telephone. Resident B stated he has been experiencing symptoms for a few weeks. He was taken to urgent care, and they said if symptoms continue to go to the emergency room. Resident B said the next day he called 911 and was taken to triage by EMS. Resident B did not notify staff that he was calling 911. Resident B said he felt like his balance was off and it was causing him to fall. Resident

B stated he did not notify staff of his symptoms because when he reports medical symptoms they tell him he cannot receive medical care because they are trying to follow his guardians request and she said he cannot go to the hospital. Resident B stated HR manager Amyra Burks picked from the emergency room and said that she would make him a follow up appointment with a gastrology specialist the next day, but she never did. Resident B stated if Ms. Burks had scheduled an appointment he would have been contacted by the provider's office and notified of the appointment. Resident B stated he continues to have green stool, his balance is "off and on," his stomach hurts, and he cannot eat much. He has not received medical treatment for these issues.

On 03/23/26, I interviewed team lead Shakyna Taylor. Ms. Taylor stated she has no information regarding this allegation. However, to her knowledge no appointment has been made for Resident B as of the date of this interview.

On 03/24/26, I interviewed HR manager Amyra Burks via telephone. Ms. Burks stated either home manager Ms. Dobbs or team lead Ms. Taylor contacted Resident B's primary care doctor regarding his stool being green. His primary care doctor recommended that he follow up with a specialist. Ms. Burks stated she talked to Resident B and he asked her if he should go to the emergency room. Ms. Burks explained to him the recommendation was that he follow up with a specialist and she educated him that this was not an emergency. Ms. Burks stated later that day, staff took Resident B to the urgent care. The urgent care advised that Resident B follow up with his primary care doctor. Ms. Burks stated she spoke to Resident B that evening and confirmed with him that appropriate follow-up with a specialist would be arranged.

Ms. Burks stated the next day without staff knowledge Resident B called 911. Ms. Burks received a telephone call from Ms. Dobbs who informed her that Resident B was being taken to William Beaumont Hospital. Resident B was transported via EMS. Ms. Burks stated Resident B has 1:1 staffing, his 1:1 staff followed him to the hospital. Ms. Burks stated she happened to be in the area and offered to go to the hospital and meet Resident B. Ms. Burks stated when she arrived at the hospital she found Resident B in the waiting room alone, his 1:1 staff had not arrived. Resident B told her that he wanted to get his stool checked. Ms. Burks explained to Resident B that this was not an emergency and that it was recommended by his primary care doctor that he follow up with a specialist. Resident B agreed. Resident B and Ms. Burks left the emergency room. Ms. Burks stated she was at the hospital for approximately five minutes, Resident B's 1:1 staff did not show up. Ms. Burks is unaware of who Resident B's assigned 1:1 staff was. Ms. Burks said she is unaware if an appointment has been made for Resident B to follow up with a specialist. Ms. Burks stated Ms. Dobbs is responsible for scheduling resident appointments. Ms. Burks stated she does not schedule or facilitate resident appointments.

On 03/24/26, I completed a second interview with home manager Santecia Dobbs. Ms. Dobbs again emphasized that she is unaware if a follow-up appointment had been made for Resident B with a specialist to address his stool, as Ms. Burks was going to schedule the appointment.

On 03/02/26, I reviewed Resident B's Easter Seals MORC Individual Plan of Service (IPOS). In summary, Resident B has 1:1 staffing. Resident B has a goal of reducing

hospitalization. If Resident B reports that he needs to go to the hospital, and does not appear to be in immediate danger staff should offer solutions that can be done at home (i.e. first aid kit, Standing Medical Orders, coping skills, talking with family, providing ice/heating pad, ask about taking him to walk in clinic, etc...). If Southfield Police or EMS arrive, because Resident B has called them without knowledge of staff, please ask them to call his mother immediately, his guardian to work through the situation first before he is hospitalized. EMS will usually do Vitals and if normal mom can make the decision with Resident B for him to stay home or go to Urgent Care if they still feel he needs medical care. His mother can give permission if hospitalization is needed as Resident B is not his own guardian. Show the police her contact information and court paperwork.

On 03/26/26, following the exit conference, I received an email from HR manger Amyra Burks on behalf of licensee designee David Ellis requesting to provide additional documentation regarding this investigation. On 03/31/26, additional documentation was received via email. Upon review of the information provided I noted the following information relevant to this allegation:

Resident B's IPOS Training Record does not indicate that Amyra Burks and Santecia Dobbs have been in-serviced on Resident B's IPOS. Resident B's Crisis Plan Training Record indicates Ms. Dobbs completed an in-service on 10/16/25. There is no indication that Ms. Burks has been in-serviced on the crisis plan.

I reviewed an ARS Appointment Record for First Choice Urgent Care dated 02/24/26 which recommends follow up with primary care physician in 1 – 2 days, ARS provided an Appointment Record for an appointment with Resident A's primary care physician dated 03/26/26 (appointment record not signed by doctor). ARS also provided Corewell Health After Visit Summary dated 03/07/26.

APPLICABLE RULE	
R 400.689	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Based upon the information gathered during this investigation there is sufficient information to conclude that Resident B had complaints of green stool. He independently contacted 911 and was transported by EMS to the emergency room. HR manager Amyra Burks went to the emergency room and explained to Resident B that his primary care doctor recommended that he follow up with a specialist and told him that this was not an emergency. Ms. Burks then removed Resident B from the emergency room. Ms. Burks said she is unaware if an appointment has been made for Resident B to follow up with a

	<p>specialist. Ms. Burks denied that she scheduled the appointment. Ms. Burks stated home manager Santecia Dobbs is responsible for scheduling resident appointments.</p> <p>Home manager Ms. Dobbs stated that she is unaware if a follow-up appointment had been made for Resident B with a specialist to address his stool. Ms. Dobbs denied that she scheduled the appointment. Ms. Dobbs stated that Ms. Burks was going to schedule the appointment.</p> <p>Team lead Shakyna Taylor stated to her knowledge no appointment has been made for Resident B.</p> <p>Throughout the course of this investigation there was no documentation provided to reflect that the instructions and recommendations of Resident B's physician were followed to address the issue with his bowels as no appointment was scheduled with a specialist.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 03/03/26, I conducted a search on the LARA Workforce Background Check (WBC) website and determined Abound Rehabilitation Services staff Quitman Slack, Amyra Burks, and Shakyna Taylor are all cleared through the WBC system under Abound Rehabilitation Services – Murray Crescent (AS630418986) however, these staff do not have completed background checks on file affiliated with Abound Rehabilitation Services - Aberdeen Home (AS630419680). It should be noted that in the WBC system Mr. Slack was fingerprinted under an incorrect first name. His name is listed as Quickman, not Quitman. Additionally, there is also no WBC on file for Santez Halthon who is identified as the maintenance man. On 03/03/26, I conducted an onsite inspection, I observed direct care staff Ali Aljumah working alone on shift. He was preparing to take the residents to the library. Per the WBC website as of 03/03/26, Mr. Aljumah's background check was pending and therefore, he is not authorized to work alone on shift. Resident A stated he was waiting for Mr. Halthon to pick him up to go do maintenance work. While I was at home, Resident A texted Mr. Halthon and told him that he was ready. As Mr. Aljumah was the only direct care staff at the home, there was no other direct staff present to accompany Resident A to work and/or on the drive with Mr. Halthon, indicating that although Mr. Halthon is the maintenance man he has direct access to residents.

APPLICABLE RULE	
MCL 400.734b	<p>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.</p>
	<p>(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.</p>

<p>ANALYSIS:</p>	<p>Based upon the LARA Workforce Background Check website there is sufficient information to conclude Abound Rehabilitation Services staff Quitman Slack, Amyra Burks, and Shakyna Taylor are all cleared through the WBC system under Abound Rehabilitation Services – Murray Crescent (AS630418986) however, these staff do not have completed background checks on file affiliated with Abound Rehabilitation Services - Aberdeen Home (AS630419680). It is important to note that Mr. Slack was fingerprinted under an incorrect name, Quickman, instead of Quitman.</p> <p>There is no WBC on file for Santez Halthon. On 03/03/26, I conducted an onsite inspection, I observed direct care staff Ali Aljumah working alone on shift. Per the WBC website on 03/03/26, Mr. Aljumah’s background check was pending and therefore, he is not authorized to work alone on shift. While I was at the home, Resident A texted Mr. Halthon and told him that he was ready for work. As Mr. Aljumah was the only direct care staff at the home, there was no other direct care staff present to accompany Resident A to work and/or on the drive with Mr. Halthon, indicating that although Mr. Halthon is the maintenance man he has direct access to residents.</p> <p>Throughout the course of this investigation, it was consistently reported that the aforementioned Abound Rehabilitation Services staff have ongoing direct access to the residents who reside in the Aberdeen home.</p>
<p>CONCLUSION:</p>	<p>REPEAT VIOLATION ESTABLISHED Special Investigation Report # 2025A0612028; CAP dated 12/08/2025.</p>

INVESTIGATION:

On 03/24/26, I interviewed HR manager Amyra Burks via telephone. Ms. Burks stated Resident B has 1:1 staffing. When Resident B was taken to the hospital via EMS his 1:1 staff followed behind. Ms. Burks stated she happened to be in the area and offered to go to the hospital and meet Resident B. Ms. Burks stated when she arrived at the hospital she found Resident B in the waiting room alone. Ms. Burks stated it is unknown how long Resident B was alone in the emergency room. However, she was at the hospital for approximately five minutes. During this time Resident B’s 1:1 staff did not show up. Ms. Burks and Resident B left the hospital together and she took him back to the Aberdeen Home. Ms. Burks is unaware of who Resident B’s assigned 1:1 staff was.

I reviewed Resident B’s Easter Seals MORC Individual Plan of Service (IPOS). In summary, Resident B has enhanced 1:1 staffing outlined as 16 hours daily (no

enhanced staff during sleeping midnight hours) to provide safety for the following behaviors: unable to attend events with children or family, intrusive supervision during times of suicidal ideations, locked sharps and lethal means due to safety, medications, visitor restriction/approval for home visitors, substance use, restrictions of accepting packages, and abuse and inappropriate sexual behavior with animals. Resident A cannot be alone in the community.

Resident B's IPOS further states, "(Resident B) does not fully understand health and safety rules at home or how to handle an emergency. He cannot be left alone because of probation rules..."

"Staff or family make sure (Resident B) goes to all medical appointments and follows the doctor's advice."

On 03/25/26, I placed a telephone call to licensee designee David Ellis to conduct an exit conference and review my findings. Regarding the allegation of Resident A jumping out of the car, Mr. Ellis stated that he was informed that the car was stopped at a stop sign when Resident A got out and there were no reported injuries. Mr. Ellis discussed Resident A's extensive mental health history and explained that he is a high acuity resident. Mr. Ellis stated Resident A's maintenance work is part of a volunteer program that promotes community involvement. Mr. Ellis stated Resident A is not an employee however, he has received payment as a reward system so that he has "extra money" for spending. Mr. Ellis stated that Resident A's IPOS does not indicate that he is unsafe around tools or caustics and he further reported that Resident A has a saw that was given to him by his dad. Mr. Ellis emphatically disagreed with the citation regarding Resident B not having 1:1 staffing in the emergency room as Resident B only has 1:1 staffing for 16 hours a day to be used at their discretion. Mr. Ellis disagreed with the citation regarding workforce background checks stating the staff identified have been fingerprinted under other homes in the providers' network, however, they have been unable to successfully link the staff to all the Abound Rehabilitation Services homes that they work in. Additionally, Mr. Ellis stated that Santez Halthon is not a direct care staff, he is a maintenance man, he is also employed as a staff at another home within the providers network located in Wayne County that is not a licensed AFC and therefore, he should not require a WBC. When asked if Mr. Halthon had direct access to Resident A, including driving him, Mr. Ellis stated he is unsure if Mr. Halthon drives Resident A, but if he does a direct care staff is with him. Mr. Ellis disagrees with the recommendation of revocation, remarking that these are not all repeat violations. Mr. Ellis indicated that Abound Rehabilitation Services has an impeccable reputation in the community. I advised Mr. Ellis of his right to a compliance conference, and he indicated that he would be obtaining legal counsel.

On 04/01/26, upon review of the additional documentation submitted by Abound Rehabilitation Services following the exit conference I sent an email to Mr. Ellis indicating that I recommend revocation of the license.

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:	<p>Based upon the information gathered during this investigation there is sufficient information to conclude staffing was not provided to Resident B in accordance with his individual plan of service.</p> <p>Per Resident B's Easter Seals MORC Individual Plan of Service Resident B has enhanced 1:1 staffing outlined as 16 hours daily (no enhanced staff during sleeping midnight hours) to provide safety for a variety of reasons. Additionally, Resident B does not fully understand health and safety rules or how to handle an emergency. Resident B was transported to the hospital via EMS. When HR manager Amyra Burks arrived at the hospital she found Resident B in the waiting room alone, his 1:1 staff had not arrived. Ms. Burks stated it is unknown how long Resident B was alone in the emergency room. However, she was at the hospital for approximately five minutes. During this time Resident B's 1:1 staff did not show up. Ms. Burks and Resident B left the hospital together and she took him back to the Aberdeen home.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

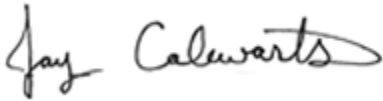


04/07/2026

Johnna Cade
Licensing Consultant

Date

Approved By:



For

04/08/2026

Denise Y. Nunn
Area Manager

Date