GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24, 2026

David Ellis Sr
Abound Rehabilitation Services, INC.
1221 E. Lincoln Ave.
Royal Oak, MI 48067

RE: License #: AS630418986
Investigation #: 2026A0991019
Abound Rehabilitation Services - Murray Crescent

Dear David Ellis Sr:

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. A previous recommendation for revocation was made in SIR #: 2026A0991014, which remains in effect. 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,

Kristen Donnay

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630418986
Investigation #:	2026A0991019
Complaint Receipt Date:	04/14/2026
Investigation Initiation Date:	04/15/2026
Report Due Date:	06/13/2026
Licensee Name:	Abound Rehabilitation Services, INC.
Licensee Address:	1221 E. Lincoln Ave. Royal Oak, MI 48067
Licensee Telephone #:	(313) 676-0013
Licensee Designee/Administrator:	David Ellis Sr
Name of Facility:	Abound Rehabilitation Services - Murray Crescent
Facility Address:	29361 Murray Crescent Dr Southfield, MI 48076
Facility Telephone #:	(248) 232-6588
Original Issuance Date:	04/17/2025
License Status:	1ST PROVISIONAL
Effective Date:	12/17/2025
Expiration Date:	06/16/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident D is not receiving his medications properly. He is not taking his medications, but staff are telling the doctors that he is taking them.	Yes

III. METHODOLOGY

04/14/2026	Special Investigation Intake 2026A0991019
04/15/2026	Special Investigation Initiated - Telephone To Adult Protective Services (APS)
04/15/2026	APS Referral Received from Adult Protective Services (APS)- not assigning for investigation
04/15/2026	Contact - Telephone call made To complainant- phone number not in service
04/15/2026	Referral - Recipient Rights Referred to Office of Recipient Rights (ORR)
04/16/2026	Inspection Completed On-site Interviewed staff, Resident D, and reviewed medications
04/16/2026	Contact - Telephone call received From licensee David Ellis, during onsite inspection
04/17/2026	Contact - Telephone call received Email from compliance director, Amyra Burks with written statement
04/17/2026	Contact - Document Sent Requested additional documentation and verification of medication training
04/20/2026	Contact - Telephone call made Left message for Amyra Burks
04/20/2026	Contact - Telephone call made To licensee designee, David Ellis

04/20/2026	Contact - Telephone call received From Amyra Burks
04/20/2026	Contact - Document Received Medical documentation, staff statements, training verification
04/20/2026	Contact - Telephone call made To complainant
04/20/2026	Contact - Telephone call made Interviewed team lead, Shannon Harper
04/21/2026	Contact - Document Received Medication training certificates
04/22/2026	Contact - Telephone call made To medication coordinator, Arthur Paschal
04/23/2026	Exit Conference Via telephone with licensee designee, David Ellis

ALLEGATION:

Resident D is not receiving his medications properly. He is not taking his medications, but staff are telling the doctors that he is taking them.

INVESTIGATION:

On 04/15/26, I received a complaint from Adult Protective Services (APS) alleging that Resident D's medications are not being administered properly. The complaint alleged that Resident D is not taking his medications, but staff are telling the doctors that he is taking them. I initiated my investigation on 04/15/26 by contacting APS and making a referral to the Office of Recipient Rights (ORR).

On 04/16/26, I conducted an unannounced onsite inspection at Abound Rehabilitation Services – Murray Crescent. I interviewed Resident D. Resident D stated that he recently returned to the home from the hospital. He stated that he has been feeling better. He is taking his medications, except for the "green and white pill." I reviewed Resident D's medications and identified the "green and white pill" as Hydroxyzine Pam 50mg- take one capsule by mouth twice daily. Resident D stated that he does not like this medication because it makes him feel sick. He stated that he refuses to take this pill, but he takes the rest of his medications. Resident D stated that he also has a "big pill" that he does not like because it makes him feel sleepy. He did not know if he took

the big pill at morning or night. He stated that he wants to talk to the doctor about not taking the green and white pill or the big pill, and he would like to refuse these medications.

On 04/16/26, I interviewed the medication coordinator, Arthur Paschal. Mr. Paschal stated that he has worked in the home since December 2025. He recently became the medication coordinator on 03/16/26. He stated that Resident D has not been refusing to take his Hydroxyzine medication. He stated that Resident D never refuses to take medications for him, and he is the one who typically administers medications to Resident D, because Resident D cooperates for him. Mr. Paschal stated that if he is at the home, Resident D takes his medications. Mr. Paschal stated that staff are trained to complete an incident report for any medication refusals.

I received and reviewed the discharge summary from Henry Ford Behavioral Health, which indicates that Resident D was admitted to the hospital on 02/27/26 and discharged at 11:30am on 03/25/26.

During the onsite inspection, I reviewed Resident D's March 2026 and April 2026 Medication Administration Record (MAR) and medications. I noted the following:

- Resident D's March 2026 MAR was not initialed for 8:00am medications on 03/26/26 or his 2:00pm medication on 03/26/26, the day after his discharge from the hospital.
- The March 2026 MAR shows that Resident D refused his 8:00pm dose of Hydroxyzine Pam 50mg CAP on 03/26/26 and 03/27/26.
- Resident D's March 2026 MAR shows that the 8:00am and 8:00pm dose of Hydroxyzine Pam 50mg were discontinued on 03/31/26. The letters "DC" are written with a dash through the box. The April 2026 MAR shows that the medication is not discontinued and is being administered twice daily.
- Resident D's March 2026 MAR was not initialed for the 8:00pm dose of Lorazepam 0.5mg- take one tablet by mouth twice daily on 03/30/26 and 03/31/26.
- The home uses a numbering system for staff to indicate who administered medications on the MAR. The key on Resident D's March 2026 MAR did not indicate which staff was assigned the number 11.

Following the review of the medications and MARs, I interviewed the home manager, Erica Johnson, and the medication coordinator, Arthur Paschal. The licensee designee/administrator, David Ellis, also called via telephone during the onsite inspection and I reviewed the medication errors with him. Ms. Johnson, Mr. Paschal, and Mr. Ellis stated that they were not aware of the errors on Resident D's March 2026 MAR. After reviewing the staff schedule and numbers on the MAR, it was determined

that the shift lead, Shannon Harper, was the schedule medication passer on 03/30/26 and 03/31/26 when the MAR was not initialed for the 8:00pm dose of Lorazepam.

It was determined that Brianna Mathis was the assigned medication passer when Resident D refused his Hydroxyzine Pam 50mg CAP on 03/26/26 and 03/27/26. I interviewed Ms. Mathis during the onsite inspection, and she stated that Resident D refused to take the medication. She did not complete an incident report or notify a licensed health care professional regarding the refused medication. The home manager and medication coordinator instructed Ms. Mathis to complete incident reports at the time of my onsite inspection on 04/16/26. Mr. Paschal stated that all staff completed medication refresher training after medication errors were previously identified during my interim inspection at the home.

During the onsite inspection, I requested any documentation regarding Resident D's recent medical appointments or medication changes. I received documentation regarding his hospitalization from Henry Ford Behavioral Health. Staff indicated that there was no other documentation regarding appointments or medications.

On 04/17/26, I received an email from the Human Resources (HR) and Compliance Manager, Amyra Burks. Ms. Burks stated that upon completing an end-of-month review, Abound identified two missing signatures and an incorrect "DC" (discontinued) notation on Resident D's MAR. Although these were documentation errors, an internal audit confirmed that Resident D did receive all scheduled medications; therefore, a formal incident report was not generated at that time as Resident D's health or safety was not compromised. Ms. Burks indicated that the staff member responsible for the error provided a formal statement on 04/01/26, which was placed in their personnel file along with a verbal warning/counseling. Ms. Burks also stated that to prevent future occurrences, they appointed a medication coordinator. The medication coordinator is now responsible for overseeing MARs and ensuring 100% accuracy. The medication coordinator will provide immediate remedial training for any staff member who demonstrates a need for additional support in medication documentation.

Ms. Burks included a written statement dated 04/01/26 from team lead, Shannon Harper, which stated, "On 3/30-3/31 I forgot to put my number down for these two days, but the med was given to the consumer. I will double check going further. The meds that was discontinued was not discontinue until his doctor discontinue the med, so it should not have been DC on the med."

I received and reviewed a written disciplinary form from Abound Rehabilitation Services dated 04/01/26 for team lead, Shannon Harper. The disciplinary form notes that Ms. Harper received a verbal warning after it was noted during the monthly review of Resident D's MARs that Ms. Harper forgot to enter her number confirming she passed Resident D his medication during the evening medication pass on 03/30/26 and

03/31/26. It notes that although the medication was passed, there was an error in documentation. The form notes that the corrective action plan is re-training for medication passing via the toolbox training. The disciplinary form is signed by Ms. Harper and the licensee designee, David Ellis, and dated 04/01/26. It should be noted that during the onsite inspection on 04/16/26, Mr. Ellis did not indicate that he was aware of the documentation error on Resident D's MAR or that Ms. Harper received disciplinary action.

On 04/20/26, I interviewed the team lead, Shannon Harper. Ms. Harper stated that on 04/01/26, they were switching over the medications for the new month. The medication coordinator, Arthur, did a check behind her and noticed that she missed her number on the MAR. She stated that all medications were passed, as the bubble packs were checked. She stated that she received a phone call about the missed numbers, and she wrote a statement on 04/01/26. Ms. Harper stated that she did not know who it was that called her. Ms. Harper stated that she did not get written up or disciplined as a result of the documentation error. Ms. Harper stated that she participated in a video appointment with Resident D and his psychiatric doctor, Dr. Sidhu, on 03/30/26 at 3:00pm. Resident D told the doctor that he does not like his "green and white pill" and the doctor stated that they could discontinue it. Ms. Harper stated that the doctor did not send an order showing that the medication was discontinued. She stated that she did not write "DC" on Resident D's MAR, and she did not know who wrote it. Ms. Harper stated that she does not have any issues with getting Resident D to take his medications. He only says that he does not want the green and white pill.

On 04/20/26, I spoke with the licensee designee, David Ellis, via telephone. Mr. Ellis stated that Arthur Paschal and Shannon Harper picked up on the documentation errors during the changeover of medications on 04/01/26. He stated that Resident D recently had an appointment with his primary care physician, Dr. Desir, but the primary care physician does not have the authority to discontinue psychiatric medications. Mr. Ellis stated that Resident D also had a Zoom appointment with his psychiatric doctor, but they did not receive an order to discontinue the medication, so it was not discontinued. Mr. Ellis stated that he was not aware that a health care professional needed to be contacted regarding medication refusals. He stated that they complete an incident report and send it to the case manager.

On 04/20/26, Amyra Burks forwarded me a copy of Resident D's Medication Review Note from Copper Country CMH, which was completed by Dr. Sidhu on 03/30/26. The notes indicate that Resident D reported good sleep and appetite. Resident D said he has been feeling tired from the "green and white" pill and has been refusing it. He said he did not want to take it. Resident D said he did not have thoughts of suicide, hurting himself, or others. Resident D stated that he did not hear voices that others could not hear and did not see things others could not see. Staff, Shannon Harper, reported that

Resident D has been refusing Hydroxyzine specifically, because he said it makes him tired. She stated he has been compliant with all his other medications.

I reviewed the medication plan/prescribed medications noted in the psychiatric medication plan dated 03/30/26 compared to Resident D's April 2026 MAR and noted the following discrepancies:

- The psychiatric medication plan notes to discontinue Hydroxyzine Pamoate 50mg BID (twice daily) and monitor tiredness. Resident D's April 2026 MAR shows medication is still being administered twice daily from 04/01/26-04/16/26.
- The psychiatric medication plan notes Resident D is prescribed Lorazepam TID (three times daily) 8:00am, 2:00pm, and 8:00pm. Resident D's April 2026 MAR shows the medication is being given twice daily at 8:00am and 8:00pm. The 2:00pm dose was not listed on Resident D's April 2026 MAR and the medication was not in the home at the time of my onsite inspection on 04/16/26.
- The psychiatric medication plan notes Resident D is prescribed Olanzapine 10mg bedtime (8pm) and Olanzapine 2.5mg daily PRN. Resident D's April 2026 MAR shows he is receiving Olanzapine 10mg at 8:00pm and Olanzapine 15mg at 8:00pm. Olanzapine 2.5mg PRN was not listed on Resident D's April 2026 MAR.
- The psychiatric medication plan notes Resident D is prescribed Trazadone 50mg bedtime (8pm). Trazadone 50mg was not listed on Resident D's April 2026 MAR and the medication was not in the facility at the time of my onsite inspection on 04/16/26.

Resident D's case manager sent the Copper Country CMH Medication Review Note to Abound on 04/20/26, and he indicated that he asked Dr. Sidhu's nurse to call in the changes to the pharmacy. He noted that he apologized for the mishap and indicated that they are taking steps to prevent a similar occurrence moving forward.

On 04/20/26, I received and reviewed notes from Resident D's office visit on 04/13/26 with his primary care physician (PCP), Dr. Desir. The notes were sent to Abound on 04/20/26. The notes indicate that a medication reconciliation was completed. I noted the following discrepancies between the medications listed on the PCPs reconciled medication list, Resident D's April 2026 MAR, and the medication plan from the psychiatric doctor:

- The PCP medication list indicates Resident D is prescribed Hydroxyzine Pamoate 50mg capsule- take 1 capsule by mouth two times per day as needed. Resident D's April 2026 MAR does not indicate the medication is a PRN. This order also conflicts with the psychiatric medication plan from 03/30/26 to discontinue the medication.

- The PCP medication list indicates Resident D is prescribed Lorazepam 0.5mg tablet- take one tablet by mouth three times per day as needed. Resident D's April 2026 MAR shows the medication is being given twice daily at 8:00am and 8:00pm, not three times per day as needed. This order also conflicts with the psychiatric medication plan from 03/30/26 for Lorazepam TID (three times daily) 8:00am, 2:00pm, and 8:00pm.
- The PCP medication list indicates Resident D is prescribed Olanzapine 15mg oral tablet- take one tablet by mouth at bedtime and Olanzapine 2.5mg oral tablet- Take 1 tablet by mouth BID (twice daily). Resident D's April 2026 MAR shows he is receiving Olanzapine 10mg at 8:00pm and Olanzapine 15mg at 8:00pm. Olanzapine 2.5mg twice daily was not listed on Resident D's April 2026 MAR. This order also conflicts with the psychiatric medication plan from 03/30/26 for Olanzapine 10mg bedtime (8pm) and Olanzapine 2.5mg daily PRN.
- The PCP medication list does not include Valproic Acid 250mgg/5mL solution- take 10ml by mouth two times a day, which is listed on Resident D's April 2026 MAR.

On 04/23/26, I contacted the medication coordinator, Arthur Paschal. He confirmed that Resident D is receiving Olanzapine 10mg and Olanzapine 15mg at 8:00pm. The Olanzapine 15mg was prescribed by Dr. Amit Razdan, and the 10mg was prescribed by Dr. Gurkanwal Sidhu. He sent pictures of the bubble packs, which show both medications were administered from 04/01/26-04/22/26.

On 04/23/2026, I conducted an exit conference via telephone with licensee designee, David Ellis. Mr. Ellis stated that he is in the process of communicating with the pharmacy and the Copper Country CMH to resolve the issues with Resident D's medications and will have the issues resolved today. He stated that the orders were never sent to the pharmacy following Resident D's 03/30/26 appointment. The pharmacy was filling two prescriptions for Olanzapine, one from Resident D's current psychiatrist, Dr. Sidhu, and the other from his previous psychiatrist, Dr. Razdan. Mr. Ellis stated that they would be terminating the employment of the team lead, Shannon Harper, due to the medication errors. He stated that the medication refusals were reported to the team lead, but she did not initiate having an incident report written.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident D's medications were not being given as prescribed. Resident D had a psychiatric telehealth appointment on 03/30/26 with Dr. Sidhu to review his medications. Several medication changes were made, including discontinuing Resident D's Hydroxyzine Pamoate 50mg capsule, adding a 2:00pm dose of Lorazepam, and adding Trazadone 50mg. Resident D's March 2026 MAR showed that the Hydroxyzine was discontinued on 03/31/26, but staff began administering it again through the month of April. The facility failed to follow up with the doctor, pharmacy, or case manager to ensure that the orders were received and implemented in a timely manner following the psychiatric appointment on 03/30/26. There were also several discrepancies noted between the orders from the psychiatric medication review on 03/30/26 and the medication reconciliation by Resident D's primary care physician on 04/13/26, which were not addressed by the licensee. Resident D is currently receiving Olanzapine 10mg and Olanzapine 15mg at 8:00pm, which does not align with the orders from the psychiatrist or primary care physician.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Renewal Licensing Study Report Dated: 12/04/25; CAP Dated: 12/15/25**

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: (b) Complete an individual medication log that contains all of the following: (i) Medication name. (ii) Dosage. (iii) Label instructions for use. (iv) Time to be administered. (v) Initials of the individual who administered the medication at the time given. (vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not initial

	Resident D's MAR at the time medications were administered. Resident D's March 2026 MAR was not initialed for 8:00am medications on 03/26/26 or his 2:00pm medication on 03/26/26, the day after his discharge from the hospital. Resident D's March 2026 MAR was not initialed for the 8:00pm dose of Lorazepam 0.5mg- take one tablet by mouth twice daily on 03/30/26 and 03/31/26. In addition, the home uses a numbering system for staff to indicate who administered medications on the MAR. The key on Resident D's March 2026 MAR did not indicate which staff was assigned the number 11.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Renewal Licensing Study Report Dated: 12/04/25; CAP Dated: 12/15/25**

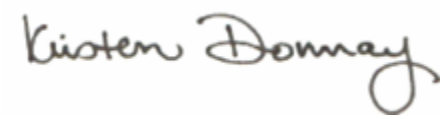
APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (e) Not adjust or modify a resident's prescription medication without instructions from a physician, physician assistant, advanced practice nurse, or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any instructions regarding a resident's prescription medication.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the licensee did not record in writing the instructions regarding Resident D's medications. Resident D had a psychiatric appointment on 03/30/26 with Dr. Sidhu to review his medications. Several medication changes were made, including discontinuing Resident D's Hydroxyzine Pamoate 50mg capsule, adding a 2:00pm dose of Lorazepam, and adding Trazadone 50mg. At the time of my onsite inspection on 04/16/26, the facility did not have any written instructions regarding these medication changes. The Copper Country CMH Medication Review Note was not obtained until 04/20/26. Staff wrote "DC" on Resident D's March 2026 MAR on 03/31/26. There was no documentation on file to show that the medication was discontinued, although the information was conveyed verbally to team lead, Shannon Harper, during the telehealth appointment on 03/30/26.

CONCLUSION:	**VIOLATION ESTABLISHED**

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: (g) Contact the appropriately licensed health care professional when a resident refuses a prescribed medication or procedure. A licensee, administrator, or staff shall document and follow the instructions given by the licensed health professional. Documented instructions may include procedures to follow when a resident refuses medication or procedures in the future.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that licensed health care professional was not contacted when Resident D refused his 8:00pm dose of Hydroxyzine Pam 50mg CAP on 03/26/26 and 03/27/26. Direct care worker, Brianna Mathis, was the scheduled medication passer. She stated that she did not complete an incident report or notify a licensed health care professional regarding the refused medication. The licensee designee, David Ellis, stated that he was not aware that a medication professional needed to be contacted for medication refusals.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

A previous recommendation for revocation was made in SIR #: 2026A0991014 due to the license currently being on a provisional license and the intervening quality of care violations. The recommendation for revocation remains in effect.



04/23/2026

Kristen Donnay Date
Licensing Consultant

Approved By:

For 4/24/2026

Denise Y. Nunn Date
Area Manager