GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2026

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

RE: License #: AS630419995
Investigation #: 2026A0626023
Abound Rehabilitation Services - Almond Lane

Dear Mr. Ellis Sr:

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

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 972-9136.

Sincerely,

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 #:	AS630419995
Investigation #:	2026A0626023
Complaint Receipt Date:	05/11/2026
Investigation Initiation Date:	05/12/2026
Report Due Date:	07/10/2026
Licensee Name:	Abound Rehabilitation Services, INC.
Licensee Address:	1221 E. Lincoln Ave. Royal Oak, MI 48067
Licensee Telephone #:	(313) 676-0013
Administrator:	David Ellis Sr
Licensee Designee:	David Ellis Sr
Name of Facility:	Abound Rehabilitation Services - Almond Lane
Facility Address:	6443 Almond Lane Clarkston, MI 48346
Facility Telephone #:	(248) 232-3276
Original Issuance Date:	04/07/2026
License Status:	TEMPORARY
Effective Date:	04/07/2026
Expiration Date:	10/06/2026
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A had an accident in her pants and staff would not change her.	No
Additional Findings	Yes

II. METHODOLOGY

05/11/2026	Special Investigation Intake 2026A0626023
05/12/2026	Contact - Telephone call made I attempted a telephone interview with recipient rights specialist, Sarah Rupkus. A message was left requesting a return call.
05/12/2026	Special Investigation Initiated - Telephone I completed a telephone interview with Relative A1.
05/12/2026	APS Referral I submitted a referral to Adult Protective Services via the mandated reporter portal.
05/18/2026	Contact - Face to Face I completed an unannounced onsite investigation at Almond Lane. I completed interviews with home manager, Santiya Halthon, direct care staff member, Cardi Stitts, and a private interview with Resident B.
05/27/2026	Contact - Telephone call made I completed an interview with Resident B's guardian, Jim Stark, via telephone.
05/27/2026	Contact - Telephone call made I completed telephone interviews with Keyshia Harris, care coordinator at Lahser Vocational Program and Keilee Grice, community skills specialist at Lahser Vocational Program.

06/10/2026	Contact - Document Received I received an email from recipient rights specialist, Sarah Rupkus, indicating she is not substantiating on her investigation.
06/11/2026	Contact - Document Received I received an email from APS investigator, Lisa Black, indicating she is substantiating regarding the missed doctor appointment.
06/16/2026	Exit conference I completed an exit conference, via telephone, with licensee designee, David Ellis. The findings were discussed.

ALLEGATION:

Resident A had an accident in her pants and staff would not change her.

INVESTIGATION:

On 05/12/2026, I received a complaint, via email, which alleged that on 05/05/2026, Resident A was picked up for workshop and told the driver that she had a bowel movement in her pants. The driver took Resident A back to the home to be changed and was told by staff that Resident A could not be changed due to not having any fresh clothing.

The complaint also alleged that Resident A was not receiving prescribed seizure medication from 11/12/2025-12/28/2025 and suffered a seizure. In addition, the complaint stated that Resident A missed a follow-up appointment with her neurologist on 03/20/2026, due to staff not taking her. According to the Bureau Information Tracking System (BITS), the temporary adult foster care license for Abound Rehabilitation Services - Almond Lane was issued to Abound Rehabilitation Services, INC. on 04/07/26. The allegations regarding Resident A's missed medications and missed appointment are not addressed in this investigation, as the alleged incidents happened prior to the license being issued to Abound Rehabilitation Services on 04/07/26. These allegations were referred to Adult Protective Services (APS) and the Office of Recipient Rights (ORR).

On 05/12/2026, I initiated the investigation by completing a telephone interview with Relative A1. Relative A1 stated that she has had ongoing concerns with the home since the current licensee took over operating the home in November 2025. She stated that Resident A had a seizure and was hospitalized in December 2025 due to staff not administering Resident A's phenobarbital. Relative A1 stated that on 05/05/2026, Resident A was picked up to go to her day program and she told the driver, "I am poopy". The driver took her back home, and the direct care staff

member would not change her, stating she had no clothes, but Relative A1 insists Resident A has lots of clothing. In January, direct care staff members asked Resident A if she "wanted to go to work" and Resident A said no. She lost a day in her program for missing, and they should not be asking if she wants to go. Relative A1 stated that she arranged for Resident A to have an overnight visit at a new home tomorrow night, as she wants her moved. She stated that Resident A functions around a three-year-old level and would not be able to participate in an interview.

On 05/18/2026, I completed an unannounced, onsite investigation at Almond Lane. I completed an interview, via telephone, with the team lead, Santiya Halthon. She discussed the "poopy" incident with Adult Protective Services, as they came to the home last week. She gathered statements from staff and explained that Resident A had been recovering from a "bug" that was going through the home and some staff had been out as well. She believed Resident A had an accident in the van and told the driver. The driver brought her back and told them to change her and if they were not quick, the driver would have to leave. She was not sent out like that and the staff members did not tell anyone there weren't any clothes, nor did they refuse to clean her up

On 05/18/2026, I completed an in-person interview with direct care staff member, Cardi Stitts. Ms. Stitts has been working at the home for a few weeks and was working the day Resident A had the accident. She stated it was her first day working at the home and she assisted Resident A on the bus and buckled her in. Resident A did not tell her anything about an accident and she did not smell anything that would lead her to believe there was one. They left and then the van driver brought Resident A back to the home. She did not know where Resident A's clothing was, as it was her first day. She took Resident A back into the home, asked another staff member where her clothes were, and gave her a shower, the driver left and Resident A was upset about missing workshop.

On 05/18/2026, during my onsite investigation, I completed a private interview with Resident B. Resident B shared that she is really upset right now because her friend moved out today. She expressed being upset because when her mother died, her cousin was supposed to take care of her, and he just took her money and dumped her at this home. She doesn't feel very safe here, no one has hurt her, but she would like a different home. She could not explain to me why she does not feel safe. She began to tell me about her childhood and how she misses her siblings.

On 05/27/2026, I completed a telephone interview with Resident B's public guardian, Jim Stark. Mr. Stark stated he has only been to Almond Lane one time since the new owners took over. He didn't feel they were warm and fuzzy, but he didn't see anything that would cause him to be concerned. He can’t say anything good or bad now. He stated Resident B is more vocal about her displeasure; she didn't like a roommate before and there is a direct care staff member who she does not like, but he has no proof of them doing anything wrong.

On 05/27/2026, I completed a telephone interview with Keyshia Harris, care coordinator at Lahser Vocational Program. Ms. Harris did not pick up that day but was contacted by the driver who did. She stated the driver went to pick up Resident A and had just left when Resident A told her she was "poopy". The driver contacted the vocational coordinator who told her to take her back to the home to be cleaned up. She took Resident A back to the home and the staff said there weren't any clothes for her. They ended up handling it and the driver had to leave her behind due to time constraints. She has not had other concerns or issues.

On 05/27/2026, I completed a telephone interview with Keilee Grice, community skills specialist at Lahser Vocational Program. She was the driver the day Resident A had her accident. Ms. Grice stated that she pulled up to the home to pick up Resident A and the direct care staff member brought her out. She was crying when she got into the van and after she started driving, she asked Resident A if she was ok. Resident A stated, "I pooped my pants". Ms. Grice pulled over and contacted her supervisor. She was instructed to transport Resident A back to the home and to tell the staff they had to take her back and clean her up. The staff member tried telling her she had to wait for Resident A, but she told them she could not wait. There was some arguing back and forth about who was supposed to clean her up. Ms. Grice stated that the direct care staff member was new and told her she did not know where Resident A's clothes were. She left after they took Resident A back into the home.

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(1) (2) A licensee shall ensure the resident receives or has access to all of the following: **(c) Assistance with resident hygiene as needed.**
ANALYSIS:	Based on the evidence obtained during my special investigation, there is not enough evidence to support that Resident A was not provided assistance with hygiene. Resident A was not known to have had an accident prior to get into the transportation van to go to her day program. When it was revealed, the driver took her back. The direct care staff member who got her from the van, did not know where her clothing was and did not want Resident A to miss out on her program. As soon as the van left, Resident A was showered and changed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection on 05/18/2026, I reviewed the medications and medication administration records (MARs) for the residents in the home due to the concerns raised about Resident A's missed medications.

Resident B has a prescription for cetirizine hydrochloride 10mg PO tablet, take one tablet by mouth daily. This was not initialed as having been administered on 05/13/2026 and 05/16/2026.

Resident C has a prescription for mupirocin 2% topical ointment, apply to the affected area twice daily. This medication was not initialed as having been administered on 05/14/2026 in the pm, or on 05/18/2026 in the am.

Resident D has a prescription for metoclopramide hydrochloride 10mg tablet, take one tablet by mouth three times daily. This medication was not initialed as having been administered on 05/12/2026 for the third dose at 8pm and on 05/18/2026, for the 2pm dose.

Resident D has a prescription for metoprolol succinate ER 25 mg , take one tablet by mouth every morning. This was not initialed as having been administered on 05/13/2026.

Resident D has a prescription for lorazepam 1mg PO tablet, take 1.5 tablets mouth, twice daily. This was not initialed as having been administered on 05/15/2026 and 05/16/2026 for the am dose, and on 05/16/2026 for the pm dose.

Resident D has a prescription for paliperidone ER 9mg, take one tablet by mouth every morning. This was not initialed as having been administered on 05/18/2026.

Resident D has a prescription for divalproex 250 mg ER tablet, take one tablet by mouth, daily in the evening. This was initialed as having been administered in the am on 05/11/2026 and 05/14/2026.

I was not able to view the MAR for Resident A, as they no longer had it onsite, due to her moving that day.

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:** **(v) Initials of the individual who administered the medication at the time given.**
ANALYSIS:	Based on the information collected during my special investigation, it has been determined that there is sufficient evidence to support that medication administration records are not consistently initialed when medications are administered. This was evidenced by the medication administration logs of the residents in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license.

Sara E Shaughnessy 06/16/2026

Sara Shaughnessy Date
Licensing Consultant

Approved By:

Jay Calewarts For 06/17/2026

Denise Y. Nunn Date
Area Manager