GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 19, 2026

Karon Lee
Michigan Community Services, Inc.
PO Box 317
Swartz Creek, MI 48473

RE: License #: AS250278187
Investigation #: 2026A0872042
Ameno Home

Dear Karon Lee:

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 (517) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AS250278187 |
| | |
| **Investigation #:** | 2026A0872042 |
| | |
| **Complaint Receipt Date:** | 06/30/2026 |
| | |
| **Investigation Initiation Date:** | 07/01/2026 |
| | |
| **Report Due Date:** | 08/29/2026 |
| | |
| **Licensee Name:** | Michigan Community Services, Inc. |
| | |
| **Licensee Address:** | 5239 Morrish Rd.<br>Swartz Creek, MI 48473 |
| | |
| **Licensee Telephone #:** | (810) 635-4407 |
| | |
| **Administrator:** | Lena Crosson |
| | |
| **Licensee Designee:** | Karon Lee |
| | |
| **Name of Facility:** | Ameno Home |
| | |
| **Facility Address:** | 5452 Ameno Lane<br>Swartz Creek, MI 48473-8884 |
| | |
| **Facility Telephone #:** | (810) 655-4215 |
| | |
| **Original Issuance Date:** | 10/28/2005 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 06/19/2026 |
| | |
| **Expiration Date:** | 06/18/2028 |
| | |
| **Capacity:** | 6 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>DEVELOPMENTALLY DISABLED |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| **On 06/28/2026, staff Junetta Christian did not treat Resident A with dignity and respect.** | **Yes** |

## III. METHODOLOGY

| | |
|---|---|
| 06/30/2026 | Special Investigation Intake<br>2026A0872042 |
| 07/01/2026 | Special Investigation Initiated - On Site<br>Unannounced |
| 07/01/2026 | Contact - Document Received<br>Document received from Lena Crosson |
| 07/08/2026 | Inspection Completed On-site<br>Unannounced |
| 07/15/2026 | Contact - Telephone call received<br>I spoke to the AD, Lena Crosson |
| 08/03/2026 | Contact - Document Sent<br>I emailed the facility requesting information related to this complaint |
| 08/03/2026 | Contact - Document Received<br>AFC documents received |
| 08/18/2026 | Contact - Face to Face<br>I conducted a FaceTime interview with Resident A |
| 08/18/2026 | Exit Conference<br>I conducted an exit conference with the LD, Karon Lee |
| 08/19/2026 | Exit Conference<br>I conducted another exit conference with LD, Karon Lee |

**ALLEGATION: On 06/28/2026, staff Junetta Christian did not treat Resident A with dignity and respect.**

**INVESTIGATION:** On 07/01/2026, I conducted an unannounced onsite inspection of Ameno Home Adult Foster Care facility, and I interviewed the home manager, (HM) Dana Kimbrough-McNeal. Resident A and Resident B were at summer camp, so I could not interview them. However, I observed two other residents who were clean, dressed appropriately, and were supervised by staff.

According to HM Kimbrough-McNeal, one morning Resident A approached her and told her that she is “tired of being bullied.” Resident A reported that on 06/28/2026, she woke up and wanted to come out of her room and staff Junetta Christian yelled at her and told her it was too early. HM Kimbrough-McNeal spoke to staff Taneshia Burnett who said that she heard Staff Christian tell Resident A not to come out of her room and told her that it was inappropriate for her to say that. Staff Burnett said that she told Resident A that it was okay to come out of her room, so she did.

On 07/01/2026, I received a written statement dated 06/30/2026 at 9:50am completed by staff Taneshia Burnett. According to this statement, on Sunday, June 28 at approximately 6:15am, Resident A came into the dining room, and staff Junetta Christian loudly told her it was too early and to go lie back down. Resident A said she was ready to get up but Staff Christian again loudly told her to go lie back down. Staff Burnett told Staff Christian that HM Kimbrough-McNeal told staff that they are not allowed to make the residents stay in bed and they are not allowed to tell them to go to bed. Staff Christian again told Resident A to go back to bed. Resident B then got up, and Staff Christian told her to go to bed too. Staff Burnett went into Resident A and Resident B’s bedroom and found Resident A upset and crying. Staff Burnett told them both that they could get up. Resident A and Resident B then got up, dressed, and ready for the day.

I reviewed a written statemen dated 07/01/2026 completed by HM Kimbrough-McNeal. According to this report, on the afternoon of 06/28/2026, Resident A approached her and told her that earlier that morning, staff Junetta Christian yelled at her and told her she could not get up for the day. Resident A told HM Kimbrough-McNeal that she went back to her room and cried. She said that staff Taneshia Burnett then came into her room and told her she could get up for the day.

On 07/08/26, I conducted another unannounced onsite inspection of Ameno Home AFC. I interviewed Resident B and HM Kimbrough-McNeal. Resident A was at a job interview so I could not interview her. I reviewed the allegations with Resident B. Resident B confirmed that she and Resident A are roommates. According to Resident B, on one occasion Resident A wanted to come out of her room and staff Junetta Christian yelled at her and told her no. Resident B said that Resident A did not cry. Resident B said that it made her sad and scared that Staff Christian yelled at Resident A. Resident B stated that none of the other staff have ever yelled at her or any of the

other residents. I asked Resident B if Staff Christian cussed at Resident A or called her any names and she said no.

HM Kimbrough-McNeal told me that because of this incident, Staff Christion has been fired. On 07/15/2026, I received a telephone call from the administrator, Lena Crosson. AD Crosson confirmed that staff Junetta Christian has been fired because of this incident.

On 08/18/2026, I conducted a FaceTime interview with Resident A. I reviewed the allegations with her, and she confirmed that on one occasion, Staff Christian yelled at her and told her it was too early to get up. Resident A said that she went back to her room and cried. I asked Resident A if Staff Christian cussed at her or called her names and she said no. Resident A said that Staff Christian has a loud voice and she used to tell Resident A to do things like “eat your dinner” and “go take a shower” and she does not feel Staff Christian had the right to do that. Resident A confirmed that Staff Christian is no longer working at her home. Resident A told me that none of the other staff have ever yelled at her or told her what to do.

I have attempted to contact former staff, Junetta Christian. As of 08/19/2026, she has not returned my phone calls or messages.

| **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:** | According to staff Taneshia Burnett, on the morning of 06/28/2026, Resident A wanted to get up for the day, but staff Junetta Christian loudly told her it was too early and she needed to go back to bed. Staff Burnett intervened and told Staff Christian that it was inappropriate for her to say that. Staff Burnett then went and told Resident A that she could get up for the day. Staff Burnett said that Resident A was upset and crying.<br><br>Resident B said that one morning, Staff Christian yelled at Resident A and told her to go back to bed. Resident B said that Resident A did not cry. Resident A said that one morning, she wanted to get up for the day, but Staff Christian yelled at her and told her to go back to bed. Resident A said that she cried due to this incident. She said that Staff Christian is no longer working at her home. I conclude that there is sufficient evidence to substantiate this rule violation at this time. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

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On 08/18/2026, I conducted an exit conference with the licensee designee, Karon Lee. On 08/19/2026, I conducted another exit conference with LD, Karon Lee. I discussed my findings and explained which rule violation I am substantiating. I asked her to complete and submit a corrective action plan upon the receipt of my investigation report.

## IV. RECOMMENDATION

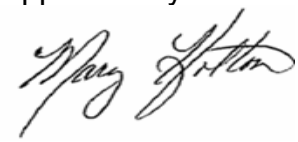
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.

August 19, 2026

Susan Hutchinson
Licensing Consultant

Date

Approved By:



August 19, 2026

Mary E. Holton
Area Manager

Date