GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 6, 2026

Rielle Randle
Preserve Independence Management LLC dba Abound Rehabilitation Services Lincoln Park LLC
1962 Lietch Street
Ferndale, MI 48220

RE: License #: AS820415601
Investigation #: 2026A0116048
Abound Rehabilitation Services-Lincoln Park

Dear Ms. Randle:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (313) 456-0380.

Sincerely,



Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place Ste 2-730
3044 W Grand Blvd, Annex
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820415601
Investigation #:	2026A0116048
Complaint Receipt Date:	08/31/2026
Investigation Initiation Date:	09/01/2026
Report Due Date:	10/30/2026
Licensee Name:	Preserve Independence Management LLC dba Abound Rehabilitation Services Lincoln Park LLC
Licensee Address:	1962 Lietch Street Ferndale, MI 48220
Licensee Telephone #:	(734) 646-5206
Administrator:	Rielle Randle
Licensee Designee:	Rielle Randle
Name of Facility:	Abound Rehabilitation Services-Lincoln Park
Facility Address:	1374 Chandler St Lincoln Park, MI 48146
Facility Telephone #:	(248) 997-7635
Original Issuance Date:	10/18/2023
License **Status:**	REGULAR
Effective Date:	10/18/2024
Expiration Date:	10/17/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Staff, Kyrisha Baldwin, allegedly made and used a homemade straitjacket-style garment to restrain Resident A's arms. Ms. Baldwin admitted it to staff, Prince Stewart, and remains employed.	Yes
There are 6 residents who reside in the home 4 of them require 1:1 staffing. The home is short staffed and only has 3 to 4 staff on each shift.	Yes

III. METHODOLOGY

08/31/2026	Special Investigation Intake 2026A0116048
08/31/2026	APS Referral Received.
09/01/2026	Special Investigation Initiated - On Site Home manager, Michelle Seaborn, staff, Candace Thornton, Aaron Fondren, Shantel Hill, Residents A-E and visually observed Resident F. Reviewed Resident A, D-F individual plans of service (IPOSs) and staff schedules.
09/02/2026	Referral - Recipient Rights Made.
09/02/2026	Contact - Telephone call made Resident F's case manager, Shareil Spencer, left a message requesting a return call.
09/02/2026	Contact - Telephone call received Licensee designee, Rielle Randle, left a message requesting a return call.
09/02/2026	Contact - Telephone call made Licensee designee, Rielle Randle.
09/02/2026	Contact - Telephone call made Assistant manager, Kiarra Smith.
09/02/2026	Contact - Telephone call made

	Staff, Marrianne Herron.
09/02/2026	Contact - Telephone call made Staff, Kyrisha Baldwin, left a message requesting a return call.
09/02/2026	Contact - Telephone call made Staff, Cardijah Stitts.
09/02/2026	Contact - Telephone call made Staff, Prince Stewart.
09/08/2026	Contact - Telephone call made Staff, Kyrisha Baldwin.
09/09/2026	Contact - Telephone call received Staff, Prince Stewart.
09/09/2026	Inspection Completed-BCAL Sub. Non-Compliance
10/02/26	Exit Conference Licensee designee, Rielle Randle.

ALLEGATION:

Staff, Kyrisha Baldwin, allegedly made and used a homemade straitjacket-style garment to restrain Resident A's arms. Ms. Baldwin admitted it to staff, Prince Stewart, and remains employed.

INVESTIGATION:

On 09/01/26, I conducted an unscheduled onsite inspection and interviewed home manager, Michelle Seaborn, staff, Candace Thornton, Aaron Fondren, Shantell Hill, Residents A-E and visually observed Resident F. Ms. Seaborn reported that a former employee informed licensee designee, Rielle Randle, that a staff (name not told to her) had tied Resident A up with a sweater making it into a straitjacket. Ms. Seaborn reported that Ms. Randle came to the home on or about 08/14/26 and met with her, assistant manager, Kiarra Smith and staff, Marrianne Herron. She reported that Ms. Randle informed them of what she was told and reported she would be

conducting an internal investigation into the matter. Ms. Seaborn denied any knowledge of the alleged incident.

I interviewed staff, Candace Thornton, Aaron Fondren, and Shantel Hill, separately. They all denied observing or hearing about an incident where staff had tied/restrained Resident A with a sweater/jacket.

I interviewed Resident A in the presence of her 1:1 staff, Shantel Hill. Resident A reported that her hands have been tied up with a green/blue sweater. Resident A demonstrated by placing her arms across each other on her chest. Resident A was unable to recall when it last happened, however, reported that it was more than once. I asked who was tying her hands across her chest, but she refused to answer.

I interviewed Resident B and she reported that she has observed Resident A with a few different sweaters/long sleeve shirts being used as a straitjacket to restrain her and prevent her from moving her upper body. Resident B reported that she would not disclose the staff person that she has observed doing this. Resident B reported that this staff is not a nice person. Resident B reported that most of staff know about this and they do not intervene to help Resident A.

I interviewed Resident C and she denied observing any staff tie Resident A's arms up in a sweater/shirt. Resident C reported that she stays to herself. Resident C reported that the staff treat her pretty good.

I interviewed Residents D and E separately, but in the presence of their 1:1 staff. They both denied observing any staff using a sweater/shirt to tie up/restrain Resident A's arms as alleged. They both reported that staff treat them good and they have no concerns.

I visually observed Resident F sitting at the kitchen table with her 1:1 staff. Resident F would smile and point in the kitchen when I attempted to interview her. Resident F would not verbally respond.

I reviewed Resident A's IPOS effective 10/06/25. The plan documents that Resident A requires 1:1 staffing 24 hours per day. The plan documents that when Resident A is exhibiting agitation, verbal/physical aggression, and/or self-injurious behaviors, staff are to engage her, interrupt the behavior via verbal directive, and/or redirect her into an activity she enjoys. The plan documents that if Resident A still does not calm down and continues to engage in aggression that will harm herself or others, staff should call 911 for assistance.

On 09/02/26, I interviewed licensee designee, Rielle Randle, and she reported that the allegation was reported to her by Jayla Jefferson, a former employee. Ms. Randle reported that she was told that the staff were restraining Resident A with a jacket/sweater. She reported that she went to the home to begin her internal investigation and initially spoke with home manager, Michelle Seaborn, assistant

home manager, Kiarra Smith and staff, Marrianne Herron. She reported that they all denied observing any staff use a sweater or jacket as a restraint on Resident A. Ms. Randle reported that she interviewed all of the staff employed in the home and Kyrisha Baldwin's name was brought up as the staff alleged to have been involved. Ms. Randle reported all staff denied observing Ms. Baldwin or any other staff restrain Resident A. Ms. Randle reported some of the staff admitted hearing rumors that this was happening and that Ms. Baldwin may not have been the only staff to have use a sweater/jacket to restrain Resident A. Ms. Randle reported that Ms. Baldwin admitted that there was an incident in May of 2025 where she used a sweater to restrain Resident A. Ms. Randle recommended I contact Ms. Baldwin so that she could provide the specifics of the incident.

On 09/02/26, I interviewed assistant manager, Kiarra Smith, and she denied observing staff, Kyrisha Baldwin, or any other staff use a sweater/jacket/shirt as a way to restrain Resident A. Ms. Smith reported that she does not believe that Ms. Baldwin would do anything like that.

On 09/02/26, I interviewed staff, Marrianne Herron, and she reported that she did not witness Ms. Baldwin or any staff, use a jacket/sweater as a way to tie up and restrain Resident A. Ms. Herron reported that she heard the rumors and honestly would not be surprised if Ms. Baldwin did it.

On 09/08/26, I interviewed staff Kyrisha Baldwin. Ms. Baldwin reported that in May of 2025, the home was being treated for bedbugs and she and another staff had taken all six residents to the park. Ms. Baldwin would not disclose who the other staff was. She reported that Resident A was having extreme behaviors and was not able to be re-directed. She reported at the time the home had three residents who required 1:1 staffing and there should have been a total of four staff instead of just two. Ms. Baldwin reported that added another level of stress to the situation. Ms. Baldwin reported that Resident A was spitting, kicking, digging, and trying to attack staff and random people in the park. Ms. Baldwin reported that she put Resident A in the vehicle, took her sweater and used it to restrict movement of her arms. She admitted that she had Resident A fold her arms in front of her and tied the sweater to prevent her from moving and trying to take her helmet off. Ms. Baldwin reported that Resident A was banging her head in the vehicle and the helmet protected her from hurting herself. Ms. Baldwin reported that she didn't know what else to do and believed it was in Resident A's best interest at the time. Ms. Baldwin reported that Resident A was restrained for about 15-20 minutes as they were cleared to return back to the home. Ms. Baldwin reported that she told the company's human resource department, home manager, Michelle Seaborn, assistant manager, Kiarra Smith, and staff, Prince Stewart, of the incident. Ms. Baldwin reported that she did not report this incident to APS or recipient rights at the time. Ms. Baldwin reported

that recipient rights is currently investigating the matter and reported she was honest and disclosed what she did.

Ms. Baldwin reported that was the only time she restrained Resident A and reported that she heard that some of the afternoon staff are continuing to restrain Resident A due to her behaviors but denied observing it.

On 09/09/26, I interviewed staff, Prince Stewart, and he reported that last year, staff, Kyrisha Baldwin, told him about an incident in the park where Resident A was acting out so bad that she had to use her sweater to restrain her. Mr. Stewart reported that he did not observe the incident and has not observed or heard any rumors about staff still restraining Resident A. He reported that he works the midnight shift (12:00 a.m. to 8:00 a.m.) and he has not restrained or observed anyone on midnight shift restrain Resident A. Mr. Prince admitted that he did not report this incident to management, APS or recipient rights.

On 10/02/26, I conducted the exit conference with licensee designee, Rielle Randle, and informed her of the findings of the investigation and the specific rule cited. Ms. Randle reported an understanding. Ms. Randle reported that Ms. Baldwin has been terminated and terminations are in the process for a couple more staff. Ms. Randle reported her desire and commitment to come into compliance with all licensing rules. Ms. Randle reported that she would be accepting the provisional license and submitting an acceptable corrective action plan.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(c) Restrain a resident's movement for the purpose of immobilizing the resident.**
ANALYSIS:	Based on the findings of the investigation, which included interviews with home manager, Michelle Seaborn, Residents A-B, assistant manager, Kiarra Smith, staff, Marrianne Herron, Kyrisha Baldwin, Prince Stewart, licensee designee, Rielle Randle and my review of Resident A's IPOS, there is a preponderance of evidence to substantiate the allegation that staff, Kyrisha Baldwin, used Resident A's sweater to restrain her movement for the purpose of immobilizing her.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There are 6 residents who reside in the home 4 of them require 1:1 staffing. The home is short staffed and only has 3 to 4 staff on each shift.

INVESTIGATION:

On 09/01/26, I conducted an unscheduled onsite inspection and interviewed home manager, Michelle Seaborn, staff, Aaron Fondren, Shantel Hill and reviewed Resident A, D-F IPOSs. Ms. Seaborn reported that there are currently four residents who require 1:1 staffing in the home. She reported that Residents A, D-E requires 1:1 staffing 24 hours per day and Resident F requires 15 hours of 1:1 staffing. I asked Ms. Seaborn if the hours that Resident F requires 1:1 staffing are documented in her IPOS, and she reported that they were not. Ms. Seaborn reported that she tries to ensure that there is a staff assigned to Resident F until about 9:00 p.m. - 10:00 p.m. daily. I reminded Ms. Seaborn that this was discussed and was supposed to be rectified during my last investigation (SIR#2026A0116029). Ms. Seaborn reported that they have been working with Resident F's case manager to update the plan, so it reflects the specific times she requires 1:1 staffing.

I interviewed staff, Aaron Fondren, and he reported that there have been some issues with staffing, however, reported that home manager, Ms. Seaborn, will pick up additional hours to try to ensure proper coverage. Mr. Fondren reported to his knowledge there should be five staff on day shift, five staff on afternoon shift and four staff on midnight shift. Mr. Fondren reported that Resident F does not require 1:1 staffing at night after 8:00 p.m. Mr. Fondren reported his belief that her IPOS documents that.

I interviewed staff, Shantel Hill, and she reported that staffing is not an issue as far as she knows. She reported that three of the Residents A, D-F require 1:1 staffing 24 hours per day and Resident F requires 1:1 staffing during the day, but not at night. Ms. Hill reported that she thinks that is documented in Resident F's plan.

I reviewed the IPOSs for Resident A, D-F. Resident A's plan effective 10/06/25 documents that she requires 1:1 staffing 24 hours per day. Resident D's plan effective 08/28/25, documents that she requires 1:1 staffing 24 hours per day. Resident E's plan effective 01/29/26, documents she requires 1:1 staffing 24 hours per day. Resident F's plan effective 09/09/25 documents that she requires 1:1

staffing. The plan does not document the number of hours allotted per day that Resident F requires 1:1 staffing.

I requested the last 90 days of staff schedules for review. Ms. Seaborn provided the schedules.

During my onsite, I observed assistant manager, Kiarra Smith and staff, Cardijah Stitts, return from an outing in the park with three residents. The three residents were Resident A, D and E. These three residents each require 1:1 staffing. Ms. Smith and Ms. Stitts were the only staff on the outing with the three residents.

On 09/02/26, I interviewed licensee designee, Rielle Randle, and she reported that she is aware that the home requires five staff per shift for day and afternoon shift. Ms. Randle reported her understanding that Resident F does not require 1:1 staffing at night. Ms. Randle reminded me that she was newly appointed as licensee designee and administrator and is really working hard to ensure compliance with all licensing requirements. I informed Ms. Randle of the special investigation (SIR#2026A0116029) that I recently completed and found the home in non-compliance regarding this exact matter. I provided technical assistance to Ms. Randle and recommended that if after speaking to Resident F's case manager, with the request to include the specific hours Resident F requires 1:1 staffing, is unsuccessful, then she should complete the department's Resident Assessment Plan. I informed Ms. Randle that based on her assessment of Resident F's needs she can document the hours the staff will provide the 1:1 staffing determined by the number of staffing hours approved by the contract agency. I informed Ms. Randle as it currently stands, when the IPOS states 1:1 staffing, it is assumed if not clearly defined that 24-hour staffing is required. Ms. Randle reported that she would be contacting Resident F's case manager and DWIHN to resolve this matter. She also reported that she would complete the assessment plan in the interim.

On 09/02/26, I interviewed assistant manager, Kiarra Smith, Ms. Smith confirmed that on 09/01/26, that she and staff Cardijah Stiits, were the two staff responsible for Residents A-D-E, who all require 1:1 staffing.

On 09/02/26, I interviewed staff, Cardijah Stitts. Ms. Stitts confirmed that on 09/01/26, she and Ms. Smith were on an outing at the park with Residents A, D-E. Ms. Stitts confirmed that each of these residents require 1:1 staffing.

On 09/02/26, I interviewed staff, Marrianne Herron, and she reported that for the most part staff chip in and try to cover shifts, however, admitted at times they are short staffed. Ms. Herron reported that her understanding is based on my last investigation, that each shift requires five staff, because of the four residents who require 1:1 staffing and a staff for the two residents who do not. Ms. Herron reported they are doing the best they can to work together to provide adequate staffing. Ms.

Herron reported that today was her first day back to work from a leave. Ms. Herron reported that she was off from 08/20/26 through 09/02/26.

I reviewed the last 90 days of staff schedules, the charts below depict the staffing levels each day, which were not sufficient based on the required staff to resident ratio. Resident D was hospitalized from 06/04/26-07/03/26 allowing the home to have four staff per shift during her absence from the home and there were still times when staffing fell below that requirement.

	6/1	**6/2**	**6/3**	**6/4**	**6/5**	**6/6**	**6/7**
8:00-8:30a	4 staff	4 staff	4 staff	4 staff	3 staff		
8:00-9:00a							
10:00-11:00a							
12:00-1:00p							
2:00-3:00p							
4:00-5:00p	4 staff (4-12a)						
6:00-7:00p							
7:00-8:00p							3 staff (8-4a)
8:00-9:00p							
10:00-11:00p		4 staff (9:30-12a)	4 staff (9:30-12a)	4 staff (9-12a)			
12:00a-1:00a	4 staff (12-8a)	4 staff (12-8a)	4 staff (12-8a)	4 staff (12-8a)	3 staff (12-8a)		
2:00-3:00a							
4:00-5:00a							2 staff (4-8)
6:00-7:00a							

	6/8	6/9	6/10	6/11	6/12	6/13	6/14
8:00-8:30a		3 staff	3 staff	2 staff	3 staff		
8:00-9:00a				3 staff (8:30-2p)			
10:00-11:00a							
12:00-1:00p							
2:00-3:00p					3 staff (2:30-4p)		
4:00-5:00p							3 staff (4-4a)
6:00-7:00p							
7:00-8:00p						3 staff (8-8a)	
8:00-9:00p							
10:00-11:00p							
12:00a-1:00a			3 staff (12-8a)		3 staff (12-8a)		
2:00-3:00a							2 staff (4-8a)
4:00-5:00a							
6:00-7:00a							

	6/15	6/16	6/17	6/18	6/19	6/20	6/21
8:00-8:30a	3 staff	3 staff	3 staff		2 staff		3 staff
8:00-9:00a					3 staff (8:30-4p)		
10:00-11:00a							
12:00-1:00p							
2:00-3:00p							
4:00-5:00p							
6:00-7:00p							
7:00-8:00p							
8:00-9:00p			3 staff (9:30-12a)			3 staff (8-9:30p) 2 staff (9:30-8a)	3 staff (8-4a)
10:00-11:00p							
12:00a-1:00a	3 staff (12-8a)	3 staff (12-8a)	3 staff (12-8a)	3 staff (12-8a)			
2:00-3:00a							
4:00-5:00a							2 staff (4-8a)
6:00-7:00a							

	6/22	6/23	6/24	6/25	6/26	6/27	6/28
8:00-8:30a	3 staff		3 staff	3 staff	3 staff		
8:00-9:00a							
10:00-11:00a							
12:00-1:00p	3 staff (12-8a)						
2:00-3:00p							
4:00-5:00p				2 staff (4:30-12a)			
6:00-7:00p							
7:00-8:00p							
8:00-9:00p		3 staff (9:30-12a)	2 staff (9:30-8a)		3 staff (9:30-8a)	3 staff (9:30-8a)	3 staff (8-4a)
10:00-11:00p							
12:00a-1:00a							
2:00-3:00a							
4:00-5:00a							2 staff (4-8a)
6:00-7:00a							

	6/29	6/30	7/1	7/2	7/3	7/4	7/5

8:00-8:30a			3 staff				
8:00-9:00a							
10:00-11:00a							
12:00-1:00p							
2:00-3:00p							
4:00-5:00p							
6:00-7:00p							
7:00-8:00p							
8:00-9:00p			3 staff (9:30-12a)			4 staff (9:30-8a)	
10:00-11:00p		3 staff (10-8a)					4 staff (10-8a)
12:00a-1:00a	3 staff (12-8a)			3 staff (12-8a)			
2:00-3:00a							
4:00-5:00a							
6:00-7:00a							
	7/6	**7/7**	**7/8**	**7/9**	**7/10**	**7/11**	**7/12**

8:00-8:30a	4 staff		4 staff	4 staff	4 staff		
8:00-9:00a							
10:00-11:00a							
12:00-1:00p	4 staff (12-4p)		4 staff (12-4p)				
2:00-3:00p							
4:00-5:00p							
6:00-7:00p							
7:00-8:00p							
8:00-9:00p	4 staff (8:30-8a)					4 staff (9:30-8a)	4 staff (9:30-8a)
10:00-11:00p		4 staff (10-8a)	3 staff (10-8a)				
12:00a-1:00a				4 staff (12-8a)	4 staff (12-8a)		
2:00-3:00a							
4:00-5:00a							
6:00-7:00a							

	7/13	**7/14**	**7/15**	**7/16**	**7/17**	**7/18**	**7/19**

8:00-8:30a	4 staff			4 staff			
8:00-9:00a				4 staff (8:30-4p)		4 staff (8-8p)	4 staff (8-8p)
10:00-11:00a							
12:00-1:00p	4 staff (12-4p)						
2:00-3:00p							
4:00-5:00p		4 staff (4-8p)			4 staff (4-10p)		
6:00-7:00p							
7:00-8:00p							
8:00-9:00p		4 staff (8-8a)				4 staff (9:30-8a)	
10:00-11:00p				4 staff (10-8a)	3 staff (10-12a)		
12:00a-1:00a	4staff (12-8a)		4 staff (12-8a)		4 staff (12-8a)		
2:00-3:00a							
4:00-5:00a							
6:00-7:00a							

	7/20	**7/21**	**7/22**	**7/23**	**7/24**	**7/25**	**7/26**

8:00-8:30a	4 staff		4 staff	4 staff			
8:00-9:00a							
10:00-11:00a							
12:00-1:00p	4 staff (12-4p)						
2:00-3:00p							
4:00-5:00p							
6:00-7:00p							
7:00-8:00p							
8:00-9:00p							
10:00-11:00p	4 staff (10-8a)		4 staff (10-8a)	4 staff (10-12a)			
12:00a-1:00a		4 staff (12-8a)		3 staff (12-8a)			
2:00-3:00a							
4:00-5:00a							
6:00-7:00a							
	7/27	**7/28**	**7/29**	**7/30**	**7/31**	**8/1**	**8/2**

8:00-8:30a	4 staff		4 staff		4 staff		
8:00-9:00a						4 staff (8-8p)	
10:00-11:00a							
12:00-1:00p							
2:00-3:00p							
4:00-5:00p							
6:00-7:00p							
7:00-8:00p							
8:00-9:00p							
10:00-11:00p			4 staff (10-12a)	4 staff (10-8a)		4 staff (11-8a)	4 staff (11-8a)
12:00a-1:00a	4 staff (12-8a)				4 staff (12-8a)		
2:00-3:00a							
4:00-5:00a							
6:00-7:00a							
	8/3	**8/4**	**8/5**	**8/6**	**8/7**	**8/8**	**8/9**

8:00-8:30a			4 staff	4 staff	4 staff		
8:00-9:00a							
10:00-11:00a							
12:00-1:00p				4 staff (12-4p)			
2:00-3:00p							
4:00-5:00p						4 staff (4-8p)	4 staff (4-8p)
6:00-7:00p							
7:00-8:00p							
8:00-9:00p					4 staff (9:30-8a)		
10:00-11:00p			4 staff (10-8a)			3 staff (10-8a)	
12:00a-1:00a	4 staff (12-8a)	4 staff (1-8a)		4 staff (12-8a)			
2:00-3:00a							
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6:00-7:00a							
	8/10	**8/11**	**8/12**	**8/13**	**8/14**	**8/15**	**8/16**

8:00-8:30a				4 staff			
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7:00-8:00p							
8:00-9:00p							
10:00-11:00p						4 staff (11-8a)	4 staff 10-7a)
12:00a-1:00a	4 staff (12-8a)	4 staff (12-8a)	4 staff (12-8a)	4 staff (12-8a)	4 staff (12-8a)		
2:00-3:00a							
4:00-5:00a							
6:00-7:00a							4 staff (7-8a)
	8/17	**8/18**	**8/19**	**8/20**	**8/21**	**8/22**	**8/23**

8:00-8:30a					4 staff	4 staff	4 staff
8:00-9:00a						4 staff (8:30-8p)	
10:00-11:00a							
12:00-1:00p		4 staff (12-2p)					
2:00-3:00p							
4:00-5:00p							
6:00-7:00p							
7:00-8:00p							
8:00-9:00p				3 staff (9-8a)		3 staff (8-11p)	4 staff (8-11p)
10:00-11:00p			4 staff (10-6a)			2 staff (11-8a)	3 staff (11-6a)
12:00a-1:00a	4 staff (12-6a)	3 staff (12-6a)			3 staff (12-8a)		
2:00-3:00a							
4:00-5:00a							
6:00-7:00a		4 staff (6-8a)	4 staff (6-8:30a)	4 staff (6-8:30a)			
	8/24	**8/25**	**8/26**	**8/27**	**8/28**	**8/29**	**8/30**

8:00-8:30a	4 staff		4 staff		4 staff	
		4 staff				4 staff
8:00-9:00a		(8-4p)				(8-8p)
10:00-11:00a						
12:00-1:00p						
2:00-3:00p						
4:00-5:00p						
6:00-7:00p						
7:00-8:00p						
8:00-9:00p				3 staff		4 staff
				(9-12a)		(8-8a)
10:00-11:00p		4 staff				
		(10-6a)				
12:00a-1:00a	4 staff		4 staff		3 staff	
	(12-8a)		(12-6a)		(12-8a)	
2:00-3:00a						
4:00-5:00a						
6:00-7:00a				4 staff		
				(6-8:30a)		

						4 staff	4 staff
						(8-8p)	(8-8p)

On 10/02/26, I conducted the exit conference with licensee designee, Rielle Randle, and informed her of the findings of the investigation and the specific rule cited. Ms. Randle reported an understanding of the seriousness of the matter. She reported that she has met with and has had several conversations with the case managers regarding the IPOSs as it relates to staffing. Ms. Randle reported this matter is nearing resolution.

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:	Based on the findings of the investigation, which included interviews with home manager, Michelle Seaborn, staff, Aaron Fondren, Shantel Hill, Kiarra Smith, Cardijah Stitts, my observation and review of Resident A-D-F IPOSs and review of the staff schedules, there is a preponderance of evidence to substantiate the allegations that the homes staffing levels are insufficient to meet the needs of the residents in accordance with their individual plans of service. Resident A, C-F IPOSs all document that they require 1:1 staffing. Residents A, C-D IPOSs document that there 1:1 staffing requirement is 24 hours per day. Resident F' IPOS just documents 1:1 staffing and does not designate the specific hours. I informed the licensee designee, that it is her responsibility to find out the hours Resident F requires 1:1 staff so that she can ensure she has sufficient staffing at all times. Additionally, during my onsite inspection on 09/01/26, I observed assistant manager, Kiarra Smith and staff, Cardijah Stitts, return from an outing in the park with Resident A, D and E. These three residents each require 1:1 staffing. Ms. Smith and Ms. Stitts were the only staff on the outing with the three residents. ***THREEPEAT VIOLATION ESTABLISHED* SIR#2026A0116012; CAP dated 02/23/26, SIR#2026A116029; CAP dated 06/30/26.**
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend modification of the license to provisional.



10/02/26

_____

Pandrea Robinson — Date
Licensing Consultant

Approved By:



10/06/26

_____

Ardra Hunter — Date
Area Manager