STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

March 24, 2026

Shaniya Cason
A Second Home AFC, LLC
18501 Empire Ave
Eastpointe, MI 48021

RE: License #: AS500418767
Investigation #: 2026A0617009
A Second Home AFC

Dear Ms. Cason:

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500418767
Investigation #:	2026A0617009
Complaint Receipt Date:	01/26/2026
Investigation Initiation Date:	01/27/2026
Report Due Date:	03/27/2026
Licensee Name:	A Second Home AFC, LLC
Licensee Address:	18501 Empire Ave Eastpointe, MI 48021
Licensee Telephone #:	(586) 441-5717
Administrator:	Shaniya Cason,
Licensee Designee:	Shaniya Cason,
Name of Facility:	A Second Home AFC
Facility Address:	18501 Empire Ave Eastpointe, MI 48021
Facility Telephone #:	(313) 681-0776
Original Issuance Date:	01/27/2025
License Status:	1ST PROVISIONAL
Effective Date:	08/08/2025
Expiration Date:	02/07/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is making Resident A stay at guardians home instead of at facility.	No
Staff only give Resident A one sandwich for lunch.	No
Resident A's medication is being taken out of the original containers and prepacked into alternate containers.	Yes

III. METHODOLOGY

01/26/2026	Special Investigation Intake 2026A0617009
01/27/2026	Special Investigation Initiated – Telephone made to complainant
02/06/2026	Contact - Telephone call made- I interviewed Resident A's mother.
02/06/2026	Inspection Completed On-site- I conducted an unannounced onsite investigation. I interviewed staff Richard Barnette, Shaniya Cason and Resident B.
02/10/2026	APS Referral- Adult Protective Services Referral received- Denied
02/10/2026	Referral - Recipient Rights- Referral to Recipient Rights was completed.
02/11/2026	Contact - Document Received- I received a copy of an emergency discharge notice for Resident A.
02/25/2026	Contact - Telephone call received- TC with Ms. Cason
02/25/2026	Contact - Telephone call made- I interviewed Ms. Cason.
02/26/2026	Contact - Telephone call made- I interviewed Resident A
02/26/2026	Contact - Telephone call received- I interviewed Christina Masella
02/26/2026	Contact - Telephone call made- I interviewed Resident A's mother
02/27/2026	Exit Conference with licensee designee Ms. Shaniya Cason informing her of the findings of the investigation.

ALLEGATION:

The facility is making Resident A stay at his guardian's home instead of at facility.

INVESTIGATION:

On 01/27/26, I received a complaint on the A Second Home AFC facility. According to the complaint, staff threatened to kick Resident A out of the home. The facility is making Resident A stay at his guardian, Guardian A1's, home instead of at facility. Staff only give Resident A one sandwich for lunch.

On 02/24/26, I received a second complaint on the facility. According to the complaint, Shaniya Cason popped out Resident A's medicine from the bubble packs and tried to make his mother take the popped-out medication in a 7-day pill container. When Resident A's mother disagreed with Ms. Cason, she started to yell at Resident A's mother.

On 02/06/26, I interviewed Resident A's guardian, Guardian A1, who is also Resident A's mother. According to Guardian A1, Resident A has been a resident of the facility for approximately 60 days but has only stayed at the facility for 19 of those days. Resident A often goes home for an extended period of time. Resident A's mother stated that on 12/19/25, facility owner Shaniya Cason texted her a 30-day discharge notice. Resident A's mother felt that it was inappropriate to text a 30-day discharge. On 12/20/25, Ms. Cason called Resident A's mother and told her that Resident A had to be picked up and was no longer able to stay in the facility. Resident A's mother stated that Resident A was home from 12/20/25 to 01/06/26. On 01/06/26, Resident A's mother decided to take him back to the facility and dropped him off. Resident A's mother stated that Resident A and Ms. Cason get into arguments, therefore Resident A's family takes him back home. Resident A went back home on 01/13-01/15, and 01/18 to 01/30. Resident A's mother stated that Ms. Cason has not forced Resident A to leave the facility and he is free to return at any time until a new placement is found.

On 02/06/26, I conducted an unannounced onsite investigation. I interviewed staff Richard Barnette, Licensee Designee Shaniya Cason and Resident B.

According to Mr. Richard Barnette, he has never witnessed Resident A being told that he had to leave by Ms. Cason. Mr. Barnette stated that Resident A was given a 30-day discharge notice but there is not a copy in his file. Mr. Barnette stated that Resident A goes to workshop Monday through Friday from 7am to 3pm. According to Mr. Barnette, Resident A has been in the facility for the last several days, but he goes home for extended periods of time.

During the onsite investigation I reviewed Resident A's file and there was not a copy of the 30-day discharge notice. I observed that Resident A's resident Identification form was incomplete.

According to licensee designee Shaniya Cason, she has never threatened to kick Resident A out or suggested he should leave. Ms. Cason gave Resident A a 30-day discharge notice on 12/19/25 via text message. Ms. Cason stated that she did not have a copy of the notice on file. Ms. Cason showed a copy of the discharge notice on her phone. Ms. Cason stated that she told Resident A's mother that Resident A is welcome to go home whenever he wants. Resident A still resides in the facility. Ms. Cason stated that Resident A is welcome in the home until a new placement is found.

On 02/11/26, I received a copy of an emergency discharge notice for Resident A dated 2/10/26. According to the discharge notice, Resident A is being discharged for the following reasons: A Second Home AFC is unable to provide required services through Macomb County Community Health due to Resident A's ongoing and consistent absence from the home. Resident A is rarely present in the licensed residence, which makes it impossible for staff to provide supervision, personal care, medication management, and other required services as outlined under Michigan Adult Foster Care licensing rules and Macomb County Community Health service requirements. He spends majority of his week with his natural support (his mother) – approximately 3-4 days out of a week. Because Resident A is not residing in the facility as required, A Second Home AFC cannot ensure health, safety, supervision, or compliance with Macomb County Community Health service delivery standards. Continuing placement under these circumstances places the provider at risk of noncompliance and prevents us from fulfilling our legal and contractual obligations.

After reviewing the emergency discharge notice, the notice did not state the alternatives to discharge that have been attempted by the facility. Based on the notice, the reasons listed were not appropriate reasons for an emergency discharge.

On 02/26/26, I interviewed Resident A. According to Resident A, since he was given a discharge notice, Ms. Cason has been rude to him. Resident A stated that Ms. Cason forces him to clean his room and randomly will make him stop watching tv in the living room and go to his room.

On 02/26/26, I interviewed Christina Masella, Chief Network officer at Macomb County Community Health. According to Ms. Masella, Resident A has a history of being a difficult resident and much of it is due to his mother. Ms. Masella stated that Resident A's mother has a history of causing problems and she does not understand her impact on disrupting his treatment. According to Ms. Masella, Resident A's mother has caused problems at almost every previous placement. Ms. Masella stated that since Resident A goes home for extended periods of time, she believes that he could be discharged to his mother's care, but his mother is refusing to take placement. Ms. Masella has offered to provide in-home services for Resident A in

his mother's home, but Resident A’s mother has declined the services. Ms. Massella stated that due to Resident A’s mother and her history, finding placement has been extremely difficult. Ms. Massella stated that her office is looking into whether Resident A’s mother is an appropriate guardian.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: (q) Access their bedroom at their own discretion.
ANALYSIS:	According to Resident A’s mother and Ms. Cason, Resident A is not being forced to stay with his mother, and he goes home at his choice. Both Resident A’s mother and Ms. Cason state that Resident A is welcome in the facility until a new placement is secured.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.691	**Resident records.**
	Rule 691. (1) A licensee shall complete and maintain a separate record for each resident that includes all of the following: (c) Date of discharge and address to where the resident moved.
ANALYSIS:	According to Resident A’s mother and Ms. Cason, Resident A was given a 30-day discharge notice on 12/19/25. The notice was in writing and stated the reasons for discharge. According to Resident A’s mother and Ms. Cason, Resident A is not being forced to stay with his mother, and he goes home at his choice. Both Resident A’s mother and Ms. Cason state that Resident A is welcome in the facility until a new placement is secured. However, a copy of the written notice of discharge was not maintained in the resident record at the time of the unannounced onsite investigation. Ms. Cason showed me the notice on her phone because she did not have a copy in the file.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(5) The licensee may discharge a resident before the 30-day notice when it has been documented that there is a substantial risk or occurrence of any of the following: **(a) An inability to meet the resident's needs.** **(b) An inability to provide adequate safety and well-being of others.** **(c) Self-destructive behavior.** **(d) Serious physical assault.** **(e) Destruction of property.**
ANALYSIS:	On 02/11/26, I received a copy of an emergency discharge notice for Resident A dated 2/10/26. After reviewing the emergency discharge notice, the notice did not state the alternatives to discharge that have been attempted by the facility. Based on the notice, the reasons listed were not appropriate reasons for an emergency discharge because it did not show an inability to meet the resident's needs, an inability to provide adequate safety and well-being of others, self-destructive behavior, serious physical assault or destruction of property.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.691	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident that includes all of the following: **(a) Personal information including all of the following:** **(i) Resident's full name.** **(ii) Social Security number.** **(iii) Date of birth.** **(iv) Marital status.** **(v) Veteran's status.** **(vi) Gender identity.** **(vii) Former address.** **(viii) Name, address, and contact information of identified contact or designated representative.** **(ix) Name, address, and contact information of the person and agency responsible for the resident's placement in the facility.** **(x) Funeral provisions, preferences, and contact information.** **(xi) Resident's religious preference.**
ANALYSIS:	During the onsite investigation I reviewed Resident A's file and I observed that Resident A's resident Identification form was blank and did not have the necessary required information.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff only give Resident A one sandwich for lunch.

INVESTIGATION:

On 02/06/26, I interviewed Resident A's mother. According to Resident A's mother, staff only gives Resident A one sandwich for lunch, no snacks are available, and during dinner, he only gets one plate of food with no seconds. According to Resident A's mother, recently on an unknown date, the facility only provided her son with four chicken wings, mashed potatoes, and green beans for dinner. He was not allowed seconds, and his mother believes that was not enough food for him. Resident A's mother stated that Resident A goes to workshop around 7:30am and breakfast is not available to him prior to him leaving. According to Resident A's mother, she provides him with snacks, lunch and occasionally additional dinners.

On 02/06/26, I interviewed Mr. Barnette. According to Mr. Barnette, if residents are still hungry after eating, they are allowed seconds if there is food leftover. Mr. Barnette stated that there are snacks available.

On 02/06/26, I interviewed Ms. Cason. According to Ms. Cason, residents are allowed to have seconds if there is leftover food. Residents have free access to food and snacks any time. Ms. Cason stated that Resident A refuses breakfast prior to going to workshop, but it is available if he would like it.

On 02/06/26, I interviewed Resident B. According to Resident B, there is enough food in the home and he had no concerns.

During the onsite investigation on 02/06/26, I observed that there was not a current menu posted in the home. I observed the cabinets, refrigerator, and freezer to be well stocked with food.

On 02/26/26, I interviewed Resident A. According to Resident A, Ms. Cason calls him fat and doesn't allow him to have seconds of food. Resident A stated that his mother provides him with snacks and lunch because the facility only gives him one sandwich to take to workshop with him and that is not enough food. Resident A stated that he is not allowed to have the facility snacks so his mother provides snacks for him. Resident A stated that breakfast is offered in the facility, but he often refuses.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	According to Resident A, Ms. Cason and staff, Resident A is provided daily with three nutritious meals. Resident A stated that breakfast is offered but he often refuses. Resident A stated that the facility provides him with a sandwich to take with him to workshop. Residents are allowed to have seconds and are provided snacks. Resident A's mother stated that the facility provides him with lunch and dinner, but it is not enough food because Resident A. There is insufficient evidence to show that the residents are not getting a minimum of 3 nutritious meals a day.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented.
ANALYSIS:	During the onsite investigation on 02/06/26, I observed that there was not a current menu posted in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Resident A's medication is being taken out of the original containers and prepacked into alternate containers.

INVESTIGATION:

On 02/25/26, I interviewed Ms. Cason. According to Ms. Cason, on 02/20/26, she received notice from Resident A's mother that she would be picking him up to stay with her for a few days. When Resident A's mother arrived at the home, Ms. Cason stated that she began popping the pills out of the pharmacy issued bubble packs and placed the pills in a 7-day pill container. When Resident A's mother saw this, she became disgruntled and began yelling, causing a disturbance in the home for the other residents. Ms. Cason stated that one of the other residents became very agitated by the altercation. According to Ms. Cason, it is the house rules and procedures that medications are prepacked into alternate containers when residents leave the facility and require medication. Ms. Cason stated that she does not allow the original medication packs to leave the facility due to fear of medication errors and misuse.

On 02/26/26, I interviewed Resident A's mother. According to Resident A's mother, on 02/13/26, she contacted Ms. Cason to give her advance notice that she would be taking Resident A home for the weekend and to prepare his medications for the leave. When Resident A's mother arrived at the facility, Ms. Cason was popping out Resident A's medication out of the pharmacy supplied bubble packs and placing the pills into a 7-day pill container. When Resident A's mother tried to stop Ms. Cason, Ms. Cason started yelling at Resident A's mother, stating that is how it is done. Resident A's mother took the bubble packs from Ms. Cason and began putting the pills back into the original container as best she could. According to Resident A's mother, Ms. Cason tried to force her to sign a document stating that she was refusing to take Resident A's medication but Resident A's mother states that she was only refusing to take the medication in the unauthorized pill containers. Resident A's mother stated that she took the bubble packs and left the facility. According to Resident A's mother, this is not the first time this has happened.

On 02/26/26, I interviewed Resident A. According to Resident A, on an unknown date, Ms. Cason popped his medication out of the pharmacy issued bubble packs and placed the pills in a 7-day pill container.

On 02/27/26, I held an exit conference with licensee designee Ms. Shaniya Cason informing her of the findings of the investigation. Ms. Cason did not answer and a voicemail was left.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.
ANALYSIS:	According to Resident A's mother, prior to going home on a visit, Ms. Cason popped out Resident A's medication out of the pharmacy supplied bubble packs and placed the pills into a 7-day pill container. Ms. Cason admitted to popping the pills out of the pharmacy issued bubble packs and placed the pills in a 7-day pill container.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend the license be renewed to a regular license.

02/27/26

Eric Johnson Date
Licensing Consultant

Approved By:

For 03/24/2026

Denise Y. Nunn Date
Area Manager