GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 15, 2026

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

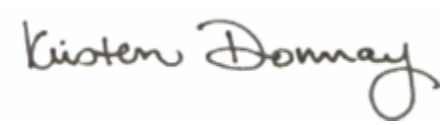
RE: License #: AS630418986
Investigation #: 2026A0991014
Abound Rehabilitation Services - Murray Crescent

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. 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, 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 #:	2026A0991014
Complaint Receipt Date:	02/25/2026
Investigation Initiation Date:	02/25/2026
Report Due Date:	04/26/2026
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 - 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?
During an unannounced onsite visit, an Adult Protective Services worker observed that a staff person smelled strongly of marijuana.	Yes
Direct care worker, Zeeland Shephard, physically and sexually abused Resident C.	No
Additional Findings	Yes

III. METHODOLOGY

02/25/2026	Special Investigation Intake 2026A0991014
02/25/2026	Special Investigation Initiated - Telephone Contacted Adult Protective Services (APS) worker, Marcie Fincher
02/25/2026	APS Referral Received from Adult Protective Services (APS)- APS did not assign for investigation
02/26/2026	Contact - Document Sent Email to/from APS worker, Marcie Fincher
02/26/2026	Referral - Recipient Rights Sent referral to Office of Recipient Rights (ORR)- not opening for investigation
03/03/2026	Inspection Completed On-site Unannounced onsite inspection- interviewed staff and residents
03/04/2026	Contact - Telephone call received From APS worker, Marcie Fincher- re: additional allegations
03/04/2026	Contact - Document Received Intake email from APS with additional allegations- assigned to APS worker, Jordan Walker
03/04/2026	Referral - Recipient Rights Referred additional allegations to ORR- assigned to Amanda Clasman

03/05/2026	Contact - Document Received Email from ORR- made request for interpreter
03/11/2026	Contact - Document Received Email from ORR worker- interpreter not available for scheduled appointment- sent additional requests for interpreter
03/12/2026	Contact - Document Received Incident report and staff statements
03/13/2026	Inspection Completed On-site Interviewed staff
03/13/2026	Contact - Document Received Copies of text message exchange
03/13/2026	Contact - Document Received Police report from Southfield Police Department
03/16/2026	Contact - Telephone call made Interviewed direct care worker, Latonia Brown
03/16/2026	Contact - Document Received Medical records for Resident C
03/17/2026	Contact - Telephone call made Interviewed area manager, Santecia Dobbs
03/17/2026	Contact - Telephone call made Interviewed staff, Zeeland Shephard w/video relay services
03/17/2026	Contact - Telephone call made Interviewed staff Santiya Halthon
03/18/2026	Contact - Document Received Staff schedule, medication administration records, discipline notice, plans of service, and staff files
03/18/2026	Contact - Document Received Updated police report from Southfield Police Department
03/20/2026	Inspection Completed On-site Interviewed Resident C w/interpreter
04/02/2026	Contact - Face to Face With licensee designee, David Ellis, at Abound- Almond Lane. Discussed findings of investigation and recommendation

04/09/2026	Contact - Telephone call made Left message for licensee designee, David Ellis re: exit conference
04/14/2026	Exit Conference Via telephone with licensee designee, David Ellis

ALLEGATION:

During an unannounced onsite visit, an Adult Protective Services worker observed that a staff person smelled strongly of marijuana.

INVESTIGATION:

On 02/25/26, I received a complaint from Adult Protective Services (APS), alleging that on 02/22/26, during an unannounced visit to Abound- Murray Crescent, a staff person smelled strongly of marijuana when he got out of a car that was parked in the driveway to greet the APS worker who was conducting an unannounced visit at the home. APS did not open an investigation. I referred the complaint to the Office of Recipient Rights (ORR), but it was not assigned for investigation.

I initiated my investigation on 02/26/26 by contacting APS worker, Marcie Fincher. Ms. Fincher stated that she conducted an unannounced onsite inspection at Abound-Murray Crescent on Sunday, 02/22/26, at approximately 1:20pm. She stated that she approached the home and the front door was open. Through the screen door, she could see a resident coming to the door. As she was standing at the door, a thin, African American man with long braids or dreadlocks got out of a red car that was parked on the driveway and walked up to her. She introduced herself and let him know that she was with APS. As the man walked past her, he “reeked like marijuana.” Ms. Fincher stated that she believed the man had been smoking marijuana in the car that was parked on the driveway. She stated that the man did not tell her his name or identify himself as staff, but he acted as though he was staff and provided her with information regarding the resident who she was looking for who lived at a different Abound home. As Ms. Fincher was leaving, she observed another male in the car as well, but she did not know if the individual was a resident or a staff person at the home. Ms. Fincher stated that after she left the home, she contacted the area manager, Santecia Dobbs, to express her concerns. Ms. Dobbs stated that she could not say if the individual was a staff member or not, as they have a lot of contractors coming in and out of the home. Ms. Dobbs stated that she would look into the matter and get back to Ms. Fincher; however, she never called back. Ms. Fincher stated that there was at least one resident

in the home during this interaction. She did not observe any other staff or residents in the home.

On 03/03/26, I conducted an unannounced onsite inspection at Abound Rehabilitation Services - Murray Crescent. I interviewed Resident E. Resident E stated that he never noticed any staff who smell like marijuana. He stated that he never saw staff smoking marijuana. Staff do go out and sit in their cars. Staff leave the residents alone in the home sometimes. It is usually quick when they do this. He could not name which staff sit in their cars. Resident E stated that Resident D smokes marijuana. He goes outside and smokes. He never saw staff smoking marijuana with Resident D. Resident E stated that he did not have any concerns about the home.

On 03/03/26, I interviewed the area manager, Santecia Dobbs. Ms. Dobbs stated that she was aware of the incident that happened on 02/22/26 when APS came to the home. She stated that direct care worker, Jaivyon Hawkins, took Resident D on an outing. They went to the smoke shop so Resident D could purchase CBD (cannabidiol) flower, which Resident D purchases in flower form, rolls, and smokes. Ms. Dobbs stated that CBD flower is different from marijuana, as it is natural hemp and does not contain THC (tetrahydrocannabinol), so Resident D does not get high from smoking it. Ms. Dobbs stated that on 02/22/26, Mr. Hawkins let Resident D smoke the CBD flower in his personal vehicle. He stated that Resident D knows that he cannot smoke in the company van, but staff thought it would be okay since it was his own car. She felt Mr. Hawkins was trying to pacify Resident D. Ms. Dobbs stated that Mr. Hawkins told her that he was not smoking with Resident D. She stated that Resident D's doctor and case manager know that he smokes. There is nothing in Resident D's plan of service stating whether he can or cannot use cannabis. Resident D has bongs that he uses to smoke. Ms. Dobbs stated that she has not observed staff smelling like marijuana. She never smelled marijuana on Jaivyon Hawkins. She did not have any concerns about Jaivyon Hawkins or any other staff being under the influence of marijuana while at work.

On 03/04/26, I spoke with APS worker, Marcie Fincher, via telephone. I informed Ms. Fincher of the explanation provided by Santecia Dobbs. Ms. Fincher stated that if Resident D was the other individual in the car, then Mr. Hawkins left him in a running vehicle alone for several minutes when he accompanied her into the home.

On 03/13/26, I conducted a follow-up onsite inspection at Abound Rehabilitation Services – Murray Crescent. I interviewed direct care worker, Jacob Barrett. Mr. Barrett stated that he has worked in the home for two or three weeks. Mr. Barrett stated that Resident D smokes weed. He usually smokes it in the backyard. Mr. Barrett stated that he never saw staff smoking marijuana and never smelled marijuana on staff. Mr. Barrett stated that he personally smokes marijuana at home, but only at night. He has never smoked while on shift and has never come to work high.

On 03/13/26, I interviewed Resident A. Resident A stated that they never saw staff smoking marijuana, and they have not smelled marijuana on any staff in the home.

On 03/13/26, I interviewed direct care worker, Equoiya Johnson. Ms. Johnson stated that she has worked in the home for approximately two months. She stated that she has never observed any staff smoking marijuana. She stated that there have been times when she smelled marijuana on other staff. Staff will go outside and “spray down” to cover up the smell. She did not provide any specific instance of when this happened and did not name which staff did this. Ms. Johnson stated that she was not aware of Resident D smoking marijuana. She stated that she stays away from Resident D, because he is very aggressive towards females. Resident D typically locks his door and does not let staff into his room.

On 03/13/26, I interviewed direct care worker, Jaivyon Hawkins. Mr. Hawkins stated that he has worked at the Murray Crescent home since the end of January 2026. Mr. Hawkins stated that he was working when APS came to the home looking for a resident who lives at the Aberdeen home. He stated that he had just returned to the home after taking Resident D for a drive to get cigarettes for another resident who had run out. Mr. Hawkins stated that they were gone for about ten minutes. The APS worker pulled up in the driveway right after him. He stated that she was at the door knocking, and he was waiting to see if another staff would come to the door. After a minute, he got out of the car to talk to the APS worker. Mr. Hawkins stated that Resident D had been smoking marijuana in his car, and the smell stuck on him. He stated that he was not smoking marijuana with Resident D. Resident D tries to get him to smoke with him, but he always tells Resident D no. Mr. Hawkins stated that he will let Resident D smoke inside his car if it is cold outside. Mr. Hawkins stated that Resident D was in the car when he went inside with the APS worker. They stepped inside for about 30 seconds. He stated that Resident D was getting out of the car when the APS worker was leaving the home. Mr. Hawkins was not aware of any staff smoking marijuana while at work. He stated that Resident D is the only one who smokes marijuana. Mr. Hawkins stated that he personally smokes Breeze E-cigarettes, but he does not bring them to the home and does not smoke while at work.

On 03/13/26, I interviewed the director of compliance and human resources, Amyra Burks. Ms. Burks stated that Resident D smokes marijuana. It is in his individual plan of service (IPOS), and his guardian knows about it. She stated that staff are around him when he is smoking, which is why they smell like marijuana. Staff are not allowed to smoke and do not even smoke cigarettes at the home. She was not aware of any staff smoking marijuana while at work. She stated that Resident D smokes in the van with staff and has smoked in staff’s car. She was aware of Resident D smoking in Javyion Hawkins’s car. Ms. Burks stated that Resident D can smoke “wherever he wants.” She stated, “That is his right.” She then stated that Resident D is not allowed to smoke in the

company van, but he can smoke in staff's personal vehicles. Ms. Burks stated that the home has designated smoking areas outside. She conceded that a staff person's vehicle is not a designated smoking area. She then stated that it is not okay for a resident to smoke in a staff person's car, but Resident D has done it. Ms. Burks stated that Jaivyon Hawkins was disciplined and received a write up for allowing Resident D to smoke in his car.

I received and reviewed a written disciplinary form for Jaivyon Hawkins dated 02/24/26. The disciplinary form notes that on 02/22/26, staff Jaivyon Hawkins allowed (Resident D) to sit in his vehicle due to the cold weather and smoke in his car. The disciplinary form notes that although the weather was cold, staff are not allowed to smoke or allow any consumers in their vehicles (personal or company) to smoke either. The form states, "This is your only warning. If this occurs again all staff involved will be terminated."

I received and reviewed Resident D's individual plan of service (IPOS) dated 08/07/25. One of the goals notes that Resident D stated the only medication he needs is marijuana and nothing else works for his anxiety. The goal lists an objective of Resident D verbalizing two ways on how smoking marijuana can increase some of his symptoms associated with schizophrenia, in relation to some of his past hospitalizations. Resident D's IPOS notes that Abound AFC staff are to accompany Resident D out within the community. Resident D was not able to participate in an interview due to being hospitalized for psychiatric reasons.

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:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff, Jaivyon Hawkins, smoked marijuana or was under the influence while on shift. The APS worker, Marcie Fincher, noted a strong smell of marijuana on staff, who was later determined to be Jaivyon Hawkins, when she conducted an unannounced onsite visit at the home. Mr. Hawkins denied smoking marijuana while on shift, and stated that he allowed Resident D to smoke marijuana in his personal vehicle which caused him to smell like marijuana. None of the residents or staff who were interviewed had knowledge of Mr. Hawkins smoking marijuana while on shift. There is sufficient information to conclude that Mr. Hawkins did not ensure Resident D's safety and protection when he left him

	unattended in a running vehicle when he went inside the home to speak with an APS worker on 02/22/26. The APS worker, Marcie Fincher, stated that Mr. Hawkins left Resident D inside a vehicle on the driveway, which was running, when he entered the home with her for several minutes. Resident D's IPOS indicates that Abound AFC staff are to accompany Resident D out within the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care worker, Zeeland Shephard, physically and sexually abused Resident C.

INVESTIGATION:

On 03/04/26, I received additional allegations from APS which state that Resident C is cognitively impaired and deaf. Zeeland Shephard is a direct care worker at the AFC home who is deaf and is assigned to work with Resident C as a one on one staff, as he can communicate with Resident C using American Sign Language (ASL). On 03/03/26, Resident C was taken to the hospital with complaints of stomach and anal pain. The complaint alleged that Zeeland physically and sexually assaulted Resident C. Zeeland touched Resident C's butt and laid in bed with him for hours. On 03/02/26, direct care worker, Latonia, reported that on a prior date Zeeland was in Resident C's bedroom with the door locked for hours. On 03/02/26, Zeeland punched Resident C in the chest while driving. Law enforcement was contacted to report the concerns of physical and sexual assault. A visual medical exam was completed at the hospital on 03/03/26, resulting in no evidence of an assault. No physical injuries were noted on Resident C. Zeeland is still employed by Abound Rehabilitation Services, but he was sent home for the day. The complaint was assigned to APS worker, Jordan Walker, for investigation. I referred the complaint to the Office of Recipient Rights (ORR), and it was assigned to ORR worker, Amanda Clasman, for investigation.

On 03/13/26, I conducted an onsite inspection with the assigned ORR worker, Amanda Clasman. I interviewed direct care worker, Jacob Barrett. Mr. Barrett stated that he has worked in the home for two to three weeks. Mr. Barrett stated he heard from another staff person that Resident C's staff/interpreter, Zeeland Shephard, touched him and was in Resident C's bedroom with the door locked. Mr. Barrett stated that this was unexpected, and he would not think that Mr. Shephard would do that. He stated that he

never saw Mr. Shephard in Resident C's room with the door locked. He stated that Mr. Shephard usually sits in Resident C's bedroom and looks out the window. He stated that he never saw Mr. Shephard in bed with Resident C. He never saw Mr. Shephard touch Resident C's buttocks or punch Resident C. Resident C never reported any concerns about Mr. Shephard to Mr. Barrett using his iPad. He stated that Resident C will often point at the schedule looking for Mr. Shephard. Mr. Barrett stated that Mr. Shephard has not returned to the home since these allegations came up. Mr. Barrett stated that he did not have any concerns about any of the staff who work with Resident C.

On 03/13/26, I interviewed direct care worker, Equoiya Johnson. Ms. Johnson stated that she has worked in the home since January 2026. She stated that she was not working on 03/02/26, but she worked on 03/03/26 from 4:00pm-12:00am, which was the day that Resident C went to the hospital. She asked where Resident C was, and the area manager, Santecia Dobbs, told her that Resident C was at the hospital. She did not know why Resident C went to the hospital. Ms. Johnson stated that staff complete 30-minute checks on the residents throughout their shifts. She stated that when she checks on Resident C, the door is sometimes closed, and Zeeland Shephard is in the room with him. If the door is closed, she opens it and texts Mr. Shephard to tell him that the door needs to be open. She stated that if any resident is in their bedroom with their 1:1 staff for a long period, the door needs to be open. She never observed that the door was locked, or that Mr. Shephard was laying in bed with Resident C. She stated that Mr. Shephard usually sits in the chair in Resident C's room by his dresser. Ms. Johnson stated that she never saw Mr. Shephard punching Resident C or touching his butt. Resident C always says he is happy and has never expressed any concerns about Mr. Shephard to Ms. Johnson. Ms. Johnson stated that she did not have any concerns about Mr. Shephard.

On 03/13/26, I interviewed the director of compliance and human resources, Amyra Burks. Ms. Burks stated that Resident C has known Zeeland Shephard for over ten years. Mr. Shephard was Resident C's staff at his previous group home and came to work for Abound when Resident C moved into the home. She stated that Mr. Shephard knows Resident C's family and has a good relationship with everyone. There was never a vibe that anything was going on. Ms. Burks stated that Resident C's bedroom door is always open when she is at the home. She never saw Mr. Shephard touch Resident C in any capacity. She stated that when Mr. Shephard was previously removed from the schedule, Resident C would get upset and ask for him; however, Resident C has not asked for him at all during Mr. Shephard's current suspension from the home. Ms. Burks stated that the area manager, Santecia Dobbs, took Resident C to the hospital on 03/03/26 after the allegations were made the night before in text messages that Resident C sent to Ms. Dobbs. A rape kit was not done, as the hospital felt that it was

too invasive. Ms. Burks stated that they did a physical examination, which showed bruising on Resident C's shoulder. Ms. Burks stated that an interpreter was present when Resident C was at the hospital. Ms. Dobbs took Resident C to a forensic interview at Care House the following day. Mr. Shephard has been removed from the schedule pending the outcome of the investigation.

On 03/13/26, I interviewed direct care worker, Jaivyon Hawkins. Mr. Hawkins stated that he did not know much about the situation with Resident C and Zeeland Shephard and was not aware of any problems. Mr. Hawkins stated that on a few occasions, Mr. Shephard was not scheduled to work the night shift, but he would stay for the night shift anyway. Mr. Shephard stayed in Resident C's room all night. If another staff did not come in for their shift, Mr. Shephard would stay. He would just sit with Resident C the whole time, and he would not assist with any other tasks around the home. There were also times when Mr. Shephard would get Resident C "riled up" on purpose before the end of his shift, so that he could stay longer and calm him down. Mr. Hawkins stated that he observed Mr. Shephard in the room with Resident C with the door closed on several occasions, but the door was never locked. He stated that he would conduct checks every 30 minutes to one hour, and the door was always unlocked. Mr. Hawkins stated that at no time should staff be in a bedroom with a resident with the door closed or locked. Mr. Hawkins stated that about a week and a half ago, he contacted the area manager, Santecia Dobbs, because Resident C motioned towards his stomach and indicated that Mr. Shephard hurt him. He stated that Resident C was pointing to his stomach and was indicating "big" and "want to eat healthy." Resident C signed "Z" which is his sign for Zeeland Shephard and pointed at his stomach and signed "hurt." Mr. Hawkins stated that he is not fluent in sign language, but he has picked up on some signs from working with Resident C. Mr. Hawkins stated that Resident C facetimed with the area manager, Santecia Dobbs, for an hour. Ms. Dobbs is not fluent in sign language either. Mr. Hawkins stated that Resident C sent a message to Ms. Dobbs indicating, "Zeeland hurt me." Mr. Hawkins stated that he never saw Mr. Shephard hit or punch Resident C. He never saw him touch Resident C's butt. He stated that Mr. Shephard would sometimes push Resident C on the shoulder in a laughing and playful way, but never to hurt him. Mr. Hawkins did not have any concerns about Mr. Shephard harming or hurting Resident C. Mr. Hawkins stated that Resident C has been happy since Mr. Shephard was removed from the schedule. Resident C has been very happy and bubbly since that day.

On 03/16/26, I interviewed direct care worker, Latonia Brown, via telephone. Ms. Brown stated that she had only been working at the home for four or five weeks when she noticed that Zeeland Shephard would lock himself in the room with Resident C. She stated that she worked three shifts with Mr. Shephard, and she noticed that the door was locked when she went to do her rounds every fifteen minutes. She stated that Mr.

Shephard would be in Resident C's bedroom with the door closed for half of the shift. She checked the door knob every time and the door was locked. Ms. Brown stated that she did not have a key to the door. Ms. Brown stated that during the last shift she worked with Mr. Shephard she heard a sound, "like a moan," coming from Resident C's bedroom when Mr. Shephard was in the room. She stated that it sounded different from the sounds that Resident C typically makes, and it raised a red flag with her. Ms. Brown stated that she was working on the night of 03/02/26, when Resident C came running out of his room at 1:30am, stating that he was in pain. Ms. Brown stated that she does not know sign language, so she gave Resident C her phone to communicate with him. He said that his rear end was hurting, and he touched his "front parts and stomach." Ms. Brown asked him if he needed medicine and he said yes. Ms. Brown stated that she cannot pass medications, so she called the area manager, Santecia Dobbs. Ms. Dobbs was asking Resident A what was wrong, and Resident C was looking around in a frantic way. He left to get his iPad and was closing out apps and texts. He then started messaging with Ms. Dobbs. Resident C typed the words, 'Zeeland', 'bad person', 'sex', and 'December'. Ms. Brown stated that Ms. Dobbs told her to give Resident C ibuprofen and something for his stomach, so she did. Ms. Brown stated that she was not sure how often Resident C was going to the bathroom that night. She was not aware of him having diarrhea. Ms. Brown stated that she never saw Mr. Shephard touch Resident C's butt. She never saw Mr. Shephard in bed with Resident C. She stated that Mr. Shephard typically sits in the chair by Resident C's bed, next to the window.

I received and reviewed a written statement from direct care worker, Latonia Brown, dated 03/03/26. Ms. Brown noted the following information in her written statement:

- Her first scheduled shift was 02/22/26 from 8:00am-8:00pm. She noticed Zeeland Shephard locking himself in the room with Resident C.
- On 02/27/26, she noticed a change in Resident C's behavior. He was agitated and spoke of pain. Another staff, Jaiyvion, who she was relieving suggested that she call Zeeland Shephard. Mr. Shephard responded and said to have Resident C email him. She reached back out to Mr. Shephard a few minutes later to ask if Resident C was okay. Mr. Shephard responded, "He probably is. I told him to go to bed now." Resident C eventually went to bed on his own.
- On 02/28/26, Ms. Brown worked another 8:00am-8:00pm shift with Zeeland Shephard. She noticed that Resident C and Mr. Shephard were in Resident C's room with the door locked for half of the eight hour shift.
- On 03/01/26, Ms. Brown was doing rounds inside the home, when she heard a noise coming from Resident C inside his room. She tried to enter the room, but the door was locked with Mr. Shephard inside. Mr. Shephard and Resident C remained in Resident C's bedroom with the door locked for half of the shift.

- At the beginning of her shift on 03/02/26 at 11:55pm, Resident C exited his room in a hurry, stating that he was in pain. Ms. Brown communicated with Resident C via text. She contacted the area manager, Santecia Dobbs, for further instructions, because Resident C began explaining that not only did his stomach hurt, but his rear end was in pain every day as well.
- Ms. Brown could tell that Resident C did not want to share everything with her, so she told him to reach out to Santecia Dobbs. Ms. Dobbs told Ms. Brown to give Resident C ibuprofen for pain. Resident C became relaxed after taking the ibuprofen and stomach relief. Ms. Brown and Resident C hugged it out and she walked him to his room. He eventually went to sleep.

On 03/17/26, I interviewed the area manager, Santecia Dobbs, via telephone. Ms. Dobbs stated that she received a phone call from staff, Latonia Brown, at 1:30am on 03/03/26. Ms. Brown told her that Resident C came storming out of his room saying that his stomach was upset and his rectum were bothering him. He was touching his penis and indicating that he was in pain. Ms. Dobbs stated that she texted Resident C to ask him what was wrong and who hurt him. Resident C said, ‘sick butt’ and ‘sick butt messy.” Ms. Dobbs stated that she asked Resident C if he was saying that Zeeland touched him, and Resident C said yes. Ms. Dobbs stated that she Facetimed with Ms. Brown and walked her through giving Resident C a PRN for pain. Ms. Brown told her that she heard a moaning noise from Resident C’s room previously, and that the door was locked. Ms. Dobbs asked Ms. Brown to write a statement. Ms. Dobbs stated that she contacted the licensee designee, David Ellis, and informed him of what was going on and that they wanted to take Resident C to the hospital. Ms. Dobbs stated that they got on the phone with Zeeland Shephard with an interpreter the following morning and informed him that he was off work pending an investigation. She stated that she attempted to contact Resident C’s parents, but they were out of town, and it went to voicemail. She took Resident C to the hospital. She stated that while Resident C was at the hospital, an interpreter was present. Resident C was making comments such as, ‘Zeeland bad’ and ‘in bed’. Resident C was stating that Zeeland hurt him and was hitting him. They determined that there was physical abuse. This was based off a bruise on Resident C’s right shoulder and Resident C’s statements. Ms. Dobbs stated that the bruise was light and did not look fresh. They did not observe any bruising anywhere else on Resident C’s body. The doctor stated that they did not want to do a rape kit, as there was no clear timeframe for when a sexual assault might have occurred and they felt it was too invasive. They did a visual examination at the hospital and did not note any tears or injuries. Ms. Dobbs stated that they notified the police of the allegations. Officers came to the home, but they did not find any physical evidence indicative of a sexual assault. Ms. Dobbs stated that they scheduled a forensic interview at Care House the following day. Ms. Dobbs took Resident C to the interview. She stated that

she received a message from the assigned detective on 03/17/26 indicating that the prosecutor denied the charges.

Ms. Dobbs stated that she did not assume that Resident C was talking about having diarrhea when he was saying, “sick, messy butt.” She stated that Latonia told her that Resident C was grabbing his penis and was also saying, “Zeeland gone…Zeeland bad,” so that is why she asked Resident C if Zeeland Shephard touched him. Ms. Dobbs stated that she never saw Mr. Shephard in bed with Resident C. She never saw Mr. Shephard in Resident C’s bedroom with the door closed or locked. She stated that the door was never closed when she was at the home. Ms. Dobbs stated that she was not aware of any policy that doors cannot be closed or locked, but they tell staff this information. Ms. Dobbs stated that Mr. Shephard was aware that that the door should not be closed. Ms. Dobbs stated that she never saw Mr. Shephard touch Resident C’s butt, hit him, or touch him inappropriately. Prior to these messages, Resident C never said Mr. Shephard hit him or touched him.

I received and reviewed an incident report completed by the area manager, Santecia Dobbs, dated 03/03/26. The incident report notes that on 03/03/26 at 1:20am, Resident C stormed out of his room complaining of abdominal and rectal pain. He then began to touch his penis area. Ms. Dobbs was contacted and communicated with Resident C via text. Resident C informed Ms. Dobbs that Zeeland Shephard had physically and sexually assaulted him. Ms. Dobbs transported Resident C to Corewell Hospital to be assessed for injuries. Ms. Dobbs requested that the Southfield Police Department (PD) initiate an investigation. The Southfield PD conducted an initial investigation and will follow up with Care House of Oakland County for a criminal sexual conduct investigation. The incident report notes that staff, Zeeland Shephard, was removed from the schedule and staff will closely monitor Resident C for health and safety.

I received and reviewed screenshots of text messages sent between the area manager, Santecia Dobbs and Resident C. Below is a summary of the text messages:

- On 03/02/26 at 10:57am, Resident C texted Ms. Dobbs, “Coming Today see you talk to you soon???” “Great behavior proud of you (Resident C) today yeah!!!” and “Activity in future calendar please with Zeeland march schedule when talk you soon???”
- Ms. Dobbs replied stating that she was not feeling well and needed to go to the doctor. She told Resident C that she would Facetime with him later.
- Resident C replied with several text messages in a row stating, “Great behavior proud of you (Resident C) today yeah!!!”
- Ms. Dobbs responded that she was proud of Resident C and stated that they could Facetime after she left the doctor's office.

- Resident C sent numerous text messages between 2:08pm-5:38pm on 03/02/26, with no response, asking Ms. Dobbs to respond and to Facetime soon. He again requested, “Activity in future calendar with Zeeland march schedule when talk you soon???”
- Resident C then sent a text message that stated, “Zeeland skinny healthy food fruit and veggies Yes oh crying and I am sad very bed Zeeland Hurt me and my helping Andre Drummond back Detroit Pistons miss you??? Zeeland big tummy sorry up tigers game and pistons games Future sorry home stay no more Yes great behavior must outing try Detroit Pistons game want tell you and Detroit tiger game outing please Detroit downtown future tigers game outing please Detroit downtown future tigers game outing please Detroit downtown future tigers game and Detroit Pistons??? Injection stopped very soon future call mom dad Try arm hard shots very stopped??? Yes great behavior must!!!!!!”
- Ms. Dobbs responded to this text message, “Who hurt you”
- Resident C responded, “Zeeland tummy small and skinny please future Yes must food fruit and veggies and sugar no more Help sort talking yes can tell you???”
- Ms. Dobbs responded, “Okay, I’ll get you some fruit and veggies.”
- Resident C responded, “Arm (RESIDENT C) injection stopped very soon future please???” and Ms. Dobbs replied, “We will talk with them about it”
- Resident C texted, “Feel sad Friday Saturday Monday crying upset??? Andre Drummond back Detroit Pistons miss you??? Yes great behavior must outing try Detroit Pistons game want tell you and Detroit tigers game outing please Detroit downtown future tigers game and Detroit Pistons??? Injection stopped very soon future call mom dad Try arm hard shots very stopped??? Yes great behavior must!!!!!!”
- Ms. Dobbs asked Resident C why he was sad and texted him that she missed him too and would be back, but she was just not feeling well.
- Resident C responded with more messages about the Detroit Pistons and Tigers and having great behavior.
- On 03/03/26 at 1:20am, Ms. Dobbs texted Resident C, “What’s wrong” and “Did someone hurt you?”
- Resident C responded, “Sick butt messy everyday Yes sick salt mouth Zeeland delete tummy big mad Bad Zeeland kick out???”
- Ms. Dobb’s replied, “Did Zeeland hurt you”
- Resident C replied, “(RESIDENT C) sick butt messy”
- Ms. Dobbs replied, “Are you telling me that he touched your butt?” “Yes or no?”
- Resident C replied, “Yes!!!”
- Ms. Dobbs texted, “Oh No!!!!! Baby I am so so so sorry. I am going to keep you safe I promise” and “How long”

- Resident C texted, “Yes but you sick yes please (RESIDENT C) butt everyday starts been December since!!!!!”
- On 03/03/26, Resident C sent a message stating, “Zeeland stay safe feeling better today happy want Zeeland please stay great and safe and happy!!!!”
- On 03/03/26, Resident C sent more messages asking about the Detroit Pistons and great behavior.

On 03/17/26, I interviewed direct care worker, Zeeland Shephard, via telephone with a video relay interpreter. Mr. Shephard stated that on 02/27/26, Abound was supposed to get tickets for Resident C to go to a Detroit Pistons NBA basketball game with staff. Resident C was very excited about going to the basketball game. When they went to pick up the tickets from the office, the HR (human resources) manager stated that they did not have the tickets. Mr. Shephard stated that this was pretty typical for Abound to cancel things at the last minute. Mr. Shephard told Resident C that the Pistons game was cancelled. Resident C became upset and kept asking why. Mr. Shephard told Resident C that he would have to talk to the manager or his parents about it. He stated that he tried to de-escalate Resident C by taking him to get pop and a snack. He told Jason, the staff coming on shift next to work with Resident C, that Resident C might be upset and to be prepared because Resident C is easily triggered. Later that night, Mr. Shephard’s nephew was having an event for his business selling candles. Jason brought Resident C to the event to support Mr. Shephard’s nephew. They had a good time and there were no issues. Later that night, around 12:30am, Mr. Shephard received a message from another staff around 12:30am stating that Resident C was out of control and they needed help because Resident C was upset and looking for Mr. Shephard. Mr. Shephard told the staff to have Resident C message him. Resident C said he was upset and his belly hurt. Mr. Shephard told Resident C to go to bed and he would see him in the morning. Around 1:00am, the staff on shift said it was all good and Resident C was going to bed. At 8:00am, Mr. Shephard returned to the home. Resident C was feeling frustrated and kept saying things about the Pistons. Mr. Shephard stated that he knew that was why Resident C was upset. He was trying to calm Resident C down and told him not to stress, eat, and that he needed to drink water. At 3:00pm that day, Resident C was fixated on getting a deaf roommate and more deaf staff, which is something that he talks about frequently and had recently been discussed during his IPOS meeting. Mr. Shephard stated that Saturday night and Sunday were good. Resident C was still complaining about a stomachache occasionally, and Mr. Shephard was reminding him not to eat so much, because he was stress eating. Around 1:00-2:00pm on Monday, 03/02/26, Resident C began getting upset again. He was talking about wanting a deaf roommate and about the Pistons game. Mr. Shephard stated that Resident C was stewing. He decided to take Resident C out in order to keep him calm. They went to Smoothie King and got two smoothies. Mr. Shephard got a smoothie for

himself that had a metabolic add-in. Resident C wanted to drink Mr. Shephard's smoothie with the metabolic add-in and kept asking for it. Mr. Shephard stated that he tapped Resident C's arm to tell him to stop and to get him to calm down and finish his own smoothie. He talked with Resident C and told Resident C that he is a man and he needs to act independent and have good behavior. They drove back to the house. Resident C finished his smoothie, and Mr. Shephard gave him some of the other smoothie that had the metabolic in it. He stated that he did not think much of it. Resident C drank the smoothie in the house, and he said that it helps him calm down. On Tuesday, 03/03/26, Mr. Shephard arrived for his shift at 8:00am. Resident C woke up and Mr. Shephard gave him his medications and breakfast. Resident C was happy. He smiled and gave Mr. Shephard a thumbs up. As they were going to Resident C's room to clean up and change the sheets, another staff, Arthur, told Mr. Shephard, "You did a bad thing." Mr. Shephard stated that he had no idea what he was talking about and that it made no sense. Arthur told Mr. Shephard that Resident C had talked about it. Mr. Shephard asked Resident C if something was wrong. Resident C told Mr. Shephard that he hurt his arm. Mr. Shephard stated that Resident C gets injections every four weeks for his medication, so he thought that was what he was talking about. Arthur told Mr. Shephard, "See, there is something wrong with his arm. (Resident C) said something bad was going on with you." Mr. Shephard stated that Arthur had a very serious look and kept looking at him strangely, but he had no idea what was going on. A short while later, the licensee designee, David Ellis, asked Mr. Shephard to call him. Mr. Shephard called Mr. Ellis using video relay. Mr. Ellis told Mr. Shephard that Resident C sent messages last night saying that his stomach hurt and his butt hurt. When Resident C explained it a little more, he said Mr. Shephard was touching him sexually. Mr. Shephard stated that he was puzzled and could not believe what Mr. Ellis was saying. Resident C was sitting right next to him and was fine. He stated that there is no way that Resident C would ever let him touch him. Resident C would fight him and would say something. Mr. Ellis told him that they were taking Resident C to the hospital to prove everything and told Mr. Shephard to go home. Mr. Shephard stated that as he was leaving, Resident C was telling him that he was fat and needed to lose weight. He stated that Resident C was trying to change the subject. Mr. Shephard stated that he told Resident C that he needed to leave, and Resident C told him no and not to quit. Resident C gave him a hug and told Mr. Shephard that he loved him.

Mr. Shephard stated that there were a few occasions when he laid in bed with Resident C, but it was a long time ago. He stated that Resident C would ask him to lay in bed. They would lie facing opposite ends while Resident C was talking or on the phone. Mr. Shephard stated that he has never been in the room with Resident C with the door locked. He stated that Resident C used to try to lock the door, but he told him never to lock the door. This happened when they first moved into the Murray Crescent home. He was not aware of the door being locked at any point in February or March of this year.

Mr. Shephard told Resident C that he cannot lock the door for safety reasons. Mr. Shephard stated that sometimes the door is closed when they go into Resident C's room to clean or chat, but it is never locked. Mr. Shephard stated that Resident C always sleeps with the door closed, but staff are able to enter the room to check on him. Mr. Shephard stated that he never touched Resident C's butt. He stated that there might have been a time when they were doing the dishes in the kitchen, and he tapped Resident C on the bottom to say good job, but never in a sexual manner. Mr. Shephard stated that he was not aware of Resident C having diarrhea or going back and forth to the bathroom frequently. He stated that this might have happened during the afternoon or evening shifts when he was not at the home. Mr. Shephard stated that Resident C rarely has stomach issues. Mr. Shephard stated that he has never touched Resident C sexually. He never hit Resident C. Mr. Shephard stated that Resident C is like a brother to him, and he has known him for a very long time. He has a good relationship with Resident C's parents, and they know that he does well with addressing Resident C's behaviors. Mr. Shephard stated that he has nodded off a few times while on shift, but he never fully sleeps while at work.

On 03/17/26, I interviewed Santiya Halthon via telephone. Ms. Halthon stated that she is the lead staff at Abound's Clarkston home, but she took Resident C to the hospital with Santecia Dobbs on 03/03/26. Ms. Halthon stated that she received a call from Ms. Dobbs at 2:00am, and Ms. Dobbs told her that Resident C had been touched by his 1:1 staff. They discussed the next steps and Ms. Halthon stated that she would go to the hospital with them the next morning. At the hospital, Resident C said that his 1:1 staff is a bad person and needs to leave. He stated, "Men aren't supposed to do that. That's wrong." Ms. Halthon stated that they were not sure if Resident C had been sexually assaulted, or if it had happened within the last 72 hours, so they decided not to put him through the process of doing a rape kit. She stated that they did a physical exam and did not find any tearing or bruising. Ms. Halthon stated that Resident C kept saying that Zeeland is a bad, terrible person and needs to go. Ms. Halthon stated that she never observed Zeeland Shephard in the room with Resident C with the door closed. She stated that there have been times when they were in Resident C's bedroom for a while. She never saw Mr. Shephard lying in bed with Resident C. She stated that Mr. Shephard usually sits in the chair while Resident C is in bed. Mr. Halthon stated that she never saw Mr. Shephard touch Resident C's butt or hit him.

On 03/20/26, I interviewed Resident C at Abound Rehabilitation Services - Murray Crescent with an American Sign Language interpreter from Deaf C.A.N. and the assigned ORR worker, Amanda Clasman. When asked about Zeeland Shephard, Resident C stated, "He was wrong. Touch me hard." Resident C stated that it was "a little bit playing" when Zeeland touched him hard. He stated, "Zeeland bad. Zeeland was wrong." Resident C stated, "Zeeland bad- mean, mean, mean. Wrong." He stated, "He's

wrong. He's lazy. It's bad. Not allowed." He stated that Zeeland sleeps a lot, and stated, "Illegal to sleep. Not supposed to sleep." Resident C said that he tries to wake up Zeeland, and Zeeland is wrong. Resident C stated that when he went to the hospital, he was sick. He said yes, he had diarrhea, and he threw up. He said yes, he had diarrhea on 02/28/26, 03/01/26, and 03/02/26. He stated that he was sad. He said that his butt hurt from diarrhea and he was sad. Resident C said he was upset on 02/27/26, because they could not go to Detroit. He said Zeeland is bad and wrong. He was sad that they did not get tickets. Resident C said that he understands now that it was not Zeeland's fault he could not get tickets. He said, "I say sorry. I understand." Resident C said Zeeland touched his butt and it is illegal. He had clothes on. Zeeland said good job, but he is not supposed to touch his butt. He said they laid in bed, but they were not facing each other. Resident C stated that Zeeland punched him in the chest. They were in his bedroom. They were playing around and teasing, but it was too hard and Resident C did not like it. When asked if he feels safe with Zeeland, Resident C motioned to "put him to the side." He stated that he Facetimed with Zeeland recently and that was good. He said that he told Santecia that Zeeland touched his butt and that was bad and wrong. He stated that Zeeland closes the door, but they do not lock it. The door has to be open. Keeping the door closed is wrong.

I received and reviewed the emergency department notes from Resident C's visit to Corewell Health William Beaumont University Hospital on 03/03/26. The notes indicate that Resident C presented with rectal pain and concerns of sexual assault. The notes indicate that Resident C's history was obtained from Resident C and the group home provider with an ASL translator. The notes indicate that Resident C has been experiencing rectal pain since yesterday, which he indicated by pointing to his buttocks and stating "pain, rectal pain." The pain began around 1:00-2:00pm. Resident C communicated through his iPad that his primary interpreter, Zeeland, was involved in causing the pain and expressed a desire for him to be removed from his care environment. Resident C's group home caregivers were concerned that he communicated via text message that he was sexually assaulted by Zeeland; however, it is unclear from the details if there was a possible sexual assault. It is unknown when this incident may have occurred. Resident C reports that he was assaulted and hit multiple times over several months. Resident C has been experiencing diarrhea since December, describing it as frequent and ongoing. He reported having diarrhea "five hundred times" yesterday. Resident C also mentioned vomiting on Saturday and feeling unwell with symptoms of sweating and chills. He has been taking Pepto-Bismol, which he noted helps with his stomach discomfort. The notes indicate that Resident C's communication is primarily through his iPad and sign language due to limited verbal and sign language skills. He is developmentally delayed. Resident C's home health team assists him in conveying his symptoms and concerns. He has expressed feelings of sadness and distress related to the events and his current symptoms.

The emergency department provider notes indicate that Resident C's vitals were stable and the exam was unremarkable. The genitourinary physical exam noted the penis, tests, and rectum were normal. The physical exam of the skin showed no findings of bruising. There were no signs of STI (sexually transmitted infection) or anogenital trauma. Resident C had no bruising, injury of trunk, extremities, or head/neck. The notes indicate that they will obtain basic labs and electrolytes due to concerns of diarrhea. Diarrhea is likely self-limited without history of bloody diarrhea or systemic symptoms. The notes indicate that on reassessment, after discussion with Resident C, the group home manager, and interpreter, Resident C will no longer have contact with the staff member who is reported to have assaulted him. Staff and Resident C report inappropriate contact, but there does not appear to be any confirmed history of sexual contact. They do not wish to proceed with a rape kit at this time. The lab results and imaging showed no signs of dehydration or electrolyte abnormalities. The notes indicate that Imodium is recommended if needed for diarrhea, and Resident C should return for persistent or worsening diarrhea. Resident C was determined to be stable for discharge.

I reviewed the nursing notes from Resident C's hospitalization dated 03/03/26, which note that a patient history was obtained with an ASL interpreter. The notes indicate that the accuracy is in question due to Resident C's mental status and communication barriers. Initially, Resident C was brought to the emergency department with concern of assault. Staff from the group home stated that Resident C was reporting that his primary ASL interpreter, Zeeland was "bad" and communicated that he hurt him in the butt. Resident C was brought in for further evaluation and to report the incident. With ASL interpreter and ECP (emergency care practitioner) present, Resident C was asked thoroughly about the precipitating events. When asked directly if he was penetrated or sexually assaulted by his interpreter, Resident C denied it and stated that all the "hurt" was on the outside. He continuously pointed to the butt cheeks, RUE (right upper extremity), and abdomen. Resident C was also reporting a significant history of loose, brown diarrhea that was causing his butt to hurt. The notes indicate that during further questioning, Resident C communicated that Zeeland was in bed with him and signed, "This is wrong. Man and man should not be together." Multiple attempts to determine if physical contact with sexual intent or penetration occurred. It was unable to be determined specifically if anything sexual occurred.

I received and reviewed a copy of the police case report from the Southfield Police Department, which included details of Resident C's forensic interview with an interpreter at Care House of Oakland County. During the interview, Resident C said that Zeeland was doing "funny things" that he should not have done three days ago. He stated that Zeeland is lazy and what he is doing is against the law. Resident C said that Zeeland should go and it would make him happier. Resident C stated that Zeeland hit him with his hands. He said he was hit in the chest area and had a red mark. He did not say

when this happened, but said it happens four to five hundred times. Resident C said that Zeeland needs to go away. Zeeland does bad things and needs to go bye-bye. During the interview, Resident C began talking about things that happened at his previous placement with JARC. The police report notes that on 03/17/26, the Oakland County Prosecutor's Office (OCPO) declined to authorize charges.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	Based on the information gathered through my investigation, there is insufficient information to conclude that staff, Zeeland Shepherd, mistreated Resident C by physically or sexually assaulting him. Resident C is deaf and cognitively impaired, which impacts his ability to effectively communicate with hearing staff at the home who do not know American Sign Language. While Resident C made comments about Zeeland being bad, hurting him, and wanting him to go away, it could not be determined if this was due to Resident C blaming Zeeland for not being able to go to a Detroit Pistons basketball game or for other reasons. The hospital found no physical signs of physical or sexual abuse. Resident C was diagnosed with having diarrhea at the hospital, which may be what he was trying to convey when texting that his butt hurt and was messy. The prosecutor’s office declined to authorize charges after an investigation by the Southfield Police Department.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation, I received and reviewed the employee file for direct care worker, Denzell Sutton. The employee file indicates that Mr. Sutton’s date of hire was 02/11/26. There was no verification on file that fingerprinting was completed for Denzell Sutton through the Michigan Workforce Background Check System. Mr. Sutton signed the Michigan Workforce Background Check Consent and Disclosure form on 02/11/26 and an ICHAT (internet criminal history assessment tool) background check was

completed on 2/13/26. As of 04/15/26, Mr. Sutton had not been fingerprinted in the Michigan Workforce Background Check System.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that direct care

	worker, Denzell Sutton, did not have verification of fingerprinting completed through the Michigan Workforce Background Check System.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Renewal Licensing Study Report Dated: 12/04/25; CAP Dated: 12/15/25**

INVESTIGATION:

During the investigation, the Abound- Murray Crescent staff who were interviewed stated that direct care worker, Zeeland Shephard, who is assigned to work one on one with Resident C, was frequently observed sleeping while on shift. Direct care worker, Jacob Barett, stated that Mr. Shephard sleeps when Resident C sleeps. Mr. Barrett has observed him sleeping through the window. Direct care worker, Equoiya Johnson, stated that she observed Mr. Shephard sleeping and snoring on at least one occasion. She stated that she told Mr. Shephard that he is not supposed to be sleeping, and that he needs to help with laundry and chores around the home. Direct care worker, Latonia Brown, stated that she observed Mr. Shephard sleeping during his shifts, as he snores when he is sleeping. He would sleep in an office chair in the front room during the first few hours of his shift, then he would go into Resident C's bedroom and shut and lock the door. The area manager, Santecia Dobbs, stated that she was aware of Mr. Shephard sleeping while on shift and not engaging with Resident C. She stated that this was the biggest issue with Mr. Shephard. She reported this to Amyra Burks, the director of compliance and human resources. She was not aware of Mr. Shephard being disciplined for sleeping. She stated that the expectation is for all staff to be awake during their scheduled shifts. Direct care worker, Santiya Halthon, stated that she observed Mr. Shephard sleeping while on shift. She stated that she saw him and heard him snoring. She stated that this happened almost every time she was at the home. She had to instruct him to get up and do activities with Resident C. Resident C also stated that Mr. Shephard sleeps while at the home. He stated, "He's wrong. He's lazy. It's bad. Not allowed." He stated that Zeeland sleeps a lot, and stated, "Illegal to sleep. Not supposed to sleep." Direct care worker, Zeeland Shephard, denied sleeping while on shift. Mr. Shephard stated that he has nodded off a few times while on shift, but he never fully sleeps while at work.

During the investigation, direct care worker, Latonia Brown, also stated that she observed Resident C and Zeeland Shephard in Resident C's bedroom with the door closed and locked on several occasions. She checked the doorknob and could not open the door. She provided a written statement indicating that she observed the door was locked during her shifts on 02/22/26, 02/27/26, and 02/28/26. Both Resident C and staff,

Zeeland Shephard, are deaf and could not hear or respond to a knock on the door. Ms. Brown stated that she did not have a key to any of the residents' bedrooms, and she did not know where the keys were located. Ms. Brown stated that she was working with a new staff, Denzell, who did not have keys to the bedrooms. While the other staff who were interviewed stated that they never observed Resident C's bedroom door to be locked, Ms. Brown asserted that the door was locked during her shifts.

During my interview with the area manager, Santecia Dobbs, on 03/17/26, Ms. Dobbs stated that the keys for all resident bedrooms are located in a desk drawer in the office area. She stated that not all staff are aware that the keys are kept in the drawer. Ms. Dobbs stated that everyone has access to the keys, as the drawer is not locked, but only lead staff know that the keys are in the drawer. Ms. Dobbs stated that Latonia Brown and Denzell Sutton are not lead workers. She stated that there is typically no lead staff on third shift. During the third shift, staff would have to call someone to ask for the keys, as they would not know where to locate them. Ms. Dobbs stated that she did not have any concerns about this, as the doors are never locked and she always answers her phone.

During my onsite inspection, I observed that all of the bedroom doors can be locked from the inside with non-locking against egress hardware, and they require a key to enter from the outside if locked.

APPLICABLE RULE	
R 400.621	**Capability.**
	Licensees, staff, volunteers, and members of the household shall be capable of ensuring the welfare of residents.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff are not capable of ensuring the welfare of the residents. Direct care worker, Zeeland Shephard, was observed by several staff to be sleeping throughout his shifts in the home. Zeeland Shephard is assigned to be Resident C's one on one staff, due to being able to communicate with Resident C using American Sign Language, as they are both deaf. He is not capable of engaging with Resident C and ensuring his safety and welfare while sleeping on shift. In addition, staff Latonia Brown stated that she observed Resident C's bedroom door was locked during her shifts at the home. Ms. Brown stated that she did not know where the keys were located to open any of the residents' bedroom doors. The area manager, Santecia Dobbs, stated that the keys are in a

	desk drawer, and only shift leads know where the keys are located. There is no shift lead scheduled to work on third shift. Staff would have to call someone to locate the keys. Ms. Dobbs stated that the bedroom doors are never locked; however, all of the bedroom doors can be locked from the inside. Staff on third shift would not be capable of ensuring the welfare of the residents if there was a medical, psychiatric, or environmental emergency and the bedroom door was locked from the inside, as they do not have knowledge of where the keys are located. Resident C and his one-on-one staff are deaf and would not be able to hear a knock on the door or a fire alarm, further jeopardizing their safety and welfare.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my interview with direct care worker, Latonia Brown, Ms. Brown stated that on 03/02/26, Resident C came running out of his room, stating that he was in pain. Ms. Brown stated that she cannot pass medications, so she called the area manager, Santecia Dobbs. Ms. Brown stated that Ms. Dobbs told her to give Resident C ibuprofen and medication for his stomach, so she did. She stated that she administered the medication and documented it in Resident C's medication administration record (MAR).

During my interview with the area manager, Santecia Dobbs, Ms. Dobbs stated that she Facetimed with Ms. Brown and walked her through giving Resident C PRN medication for pain, after receiving a phone call from Ms. Brown around 1:30am on 03/03/26 stating that Resident C was complaining of pain. Ms. Dobbs stated that Ms. Brown is trained to pass medications, but she is not typically a med passer in the home.

I received and reviewed a copy of Latonia Brown's employee file. There was no documentation on file to show that she completed medication training.

I received and reviewed a copy of Resident C's February 2026 and March 2026 MARs. I noted the following:

- Resident C's February 2026 MAR was not initialed on 02/28/26 for the 8:00am dose of Risperidone Odt 1mg tab, Thera M tab, or Vaylar 6mg Cap.
- Resident C's February 2026 MAR was not initialed on 02/28/26 for the 8:00pm dose of Risperidone Odt 1mg tab.
- Resident C is prescribed the PRN medication Ibuprofen 600mg Tab- take one tablet by mouth twice daily as needed. Resident C's March 2026 MAR was not

initialed to show that the medication was administered during the midnight shift on 03/02/26-03/03/26 as stated by direct care worker, Latonia Brown and area manager, Santecia Dobbs.

- Resident C's March 2026 MAR does not indicate that he is prescribed any PRN stomach medication or that it was administered during the midnight shift from 03/02/26-03/03/26, as stated by direct care worker, Latonia Brown.

On 04/14/26, I conducted an exit conference via telephone with the licensee designee, David Ellis. Mr. Ellis stated that he felt things had improved drastically at the home since he took over as licensee designee in March 2026. He stated that he has been running AFC homes for 40 years and has never had any disciplinary action taken against him. He expressed his intent to attend the compliance conference and dispute the recommendation of revocation.

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: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that direct care worker, Latonia Brown, was not trained in the proper handling and administration of medication prior to passing PRN medication to Resident C during the night shift from 03/02/26-03/03/26. There was no documentation in Ms. Brown's employee file to show that she completed medication training, and Ms. Brown stated that she called the area manager, because she could not pass medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

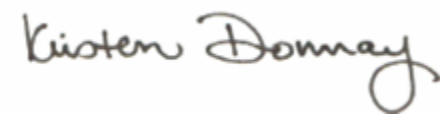
APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (b) Complete an individual medication log that contains all of the following: (i) Medication name.

	(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.
ANALYSIS:	During the investigation, I observed that Resident C's February 2026 medication administration record (MAR) was not initialed on 02/28/26 for the 8:00am dose of Risperidone Odt 1mg tab, Thera M tab, or Vaylar 6mg Cap or the 8:00pm dose of Risperidone Odt 1mg tab. Direct care worker, Latonia Brown, stated that she administered PRN medications, ibuprofen and stomach medicine, to Resident C during the night shift from 03/02/26-03/03/26; however, Resident C's March 2026 MAR was not initialed to indicate that his PRN ibuprofen was passed. Resident C's March 2026 MAR did not list any PRN stomach medications.
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: (c) Record the reason for each administration of medication that is prescribed on an as needed basis.
ANALYSIS:	During the investigation, direct care worker, Latonia Brown, stated that she administered PRN medications, ibuprofen and stomach medicine, to Resident C during the night shift from 03/02/26-03/03/26. Resident C's March 2026 MAR was not initialed for these medications, and there was no reason recorded for the administration of the medication that is prescribed on an as needed basis.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to the license currently being on a provisional license and the intervening quality of care violations, I recommend revocation of the license.



04/15/2026

Kristen Donnay Date
Licensing Consultant

Approved By:

For 04/15/2026

Denise Y. Nunn Date
Area Manager