GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 11, 2026

David Ellis Sr
Preserve Independence Management, LLC
dba Abound Rehabilitation Services Lincoln Park, LLC.
1962 Lietch Street
Ferndale, MI 48220

RE: License #: AS820415601
Investigation #: 2026A0116029
Abound Rehabilitation Services-Lincoln Park

Dear Mr. Ellis Sr:

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

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

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

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd
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 #:	2026A0116029
Complaint Receipt Date:	04/22/2026
Investigation Initiation Date:	04/22/2026
Report Due Date:	06/21/2026
Licensee Name:	Preserve Independence Management, LLC dba Abound Rehabilitation Services Lincoln Park, LLC.
Licensee Address:	1962 Lietch Street Ferndale, MI 48220
Licensee Telephone #:	(586) 872-5759
Administrator:	David Ellis Sr
Licensee Designee:	David Ellis Sr
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?
Resident A requires 1:1 staffing. On 04/10/26, Resident A was combative with staff and fell and hit her head. On 04/11/26, Resident A fell out of bed and hit her head on the floor and suffered a laceration to her scalp. Resident A is required to wear a helmet during behavioral outburst. During both incidents she did not have her helmet on. Additionally, there are concerns regarding staff supervision during the fall.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/22/2026	Special Investigation Intake 2026A0116029
04/22/2026	APS Referral Received.
04/22/2026	Special Investigation Initiated - Letter Referral emailed to the Office of Recipient Rights.
04/22/2026	Referral - Recipient Rights
04/28/2026	Inspection Completed On-site Staff, Kiara Smith, Marrianna Herron, attempted interview with Resident A, interviewed Residents B and C and reviewed Resident A’s Individual Plan of Service (IPOS).
04/29/2026	Contact - Telephone call made Recipient Rights investigator, Charles Carter.
04/29/2026	Contact - Telephone call made Staff, Dazjahn Walker.
04/29/2026	Contact - Telephone call made Staff, Darryl Porter.
04/30/2026	Contact - Telephone call made Staff, Shantel Hill.
04/30/2026	Contact - Telephone call made

	Staff, Diamond Van, left message requesting a return call.
04/30/2026	Contact – Telephone call received Charles Carter, recipient rights investigator.
05/07/2026	Inspection Completed On-site Michelle Seaborn, Home manager, requested staff schedules.
05/07/2026	Inspection Completed-BCAL Sub. Compliance
06/02/2026	Contact - Telephone call made David Ellis, licensee designee.
06/02/2026	Contact - Document Received Received copies of Resident's B-D (IPOSs).
06/10/2026	Exit Conference Licensee designee, David Ellis.

ALLEGATION:

Resident A requires 1:1 staffing. On 04/10/26, Resident A was combative with staff and fell and hit her head. On 04/11/26, Resident A fell out of bed and hit her head on the floor and suffered a laceration to her scalp. Resident A is required to wear a helmet during behavioral outburst. During both incidents she did not have her helmet on. Additionally, there are concerns regarding staff supervision during the fall.

INVESTIGATION:

On 04/28/26, I conducted an unannounced onsite inspection and interviewed staff, Kiara Smith, Marrianne Herron, attempted interview with Resident A, interviewed Residents B and C and reviewed Resident A's IPOS. Ms. Smith reported that she was on shift on 04/10/26 and Resident A's 1:1 was Shantel Hill. Ms. Smith reported that she witnessed Resident A as she was having a behavior. Ms. Smith reported that Resident A was trying to fight her and Ms. Hill and took her helmet off and threw it at them. She reported that Resident A then did a "dead drop" which she often does where she purposely falls backward oftentimes hitting her head on the floor. Ms. Smith reported that she called 911 and Resident A was transported to the hospital. Ms. Smith reported she followed the ambulance to the hospital and remained with

Resident A. She reported Resident A required six staples to the back of her head and was discharged back to the home the same evening.

Ms. Smith reported that staff encourage Resident A to wear her helmet at all times, however, reported that they cannot force her to keep it on. Ms. Smith reported that Resident A takes her helmet off most days and uses it during behaviors to hit or throw at staff.

Ms. Smith reported that she was not at work during the second fall during the early morning hours on 04/11/26. Ms. Smith reported that she heard about it when she returned to work. Ms. Smith reported that EMS was called but wasn't sure by whom and Resident A was transported back to the hospital. Ms. Smith reported Resident A was in the hospital for two days for observation.

I interviewed staff, Marrienna Herron, and she reported that she did not work on 04/10/26 or 04/11/26 and only heard about the incidents when she returned to work. Ms. Herron reported that all of the staff encourage Resident A to keep her helmet on as required, however, Resident A picks and chooses when she wants to comply.

I attempted to interview Resident A, however, she would not respond to any of my questions. Resident A was observed with her helmet on and was neatly dressed and groomed.

I interviewed Residents B and C, and they both reported that Resident A falls a lot and that she does it on purpose. They reported that staff put Resident A's helmet on every day, but she takes it off and throws it at the staff and residents when she is having a behavior. Resident C reported that Resident A purposely falls almost every day.

I reviewed Resident A's IPOS effective 10/06/25-10/05/26 with an update/addendum date of 02/17/26. The plan documents that Resident A requires 1:1 staffing 24 hours per day and she can never be left alone. The plan documents in great detail that during sleeping hours the 1:1 staff assigned to Resident A is to sit in close proximity to her bed to watch and assist her as needed. It documents that if the assigned staff must use the bathroom, eat a meal, take a break or for any other personal matter during the work shift, this person will swap out with another person to assure that Resident A is supervised at all times. The plan also acknowledges that Resident A should be wearing her helmet for safety due to her self-injurious behaviors such as hitting her head on the wall or purposely falling to the ground, however, Resident A does not tolerate the use of the helmet and it is often not on her head as a result.

On 04/29/26, I interviewed recipient rights investigator, Charles Carter. Mr. Carter reported that he is still investigating the allegations, however, based on his review of Resident A's current IPOS, the staff did not follow the plan as it appears during the

second fall during the midnight hour 04/10/26 going into 04/11/26, Resident A was left alone.

On 04/29/26, I interviewed staff, Dazjahn Walker, and she reported that she worked from 12:00 a.m. to 8:00 a.m. on the night of 04/10/26 going into 04/11/26 and was the assigned 1:1 staff for Resident A. Ms. Walker reported that she relieved staff, Diamond Van Ms. Walker and that she arrived on shift 10-15 minutes early and told Ms. Van she could go ahead and leave. Ms. Walker reported she went into Resident A's bedroom and observed her asleep. Ms. Walker reported that Resident A did not have her helmet on as she refuses, most times, to wear it. Ms. Walker reported that staff, Darryl Porter, Prince Steward and Brian Street, were the other staff on shift if she recalled correctly. Ms. Walker reported that she left Resident A's bedroom and went to the bathroom. She reported that Mr. Porter and Mr. Steward were in the living room area at the time. She reported that when she came out of the bathroom, she saw Mr. Porter in Resident A's bedroom assisting her off the floor. Mr. Porter informed her that Resident A did a "dead drop" and hit her head on the floor. Ms. Walker reported that Resident A was not bleeding but said she was dizzy. Ms. Walker reported that Mr. Porter or Mr. Steward called 911 and Resident A was transported to the hospital.

Ms. Walker reported that staff are not required to be in Resident A's bedroom during sleeping hours. Ms. Walker reported that staff are only required to check on her hourly throughout the night.

On 04/29/26, I interviewed staff, Darryl Porter. Mr. Porter reported that he thinks he worked from 12:00 a.m. to 8:00 a.m. on the night of 04/10/26 going into the morning of 04/11/26. Mr. Porter reported that he was not assigned to Resident A, however, while Ms. Walker was in the bathroom he was walking down the hallway and saw Resident A getting out of bed and then purposely fall to the ground, hitting her head. He reported that she did not have her helmet on because she refuses to wear it most days. Mr. Porter reported he couldn't get to Resident A quickly enough to prevent her from falling but assisted her off the floor. He reported that he noticed some light bleeding coming from the back of head and was concerned as Resident A had fallen and hit her head earlier that day resulting in her requiring 6 staples to close the laceration. Mr. Porter reported that staff, Prince Steward, called 911 and Resident A was transported by ambulance to the hospital. Mr. Porter reported that Mr. Steward went to the hospital with Resident A.

I asked Mr. Porter if Resident A's IPOS required staff to be in her bedroom during sleeping hours. Mr. Porter responded, "That's a good question but I think we just have to do hourly checks on her".

On 04/30/26, I interviewed staff, Shantel Hill, and she reported that she was the staff assigned to Resident A during the 4:00 p.m. to 12:00 a.m. shift on 04/10/26. Ms. Hill reported that at about 5:30 p.m. Resident A was being combative, hitting and spitting at her and staff, and took her helmet off and thew it. She reported that that went on

for a while and she and staff, Kiara Smith, were attempting to redirect her to no avail. Ms. Hill reported that Resident A then did a “dead drop” and hit her head on the floor. She reported she was bleeding, so Ms. Smith called 911 and Resident A was transported to the hospital. Ms. Hill reported that she left at 12:00 a.m. and did not observe the second fall that occurred shortly after midnight.

Ms. Hill reported that staff are not required to be in Resident A’s bedroom during sleeping hours. She reported that staff do 15-30 minutes checks during the night and try to give her privacy when she sleeps.

On 04/30/26, I spoke with recipient rights investigator, Charles Carter, and he reported that all the staff are changing their stories about who worked and the number of staff that were working. He reported that he went to the home to review the staff schedules, and the home manager, Michelle Seaborn, told him they were not available for him to review. Mr. Carter reported that it is likely because the home is not being properly staffed. Mr. Carter reported that he will be substantiating the allegations as it is clear that none of the staff is adhering to Resident A’s IPOS.

On 05/07/26, I conducted an unannounced onsite inspection and requested the staff schedules for the last 90 days. I also confirmed with home manager, Michelle Seaborn, that four of the six residents require 1:1 staffing 24 hours per day.

On 06/02/26, I interviewed licensee designee, David Ellis. Mr. Ellis reported that he is aware of both incidents with Resident A and reported that at both times immediate medical treatment was sought. Mr. Ellis also reported that although Resident A should be wearing her helmet at all times, she will not comply. He reported that his staff encourages her to wear her helmet, but Resident A is not always compliant.

Mr. Ellis reported his understanding that Resident F only required 1:1 staffing 16 hours per day and confirmed that Resident A, D, and E required 1:1 staffing 24 hours per day. I requested copies of the IPOSs for Residents D-F.

On 06/02/26, I received and reviewed the IPOSs for Residents D-F and confirmed that each of them requires 1:1 staffing 24 hours per day. Based on their plans and the care of Residents B and C there should be five staff on every shift.

I reviewed staff schedules for the weeks of 04/04-26-04/10/26, 04/11/26-04/17/26, 04/25/26-05/01/26 and 05/02/26-05/08/26. The charts below depict the staffing levels on each day, which were not sufficient based on the required staff to resident ratio.

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

	4/11	4/12	4/13	4/14	4/15	4/16	4/17
8:00-8:30a			4 staff	3 staff	2 staff	4 staff	4 staff
8:00-9:00a	3 staff (8-11)	3 staff (8-11)			4 staff (8:30-4)		
10:00-11:00a	4 staff (11-7)	4 staff (11-7)					
12:00-1:00p							
2:00-3:00p							

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

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

2:00-3:00a	
4:00-5:00a	
6:00-7:00a	
8:00a	

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

On 06/10/26, I conducted the exit conference with licensee designee, David Ellis, and informed him of the findings of the investigation and the rules cited. Mr. Ellis reported an understanding and accepted responsibility for his staff not adhering to the residents' IPOS relating to supervision and proper staffing of the home. Mr. Ellis

reported he would be working more closely with the home manager to ensure that this is corrected immediately.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the findings of the investigation, which included interviews with staff, Kiara Smith, Residents B-C, recipient rights investigator, Charles Carter, staff, Dazjahn Walker, Darryl Porter, Shantel Hill, and my review of Resident A's IPOS, there is a preponderance of evidence to substantiate that the home did not provide the supervision, protection and personal care as specified in Resident A's IPOS. Although, Resident A will not comply with consistently wearing her helmet, as reported by the staff, and documented in the IPOS, the staff is still required to provide 24-hour supervision and protection that is clearly documented as necessary for Resident A's safety and well-being and required by these rules. Further, had the staff been in Resident A's bedroom during the night/early am hours of 04/11/26, sitting next to her bed as required, the fall and subsequent hospitalization could have been prevented.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) Staffing should 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 staff, Dazjahn Walker, Darryl Porter, Shantel Hill, and my review of Resident’s A and D-F IPOSs and staff schedules, there is a preponderance of evidence to substantiate that staffing levels were not sufficient to meet the needs of the residents in accordance with each of their IPOSs. Residents A and D-F all require 1:1 staffing 24 hours per day. Additionally, there are 2 other residents residing in the home. The home should have a total of 5 staff on every shift. My review of 4 separate weeks of schedules determined that there were several times throughout each day that staffing levels fell below the required 5 staff.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED; SIR#2026A0116012 dated 02/04/26, CAP dated 03/24/26.**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/07/26, I conducted an unannounced onsite inspection and interviewed home manager, Michelle Seaborn. I requested to review the resident register to confirm who was residing in the home and the admission date of Resident D.

I reviewed the resident register and observed that it did not contain dates of birth for the six residents residing in the home. Ms. Seaborn reported that she was not aware that dates of birth were required to be documented on the resident register.

On 06/10/26, I conducted the exit conference with licensee designee, David Ellis, and informed him of the findings of the investigation and the rule cited. Mr. Ellis reported an understanding. Mr. Ellis reported he would be sending the updated resident register form to the home so that it could be updated to reflect resident dates of birth.

APPLICABLE RULE	
R 400.615	**Resident register.**
	A licensee shall maintain a chronological register of all residents admitted that includes the following information for each resident: **(b) Resident date of birth.**

ANALYSIS:	Based on the findings of the investigation, which included my observation and interview with home manager, Michelle Seaborn, there is a preponderance of evidence to substantiate that the licensee did not maintain a chronological register of all residents admitted that includes their date of birth.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 05/07/26, I conducted an unannounced onsite inspection and interviewed home manager, Michelle Seaborn. I asked Ms. Seaborn for 90 days of staff work schedules. Ms. Seaborn was only able to provide 6 weeks (42 days) of schedules.

On 06/10/26, I conducted the exit conference with licensee designee, David Ellis, and informed him of the findings of the investigation and the rule cited. Mr. Ellis reported an understanding and was perplexed as to why Ms. Seaborn was unable to provide the full 90 days of staff schedules.

APPLICABLE RULE	
R 400.639	**Staff records.**
	(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following: **(a) Names of staff on duty.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Scheduling changes when made.**
ANALYSIS:	Based on the findings of the investigation, which included my review of the staff schedules, there is a preponderance of evidence to substantiate that the licensee did not maintain 90 days of staff work schedules as required by these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/11/26

Pandrea Robinson
Licensing Consultant

Date

Approved By:

06/11/26

Ardra Hunter
Area Manager

Date