GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 16, 2026

Ronda Freeman McDonald
Altum Care Homes, LLC
23408 Plum Hollow
Southfield, MI 48033

RE: License #: AS630410805
Investigation #: 2026A0626027
Sandy Lane

Dear Ronda Freeman McDonald:

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,

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202
(248) 320-3721

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AS630410805
Investigation #:	2026A0626027
Complaint Receipt Date:	06/09/2026
Investigation Initiation Date:	06/09/2026
Report Due Date:	08/08/2026
Licensee Name:	Altum Care Homes, LLC
Licensee Address:	23408 Plum Hollow Southfield, MI 48033
Licensee Telephone #:	(313) 377-3776
Licensee Designee/Administrator:	Ronda Freeman McDonald
Name of Facility:	Sandy Lane
Facility Address:	29475 Briarbank Southfield, MI 48034
Facility Telephone #:	(313) 377-3776
Original Issuance Date:	09/29/2022
License Status:	REGULAR
Effective Date:	03/29/2025
Expiration Date:	03/28/2027
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Sandy Lane is not providing sufficient staffing to protect residents.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/09/2026	Special Investigation Intake 2026A0626027
06/09/2026	APS Referral A referral to Adult Protective Services (APS) was not made due to no allegations of abuse or neglect.
06/09/2026	Special Investigation Initiated - Letter I initiated the special investigation by forwarding the complaint to the Office of Recipient Rights (ORR) at Oakland Community Health Network.
06/09/2026	Contact - Face to Face I attempted an unannounced onsite investigation at Sandy Lane. There was no one at the home.
06/15/2026	Contact - Face to Face I completed an unannounced onsite investigation at Sandy Lane. I completed interviews with direct care staff members, Ethel Johnson-Nwachu and Porasche Thomas. I also completed a private, in person interview with Resident A.
06/15/2026	Contact - Telephone call received I completed a telephone interview with licensee designee, Ronda Freeman-McDonald.
06/18/2026	Contact - Document Received I received the individual plans of service for Resident A, Resident B, and Resident C, along with staffing schedules from the licensee designee.
06/22/2026	Contact - Telephone call made I completed a telephone interview with Adult Protective Services (APS) investigator, Carmen Smith.
06/25/2026	Contact - Telephone call made

	I completed telephone interviews with Cady Tobias, CNS case manager for Resident A and Tifani Williams, Resident A's community health specialist with CNS.
06/26/2026	Contact - Document Sent I submitted a request, via email, to Southfield Police Department, for police reports from Sandy Lane.
06/26/2026	Contact - Telephone call made I completed telephone interviews with Resident A's public guardian, Kijuana Evans and direct care staff member, Yolanda Gipson.
06/26/2026	Contact - Document Received I received an email from CNS community health specialist, Tifani Williams, with an update from her visit earlier that day.
06/29/2026	Contact - Document Received I received police reports and 911 call logs for Sandy Lane, from Southfield Police Department.
06/29/2026	APS Referral Due to the concerns raised by reviewing the police reports, I completed a referral to Adult Protective Services (APS), via the MI Bridges mandated reporter portal.
06/29/2026	Contact - Telephone call made I contacted public guardian to inquire about the court status.
07/02/2026	Contact - Face to Face I completed an unannounced, onsite investigation at Sandy Lane, with ORR specialist, Amber Oliver. Interviews were completed with direct care staff members, Porasche Thomas and Kizzie Parker, home managers, Taylor Avery and Osheka Ramsey, and Resident A and Resident C.
07/06/2026	Contact - Document Sent I sent an email to APS investigator, Carmen Smith, requesting an update.
07/06/2026	Contact - Telephone call made I completed a telephone interview with Alejandra Price, case manager from Easter Seals for Resident B and Resident C.
07/07/2026	Contact - Telephone call received

	I completed a telephone interview with Resident B's public guardian
07/08/2026	Contact - Document Received I received, via email, two incident reports for Sandy Lane, from recipient rights specialist, Amber Oliver.
07/10/2026	Contact – Document Received I received, via email, Sandy Lane staff timesheets, from licensee designee, Ronda Freeman McDonald.
07/15/2026	Exit conference I completed an exit conference with licensee designee, Ronda Freeman McDonald. The findings were discussed.

ALLEGATION:

Sandy Lane is not providing sufficient staffing to protect residents.

INVESTIGATION:

On 06/09/2026, I received a complaint, via email, indicating there is insufficient staff working at Sandy Lane and the residents are not receiving one-on-one care that was promised.

On 06/09/2026, I initiated the special investigation by forwarding the complaint to the Oakland County Office of Recipient Rights (ORR).

On 06/09/2026, I attempted an unannounced onsite investigation at Sandy Lane. There was no one at the home and no vehicles in the driveway. I did not hear anyone inside.

On 06/15/2026, I completed an unannounced onsite investigation at Sandy Lane. Upon entry, I observed Resident A, Resident B, and two direct care staff members in the home.

I completed an in-person interview with direct care staff member, Ethel Johnson-Nwachu. She has worked at Sandy Lane for approximately four months. She stated they have a total of three residents in the home and one is currently in the hospital. She explained that two of the residents, Resident A and Resident B, require a 1:1 staff ratio, so they always have three direct care staff members on the day shift and usually two staff on the night shift. Ms. Johnson-Nwachu denied having any concerns with the care they provide the residents. She shared that there has been an issue with Resident A's guardian, but she did not know all the details.

During the onsite investigation, I completed an in-person interview with direct care staff member, Porasche Thomas. Ms. Thomas has worked at Sandy Lane for approximately four months. She denied having any concerns about how residents are treated. She stated there are always at least three direct care staff members on shift during the day and two at night. There are only three residents in the home, but one is currently in the hospital. She stated Resident A and Resident B both require 1:1 care.

During the onsite investigation, I completed a private interview with Resident A. Resident A has lived at Sandy Lane for approximately two years. She stated that she feels safe sometimes and explained that what makes it “sometimes” is that Resident B can be violent at times. She feels that direct care staff members intervene quickly and appropriately. Resident B has caused her to cut herself and she had to be hospitalized once. She stated the staff take good care of her and that she has no complaints. She informed me that a lot of people have been coming to see her lately and she thinks it is because they do not like her guardian here and her guardian does not like "Ms. Ronda" (licensee designee, Ronda Freeman McDonald). Her guardian wants her in a different home, because she doesn't like this one for her. She likes it here, but sometimes people get on her nerves. She stated that there have been times when there were less than three staff working, but she cannot remember when that last happened.

During the onsite investigation, I attempted to interview Resident B, but she did not want to get up, as she was having her hair braided by one of the staff.

On 06/15/2026, I completed a telephone interview with licensee designee, Ronda Freeman-McDonald. She spoke with direct care staff, Ms. Thomas, who informed her of the investigation. She stated that she was not shocked about the complaint, because there is a contentious case with Resident A's guardian. The guardian owes her money for Resident A's care. She stated at one point, Resident A had a balance of over $7,000 that the guardian was not taking care of. She waived some of what was owed. The guardian let Resident A's Medicaid lapse and that caused more problems. She stated Resident A's guardian is trying to find her a new home, thinking it will absolve her of the past due balance. They went to court in February and May regarding the issue and they have another hearing this month. She has received some payment, but there is still a past due amount of $2,600. She has petitioned the court to get a guardian ad litem for Resident A due to financial concerns, and Adult Protective Services (APS) is also involved, investigating the guardian. She stated the judge mandated that the guardian cannot move Resident A. She believes the complaint was made by the guardian in retaliation for court involvement.

Ms. Freeman-McDonald agreed to send me the individual plans of service for all three residents and her staff schedules.

On 06/18/2026, I received, via email, the individual plans of service (IPOS) for all three residents at Sandy Lane and the staff schedule.

According to Resident A's IPOS, dated 02/05/2026, Resident A is to have 1:1 staffing to cut down on her behaviors for her safety. The IPOS indicates she has 1:1 staffing and the 1:1 staff must always have eyes on her. If the staff member needs to walk away, another staff member must watch her until the designated staff returns. The staff member must stay within arm's length of Resident A. When Resident A is participating in a job or is in program, she does not require a 1:1 staff. If she is not at her program or job, she is to have this 1:1 staffing 24 hours per day.

According to Resident B's IPOS, dated 06/02/2026, Resident B currently has 2:1 staffing. Her IPOS meeting took place on 06/02/2026 and indicates she is supposed to have 2:1 staffing for at least 90 days, 24 hours per day. If she is compliant with her treatment, she can go to 2:1 staffing during waking hours and 1:1 staffing during sleep hours. The number of hours decreases as she works on her behaviors.

According to her IPOS, dated 04/23/2026, Resident C does not require 1:1 staffing.

Based on the information in each resident's IPOS, when Resident A, Resident B, and Resident C are all present in the home, there should be a minimum of four staff on shift to accommodate the 1:1 staffing for Resident A, 2:1 staffing for Resident B, and regular staffing for Resident C.

The licensee designee, Ms. Freeman-McDonald, provided the following additional information, via email:

> "From 6/7 through 6/10, (Resident B) and staff were relocated to our sister home. Accordingly, staff were assigned to the sister site on each of those days. On the evening of 6/11, (Resident C) was discharged from the hospital without advance notice, requiring us to make immediate staffing adjustments to ensure coverage. Staff were reassigned back to Sandy Lane, and (Resident B) returned to the home as well. On 6/12, (Resident A) was discharged from the hospital and returned home. On 6/15, (Resident C) was readmitted to the hospital and remains hospitalized at this time."

Ms. Freeman-McDonald provided additional clarification that Resident A was hospitalized from 06/03/26-06/12/26. Resident C was hospitalized from 06/03/26-06/12/26 and was readmitted to the hospital on 06/15/26.

The schedule provided by Ms. Freeman-McDonald was difficult to comprehend, so I requested further clarification. I then requested the timecards from Sandy Lane Home for the week of 06/15/2026-06/19/2026. I compared the schedule with the time sheets and found the following:

06/15: The timecards indicate there was one direct care staff member from 8am-11am, then two direct care staff members from 11am-7pm, three staff from 7pm-9pm, and two staff from 09:30pm-7am. The schedule provided by Ms. Freeman-McDonald indicates there were two staff scheduled from 7am-3pm, then a 1:1 staff at 9am (end time not

specified on schedule), two staff from 3pm-11pm, and two staff from 11pm-7am. Ms. Freeman-McDonald informed me that Resident A was at a relative's home that evening and Resident C was back in the hospital, so the staffing was not appropriate for the daytime, but was appropriate for the night shift.

06/16/2026: The timecards indicate two staff from 8am-9am, three staff from 9am-1:30pm, four staff from 2pm-3m, three staff from 3:30pm-6:30pm, two staff from 7pm-7am. The schedule provided indicates there were two staff scheduled from 7am-3pm, then a 1:1 staff at 9am (end time not specified on schedule), two staff from 3pm-11pm, and two staff from 11pm-7am. Resident C was out of the home, due to being hospitalized. The night staffing was not appropriate.

06/17/2026: The timecards indicate two staff from 8am-9am, two staff from 9am-3pm, 4 staff from 3pm-7pm, three staff from 7pm-9pm, one staff from 9pm-7am. The schedule indicates there were two staff scheduled from 7am-3pm, then a 1:1 staff at 9am (end time not specified on schedule), two staff from 3pm-11pm, and two staff from 11pm-7am. Resident C was hospitalized this day. The staffing was not appropriate for this day.

06/18/2026: The timecard indicates three staff from 7am-8am, two staff from 8am-3pm, three staff from 3pm-6pm, four staff from 6pm-7pm, three staff from 7pm-11pm, three staff from 11pm-7am. The schedule indicates two staff scheduled from 7am-3pm, then a 1:1 staff at 9am (end time not specified on schedule), two staff from 3pm-11pm, and two staff from 11pm-7am. Resident C was still in the hospital. The staffing was not appropriate for this day from 8am-3pm, as there should have been at least three staff members on duty.

06/19/2026: The timecard indicates four staff from 8am-9am, three staff from 9am-3:30pm, four staff from 3:30pm-6:30pm, three staff from 7pm-7:30pm, four staff from 8pm-11pm, and 3 staff from 11pm-7am. The schedule indicates there were two staff scheduled from 7am-3pm, then a 1:1 staff at 9am (end time not specified on schedule), two staff from 3pm-11am, and one staff from 11pm-7am.

On 06/25/2026, I completed a telephone interview with Cady Tobias, the case manager from CNS for Resident A. ORR specialist, Amber Oliver, also participated. Ms. Tobias stated she heard about Resident A's guardian making allegations against the home for various things. She regularly visits the home, approximately one to two times per month, but right now, due to Resident A's recent hospitalization, she has to go weekly. She stated that she always sees Resident A with her 1:1, but then stated her visits are scheduled, so they are on alert. She stated that Tiffani Williams, a member of Resident A's treatment team, informed her of concerns she has regarding supervision of Resident A. She explained that Resident A reportedly picked up a piece of glass while on a walk with staff members and was able to use it to cut herself. Ms. Tobias stated that she does not have concerns of her own regarding Resident A's care in the home. She was last there this past Monday and saw Resident A and Resident B with three staff members in the home. She did not know if Resident C was there or not, as she visits

Resident A in the living room and does not go to the other rooms. She relayed that the police were contacted when Resident A went to the hospital on 06/01/2026, as she filed a complaint against Resident B. She did not know specifics but mentioned the incident report was completed by direct care staff member, Yolanda Gipson.

On 06/25/2026, I completed a telephone interview with Tifani Williams, Resident A's community health specialist with CNS. Ms. Williams has been working with Resident A for approximately two years. She stated she knows how Resident A does things and how she looks for attention. Resident A told her that there are times that staff do not pay attention to her. She stated she went to the home to see Resident A on 06/01/2026, and she was told that Resident A was in the hospital. They told her that Resident A picked up glass while on a walk and used it to cut herself. She stated there is no way this could have been missed, if her 1:1 was paying any attention to Resident A, as Resident A is a larger woman and moves slowly. She has seen times when the direct care staff members allowed Resident B to escalate with Resident A, only stepping in when it gets physical. She stated they let Resident B do whatever she wants. She does not typically do pop-up visits but will be going out for one tomorrow. She agreed to let me know how it goes.

On 06/26/2026, I completed a telephone interview with direct care staff member, Yolanda Gipson. Ms. Gipson came onto her shift at Sandy Lane when Resident A and Resident B had their fight on 06/01/2026. She explained that they had words and then started fighting. There were three direct care staff members on shift, and she believes all three residents were in the home at the time. She stated there are generally four staff members during the day and three at night. Resident A has 1:1 staffing and Resident B has had 2:1 staffing since before Ms. Gipson started working at Sandy Lane. She denied being there when Resident A cut herself. She stated that staff sit outside Resident A’s bedroom door during the night.

On 06/26/2026, I completed a telephone interview with Guardian A1, Resident A's public guardian. Guardian A1 is planning on moving Resident A as soon as she possibly can. Resident A has a lot of problems with another resident, and she is concerned that not enough is being done to supervise the two women. She stated Resident A has a 1:1 staff member. Resident A told her the other resident has two staff. Guardian A1 stated that every time something goes wrong, there seems to be only two staff members working. She has not received any of the incident reports regarding Resident A, but she was called when Resident A was hospitalized. Resident A calls her frequently to complain. When she asks Resident A where her staff member is, Resident A usually tells her that she is braiding someone's hair in another room. She was last at the home approximately two months ago and there were only two direct care staff members working. Guardian A1’s nephew went to the home approximately one month ago to deliver a tricycle to Resident A and there were only two direct care staff members working. Guardian A1 does not inform anyone before she goes to the home. She is planning on going there on Monday and she agreed to contact me after.

On 06/26/2026, I received an email from Resident A's community health specialist with CNS, Tifani Williams, indicating she went to the home today. She observed three direct care staff members present and all three residents.

On 06/29/2026, I received thirteen reports from Southfield Police Department involving Sandy Lane. They are as follows:

01/28/2026: A call was made to 911 Dispatch reporting Resident B was acting manic and saying that staff would die. She was petitioned by staff.

02/18/2026: Officers were dispatched to 28200 Franklin Road, for a mental health call involving Resident A. The report indicates she had cut herself and was bleeding badly. The report indicates Resident A used a broken piece of plaster to intentionally slit her left forearm. The responding officer wrote, "Due to this action, I believe within the near future, she will intentionally cause further harm to herself or others." She was transported to the hospital and a mental health petition was completed.

03/02/2026: A call was made to 911 Dispatch due to Resident B having a mental episode and destroying property. She did not meet admission criteria and staff advised they did not want her to be admitted.

03/02/2026: A few hours after the previous call was made, another call came in for mental health. The report indicates the call was made for Resident B, who was having an episode and hitting staff. The report indicates Resident B wanted to go outside and staff told her she would have to wait. Resident B became upset and began trying to get outside. She grabbed the staff member who was trying to stop her by her wrist and collar on three separate occasions and told the staff member, "I'll kill you, bitch!" Resident B was transported to the hospital. The responding officer wrote, "(Resident B) can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self or others and has engaged in an act or acts or made significant threats that are substantially supportive of this expectation."

04/10/2026: A call was made to 911 Dispatch regarding Resident B. The report indicates Resident B put her hands on staff. It was documented that there was a lot of yelling in the background and the reporting person could be heard saying, "Let me go, let me go".

05/06/2026: A call was made reporting Resident B took her medications, then assaulted staff. She was transported to the hospital.

05/06/2026: A call was made regarding Resident C. The report indicates she was attempting to harm herself with a glass ash tray. She had already used a piece of broken plastic to cut her hand. She was transported to the hospital.

05/16/2026: A call was made regarding Resident B. The call log indicates she was hitting other residents. She was transported to the hospital.

05/20/2026: A call was made regarding Resident C threatening self-harm stating that she had run out of the home and was likely to run into traffic. The report indicates that when officers arrived, Resident C was in the driveway, being restrained by a staff member. Resident C had attempted to grab a piece of glass outside in the grass. She was transported to the hospital.

06/01/2026: A call was made regarding Resident B assaulting Resident A. The report indicates that they were fighting and staff were able to separate them. Resident A told officers that Resident B was unhappy and started yelling at Resident A. Resident A took a step toward Resident B and Resident B began swinging her fist at Resident A, punching her. Resident A told officers that Resident B also pulled her hair. Resident A's glasses were broken and she requested that charges be filed. Resident A had a minor cut under her right eye. Resident B was transported to the hospital.

06/02/2026: A call was made reporting Resident A cut her arm with glass. When officers arrived, Resident A no longer had the piece of glass in her possession. The wound was not actively bleeding but did have blood. She told officers she did not want to live anymore. She was transported to the hospital.

06/03/2026: A call was made reporting Resident C attempted to cut herself with plastic, then attempted to run into 12 Mile Road. She was transported to the hospital.

06/15/2026: A call was made regarding Resident C making suicidal statements. She was transported to the hospital.

On 06/29/2026, I spoke with Resident A's guardian, Guardian A1, via telephone. Guardian A1 stated they had their court hearing this morning. The judge is allowing her to move Resident A from Sandy Lane due to her concerns regarding supervision and an appropriate number of staff. Guardian A1 is able to move her, as soon as Resident A's Medicaid is approved, which she suspects will be within the next two weeks. She stated she went to the home on 06/29/2026 and there were two residents in the home, Resident A and Resident C, with only one direct care staff member. She was told that Resident B was out.

On 06/29/2026, I submitted a referral to Adult Protective Services, due to concerns regarding the police reports and call logs obtained from Southfield Police Department.

On 07/02/2026, I completed an unannounced onsite investigation at Sandy Lane Home, with ORR specialist, Amber Oliver. I completed an in-person interview with home managers, Taylor Avery and Osheka Ramsey. Ms. Avery has been a home manager for approximately one and a half years, and Ms. Ramsey has been a home manager for

three to four years. Ms. Avery stated they typically have three staff on for the night shift and four staff during the day. Resident A has 1:1 staffing and Resident B has 2:1 staffing. During the night shift, Resident A's 1:1 staff sits in a chair outside of her door while she is sleeping. Resident B's 2:1 staff will sit at the dining room table, approximately fifteen feet from her bedroom, while she is sleeping.

Ms. Ramsey stated she believes they have sufficient staff at the home, because they have strong staff. She explained that there are always three staff members on duty. She also shared that Resident B would drop from 2:1 staffing 24 hours per day to 2:1 staffing for 16 hours per day.

On 07/02/2026, I completed an in-person interview with direct care staff member, Kizzie Parker. Ms. Parker stated it is not true that they are understaffed. She stated there are always four staff members on duty when she is working. She does not believe the aggression directed toward Resident A by Resident B is unsafe, as they are “fighting like sisters.” She stated it has been a few months since the police have been called, but then she clarified that it has been a few months since they were called during her shift. She confirmed what Ms. Avery stated, indicating that staff sit outside Resident A's bedroom and at the dining room table, in eyesight of Resident B's bedroom. Staff do not sit in the bedrooms of the residents during the night.

On 07/02/2026, I completed a second in-person interview with direct care staff member, Porasche Thomas. Ms. Thomas stated there are three staff members working during the day now and she thinks there might be three working at night. She does not work nights. She feels there is sufficient staffing. She has never witnessed any of the fights between Resident A and Resident B. She stated Resident A sleeps in her bedroom, with the door open, and her 1:1 staff sits in a chair in the hallway. She believes that Resident C could probably use a 1:1 staff as well.

On 07/02/2026, I completed a second private, in person interview with Resident A. She stated that she does not like where she lives and is about to move. She feels the home is overwhelming, due to the issues with Resident B. She stated there were three or four staff members on duty yesterday. She stated there are days when there are fewer than four staff members and sometimes there are only two. She believes there is sufficient staff when there are at least three. I asked her about the day she hurt herself. She stated she was outside, with staff, and ventured away from them. She found a piece of glass and cut herself with it when she was in her bedroom, with the door partially closed, while her 1:1 was in the activity room. She saw them walking up and down the hall every so often to check on her. She shared that Resident B will frequently get out of her bed in the middle of the night and bang on her door, swearing at her. The last time this happened was just the other day and staff tried redirecting her.

On 07/02/2026, I completed a private, in person interview with Resident C. She feels safe in the home and has never felt unsafe. She shared that it is sometimes hard for the staff to give everyone attention. Last night, she believed there were two staff working the night shift. When everyone is awake and home, there are usually three staff, but

today there were four. She stated that sometimes there are only two staff members. She stated Resident B will bang on their doors around 2am, almost every night. When she is in crisis, either one of Resident B's 2:1 staff will stay with her, or Resident A's 1:1 staff. She does not think that three staff members would be sufficient if they were all in crisis.

At the time of the onsite investigation, there were three residents in the home and four staff members. Resident B would not participate in an interview.

On 07/06/2026, I completed a telephone interview with Alejandra Price, case manager for Resident B and Resident C through Easter Seals. Ms. Price has been assigned to both residents since 04/23/2026. Resident B has had a 2:1 staff ratio since she began working with her. Ms. Price stated Resident C often finds things on the ground or will try to run into traffic to cause self-harm. Resident B is always having law enforcement called on her due to her being aggressive toward staff and other residents. She is there two to three times per month and she schedules her visits. She usually sees three to four staff members while she is at the home. She stated Resident B should always have two staff members with her, and she should always be in eyesight of them. When asked if it is safe for one staff member to sit at the dining room table and watch Resident B's door, she stated that they should both be closer. Resident C should always be in eyesight and requires 60-minute checks, around the clock, per her behavior plan. Resident B has not yet started her "fade plan", but there were issues with getting her approved again for 2:1 staffing for 24 hours. Resident B now has 1:1staffing from 11pm-4am, since 06/18/2026.

On 07/06/2026, I completed a telephone interview with direct care staff member, DCW 1. DCW 1 is no longer working in the home and requested to keep her information confidential as a condition for her interview. She worked at Sandy Lane for approximately eight months and recently quit. When she left, which was approximately two months ago, there were usually two to three staff on shift during the day and at night, but she stated there were usually just two staff. They had trouble finding people to cover shifts, so they would say it was okay to have two staff on shift. She never saw more than three people working on a shift, and she did not feel they had sufficient staffing. DCW 1 and other staff members would speak up about their concerns to the licensee designee, and their concerns would be shot down. She stated when anyone had to call 911 for anything, they would contact Plum Hollow staff to come to the home so it would look like they were fully staffed, as it was only a few miles away. They would do the same thing if they knew any case managers or recipient rights specialists were coming to the home. She was not working when the incident happened between Resident A and Resident B, but she stated that if the 2:1 and 1:1 staff were doing what they were supposed to be doing, it would not have happened. Most nights, between 2am and 5am, Resident B would leave her room and wake up the whole house, then she would try to leave. Staff members did not sit inside Resident B's bedroom, nor did they sit inside Resident A's room. She stated they were told that when Resident A was sleeping, they did not have to sit outside her door and could just do hourly checks on her.

On 07/07/2026, I completed a telephone interview with Resident B's public guardian, Guardian B1. Guardian B1 has been overseeing Resident B since 2023 and admitted “she is a lot.” She stated Resident B has a risk of harm to herself and others. She stated Resident B was institutionalized before and probably should be now. She stated she believes Ms. Freeman-McDonald is a saint in her eyes. She had a difficult time finding placement for Resident B due to her behaviors. Resident B has caused damage to the home, including tearing off doors and throwing a brand-new microwave oven to the ground. Ms. Freeman-McDonald did not charge her for the damage. Resident B has assaulted staff members and Ms. Freeman-McDonald has had trouble maintaining staff due to the assaults. Resident B will call staff names and will spit in their faces one minute, then they will be doing her hair and nails later. She stated it has been a battle keeping Oakland Community Health Network from discontinuing Resident B's enhanced staffing. She stated Resident B has 2:1 staffing and that at least one of the staff should be right there with Resident B, while the other should be used as backup, then they should switch up when Resident B becomes too much. No one else would work with Resident B and she was able to get Ms. Freeman-McDonald to keep her. She stated that Ms. Freeman-McDonald is “the sweetest, most understanding, and caring woman” for the way she cares for Resident B and the staff are “all angels” for treating Resident B the way they do.

I received and reviewed an incident report dated 06/01/26, completed by direct care staff member, Yolanda Gipson. It indicates the following:

> "Upon staff arrival, (Resident A) was standing with staff when a housemate approached and began talking about an earlier outing. The housemate began pointing at (Resident A), calling her names, and getting in her face. (Resident A) told the housemate to remove her hand from her face. The housemate then struck (Resident A), and a physical altercation occurred between the two individuals. Staff intervened and separated them. (Resident A) and another resident were taken outside to de-escalate while staff remained inside with the housemate until police arrived. (Resident A) later went to urgent care for scratches she received to her right cheek during the altercation."

I received and reviewed an incident report dated 06/02/26, completed by direct care staff member, Vanisha Holt. The incident report indicates the time of the incident as 2:15pm. The incident report states the following:

> "During an hourly check, staff observed (Resident A) in the bathroom. After she returned to her room, staff noticed her bedroom door was closed and instructed her to open it. Once the door was opened, staff observed (Resident A) sitting on the bed with her hands behind her back. Staff noticed blood on the bedding and observed a bleeding injury to (Resident A's) arm. Staff immediately requested the object used, notified management, and confiscated the item. When asked why she engaged in self-harm, (Resident A) stated she did not know and reported obtaining the object

during a walk the previous day. EMS was contacted and (Resident A) was transported for further evaluation.

(Resident A's) guardian was notified of the incident. Staff informed the guardian that (Resident A) had been expressing thoughts of self-harm and stating that she did not want to live. The guardian reported being aware of these statements after seeing similar comments posted by (Resident A) on social media."

On 07/08/2026, I sent a follow-up email to Adult Protective Services investigator, Carmen Smith, requesting an update. She emailed back, letting me know that her investigation regarding the guardian is closing and that the referral made due to the concerns in the home was not assigned for investigation.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	Based upon the evidence obtained during the special investigation, there is sufficient information to support that the staffing is not sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service. There are three residents receiving care at Sandy Lane. Resident A requires 1:1 staffing, Resident B requires 2:1 staffing, and Resident C does not have any enhanced staffing. According to their individual plans of service, Resident A is to have a direct care staff member within arm's reach 24 hours per day, and Resident B requires two direct care staff members with her 24 hours per day. Based upon that information, there should be at least four direct care staff members on duty when all three residents are present in the home. When I conducted my unannounced onsite investigation on 06/15/2026, there were two staff members in the home. Resident A and B were both present, so there should have been three staff on shift. A review of the staff schedules and timesheets showed several shifts that were not staffed appropriately based on the supervision needs of the residents. Some of the shifts had only two staff scheduled, especially for the night shift. In addition, Resident B's community health specialist from CNS went to the home and observed three direct care staff members

	with all three residents on 06/26/2026. During an unannounced visit, Resident A's guardian observed Resident A and Resident C in the home, with one staff member. The staff and residents who were interviewed also stated that there are times when there are only two or three staff on shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) 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 upon the information obtained during the special investigation, there is sufficient evidence to conclude that Sandy Lane did not provide supervision and protection as specified in each resident's assessment plan. There have been many reported incidents with Resident A and Resident B, including a physical altercation. Resident A and Resident C are both awakened regularly by Resident B during the middle of the night. Resident A is supposed to have 1:1 staffing within arm's reach of her 24 hours per day; however, staff stated they sit outside her bedroom door at night, and some staff stated they were instructed to only do hourly checks while she is asleep. Resident A was able to find a piece of glass while on a walk, put it in her pocket, then used it to harm herself. Direct care staff members only became aware of this after completing an hourly check, indicating they were not within arms' reach of Resident A. On 06/01/2026, Resident A and Resident B engaged in a verbal altercation that became physical and Resident A was injured. Resident B is supposed to have 2:1 staffing 24 hours per day; however, the direct care staff members sit in another room during the night and watch her door, they are not face-to-face with her, as instructed by her individual plan of service.

	The police have been called to the home thirteen times since January 2026 due to Resident B assaulting staff and other residents, Resident C reporting suicidal ideation and running into 12 Mile Road, and Resident A harming herself.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/26/2026, I completed a search on the Michigan Workforce Background check website for Sandy Lane Home, to find a phone number for direct care worker, Yolanda Gipson. Yolanda Gipson is not listed under the home as having had a completed background check. I also observed that, according to the website, there are no active employees listed for Sandy Lane, as having fingerprints completed through the Workforce Background Check System.

On 07/13/2026, I completed a search on the Workforce Background Check website for the specific employees who worked during the month of June. The following employees had background checks completed under the Plum Hollow Home, but not Sandy Lane Home:

Porasche Thomas, Lakieta Spear, Geraldine Steele, DeShonne Reeves, Shaneka Ramsey, Osheka Ramsey, Marla Pulliam, Kizzie Parker, Tracey McLemore, Carmela LeFlore, Ethel Johnson-Nwachu, Shawna Johnson, Yolanda Gipson, Chantell Daniels, and Taylor Avery.

There was no record of a background check completed in the Michigan Workforce Background Check System for staff Ashley Andrews and DaShaun McLaughlin.

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 obtained during the special investigation, there is sufficient evidence to conclude that Sandy Lane did not complete background checks for their employees. I completed a search of the Michigan Workforce Background Check website and there were no active eligible direct care staff members listed on their page. When I looked up each individual direct care staff member, 15 of the 17 staff members had background checks completed under Plum Hollow Home, and two had no completed background checks in the Michigan Workforce Background Check System.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/18/2026, per my request, Ms. Freeman-McDonald provided a copy of the staff schedule for Sandy Lane Home. The schedule was difficult to read. The schedule had the initials of who was working the shifts, but no names and no titles. There are shifts listed, but when they were compared to the actual timesheets received on 07/10/2026, multiple discrepancies were discovered.

06/15: The timecards indicate there was one direct care staff member from 8am-11am, then two direct care staff members from 11am-7pm, three staff from 7pm-9pm, and two staff from 09:30pm-7am. The schedule provided by Ms. Freeman-McDonald indicates there were two staff scheduled from 7am-3pm, then a 1:1 staff at 9am (end time not specified on schedule), two staff from 3pm-11pm, and two staff from 11pm-7am.

06/16/2026: The timecards indicate two staff from 8am-9am, three staff from 9am-1:30pm, four staff from 2pm-3m, three staff from 3:30pm-6:30pm, two staff from 7pm-7am. The schedule provided indicates there were two staff scheduled from 7am-3pm, then a 1:1 staff at 9am (end time not specified on schedule), two staff from 3pm-11pm, and two staff from 11pm-7am.

06/17/2026: The timecards indicate two staff from 8am-9am, two staff from 9am-3pm, 4 staff from 3pm-7pm, three staff from 7pm-9pm, one staff from 9pm-7am. The schedule indicates there were two staff scheduled from 7am-3pm, then a 1:1 staff at 9am (end time not specified on schedule), two staff from 3pm-11pm, and two staff from 11pm-7am.

06/18/2026: The timecard indicates three staff from 7am-8am, two staff from 8am-3pm, three staff from 3pm-6pm, four staff from 6pm-7pm, three staff from 7pm-11pm, three staff from 11pm-7am. The schedule indicates two staff scheduled from 7am-3pm, then a 1:1 staff at 9am (end time not specified on schedule), two staff from 3pm-11pm, and two staff from 11pm-7am.

06/19/2026: The timecard indicates four staff from 8am-9am, three staff from 9am-3:30pm, four staff from 3:30pm-6:30pm, three staff from 7pm-7:30pm, four staff from 8pm-11pm, and 3 staff from 11pm-7am. The schedule indicates there were two staff scheduled from 7am-3pm, then a 1:1 staff at 9am (end time not specified on schedule), two staff from 3pm-11am, and one staff from 11pm-7am.

On 07/15/2026, I completed an exit conference via telephone, with the licensee designee, Ronda Freeman McDonald. The findings were discussed. Ms. Freeman McDonald shared that it has been difficult maintaining staff due to some of the behaviors from the residents. She stated Resident A has been discharged and she is hoping that will help make things more calm at the home, as most of the issues were between Resident A and Resident B. Ms. Freeman McDonald appeared sincere in her desire to correct the violations and provide the best care to the residents in the home.

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 information gathered during the special investigation, there is enough evidence to conclude that the schedule kept did not include the names of staff on duty, job titles, or scheduling changes, when made. The schedule that was provided to me by Ms. Freeman McDonald was difficult to decipher, when I asked for the time sheets, the information differed, from the actual schedule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

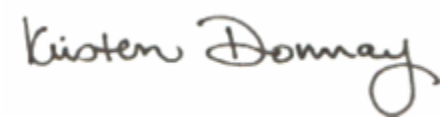
Upon receipt of an approved corrective action plan, I recommend no changes to the status of the license.

07/16/2026

_____

Sara Shaughnessy Date
Licensing Consultant

Approved By:



WOC Area Manager for 07/16/2026

_____

Denise Y. Nunn Date
Area Manager