GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
MANAGER

August 13, 2026

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

RE: License #: AS630419995
Investigation #: 2026A0629002
Abound Rehabilitation Services - Almond Lane

Dear David 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 (248) 972-9136.

Sincerely,

Kellie Garner, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3044 West Grand Boulevard
2nd Floor Annex, Suite 2-730
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630419995
Investigation #:	2026A0629002
Complaint Receipt Date:	07/01/2026
Investigation Initiation Date:	07/01/2026
Report Due Date:	08/30/2026
Licensee Name:	Abound Rehabilitation Services, INC.
Licensee Address:	1221 E. Lincoln Ave. Royal Oak, MI 48067
Licensee Telephone #:	(313) 676-0013
Licensee Designee/ Administrator:	David Ellis Sr
Name of Facility:	Abound Rehabilitation Services - Almond Lane
Facility Address:	6443 Almond Lane Clarkston, MI 48346
Facility Telephone #:	(248) 232-3276
Original Issuance Date:	04/07/2026
License Status:	TEMPORARY
Effective Date:	04/07/2026
Expiration Date:	10/06/2026
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents at Abound Rehabilitation Services- Almond Lane are being neglected, as evidenced by repeated falls, lack of safety precautions to prevent falls, significant weight loss, and poor hygiene**.**	No
On 07/04/26, staff forced Resident C and Resident D into the car, causing scratches and bruising on Resident C, and made the residents go to a party where drugs and alcohol were being used. Staff left the residents in the car while attending the party.	Yes
The team lead, Cherrell Hogan, often sends Resident C to her bedroom and makes her stay in her bedroom all day. Ms. Hogan does not allow Resident C to go in the refrigerator. She “went off” on Resident C for retrieving milk from the refrigerator.	No
Additional Findings	Yes

III. METHODOLOGY

07/01/2026	Special Investigation Intake 2026A0629002
07/01/2026	Special Investigation Initiated - Face to Face I initiated my special investigation by conducting an unannounced on-site investigation at Abound Rehabilitation Services. I completed an interview with direct care staff, Markita Nelson and observed Resident A, Resident B, and Resident C.
07/01/2026	APS Referral Received from Adult Protectives Services (APS)- denied for investigation.
07/01/2026	Contact - Document Sent I forwarded this complaint to Office of Recipient Rights (ORR), specialist, Sarah Rupkus.
07/01/2026	Contact - Document Received I received an email from ORR specialist, Sarah Rupkus. Sarah stated that no ORR investigation will be opened at this time.
07/06/2026	Contact - Document Received

	Intake #: 211378 was received from APS with additional allegations. It was dismissed and added to this investigation.
07/06/2026	Contact - Telephone call made Call to Adult Protective Services (APS), worker, Precious Whitman and ORR specialist, Sarah Rupkus
07/07/2026	Contact - Face to Face I completed a private in-person interview at Resident C's new placement.
07/13/2026	Contact - Telephone call made I made a telephone call to former Almond Lane, house lead, Cherrell Hogan.
07/13/2026	Contact - Telephone call made I made a telephone call to direct care staff, Michelle Fuller.
07/13/2026	Contact - Telephone call made I made a telephone call to direct care staff, Stephany Diaz
07/14/2026	Contact - Telephone call received I received a return telephone call from direct care staff, Stephany Diaz.
07/16/2026	Contact - Telephone call made I made a telephone call to regional manager, Rielle Randle.
07/16/2026	Contact - Document Received I received email from Rielle Randle.
07/18/2026	Contact - Document Received I received email from regional manager, Rielle Randle
07/22/2026	Contact - Telephone call made I made a telephone call to the Oakland County Sheriff's Department.
07/22/2026	Contact - Telephone call made I made a telephone call to direct care staff, Markita Nelson
07/23/2026	Contact - Telephone call made I made a telephone call to Resident A's guardian, Guardian A1
07/28/2026	Contact - Telephone call made I made a telephone call to Resident D's guardian, Guardian D1

07/28/2026	Contact - Telephone call made I made a telephone call to Resident C's guardian, Guardian C1
07/28/2026	Contact - Document Sent I sent an email to ORR specialist, Sarah Rupkus and APS worker, Precious Whitman.
07/28/2026	Contact- Telephone call made I made a telephone call to current house lead, Cardijah Stitt
07/28/2026	Contact- Document Received I received an email from house lead, Cardijah Stitt
08/05/2026	Contact - Telephone call made I made a telephone call to ORR specialist, Sarah Rupkus
08/05/2026	Contact - Telephone call made I made a telephone call to case manager, Amanda Santos
08/06/2026	Contact - Telephone call received I received a telephone call from case manager, Amanda Santos
08/07/2026	Contact- Document Received Email from Abound Rehabilitation administrator for technical assistance re: medication disposal
08/11/2026	Contact - Telephone call made I made a telephone call to licensee designee, David Ellis Sr.- phone not in service
08/11/2026	Exit Conference Conducted exit conference with incoming licensee designee, Rielle Randle

ALLEGATION:

Residents at Abound Rehabilitation Services- Almond Lane are being neglected, as evidenced by repeated falls, lack of safety precautions to prevent falls, significant weight loss, and poor hygiene.

INVESTIGATION:

On 07/01/26, I received a complaint alleging that the residents at the Almond Lane home are being neglected. The complaint stated that one of the residents in the home fell twice and lost a significant amount of weight in a month's time. This resident will lose weight quickly if she is not being fed well. Another resident fell out of bed once and was bumped or pushed over by another resident on another occasion. The resident does not wear her non-slip socks at all times. There are no safety precautions to prevent residents from falling out of bed. The complaint further stated that one resident's teeth are rotting and her hygiene is not being addressed. It also stated that the home smells like urine. I initiated this complaint by conducting an unscheduled on-site visit at the home on 07/01/26. During this visit, I observed Resident A, Resident B, and Resident D. The residents are nonverbal and were observed to be clean and free of injuries. The home was clean and free of any clutter or any obstructed walkways. The home did not have an abnormal odor or urine odor.

On 07/01/26, I interviewed direct care staff, Markita Nelson. Ms. Nelson said that she has not observed any residents fall out of bed or anywhere else. Ms. Nelson stated that she did not have knowledge of any resident falling while in the care and supervision of any other staff on other shifts. She denied any knowledge of residents having dental concerns. I asked to review incident reports for the past 60 days. Ms. Nelson could not locate any incident reports.

During the on-site visit on 07/01/26, I spoke with house lead, Cherrell Hogan, by telephone. Ms. Hogan denied any knowledge of any resident falling out of bed or anywhere else. Ms. Hogan said that if there are no incident reports "in the book," then there are no incident reports.

On 07/23/26, I made a telephone call to Resident A's guardian, Guardian A1. Guardian A1 stated that she recently had ongoing concerns about the care of Resident A in this AFC. Guardian A1 stated that Resident A was placed in this home in December 2024. She stated things were going well for a while, but since new management and staff transitioned into the home a few months ago, she has been uncomfortable with the level of care Resident A has been receiving.

Guardian A1 stated that she made a report regarding Resident A's weight loss and a mark on Resident A's shoulder that she said appeared to be a carpet burn that she observed to be in the latter stages of healing. Guardian A1 stated that she believes Resident A may have been dragged across carpet but could not confirm this. She stated that she spoke to staff Stephany and regional manager, Rielle Randle, about this without any follow-up or documentation of the incident on file. Guardian A1 stated that she was informed by staff that on at least one occasion, Resident A was accidentally bumped into by another resident, causing Resident A to fall to the ground.

On 08/05/26, I made a telephone call to ORR specialist, Sarah Rupkus. Ms. Rupkus reviewed the individual plans of service (IPOS) and crisis plans for Resident A, Resident B, Resident C, and Resident D. She stated that there are currently no occupational safeguards required for Resident A or the other residents currently placed at Abound Rehabilitation Services - Almond Lane. Resident A's crisis plan indicates that staff should be within arm's length of Resident A while in the community and within hearing distance in the home. Additionally, the crisis plan indicates that staff should make visual checks every 15 minutes of Resident A when not in the same room. Ms. Rupkus stated that Resident A's most recent physical exam was completed in February 2026. The physician documented a low Body Mass Index (BMI) during that visit and addressed it by adding Ensure to Resident A's diet. No dental concerns were noted in the IPOS. Ms. Rupkus advised me of a current contact/case note from the case manager, Amanda Santos, that indicated she visited Resident A while she was in the care and supervision of Guardian A1. The case note indicated Guardian A1 advised case manager Amanda Santos that Resident A fell while at the day program and lost several teeth.

I made a telephone call to case manager, Amanda Santos on 08/05/26. She stated that the IPOS plans for the residents do not indicate any need for nonslip socks or fall-risk precautions. The case manager also confirmed that none of the residents have bed rails in their plans and stated that Resident B uses a walker safely with no concerns. Ms. Santos stated that last week Guardian A1 informed her that Resident A received a carpet burn while in the facility's care, but no date or further details were provided. Ms. Santos stated that when she contacted the facility regarding the reported fall, staff said that Guardian A1 mentioned the incident, but no report or other information existed to support the claim. Ms. Santos stated that the home has had five different managers within the past month, resulting in inconsistent documentation and a lack of stability.

I received and reviewed the IPOS and crisis plans for Resident A, Resident B, Resident C, and Resident D. There were no indications of a fall risk for Resident A, Resident C, or Resident D. Resident B uses a walker. All other plans indicated that residents are fully ambulatory, and no bed rails were indicated for use.

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 on the information gathered during my investigation, there is insufficient information to support that the residents were neglected and their personal care needs were not met. An unscheduled on-site visit was completed on 07/01/26. Resident A, Resident B, and Resident D were observed to be clean, free of injuries, and living in a clean home with no urine odor or safety hazards. Staff and the house lead had no knowledge of falls, dental issues, or other incidents, and no incident reports were available. Guardian A1 shared concerns about Resident A's weight loss and a possible carpet burn; however, there were no dates, documentation, or confirmed details provided. The case manager later confirmed that required safety precautions such as nonslip socks or bed rails are not part of any resident's IPOS; however, a walker is included in the plan for Resident B. The case manager stated that Resident B uses the walker safely without concern. The case manager stated that Guardian A1 reported Resident A fell and lost teeth, but this occurred at the day program, not in the AFC home. The ORR specialist confirmed there are no required safeguards for any resident, that Resident A's weight was addressed by her physician, and that no dental concerns were documented. Although staff turnover may have affected documentation, there is no direct or verified evidence supporting the allegations of neglect.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

On 07/04/26, staff forced Resident C and Resident D into the car, causing scratches and bruising on Resident C, and made the residents go to a party where drugs and alcohol were being used. Staff left the residents in the car while attending the party.

INVESTIGATION:

On 07/06/26, I received additional allegations from Adult Protective Services (APS), which were added to this investigation. The complaint stated that on 07/04/26, the team lead, Cherrell Hogan, forced Resident C and Resident D to attend a party at a family member's home in Detroit. Resident C and Resident D did not want to attend the party. As a result, Ms. Hogan grabbed Resident C, forced her into the car, and

strangled her. Resident C sustained bruises to her right arm, as well as scratches on her left arm and chest, which were caused by Ms. Hogan. Resident C and Resident D did not want to get out of the car when they arrived at the party, where people were smoking marijuana and using alcohol, so Ms. Hogan left them unattended in the car with no air conditioning. The residents were eventually picked up from the party by the Almond Lane home manager and were taken back to the home. The complaint was assigned to ORR specialist, Sarah Rupkus, and APS worker, Precious Whitman, for investigation.

On 07/07/26, I conducted a private interview with Resident C at her new placement. APS worker, Precious Whitman, and ORR specialist, Sarah Rupkus, were present and participated in interviewing Resident C. Resident C said that she never wants to go back to her last home (Abound Rehabilitation Services – Almond Lane). She said that she was hurt by a staff there. Resident C said that a staff who was not supposed to be at the Almond Lane home made her and Resident D leave in a car with her. Resident C said the staff forced her into the car by grabbing her right wrist and scratched her chest, physically forcing her to get into the car. Resident C said the “owner of the house,” and another lady, “did this to her.” Resident C denied that Resident D was grabbed or dragged into the car. Resident C said a woman driver and a male child passenger were in the front seat of the car. Resident C referred to the child as the lady’s grandson. Resident C said that while she and Resident D were in the backseat of the staff’s car, she snatched the hair scarf off the woman’s head as she drove. Resident C continued recalling the allegations saying that the staff closed all the windows in the car and made her suffocate. Resident C said that she tried to run away from the staff. The driver was driving really fast and was smoking “pot” and “drinking wine and beer.” Resident C said they got to the party and more people were smoking “pot.” She said she stayed in the car for a while and then got out. Resident C insisted that the driver was a stranger who did not work at Almond Lane. She was not supposed to be there and did not want Resident C to tell anyone. She said the lady had dark short hair. She was unable to describe anything else about the person who grabbed, scratched, and took her and Resident D to the party at the park in Detroit on 07/04/26. Resident C said that the staff eventually took her and Resident D to a gas station where another staff who she referred to as a “new staff,” met them to pick up her and Resident D to transport them back home to Almond Lane. Resident C stated that she told direct care staff Stephany all the things that happened to her on Saturday, 07/04/26. Resident C confirmed that Resident D was not harmed or mistreated on that date.

On 07/07/26, I conducted an unscheduled visit at Abound Rehabilitation Services - Almond Lane with the assigned APS worker, Precious Whitman, and the assigned ORR worker, Sarah Rupkus.

On 07/07/26, I interviewed direct care staff, Cardijah Stitts. Ms. Stitts stated that she is the new house lead at Almond Lane as of 07/04/26. Ms. Stitts stated that she previously worked as a direct care staff at another home for the agency. She is taking over for previous house lead, Cherrell Hogan, who was removed from the

schedule. Ms. Stitts said she was scheduled to start as the house lead on 07/06/26, but she was asked by the regional manager, Rielle Randle, to start on 07/04/26 instead.

Ms. Stitts stated that she received a telephone call from Rielle Randle on the afternoon of 07/04/26 asking if she could help at Almond Lane. Ms. Randle asked her to get there as soon as she could. Ms. Stitts arrived at the Almond Lane Home between 6-7pm on the evening of 07/04/26. There were no residents or staff there when she arrived. About an hour or so later, the regional manager, Rielle Randle, and a staff and resident from another home, arrived at Almond Lane bringing Resident C and Resident D back home. Ms. Stitts said Rielle Randle stayed there showing her how to manage the home and where essentials and other necessary information was located, as this was her first day in a leadership role in the home. Ms. Stitts said she picked up one or two shifts at this home in the past but was new to leadership here. Ms. Stitts said that Ms. Randle and the two people with her left.

Ms. Stitts said that she gave Resident D a shower. There were no concerns. When settling in for the evening, she passed medications and checked Resident C's glucose. She said that it read 302. Resident C told her that she drank pop that day while she was at a party. Ms. Stitts stated that Resident C also told her that staff injured her by dragging her, grabbing her, and forcing her into the car because she did not want to go with them. Ms. Stitts said that she saw a bruise and scratch marks on Resident C. Resident C did not name the staff who forcefully made her get into the car and injured her, but Resident C described the staff. Based on the staff Resident C described, Ms. Stitts believes that it was the previous house lead, Cherrell Hogan.

Ms. Stitts stated that on 07/05/26, direct care staff, Stephany, came into work for day shift. Resident C told Stephany what happened on 07/04/26. Ms. Stitts stated that Stephany informed her that Resident D's guardian came to the home later that day to visit Resident D. Resident C told Guardian D1 what happened to her and Resident D on 07/04/26. Stephany told Ms. Stitts that the guardian was upset and wanted to speak to the house lead, Cherrell Hogan, who was alleged to be the person responsible. According to Stephany, Resident D's guardian and staff, Cherrell, had an escalated telephone conversation to the point where Guardian D1 called the police to advise of the complaint. The police came to the Almond Lane home in response to Guardian D1's call. The police took a report and conducted a welfare check. Ms. Stitts said that Stephany completed two incident reports to document the report made by Resident C and the police contact.

On 07/13/26, I interviewed the Almond Lane house lead, Cherrell Hogan, via telephone. Ms. Hogan stated on 07/04/26 she received a call from direct care staff, Michelle Fuller. Ms. Fuller worked the night shift at Almond Lane on Friday, 07/03/26, and was scheduled to get off work at 8am on 07/04/26. Ms. Hogan stated that staff, Michelle, began calling her because she did not see staff, Markita or Stephany, respond to the messages in the staff group chat confirming that they were

coming in on 07/04/26 to cover their 12-hour weekend shifts. Ms. Hogan stated that Stephany has had recent no call/no shows from work, and Michelle was concerned that no one would come to work to relieve her. Ms. Hogan stated that she creates the staff schedule and as house lead she does not work weekends. When Michelle began calling her with concerns of not getting off on time, and the other staff on schedule still had not confirmed that they were coming in for their shift, Ms. Hogan called regional manager, Rielle Randle, letting her know about the concern. Ms. Hogan said that she knew that it was near time for the residents to receive their 9am medications. Michelle is not authorized to pass medications, so Ms. Hogan went to the home to help. Ms. Hogan said that she had plans for the day, as did direct care staff, Michelle. Ms. Hogan stated that there were two residents at home, Resident C and Resident D. She said that she and Michelle planned to each take a resident with them for the day, due to no other staff coming into work as scheduled. Ms. Hogan stated that Resident C was verbally assaultive towards her and did not want to go with her. Resident C called her derogatory names and was becoming increasingly more aggressive. Ms. Hogan stated that Resident C was informed on Thursday, 07/02/26, that she was going to a new placement on 07/06/26. Ever since Resident C learned of her new pending placement, Resident C was being very rude to her and the other staff. She said that Resident C refused to get in the car when it was time to leave for the day. Ms. Hogan said Resident C went back inside the home. Ms. Hogan stated that she talked with Michelle, and they decided it was best that she left and that Michelle would keep both Resident C and Resident D with her for the day. Ms. Hogan said her fiancé was in the car during her visit to the home. Ms. Hogan said that she is pregnant and was not going to deal with Resident C and this behavior for the day, so she and her fiancé left.

Ms. Hogan stated that after she left, she called Ms. Randle and let her know what was going on. Shortly after leaving, she received a call from Michelle telling her that Resident D got in the car to leave without a problem and that she was finally able to get Resident C in the car. Ms. Hogan stated that she and Michelle were at separate events, but they kept in contact throughout the day. Ms. Hogan said she was on the telephone with Michelle, and she heard Resident C screaming in the background, telling strangers at the park that Michelle kidnapped her. Ms. Hogan said she heard Michelle explaining to someone that she is Resident C’s caregiver. Ms. Hogan stated that she spoke with the regional manager, Rielle Randle, several times throughout the day. Ms. Hogan said that Ms. Randle was making a plan to get the residents from Michelle and transport them back to the home. Ms. Hogan said that after she left the home that morning around 10:00-10:15am, she did not have any contact with the residents. On 07/05/26, she received a telephone call from Guardian D1 making threats to her and threatening to call the police. She said that the two had a verbal altercation and she hung up on Guardian D1 due to his vulgar language towards her. Ms. Hogan acknowledged that she and staff, Michelle Fuller, are friends outside of work.

On 07/13/26, I made a telephone call to direct care staff, Michelle Fuller. Ms. Fuller stated that she was scheduled to get off work the morning of 07/04/26, but she could

not confirm anyone was coming in for their shift that day to relieve her. She contacted house lead, Cherrell, who came to the home to pass morning medication to Resident C and Resident D. Ms. Fuller said that she needed to end her shift, as she had plans for the Fourth of July holiday. Ms. Fuller said that she and Cherell developed a plan to separate the residents for the day, each of them would take one resident with them. Michelle said Resident C was very agitated and did not want to go with Cherrell. Resident C was scratching and assaultive towards Cherrell, who was pregnant. She said Cherrell asked her to take both residents with her and left the home. Ms. Fuller said Resident D was fine going out for the day; however, Resident C did not want to leave and went back into the house. Ms. Fuller said she went into the house and encouraged Resident C to get in the car to leave for the day. Ms. Fuller encouraged Resident C to get in the car by telling her that she would get her hair cut soon and that there would be lots of food, chips and pop at the party in the park. Ms. Fuller said that Resident C and Resident D got in the car. While the residents were in the backseat of the car, Ms. Fuller said that Resident C became agitated and attacked Resident D, who eventually struck her back. Ms. Fuller said that she tried to calm Resident C down, but she could not do much because she was driving. Ms. Fuller said Resident C attacked her and snatched her bonnet off her head as she drove. Ms. Fuller stated that she has video of Resident C being aggressive with Resident D in the car.

Ms. Fuller said they arrived at the park where there were hundreds of people having holiday activities. The residents got out of the car and willingly helped her bring groceries to the table where she and her family were sitting. Ms. Fuller stated that her grandson was at the park along with many other friends and family. She denied that he was in the car with them. Ms. Fuller also denied that she was smoking marijuana or drinking alcohol while caring for Resident C and Resident D. She said this family event was at Chandler Park in Detroit. There were other people drinking alcoholic beverages and smoking marijuana at the park, but she denied that she or anyone in her party were doing so. Ms. Fuller said both residents ate and drank as much food, beverages, and snacks as they wanted. She denied that Resident C or Resident D were ever left in the car unsupervised without air with the windows closed. Ms. Fuller stated that she was in contact with Ms. Randle and Cherrell throughout the day while she was at the park. Ms. Randle did not answer her calls as frequently, but Cherrell stayed in constant contact with her. Cherrell let her know that Ms. Randle had arranged to meet her at a nearby gas station to take the residents from her care and transport them back to the Almond Lane home. Ms. Fuller said that sometime between 7-8 pm on 07/04/26, she met Ms. Randle at the gas station so the residents could be transported back home.

On 07/14/26, I interviewed direct care staff, Stephany Diaz, via telephone. Ms. Diaz stated that on 07/05/26 at approximately 7:40 AM, she arrived at work and learned of the allegations involving Resident C and Resident D. Resident C immediately came to her, showed her injuries, and asked her to call 911. Ms. Diaz asked Resident C to calm down and explain what happened. Resident C told Ms. Diaz that two staff members, whose names Resident C did not know, took Resident C to

Detroit for a party where drugs and alcohol were present. Resident C said she did not want to go and described the staff as “a stranger with a bun” and another who was “a redhead and pregnant.” Resident C stated that she was forced into the car, and that the red haired, pregnant staff member attempted to choke her twice. Resident C also said she was locked in the car, denied water, and given pop despite not wanting it. Ms. Diaz stated that Resident C told her that a new staff person later picked Resident C and Resident D up from a gas station and brought them back to the home. Resident C told her that she reported the incident and showed her injuries to the new staff who picked them up from the gas station. The new staff member was later identified as regional manager, Rielle Randle. Ms. Diaz stated that the staff described by Resident C matched staff, Sosha and Cherrell Hogan, whom she said are close friends with each other. She added that Sosha is ineligible to work in a licensed AFC due to her background check. Ms. Diaz stated she did not observe injuries on Resident D.

On 07/16/26, I interviewed regional manager, Rielle Randle, via telephone. She stated that she does not work in the home with residents and staff. On the morning of 07/04/26 she received a call from Cherrell Hogan, stating that the scheduled staff were not coming in for their shift on that date. Ms. Randle stated that Cherrell informed her that she was going to the home to pass morning medications to the residents. Ms. Randle told Cherrell that she needed to make a schedule and find staff to cover the shifts for the day. Ms. Randle said that Cherrell called her from the home and said, “We are just going to take them with us.” Ms. Randle stated that she believed, “us” referred to staff Cherrell and Michelle. Ms. Randle received calls and text messages throughout the day from Michelle and Cherrell. She stated they were following the chain of command, and Michelle would contact house lead, Cherrell, who would then contact her as needed. The contacts were regarding the next steps for getting the residents picked up to go back home. Ms. Randle stated that she received a text message from Michelle that evening inquiring about when someone would relieve her from caring for the residents. She stated that she told Michelle she would meet her at a gas station near the park where they were and she would transport the residents back to the home. Ms. Randle met Michelle at 8 mile and John R. Ms. Randle stated that the residents got out of the car with Michelle. Resident C was anxious and exclaiming that they were here and were smoking weed, drinking, and speeding. Ms. Randle stated that Resident C kept repeating that “they are evil,” and used explicit words, saying that “they” hurt her arm and she never wants to see them again. Ms. Randle observed a faint scratch on Resident C’s arm. Ms. Randle got the residents in her car and took them home. When they arrived at the home, Resident C became anxious again, afraid staff would come to the home and harm her. Ms. Randle stated staff Cardijah was present at the home and helped to calm down Resident C. Once Resident C calmed down, she began recalling more details of the incident that occurred on 07/04/26. Resident C informed her that she was injured by staff and made to stay in a hot car. She said that Resident C did not want to go with the staff. Ms. Randle stated that she left Resident C and Resident D in staff Cardijah’s care for the evening.

Ms. Randle stated that the following morning, on 07/05/26, she received a call from Resident D's guardian advising her of the concerns he learned of from an unnamed person. She stated the guardian was frustrated from learning about the incident. The guardian had a confrontational phone call with Cherrell and called the police to come to the home. Following her call with Resident D's guardian on 07/05/26, Ms. Randle called staff Cardijah Stitts to inquire further about Resident C's well-being and to advise her that the police were coming to Almond Lane due to concerns reported by Resident D's guardian. Ms. Randle stated that she called Cherrell and asked her if she was aware of the severity of the complaint reported and that there were abuse allegations against her. Ms. Randle stated that Cherrell denied harming any residents and further stated that the residents were not in her care on 07/04/26. She only came to the house that morning to pass morning medications and left. Ms. Randle stated that she was under the impression that residents were in the care of Michelle and Cherrell on 07/04/26; however, Cherrell stated that she and Michelle were at separate activities during the day. They were not together during the day, and the residents were with Michelle. Ms. Randle stated that she did not know if staff, Michelle and Cherrell, were together. Ms. Randle said she picked up the residents from Michelle at the gas station and Cherrell was not with her. Ms. Randle stated that Cherrell provided a written statement regarding her account of the incident on 07/04/26. Ms. Randle called Michelle later that night on 07/04/26, and asked Michelle specifically what happened to Resident C. Michelle said she never did anything to Resident C, she only grabbed her arm so she would get in the car. Ms. Randle said that on 07/06/26, Michelle called her and gave another account of the incident. Ms. Randle said that Michelle then informed her that Resident C and Resident D were in the back seat of the car fighting. Ms. Randle stated that she completed an incident report regarding her involvement in the incident, picking up the residents at the gas station and transporting them home.

I received and reviewed Cherell Hogan's written statement. In summary, it indicated that on 07/04/26 two scheduled staff failed to show up for their shifts, leaving the home without coverage. Cherell Hogan went in on her day off to pass morning medications and, unable to find any staff to take over, she and Michelle Fuller decided to take Resident C and Resident D out for the day. Michelle took both residents to Chandler Park, while Cherrell managed her own prior commitments and continued trying to reach the regional manager and find coverage. Cherrell later wrote up the absent staff for repeated no-call/no-shows. The next morning, Guardian D1 called, accusing Cherrell of abusing a resident, which she denied, stating the residents were never in her care that day. She informed her regional manager, but on 07/06/26, she received a termination letter based on what she described were false accusations.

On 07/22/26, I contacted the Oakland County Sheriff's Department. I spoke with Detective Ashley regarding incident report #: 260152115 made by Resident D's guardian and incident report #: 260152935 made by Adult Protective Services. She stated that she and her partner, Detective Talierchio, are still in the process of investigating and are trying to make contact with their alleged suspect, Cherrell

Hogan. Detective Ashley stated that she and Detective Talierchio are doing separate reports but will be combining their investigations. She stated she cannot share the incident report until their investigation is completed but stated that the Independence Township Substation in Oakland County received an incident report stating that Resident C and Resident D were dragged into a vehicle by suspect Cherrell. She stated the reports indicated that Resident D did not sustain any injuries, but Resident C sustained a bruise on her arm.

On 07/22/26, I made a telephone call to direct care staff, Markita Nelson. She stated that she was unable to locate an incident report for the referring incident completed by regional manager, Rielle Randle.

On 07/28/26, I interviewed Guardian D1 via telephone. Guardian D1 stated that Resident D will remain at the Almond Lane home because the AFC home is under new ownership since the complaint. Guardian D1 referenced general concerns with Abound Rehabilitation Services, stating he was not pleased with the professionalism, care, and communication of staff and management. He stated that the previous licensee, Quality Living Services, provided care for Resident D for years and were great with Resident D. However, once Abound Rehabilitation Services took over the Almond Lane home in the past year, there were some concerns with the professionalism of regional manager, Rielle Randle. Although Ms. Randle picked up Resident C and Resident D from the gas station on 07/04/26, she claimed to have no knowledge of the incident. Guardian D1 also briefly discussed his telephone conversation with the former house lead, Cherrell Hogan, on 07/05/26. He stated that because Ms. Hogan was so unprofessional, coupled with the allegations on 07/04/26, it was necessary to involve the police.

On 07/28/26 I made a telephone call to Guardian C1. Guardian C1 stated that he had general concerns with the Abound Rehabilitation Services- Almond Lane Home. He stated that his primary concern pertained to the lack of stability in management and staff, as there was a high turnover rate in this home. Guardian C1 noted Resident C was moved to a new placement and has been having some behavioral issues there. He stated that he and Resident C's case management team do not attribute the increase in behaviors to her previous placement at Almond Lane, but they have updated Resident C's assessment plan and IPOS, and have secured additional psychiatric services for Resident C.

On 08/05/26, I made a telephone call to ORR specialist, Sarah Rupkus. Ms. Rupkus confirmed there was a bruise on Resident C's arm; however, it remained unclear as to how Resident C sustained the bruise, as accounts of the incident varied, with no one corroborating Resident C's statements. Ms. Rupkus stated that she followed up with the detectives assigned to the complaint investigation and they are closing their case with no charges.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(a) Be capable of meeting the physical, emotional, intellectual, and social needs of each resident.**
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient evidence to conclude that staff were not capable of meeting the physical, emotional, and social needs of the residents. Staff Cherell Hogan and Michelle Fuller exercised poor judgment by taking residents to a party at a park on 07/04/26, where drugs and alcohol were present. When staff did not show up for their scheduled shift, Ms. Fuller and Ms. Hogan made Resident C and Resident D leave the home to attend a personal family party, despite Resident C's expressed unwillingness to leave the home. These actions demonstrate a significant lapse in appropriate decision-making skills and resident care.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 sufficient information to support that staff mistreated Resident C. Resident C had bruising and scratches on her arm following the incident on 07/04/26, which she consistently stated were caused by staff grabbing her as she was forced into the car to attend a staff's personal family party. The regional manager, Rielle Randle, observed the marks and spoke with staff, Michelle Fuller, regarding the injury. Although Ms. Fuller changed her account of the incident, she initially admitted to grabbing Resident C's arm to get her to go in the car.

CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.671	**Resident care.**
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to support that staffing was not adequate to meet the needs of the residents on 07/04/26. Two staff did not come in for their scheduled shifts on 07/04/26. Rather than finding coverage for the shifts at the home, staff took Resident C and Resident D to a personal family party from approximately 10:30am-7:00pm, at which time they were picked up from a gas station by the regional manager to return to the home. Resident C expressed that she did not want to leave the house or attend the party, but she was forced to attend due to insufficient staffing at the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

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 sufficient evidence to conclude residents were not treated with dignity and respect or kept safe and protected. Resident C stated that on 07/04/26 she was physically grabbed, scratched, and forced into a vehicle by staff. She maintained that she was taken against her will to a party where drugs and alcohol were present, an event that frightened her and made her feel unsafe. Staff admitted to coercing Resident C to leave the home by offering a haircut, snacks, and pop. Resident C also stated that she and Resident D were left unattended in the vehicle while staff attended the party.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The team lead, Cherrell Hogan, often sends Resident C to her bedroom and makes her stay in her bedroom all day. Ms. Hogan does not allow Resident C to go in the refrigerator. She "went off" on Resident C for retrieving milk from the refrigerator.

INVESTIGATION:

On 07/06/26, I received additional allegations from Adult Protective Services (APS), which were added to this investigation. The complaint alleged that team lead, Cherrell Hogan, often sends Resident C to her bedroom and makes her stay in her bedroom all day. Ms. Hogan does not allow Resident C to go in the refrigerator. The complaint stated that Ms. Hogan "went off" on Resident C for retrieving milk from the refrigerator.

On 07/07/26, I interviewed Resident C privately. Resident C could not recall a specific incident when staff, Cherell Hogan, yelled at or "went off," on her for getting milk. Resident C stated there was a time she was afraid to open the refrigerator because she did not want to get yelled at by the "homeowner," who she described as a pregnant lady with red and orange hair. When asked again about access to the refrigerator, Resident C stated that she is not restricted from getting milk or other food. She also emphasized that she really likes milk. Resident C denied that she has ever been made to stay in her room.

On 07/13/26, I interviewed direct care staff, Michelle Fuller, via telephone. Ms. Fuller stated that Resident C has never been forced to stay in her room or been yelled at for going into the refrigerator to get milk or anything else. Ms. Fuller stated that before her shift ends in the morning, she prepares breakfast. Sometimes Resident C prefers to eat milk and cereal, so she is allowed to do so. Ms. Fuller said if there is milk in the refrigerator, Resident C can drink some; however, there have been occasions when there was no milk because grocery shopping needed to be done. Ms. Fuller denied that she, or anyone else to her knowledge, yelled at Resident C for going into the refrigerator or for getting milk.

On 07/14/26, I interviewed direct care staff, Stephany Diaz, via telephone. Ms. Diaz stated that to her knowledge Resident C was never prevented from accessing the refrigerator. Resident C told her once that the house lead, Cherrell Hogan, was rude to her for getting a glass of milk. Ms. Diaz also said she never saw Resident C locked in her room, or required to stay in her bedroom all day, although Resident C told her that on one occasion the house lead threatened to make her stay in her room. Ms. Diaz stated that Resident C has not been restricted from the refrigerator, but Resident C once told her the house lead, Cherrell, was rude when she got milk.

On 07/16/26, I interviewed regional manager, Rielle Randle by telephone. She said that she does not have any knowledge regarding staff prohibiting Resident C from getting milk, restricting access to the refrigerator, or making Resident C stay in her room.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(e) Withhold food, water, clothing, rest, or toilet use.** **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(h) Isolation.**
ANALYSIS:	Based upon the information gathered during this investigation, there is insufficient evidence to support that staff restricted Resident C's access to food or beverages, forced her to say in her room, or yelled at her for getting milk. Resident C stated that she has never been prevented from accessing the refrigerator, getting milk or food, or forced to stay in her room. While she recalled being frightened by the house lead's tone sometimes, she confirmed no restrictions occurred. Staff members Michelle Fuller and Stephany Diaz both stated Resident C was allowed to get milk and food freely and was never forced to stay in her room. The regional manager, Rielle Randle, had no knowledge of any such restrictions.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection on 07/01/2026, I conducted a walkthrough of the home. I observed Resident A's bedroom. The mattress was low to the ground; however, it was not properly supported by bed slats. The middle support rails on the frame were not properly in place, causing the mattress to sag downward.

APPLICABLE RULE	
R 400.661	**Bedroom furnishings.**
	(1) Bedroom furnishings must include all of the following: **(a) A bed that is not less than 36 inches wide and not less than 72 inches long with a foundation that is clean, in good condition, and provides adequate support.**
ANALYSIS:	Based on the information gathered during my investigation, there is sufficient information to conclude that the foundation of Resident A's bed was not maintained in good condition. During a walkthrough of the home, I observed that Resident A's bed did not provide adequate support. The mattress was low to the ground but was not properly supported, as the middle bed slats were out of place, causing the mattress to sag.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the onsite inspection on 07/01/26, I reviewed the medication administration records (MARs) for the residents. The following information was noted:

- Resident B is prescribed Clearcanal Earwax Softener 6.5% OT Sol Instill 5 drops in left ear twice daily. The MAR was not initialed to show the medication was administered at 8am on 06/30/26 and 8am on 07/01/26.
- Resident B is prescribed Triamcinolone Acetonide 0.1% Cream apply topically twice a day for 14 days to rash on head. The MAR was not initialed to show the medication was administered at 8pm on 06/21/26 or 8am on 06/30/26 and 07/01/26.
- Resident B is prescribed Omeprazole 20MG one capsule by mouth twice daily. The MAR was not initialed to show the medication was administered on 06/14/26 at 8am and 8pm.
- Resident B is prescribed Mupirocin 2% ointment apply topically two times daily for 7 days to rash on groin and head. The MAR was not initialed at 8AM on 07/01/26
- On 06/17/26, Resident B was prescribed Miconazole Nitrate 2% cream, apply topically (2) times daily for 14 days, may repeat PRN to rash on groin. The MAR was not initialed to show the medication was administered to Resident B at 8pm on 06/21/26 or 8am 06/27/26.
- Resident D is prescribed Ciclopirox Olamine .77% to cream, apply one application topically to affected area daily. The MAR was not initialed to show the medication was administered on 07/01/26 at 8 am.

During my investigation, I interviewed staff, Michelle Fuller and Cherell Hogan. They both stated that Michelle Fuller was not trained to administer medications. Ms. Fuller was the only staff on schedule with the residents overnight on 07/03/26. When the two staff who were scheduled to relieve Ms. Fuller did not show up for their shift on the morning of 07/04/26, the house lead, Cherrell Hogan, came to the home to administer the morning medications to the residents. During my review of the MARs, I noted that residents were prescribed PRN medications that are given on an as needed basis, and they may have required medications while Ms. Fuller was working in the home alone. During this time, there were no staff on shift trained to pass medications.

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:** **(v) Initials of the individual who administered the medication at the time given.**
ANALYSIS:	During the investigation, I reviewed the medication administration records (MARs) for the residents. There were several dates and times noted when the MARs for Resident B and Resident D were not initialed by staff to indicate that medications were administered as prescribed.
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: **(a) Be trained in the proper handling and administration of medication.**

ANALYSIS:	Based on the information gathered during this investigation, there is sufficient information to conclude that staff, Michelle Fuller, was not trained in the proper handling and administration of medication. Michelle Fuller stated that she is not trained to administer medication and was the only staff on schedule with the residents overnight, 07/03/26. While Cherell Hogan came to the home to administer the morning medications, residents in the home are prescribed PRN medications, and could have required medication while Ms. Fuller was the only staff on shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the investigation, additional information was received regarding improper storing and disposal of medication. On 08/07/26, an email was received from the program director, Stacia Collins, requesting guidance and technical assistance related to medication storage and disposal. Ms. Collins stated that following the termination of the human resources director, Amyra Burks, on 07/29/26, staff were clearing out her office and found expired medication belonging to the residents of the Almond Lane home. She stated that they were unaware that these medications were being kept in the office of Ms. Burks.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident or expired must be properly disposed of.
ANALYSIS:	There is sufficient information to conclude that medications were not properly disposed of, as the program director conveyed that expired medications belonging to the residents at the Almond Lane home were found in the office of Amyra Burks following the termination of her employment.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my onsite inspection on 07/01/26, I requested to review all resident weight records. Direct care staff, Markita Nelson, was unable to locate the weight records. Ms. Nelson made a telephone call to the house lead, Cherrell Hogan, and asked

about the weight records and incident reports. With regards to the weight records, Ms. Hogan stated they “needed to start over on the weight records.”

On 07/28/26, I called the current house lead, Cardijah Stitts, and requested the weight record for Resident A be emailed to me for review. On 07/28/26, I received an email from Ms. Stitts, indicating that the weight records are normally kept in the Almond Lane home medication book; however, Resident A’s weight record could not be located.

On 08/11/26, I attempted to contact the licensee designee, David Ellis Sr., to conduct an exit conference. The telephone number was no longer in service. Abound Rehabilitation Services is in the process of appointing a new licensee designee, Rielle Randle. The facility is also in the process of changing ownership and is currently operating under a management agreement with a new licensee. On 08/11/26, I conducted an exit conference with Rielle Randle. I discussed the rule violations and provided technical assistance, where appropriate. Ms. Randle did not share additional information or concerns during the exit conference.

APPLICABLE RULE	
R 400.691	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident that includes all of the following: **(g) Admission and monthly weight record.**
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the licensee did not maintain a monthly weight record for the residents at Almond Lane. During my investigation, I requested to review weight records for all residents at Almond Lane; however, the weight records could not be located.
CONCLUSION:	**VIOLATION ESTABLISHED**

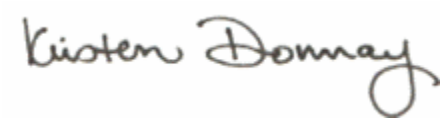
IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

08/12/2026

Kellie Garner — Date
Licensing Consultant

Approved By:



WOC Area Manager for — 08/13/2026

Denise Y. Nunn — Date
Area Manager