



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

December 16, 2024

Jason Schmidt  
New Life Services Inc  
36022 Five Mile Road  
Livonia, MI 48154

RE: License #: AS820014616  
Investigation #: 2025A0122006  
Kirkland Drive

Dear Mr. Schmidt:

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 (517) 284-9720.

Sincerely,

A handwritten signature in cursive script that reads "Vanita Bouldin".

Vanita C. Bouldin, Licensing Consultant  
Bureau of Community and Health Systems  
22 Center Street  
Ypsilanti, MI 48198  
(734) 395-4037

Enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS820014616
<b>Investigation #:</b>	2025A0122006
<b>Complaint Receipt Date:</b>	11/19/2024
<b>Investigation Initiation Date:</b>	11/19/2024
<b>Report Due Date:</b>	12/19/2024
<b>Licensee Name:</b>	New Life Services Inc
<b>Licensee Address:</b>	36022 Five Mile Road Livonia, MI 48154
<b>Licensee Telephone #:</b>	(734) 744-7334
<b>Administrator:</b>	Jason Schmidt
<b>Licensee Designee:</b>	Jason Schmidt
<b>Name of Facility:</b>	Kirkland Drive
<b>Facility Address:</b>	433 Buckingham Canton, MI 48188
<b>Facility Telephone #:</b>	(734) 397-6939
<b>Original Issuance Date:</b>	01/11/1994
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	03/08/2023
<b>Expiration Date:</b>	03/07/2025
<b>Capacity:</b>	5
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

## II. ALLEGATION(S)

	Violation Established?
On 10/28/2024, Resident A was left alone for an unknown amount of time.	Yes

## III. METHODOLOGY

11/19/2024	Special Investigation Intake 2025A0122006
11/19/2024	Special Investigation Initiated - Telephone April Dudley, Case Manager, Detroit Integrated Health Network. Unavailable, left message requesting return phone call.
11/19/2024	APS and Recipient Right Referrals made.
11/19/2024	Contact - Telephone call received Recipient Rights Officer - Completed interview with April Dudley.
11/20/2024	Inspection Completed On-site Completed interview with home manager, Kellie Johnson. Reviewed Resident A's file.
11/26/2024	Contact – Telephone call made Completed interview with staff, Davan Shirley.
12/03/2024	Exit Conference Discussed findings with licensee designee, Jason Schmidt.

**ALLEGATION:** On 10/28/2024, Resident A was left alone for an unknown amount of time.

**INVESTIGATION:** On 11/19/2024, I completed an interview with recipient rights officer, April Dudley. Ms. Dudley reported that Resident A's staffing requirements stated she must have 1:1 staffing at all times and on 10/28/2024, Resident A's 1:1 staffing, left her alone in her bedroom for an unknown amount of time.

On 11/20/2024, I completed an interview with home manager, Kellie Johnson. Ms. Johnson reported that she worked with staff, Davan Shirley, on 10/28/2024 and Mr. Shirley was assigned to be Resident A's 1:1 staffing. Ms. Johnson confirmed that Mr. Shirley left Resident A alone in her bedroom for approximately 15 minutes while taking a personal phone call.

On 11/20/2024, I reviewed Resident A's file. Resident A's Behavior Treatment Plan dated 08/22/2024 documents that Resident A is an elopement risk, and it is recommended that she have 1:1 staff "to stay with her at all times..." On 11/20/2024, I observed that Mr. Shirley signed Resident A's Behavior Treatment Plan on 09/26/2024 and was aware of Resident A's supervision requirements.

On 11/20/2024, I observed Resident A in her bedroom with 1:1 staff present. Resident A was sitting comfortably watching television, showing no signs of discomfort or distress. Resident A is diagnosed with Cerebral Palsy and Severe Intellectual Disability, she is nonverbal and therefore unable to participate in an interview.

On 11/26/2024, I completed an interview with staff, Davan Shirley. Mr. Shirley confirmed that he was assigned to be Resident A's 1:1 staffing on 10/28/2024. Mr. Shirley confirmed on 10/28/2024 that he left Resident A unattended for approximately 10 minutes to make a personal phone call. Mr. Shirley stated he obtained permission from home manager, Kellie Johnson, to make his phone call and assumed that she would supervise Resident A in his absence. Mr. Shirley stated it was miscommunication between him and Ms. Johnson on 10/28/2024 that left Resident A unsupervised.

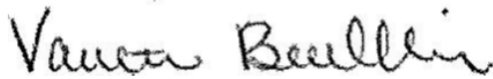
On 12/03/2024, I completed an exit conference with licensee designee, Jason Schmidt and discussed my findings with him. Mr. Schmidt agreed with findings and stated he would submit a corrective action plan to address the rule violation found.

<b>APPLICABLE RULE</b>	
<b>R 400.14206</b>	<b>Staffing requirements.</b>
	<b>(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.</b>

<b>ANALYSIS:</b>	Staff, Davan Shirley, did not provide Resident A with supervision as specified in Resident A's Behavior Treatment Plan dated 08/22/2024, when on 10/28/2024 Resident A was left unsupervised for approximately 15 minutes as confirmed by Mr. Shirley and home manager, Kellie Johnson during their interviews on 11/20/2024 and 11/26/2024 respectively.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan I recommend no change to the status of the license.



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Vanita C. Bouldin  
Licensing Consultant

Date: 12/03/2024

Approved By:



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Ardra Hunter  
Area Manager

Date: 12/16/2024