GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 9, 2025

Samantha Nieuwenbroek
Life Center Inc
Ste. 100
36975 Utica Rd.
Clinton Twp., MI 48038

RE: License #: AS500390452
Investigation #: 2025A0990014
Gilbert Group Home

Dear Ms. Nieuwenbroek:

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,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500390452
Investigation #:	2025A0990014
Complaint Receipt Date:	04/24/2025
Investigation Initiation Date:	04/24/2025
Report Due Date:	06/23/2025
Licensee Name:	Life Center Inc
Licensee Address:	Ste. 100 36975 Utica Rd. Clinton Twp., MI 48038
Licensee Telephone #:	(586) 557-0156
Administrator:	Samantha Nieuwenbroek
Licensee Designee:	Samantha Nieuwenbroek
Name of Facility:	Gilbert Group Home
Facility Address:	31751 Gilbert Warren, MI 48093
Facility Telephone #:	(586) 978-7741
Original Issuance Date:	05/08/2018
License **Status:**	REGULAR
Effective Date:	11/07/2024
Expiration Date:	11/06/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A has had four severe injuries within the past year at the facility.	No
The staff are not sending incident reports to Resident A's designated representative.	Yes
The staff are not seeking medical attention when Resident A is injured.	Yes

III. METHODOLOGY

04/24/2025	Special Investigation Intake 2025A0990014
04/24/2025	Special Investigation Initiated - Letter I emailed the Reporting Person (RP).
04/24/2025	APS Referral Adult Protective Services (APS) referral initiated at intake.
04/25/2025	Contact - Face to Face I conducted an unannounced special investigation. I interviewed direct care staff Carolyn Rogers. I observed Resident A.
05/06/2025	Contact - Document Sent I emailed Samantha Nieuwenbroek, licensee designee (LD).
05/14/2025	Contact - Document Received I reviewed Resident A resident record. I reviewed Ms. Rogers employee file.
06/11/2025	Contact - Telephone call made I conducted a phone interview with Relative A.
06/17/2025	Contact - Telephone call made I left a detailed message with Christina Brady, MORC case manager.
06/20/2025	Contact - Telephone call made I left Ms. Brady detailed voice message.

06/20/2025	Contact - Document Sent I emailed Ms. Nieuwenbroek Return emails were received.
06/23/2025	Contact - Document Sent I emailed Christina Gregory, APS Worker. APS did not substantiate their investigation.
06/23/2025	Contact - Telephone call received I conducted a phone interview with Ms. Brady.
06/23/2025	Contact - Document Received Ms. Nieuwenbroek sent ORR's incident reporting policy. I replied with AFC policy.
06/24/2025	Exit Conference I conducted an exit conference with Ms. Nieuwenbroek.

ALLEGATION:

Resident A has had four severe injuries within the past year at the facility.

INVESTIGATION:

On 04/24/20205, I received the complaint via email. In addition to the above allegation, Resident A was diagnosed with autism and microcephaly. He is minimally verbal. Relative A is Resident A's legal guardian. Resident A resides in a group home with five other adults. Resident A has had four severe injuries within the past year while living at the group home. In November 2024, his toenail was completely ripped off. Sometime in April 2025, he sustained a black eye with a cut above his eye. Relative A takes Resident A to get medical care for all these injuries.

On 04/25/2025, I conducted an unannounced special investigation. I interviewed Carolyn Rogers, the direct care staff member. Ms. Rogers has worked as a direct care staff for two years. Ms. Rogers said that she knows Resident A's eyebrow injury that occurred about two weeks ago. The injury was to his right eyebrow. Ms. Rogers could not remember the specific date but recalled working a double shift that day. Ms. Rogers said that when she returned to work, she observed the eyebrow injury. She described it as a faint scratch above his right eyebrow. Ms. Rogers added that Resident A likes to move furniture around and believes that he may have received the injury when doing this. Ms. Rogers said that on that day, Resident A was moving furniture. Ms. Rogers was unaware of Resident A's toenail injury. Ms. Rogers said that she does not recall Resident A having a black eye but recalls the scratch on his right eyebrow. Ms. Rogers believes medical treatment was sought for all injuries. Ms. Rogers said that an attempt could be made to interview Resident A. Still, he gets extremely aggressive and agitated with unfamiliar people. Resident A does not have a roommate.

On 04/24/2025, I observed Resident A. I attempted to interview him. However, he became very agitated and said, “I don’t want to talk.”

On 05/14/2025, I reviewed Resident A’s Resident record. I reviewed Resident A’s Individual Plan of Service (IPOS). Resident A is diagnosed with intermittent explosive disorder, moderate intellectual disability, mood disorder, and microcephalus. Resident A has emotional issues, verbal aggression, disrobing, self-injury, destruction of property, and physical aggression toward others. When Resident A is agitated, he swears, yells, and throws objects when upset. Resident A has minimal language. Resident A sees a psychiatrist, attends workshops, and has a behaviorist.

On 06/11/2025, I conducted a phone interview with Relative A. Relative A said that Resident A has had severe injuries this past year in the home. Relative A said that in October of 2024, he picked up Resident A for a weekend visit and noticed his finger was swollen. Relative A took him to urgent care. Resident A had a cuticle infection. Relative A said that nothing happened physically to his finger. Relative A is concerned that the staff did not observe the swollen finger. Relative A said that he informed the staff of the cuticle infection. Resident A was prescribed an antibiotic and a topical cream.

Relative A said that in November of 2024, Resident A’s toenail was completely ripped off. Resident A complained that his toe hurt when he picked him up for a weekend visit. Relative A1 observed a missing toenail on Resident A’s left foot. The toenail was missing from the toe next to the pinky toe. Resident A did not know how this happened. Relative A took Resident A to urgent care to get it treated. Relative A said that he had informed the staff of this, but they did not know how it had occurred.

Relative A said that in April of this year, Resident A was observed with a cut above his right eye. The cut was noticed when he was picked up for a weekend visit. Resident A did not know how he received the cut. Relative A asked the staff how this occurred, and the staff were not aware of the cut. Resident A was treated at urgent care and diagnosed with “blunt force trauma to the eyebrow.” Relative A said that later, a staff member told him that another resident in the home punched Resident A in the eye because Resident A bit the other Resident. Resident A does have a history of biting, which he believes began because he was bit by other residents in the home. Resident A has had physical altercations with other residents in the house. Relative A said that Resident A asks to take showers when he gets home for visits because it relaxes him. Relative A said that when he assists Resident A in the shower. He observes minor scratches and bruises on his body. Resident A sees a behaviorist weekly. Relative A said he does not believe the staff must give Resident A body checks.

06/23/2025, I conducted a phone interview with Christina Bardy, MORC case manager. Ms. Brady said that she has received several incident reports for Resident A. Ms. Bardy said Resident A’s injuries are documented on a health care chronological (HCC). Resident A had an eye injury in April of 2025, and he was treated for it. Ms. Bardy said that she had documented that the staff took him to the emergency room or urgent care.

Ms. Bardy said Relative A has also taken Resident A to urgent care for injuries. There may have been times when Relative A did not report things to the staff about Resident A's injuries. The staff at the home takes Resident A to all medical appointments. Ms. Bardy visits Resident A twice a month. There are no concerns about his care at the home. Resident A has been irritable lately and does not want to be talked with.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on this investigation, there is insufficient evidence to support that Resident A is not protected and that his safety is not attended to by staff. Resident A is diagnosed with intermittent explosive disorder, moderate intellectual disability, mood disorder, and microcephalus. Resident A has emotional issues, verbal aggression, disrobing, self-injury, destruction of property, and physical aggression toward others. When Resident A is agitated, he swears, yells, and throws objects when upset. Resident A also has had a physical altercation with other residents in the home. Resident A spends weekends with Relative A, and some injuries are observed by Relative A. Resident A also attends workshops. Resident A does not have a roommate, and he is minimally verbal and becomes agitated when interviewed by strangers. Resident A has a behaviorist to address his aggression.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

- **The staff are not sending incident reports to Resident A's designated representative.**
- **The staff are not seeking medical attention when Resident A is injured.**

INVESTIGATION:

The complaint was received via email on 04/24/2025. In addition to the above allegations, it was reported that the staff never noticed Resident A's injuries until the family pointed them out. Staff did not inform Resident A's guardian when some medical treatments were sought for injuries.

On 04/25/2025, I conducted an unannounced special investigation. Ms. Rogers said she has never written an incident report and/or discharge summary.

On 05/14/2025, I reviewed Resident A's record. I observed the following incident reports written on the *Consumer Incident, Accident, Illness, Death, or Arrest Report for Macomb County*. No incident reports were written on the AFC Licensing Division Incident / Accident Report from Michigan Department of Licensing and Regulatory Affairs. The incident reports and discharge summaries are as follows:

- 08/06/2023 - another resident bit Resident A. Persons notified: Via fax- Office of Recipient Rights (ORR); case manager (via fax) and guardian (via phone). No date or time is documented in the notifications.
- 05/24/2024 - Resident A had a physical altercation with another resident. Persons notified: Via fax: Office of Recipient Rights (ORR); Christina Brady, case manager (via phone); and Samantha Nieuwenbroek, LD (via phone). No date or time is documented in the notifications.
- 07/29/2024 - Henry Ford Hospital discharge summary for injury to left forearm. There was no incident report provided.
- 11/12/2024 - Resident A's left finger was observed swollen and turning colors. Resident A reported to staff that he hit his hand/finger on the door upstairs. The staff called the manager and the guardian. It was documented that the guardian came and took Resident A to urgent care or the emergency room. Persons notified: Via fax- Office of Recipient Rights (ORR) and case manager (via fax). No date or time is documented in the notifications. I observed a *Macomb County Community Mental Health Services Emergency Medical* form dated 11/12/2024 with a "Sterling Heights Urgent Care" stamp. There was no other information written regarding diagnosis or treatment. Karishma Waldemar, MD, signed the document. The document was on page 14 of 15. No other pages were available.
- 11/17/2024 - Warren Urgent Care visit summary observed. Resident A was diagnosed with paronychia of the finger of the left hand. Resident A was prescribed an oral antibiotic and a topical cream. There was no incident report for this visit.

On 06/11/2025, I conducted a phone interview with Relative A. Relative A said that he had been notified of some incidents; however, he had observed most of the injuries and reported these to the staff. Relative A said he was only made aware of the incidents on 08/06/2023 and 04/14/2025. Relative A does not receive written copies of incident reports. Relative A said he had no knowledge of Resident A's hospital visits on 07/29/2024.

Relative A said that in November 2024, he picked up Resident A for a weekend visit and noticed that Resident A's finger was swollen. Relative A took him to urgent care. Resident A had a cuticle infection which Relative A informed the staff.

On 06/23/2025, I interviewed Christina Bardy, MORC case manager. Resident A has had a few physical altercations with other residents, but most have subsided. Ms. Brady said that she was not made aware of a ripped toenail.

On 06/23/2025, Ms. Nieuwenbroek sent ORR's incident reporting policy. ORR incident report policy does not permit written reports to be given to designated representatives/ legal guardians. I observed ORR's incident report policy. I replied to Ms. Nieuwenbroek with the incident reporting licensing rule. Ms. Nieuwenbroek said they have never provided written incident reports to designated representatives/legal guardians. Ms. Nieuwenbroek sent Resident A's IPOS training log. I observed that ten staff were trained in February 2025 and are to do bed checks on Resident A every two hours and assist with hygiene after bowel movements,

On 06/24/2025, I conducted an exit conference with Ms. Nieuwenbroek. Ms. Nieuwenbroek expressed that many of Resident A's injuries are due to his physical aggression. Ms. Nieuwenbroek said that Resident A is also physically aggressive with Relative A. Relative A often drops him from visits and does not come inside the home. Ms. Nieuwenbroek said some injuries could have occurred at Relative A's house. Ms. Nieuwenbroek said she has instructed staff to write the incident report even if Relative A takes Resident A for medical treatment. I discussed the incident reporting licensing rule and that designated representatives/legal guardians are to receive notice verbally and in writing. Ms. Nieuwenbroek was informed that staff should be completing incident reports for licensing on the incident report form and saved in the file to be reviewed as needed or at renewal inspections. Ms. Nieuwenbroek expressed concerns about HIPPA rights when incident reports are given to designated representatives/legal guardians if other residents' information is in the report. I advised Ms. Nieuwenbroek to code the names as necessary. I informed Ms. Nieuwenbroek of the findings before supervisory approval.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(c) Physical hostility or self-inflicted harm or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.** **(3) An incident must be recorded on a department-approved form and kept in the home for a period of not less than 2 years.**

ANALYSIS:	Based on the investigation, evidence supports that Relative A was not notified by staff that Resident A was taken to urgent care for an injured forearm on 07/29/2024. No incident report was available for hospital/urgent care visits on 07/29/2024 and 11/17/2024. No incident reports were documented on the AFC Licensing Division Incident / Accident Report on the following dates: 08/06/2023, 05/24/2024 and 11/12/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the investigation, direct care staff wrote an incident report on 11/12/2024, where staff observed Resident A had a swollen finger. In the incident report, Resident A reported that he hit his finger on the upstairs door. The direct care staff documented that Resident A would be taken to urgent care or emergency room by Relative A. Relative A noticed the finger swollen during his weekend visit with Resident A. Resident A did not know what happened. Relative A said that the staff did not know as well and did not report this to him. Relative A took Resident A to Warren Urgent Care on a Sunday, 11/17/2024, five days after the incident. There is conflicting information regarding Resident A's medical for the swollen finger incident. I observed a *Macomb County Community Mental Health Services Emergency Medical* form dated 11/12/2024 with a "Sterling Heights Urgent Care stamp." In the documents, no other information was written regarding diagnosis or treatment. Karishma Waldemar, MD, signed the document. The document was on page 14 of 15 and no other pages were available. Moreover, Resident A's finger was still swollen on Sunday, 11/17/2024, and had to be taken to urgent care by Relative A.
CONCLUSION:	**VIOLATION ESTABLISHED**

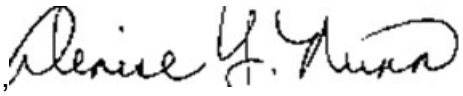
IV. RECOMMENDATION

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

06/25/2025

LaShonda Reed — Date
Licensing Consultant

Approved By:



07/09/2025

Denise Y. Nunn — Date
Area Manager