



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 20, 2026

Tyler Curtis
CBI Rehabilitation Services, Inc.
3446 E. Lake Lansing Rd.
East Lansing, MI 48823

RE: License #: AS330294925
Investigation #: 2026A0622017
CBI Rehabilitation Services, Inc.

Dear Mr. Curtis:

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) 335-5985.

Sincerely,

A handwritten signature in black ink, appearing to read 'Amanda Blasius', written in a cursive style.

Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330294925
Investigation #:	2026A0622017
Complaint Receipt Date:	01/14/2026
Investigation Initiation Date:	01/14/2026
Report Due Date:	03/15/2026
Licensee Name:	CBI Rehabilitation Services, Inc.
Licensee Address:	3446 E. Lake Lansing Rd. East Lansing, MI 48823
Licensee Telephone #:	(517) 349-6975
Administrator:	Tyler Curtis
Licensee Designee:	Tyler Curtis
Name of Facility:	CBI Rehabilitation Services, Inc.
Facility Address:	3320 Westwood Lansing, MI 48906
Facility Telephone #:	(517) 886-5629
Original Issuance Date:	07/31/2009
License Status:	REGULAR
Effective Date:	02/26/2024
Expiration Date:	02/25/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
CBI Rehabilitation Services, has six or seven residents in the home.	No
CBI Rehabilitation Services, does not monitor the residents' medication properly.	No
CBI Rehabilitation Services, has a history of verbal and physical abuse of the residents.	No
Additional Findings	Yes

III. METHODOLOGY

01/14/2026	Special Investigation Intake- 2026A0622017
01/14/2026	Referral came from an APS denied intake
01/14/2026	Special Investigation Initiated – Telephone to CBI Rehabilitation Services
02/02/2026	Inspection Completed On-site
02/09/2026	Contact - Telephone call made to Guardians, direct care worker Akila Robinson. Voicemail left for direct care worker Aurelia Gendreau.
02/10/2026	Voicemail left for direct care worker Aurelia Gendreau.
02/12/2026	Voicemail left for direct care worker Aurelia Gendreau.
02/19/2026	Phone call to direct care worker Aurelia Gendreau
02/20/2026	Exit Conference with licensee designee, Tyler Curtis

ALLEGATION: CBI Rehabilitation Services, has six or seven residents in the home.

INVESTIGATION:

On 01/14/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to Complaint CBI Rehabilitation Services, Inc. has six or seven residents within the home.

On 01/14/2026, I called the number listed in the intake and asked how many residents were living in the home. According to the person who answered the phone, they stated four residents with one, resident currently in the hospital. According to their license, CBI Rehabilitation Services, Inc. is licensed for six residents.

On 02/02/2026, I completed an unannounced onsite investigation to CBI Rehabilitation Services, Inc. and reviewed the resident register which documented five current residents living in the facility. The last resident was admitted on 11/12/2025. During the unannounced onsite investigation, I viewed two residents within the home.

On 02/02/2026, during the unannounced onsite investigation, I interviewed three direct care workers, Amanda Collins-Lightfoot, Violet Barrone and Sarah Bufford-Wallace in person. All three direct care workers reported that the home only has four current residents, with one resident being in a rehabilitation home. All three direct care workers reported that they have never witnessed more than six residents within the home.

APPLICABLE RULE	
R 400.613	Licensed capacity, occupants.
	(1) The number of residents and number of resident beds must not be greater than the capacity authorized on the license.
ANALYSIS:	Based upon the unannounced investigation, viewing documentation and interviews with direct care workers, I determined that CBI Rehabilitation Services, Inc. has only five residents placed within the home. CBI Rehabilitation Services, Inc. is licensed for six residents, therefore a violation was not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: CBI Rehabilitation Services, does not monitor the residents' medication properly.

INVESTIGATION:

On 01/14/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint CBI Rehabilitation Services, Inc. does not monitor the residents' medication properly.

On 02/02/2026, I completed an unannounced onsite investigation to CBI Rehabilitation Services, Inc. During the unannounced onsite investigation, I viewed medication administration records for all four residents within the home currently. No medication errors were found during the last month. I also compared medications

within the medication cart to Resident C’s medication administration record. No concerns were found. During the unannounced onsite investigation, I requested documentation regarding medication errors over the last three months. One incident report was provided for Resident A about medication errors. According to the *AFC licensing division, incident/accident report* on 11/03/2025, Resident A was away from the home due to a scheduled appointment. While away from the home for her scheduled appointment, she missed her scheduled 4pm and 6pm prescribed medications. The action taken was to inform managers, withheld the medications at the order of the doctor and re-education for the staff members.

On 02/02/2026, I interviewed all direct care workers on shift, DCW Amanda Collins-Lightfoot, Violet Barrone and Sarah Bufford-Wallace regarding medication administration. All three reported that they are not aware of medication errors or medication not being given properly to residents.

On 02/09/2026, I interviewed all guardians for the current residents within the home regarding concerns regarding medications being given properly. None of the guardians interviewed expressed any concerns about medication administration.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based upon documentation reviewed during the unannounced onsite investigation, no medication administration concerns were found on the medication administration records or with reviewing medications onsite. No concerns regarding how medication is administered was reported from any guardian interviewed, therefore a violation was not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: CBI Rehabilitation Services, has a history of verbal and physical abuse of the residents.

INVESTIGATION:

On 01/14/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint the home is verbally and physically abusive towards the residents. The complaint also stated that there is a history of the staff being physically abusive to clients.

On 01/14/2026, I viewed past special investigations that addressed allegations of physical abuse. Special investigation 2025A1033027, dated 5/09/2025, addressed allegations from a resident regarding physical abuse and no violations were found.

On 02/02/2026, I completed an unannounced onsite investigation to CBI Rehabilitation Services, Inc. During the unannounced onsite investigation, I interviewed direct care workers in person. During the unannounced onsite investigation, the residents within the home were unable to be interviewed due to being non-verbal.

On 02/02/2026, I interviewed direct care worker (DCW), Amanda Collins-Lightfoot in person. DCW Collins-Lightfoot identified as a manager of the home. DCW Collins-Lightfoot reported that she has not observed any staff member be verbally or physically abusive towards any of the residents. DCW Collins-Lightfoot also denied being verbally and physically abusive towards any residents. DCW Collins-Lightfoot reported that there was an incident in December with Resident A falling on the floor and was found bleeding by another staff member. DCW Collins-Lightfoot stated that she was not working when the incident occurred, but it's her understanding that Resident A fell and could not get up and direct care worker Akila Robinson chose to leave Resident A on the floor without helping her, which resulted in Resident A using the bathroom on the floor and also hurt her lip when falling. DCW Collins-Lightfoot stated that direct care worker, Sarah Bufford-Wallace, returned from shopping with clients and found Resident A on the floor, helped her up and called 911. DCW Collins-Lightfoot stated that Resident A went to the hospital, then came back to the home short term. Resident A was then sent out to rehabilitation and is currently at the rehabilitation facility.

On 02/02/2026, I interviewed direct care worker Violet Barrone in person. DCW Barrone reported that she has worked there almost a year and works all shifts. DCW Barrone reported that she has never observed a staff member, verbally or physically abuse a resident. DCW Barrone denied ever verbally or physically abusing a resident. DCW Barrone stated that the only incident that she is aware of was in December 2025, when Resident A fell and hurt her head. DCW Barrone stated that she was not working but heard about the incident.

On 02/02/2026, I interviewed direct care worker, Sarah Bufford-Wallace in person. DCW Bufford-Wallace reported that she has worked at the home for two-three years. She reported that she has never observed a staff member verbally or physically abuse a resident. DCW Bufford-Wallace denied ever verbally or physically abusing a resident. DCW Bufford-Wallace reported that she was working on 12/29/2025, when she came into the home and found Resident A on the floor bleeding. She explained that she was working on 12/29/25 but was out shopping with a resident. DCW Bufford-Wallace stated that she observed direct care worker, Aurelia Gendreau sitting in the living room when she returned and observed direct care worker, Akila Robinson outside Resident A's bedroom. DCW Bufford-Wallace stated that she went to check on Resident A in her bedroom. DCW Bufford-Wallace reported that she found Resident A on the floor and found blood on her face. She explained that she asked DCW Robinson what happened to Resident A and why she was bleeding and DCW Robinson stated "what blood?" DCW Bufford-Wallace stated that she helped

Resident A off the floor, called her managers and then 911. She explained that Resident A went to the hospital and had a black eye and cut her head. DCW Bufford-Wallace stated that Resident A does have a history of falling, but Resident A also has a one on one staffing during waking hours. DCW Bufford-Wallace reported that when Resident A returned from the hospital she was sick and lost a lot of strength and has been in rehabilitation since.

On 02/09/2026, I interviewed Guardian C1 via phone. She reported that Resident C has not expressed any concerns to her and that she has not had any concerns regarding verbal or physical abuse. Guardian C1 stated that she has been very happy with Resident C's care and he is lucky to have the group of staff he has there.

On 02/09/2026, I interviewed Guardian A1, who is also the guardian for Resident B. Guardian A1/B1 reported that she has worked with CBI Rehabilitation Services, Inc. for many years and has not had any concerns about how they treat residents. She stated that when Resident A fell in the home she did not hit her head hard and was sick, therefore her balance was off more than normal. Guardian A1 reported that she had no concerns that Resident A was not being supervised properly. Guardian A1 stated that Resident A will be returning to the home after she is done at rehab.

On 02/09/2026, I interviewed Guardian D1 via phone. She stated that Resident D has been placed there since November 2025 and has struggled some since the home has been more consistent and stricter on his behavioral plan. Guardian D1 stated that she visits often and has not had any concerns.

On 02/09/2026, I interviewed Guardian E1 via phone. She reported that she is not at the home very often, but she talks with his family often and has had no concerns regarding verbal or physical abuse.

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: (b) Use any form of restraint without an order from an appropriately licensed health care professional or physical force, other than physical restraint for crisis intervention.
ANALYSIS:	Based upon the interviews with direct care workers and guardians there was no evidence found that staff are physically abusive towards residents nor using any form of restraint with the residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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: (f) Subject a resident to any of the following: (i) Mental or emotional cruelty. (ii) Verbal abuse. (iii) Derogatory remarks. (iv) Threats.
ANALYSIS:	Based upon the interviews with direct care workers and guardians there was no evidence found that staff are verbally abusive towards residents nor are staff subjecting the residents to mental/emotional cruelty, derogatory remarks or threats.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

On 02/02/2026, I completed an unannounced onsite investigation to CBI Rehabilitation Services, Inc.. During the unannounced onsite investigation, three direct care workers were interviewed and reported the same incident that occurred on 12/30/2025 with Resident A.

On 02/02/2026, I viewed an *AFC licensing division, incident/accident report* dated 12/29/2025. The *AFC licensing division, incident/accident report* stated the following:

Explain what happened

“On 12/29/2025 at 11am, [Resident A] was found laying [sic] on the floor of her room, she informed staff that she fell out of bed. Staff members aided her off the ground and aided her to get dressed and use the restroom. [Resident A] was experiencing symptoms of dizziness, weakness, incontinence and a headache.”

Action taken by staff

“Staff members informed PC and SPC. PC and SPC informed the PM and [Resident A’s] guardian and case manager. [Resident A] was transported via ambulance to U of M Sparrow Health Emergency Department to be evaluated.”

Corrective Measures Taken

“[Resident A] received first aid care from staff members. She received an IV and acetaminophen while in the ED. Continued 1:1 supervision care. Aiding with ambulation and all activities of daily living.”

Physicians Diagnosis of injury

“Fall encounter and facial contusion.”

On 02/02/2026, I interviewed direct care worker, Sarah Bufford Wallace in person. DCW Bufford-Wallace reported that she was working on 12/29/2025, when she

came into the home and found Resident A on the floor bleeding. She explained that she was working on 12/29/25 but was just coming on shift around 10am after another DCW called in. DCW Bufford-Wallace stated that she observed DCW Aurelia Gendreau sitting in the living room when she returned and observed DCW Akila Robinson outside Resident A's bedroom. DCW Bufford-Wallace stated that she went to check on Resident A in her bedroom. DCW Bufford-Wallace reported that she found Resident A on the floor and found blood on her face. She explained that she asked DCW Robinson what happened to Resident A and why she was bleeding and DCW Robinson stated "what blood?" DCW Bufford-Wallace stated that she helped Resident A off the floor and then went out to call her managers and 911. She explained that Resident A went to the hospital and had a black eye and cut her head. DCW Bufford-Wallace stated that Resident A does have a history of falling, but Resident A also has a one on one during waking hours. DCW Bufford-Wallace reported that when Resident A returned from the hospital, she was sick and lost a lot of strength and has been in rehab since.

On 02/02/2026, I interviewed direct care worker (DCW), Amanda Collins-Lightfoot in person. DCW Collins-Lightfoot identified as a manager of the home. DCW Collins-Lightfoot reported that there was an incident in December with Resident A falling on the floor and was found bleeding by another staff member. DCW Collins-Lightfoot stated that she was not working when the incident occurred, but its her understanding that Resident A fell and could not get up and direct care worker, Akila Robinson chose to leave Resident A on the floor without helping her, which resulted in Resident A using the bathroom while lying on the floor. DCW Collins-Lightfoot also stated Resident A hurt her lip during the fall. DCW Collins-Lightfoot stated that direct care worker, Sarah Bufford-Wallace, came on shift and found Resident A on the floor, helped her up and called 911. DCW Collins-Lightfoot stated that Resident A went to the hospital, then came back to the home short term. Resident A was then sent out to rehabilitation and is currently at the rehabilitation facility.

On 02/09/2026, I interviewed direct care worker, Akila Robinson via phone. DCW Robinson reported that she was working on 12/29/25 during the first shift. She explained that Resident A had a behavior of falling on the ground and not wanting to get up. DCW Robinson stated that if Resident A is having a behavior of falling on the ground and won't get up, staff are supposed to coach her to get up or call management. DCW Robinson stated that Resident A falling was an on-going problem. DCW Robinson stated that she was sitting outside of Resident A's bedroom and was checking on her every few minutes. She stated that Resident A was on the floor of her bedroom and she was attempting to coach her to get up. DCW Robinson stated that assisting her up off the floor was out of job duties and not within the job description, as they are not supposed to lift over 20 pounds. DCW Robinson stated that she left Resident A on the floor of her bedroom and could hear her but did not have eyes on her. DCW Robinson stated the door was open, but Resident A was not in her line of sight, but she was checking on her every few minutes. She explained that Resident A was on the floor from about 8am-10am. DCW Robinson stated residents are supposed to be independent and have some

ability to care for themselves and she was not trained on how to properly lift a resident off the floor. DCW Robinson stated that lifting Resident A was out of her job description, therefore she did not lift her off the floor. DCW Robinson reported that she never saw Resident A bleeding, but when DCW Sarah Bufford-Wallace came to the home, she found her bleeding on the floor. DCW Robinson stated that Resident A must have started bleeding right before DCW Bufford-Wallace arrived at the home. DCW Robinson stated that DCW Bufford-Wallace called management and then called the ambulance to come for Resident A. DCW Robinson, reported that she was fired on 12/30/25.

On 02/09/2026, 02/10/2026 and 02/12/2026 a voicemail left for direct care worker Aurelia Gendreau. On 02/19/2026, I called CBI Rehabilitation Services, Inc..to connect with direct care worker, Aurelia Gendreau as it was reported that she was on shift. I interviewed DCW Gendreau via phone. She confirmed that she was working on 12/29/25, when Resident A was sent to the hospital. DCW Gendreau stated that she could not remember who was working with her. DCW Gendreau reported that she remembered that Resident A fell out of bed and must have scraped her head on something when she fell. She explained that she had a minor scrape and had bleeding from this scrape. DCW Gendreau could not remember if she was assigned to be Resident A's one on one or was in charge of the other resident that required a one on one. DCW Gendreau stated that she tried to give Resident A a hand to assist her with getting up, but was told that staff are not allowed to assist her with getting her off the floor. DCW Gendreau reported that she could not remember how long Resident A was on the floor, but stated she was on the floor for a while, but they were checking on her. DCW Gendreau stated the process is supposed to call management after 30 minutes of her being on the floor and not getting up. DCW Gendreau was unable to give a timeframe, and she stated that she thinks she called the manager, DCW Sarah Bufford-Wallace. DCW Gendreau confirmed that they did not apply first aid to Resident A's scrape. DCW Gendreau stated that she did not call the ambulance, and she thinks that the manager called the ambulance when she arrived.

On 02/02/2026, I viewed a discharge notice for Resident A from her visit to the hospital after her fall and incident on 12/29/25. According to the discharge notice from University of Michigan-Sparrow Lansing Emergency Room, Resident A was seen for a fall. The discharge notice stated that her diagnosis was fall, subsequent encounter, facial contusion, initial encounter. The imaging tests completed according to the discharge notice were, CT cervical spine without contrast, CT scan and EKG. The discharge notice stated, imaging was negative for new fractures or joint dislocations.

On 02/12/2026, I received a copy of Resident A's behavior support plan, dated 1/31/2025. The behavior support plan stated the following:

"[Resident A] receives 24-hour supervision in the CBI residential program. Her individualized resident to staff ratio is 1-1 during waking hours for community and individualized programming. A daily activity

schedule is followed providing support in all areas of daily living including self-care, domestic activities, social behavior and leisure.”

On 02/12/2026, I also received a copy of Resident A’s daily contract. According to the daily contract for 12/29/25, the following notes were on the form, written by DCW Akila Robinson. “[Resident A] had an accident at some point. Staff repeatedly prompted her to get up and clean herself. [Resident A] refused to listen to prompts and made herself comfortable on the floor.”

On 02/19/2026, I interviewed direct care worker, Sarah Bufford-Wallace via phone. She confirmed that she was not aware that that Resident A had fallen and been injured prior to coming into the home around 10am. She stated that they may have called her and stated she fell but was not informed of the seriousness of the incident. DCW Bufford-Wallace reported that when she arrived at the home it appeared to her that they were not even checking on Resident A. DCW Bufford-Wallace stated that Resident A had used the bathroom on the floor also. She confirmed that she called upper management and the ambulance, along with assisting Resident A with getting up off the floor.

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 upon documentation reviewed and interviews completed it was determined that Resident A had a fall on 12/29/25, which resulted in a facial contusion. During interviews with direct care worker, Akila Robinson, she reported that Resident A was on the floor for almost two hours without assisting Resident A with getting up from the floor. DCW Gendreau was unable to give a timeframe for how long Resident A was on the floor, but stated she was on the floor for a while. Based upon interviews, neither DCW Robison nor DCW Gendreau assisted Resident A with getting up off the floor or providing first aid to her scrape on her face. Neither DCW Robinson nor DCW Gendreau called the ambulance for assistance. According to Resident A's behavior support plan, she will have a 1:1 staff during waking hours to assist with self-care. During the interview with DCW Bufford-Wallace she reported that she found Resident A on the floor when she arrived around 10am and observed blood on her face, along with her urinating on herself on the floor. DCWs Robinson and Gendreau did not treat Resident A with dignity, by allowing her to remain on the floor while urinating on herself, they also denied protection and safety while allowing Resident A to remain on the floor of her bedroom for two hours while having an injury to her face that needed medical attention.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

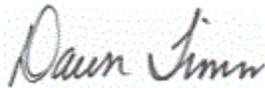


02/20/2026

Amanda Blasius
Licensing Consultant

Date

Approved By:



02/20/2026

Dawn N. Timm
Area Manager

Date