GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 16, 2026

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

RE: License #: AS500379039
Investigation #: 2026A0617017
Mile End

Dear Samantha 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500379039
Investigation #:	2026A0617017
Complaint Receipt Date:	04/09/2026
Investigation Initiation Date:	04/10/2026
Report Due Date:	06/08/2026
Licensee Name:	Life Center Inc
Licensee Address:	Ste. 100 36975 Utica Rd. Clinton Twp., MI 48038
Licensee Telephone #:	(734) 261-1094
Administrator:	Samantha Nieuwenbroek
Licensee Designee:	Samantha Nieuwenbroek
Name of Facility:	Mile End
Facility Address:	50171 Mile End Utica, MI 48317
Facility Telephone #:	(586) 726-9693
Original Issuance Date:	12/12/2016
License **Status:**	REGULAR
Effective Date:	03/28/2025
Expiration Date:	03/27/2027
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
A nonverbal, fully dependent resident was found with unexplained head injuries, raising concerns of possible staff abuse or neglect.	Yes

III. METHODOLOGY

04/09/2026	Special Investigation Intake 2026A0617017
04/09/2026	APS Referral Adult Protective Service Referral received- assigned worker Debra Johns
04/09/2026	Referral - Recipient Rights
04/10/2026	Special Investigation Initiated - Telephone TC with Resident A guardian
04/14/2026	Inspection Completed On-site I completed an unannounced investigation at the Mile End facility. During the onsite investigation, I interviewed home manager Stacey Williams Bey, staff Victoria Bartkowski. Resident A was not present as she was in the hospital.
04/14/2026	Contact - Telephone call made TC to Ms. Stewart
05/20/2026	Contact - Document Received interviewed Adult Protective Services worker Debra Johns
05/20/2026	Contact - Telephone call made TC to Ms. Stewart

06/12/2026	Contact - Telephone call made TC to Ms. Ruth Adamson
06/12/2026	Contact - Telephone call made I interviewed Ms. Nicole Stewart
06/12/2026	Exit Conference I conducted an exit conference with Licensee Designee Samantha Nieuwenbroek informing her of the findings of the investigation

ALLEGATION:

A nonverbal, fully dependent resident was found with unexplained head injuries, raising concerns of possible staff abuse or neglect.

INVESTIGATION:

On 04/09/26, I received a complaint regarding the Mile End facility. The complaint indicated that Resident A (67) is diagnosed with an intellectual disability. Resident A is non-verbal, has a feeding tube and wheelchair bound. Resident A resides in Mile End AFC home. On 4/7/2026 at 12:30 AM, Resident A was observed to have an abrasion and bruise on her forehead. It is not documented by the staff members how Resident A obtained the injury. Resident A is unable to walk on her own, and her wheelchair has a seatbelt. This restricts Resident A from falling out of the wheelchair. Resident A is transferred by utilizing a Hoyer Lift. There are concerns that Resident A has been either physically neglected or physically abused by an unknown staff member on 2nd shift. Resident A was observed by the physician on site during the afternoon on 4/6/2026 and did not have any injuries. After the injuries were discovered, Resident A was transported to Beaumont Hospital for an examination. A cat scan was completed. Resident A was found to have abrasions, a bruise and a small contusion.

On 04/10/26, I interviewed Resident A's guardian. According to Resident A's guardian, on 04/07/26, Resident A had a doctor's appointment at the home by her primary care physician. The physician noticed a bruise on her forehead. The doctor ordered that she be sent to the hospital for a cat scan. Resident A was found to have abrasions, a bruise and a small contusion. Resident A's guardian stated that the facility contacted her on 04/07/26 and told her about the bruise. Resident A's guardian stated that at first the facility stated that they were unsure how Resident A

sustained the injuries but later that day the facility told her that the injuries occurred when staff were transporting Resident A to the shower chair and Resident A fell and hit her face and head. Resident A's guardian is upset because this is the second time in the last several months that Resident A received injuries while being cared for by staff. Resident A's guardian stated that she has some concerns about the care Resident A is receiving at the home.

On 04/14/26, I completed an unannounced investigation at the Mile End facility. During the onsite investigation, I interviewed home manager Stacey Williams Bey, staff Victoria Bartkowski. Resident A was not present as she was in the hospital.

According to home manager Stacey Williams Bey, the midnight staff found the bruises on Resident A and called Ms. Williams Bey around midnight on 04/06/26 and notified her of the injuries. Midnight staff Ruth Adamsom completed an incident report and transported Resident A to the Emergency Room at Troy Beaumont. Resident A was seen and then discharged back home but on 04/12/26, Resident A had to go back to the hospital after having three seizers and for having fluid on her lungs. Ms. Williams Bey stated that Resident A also has a bruise on the bottom of her right foot. According to home manager Stacey Williams Bey, staff Nicole Stewart stated that Resident A hit her head in the shower on the wall but was unsure how it happened. Ms. Williams Bey stated that management took Ms. Stewart off of the schedule pending an investigation. Ms. Williams Bey stated that Ms. Stewart never notified her of the incident, nor did she complete an Incident report. Ms. Williams Bey stated that she made Ms. Stewart fill out an IR the next day and provided me with a copy and provided me with several pictures of Resident A's injuries. In the pictures Resident A can be seen with several red marks/bruises on her face, forehead and foot. According to the IR completed by Ms. Stewart dated 4/7/26, while Ms. Stewart was giving Resident A a shower, Resident A was sitting in her shower chair and leaned forward and hit her head on the wall. The IR stated that Ms. Stewart noticed the red marks on her head and continued to monitor. Resident A is still hospitalized. Resident A is nonverbal and unable to communicate.

On 05/20/26, I interviewed Adult Protective Services worker Debra Johns. According to Ms. Johns, the APS case will be substantiated for: Neglect and Physical Abuse. Ms. Johns stated that she and law enforcement interviewed the alleged perp Ms. Nicole Stewart and the interview was inconsistent. Resident A remains in the group home; however, Ms. Stewart has been terminated.

On 06/12/26, I interviewed Ms. Nicole Stewart. According to Ms. Stewart, she worked at the facility for 10 years with no issue. Ms. Stewart stated that Resident A hit her head in the shower but was unsure exactly how it happened. Ms. Stewart stated that she was done wrong by the facility because they terminated her after this incident.

On 06/12/26, I conducted an exit conference with Licensee Designee Samantha Nieuwenbroek informing her of the findings of the investigation. According to Ms.

Nieuwenbroek, as soon as she was made aware of the situation, she took Ms. Stewart off of the schedule pending an investigation. According to Ms. Nieuwenbroek, Ms. Stewart admitted that when she was transporting Resident A to the shower, she did not use the Hoyer lift. Ms. Nieuwenbroek stated that she terminated Ms. Stewart due to this incident. Ms. Nieuwenbroek stated that Rights substantiated Ms. Stewart for abuse. Ms. Nieuwenbroek stated that she took Ms. Stewart off of the schedule before Rights requested that she do so.

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:	On 04/06/26, Resident A was observed to have an abrasion and bruise on her forehead. The injuries occurred while staff Nicole Stewart gave Resident A a shower on 04/06/26. According to the IR completed by Ms. Stewart dated 4/7/26, while Ms. Stewart was giving Resident A a shower, Resident A was sitting in her shower chair and leaned forward and hit her head on the wall. The IR stated that Ms. Stewart noticed the red marks on her head and continued to monitor. This is the second injury Resident A sustained in the home by staff in the last four months. On 02/10/26, Resident A was observed with a significant bruise on her leg. The bruise was dark purple with yellow spots. It is unknown how Resident A sustained the bruise, but staff believes that it occurred in the home while she was being transported from her wheelchair to the shower. Resident A is not being protected and kept safe.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2026A0617011** **dated 04/13/26, CAP dated 04/20/26**

IV. RECOMMENDATION

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

06/15/26

Eric Johnson Date
Licensing Consultant

Approved By:

For 06/17/2026

Denise Y. Nunn Date
Area Manager