



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 17, 2026

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

RE: License #: AS500390452
Investigation #: 2026A0990024
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.
- 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,

A handwritten signature in cursive script, appearing to read "L. Reed".

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
3044 W Grand Boulevard
2nd Floor Annex, Suite 2-730
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 #:	2026A0990024
Complaint Receipt Date:	07/14/2026
Investigation Initiation Date:	07/15/2026
Report Due Date:	09/12/2026
Licensee Name:	Life Center Inc
Licensee Address:	Ste. 100 - 36975 Utica Rd. Clinton Twp., MI 48038
Licensee Telephone #:	(586) 739-9220
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 had an aggressive episode and attacked staff. The staff ran to the porch for safety. As a result, Resident A assaulted Resident B, causing injuries.	Yes

III. METHODOLOGY

07/14/2026	Special Investigation Intake 2026A0990024
07/14/2026	APS Referral Adult Protective Services (APS) referral - denied at intake.
07/15/2026	Special Investigation Initiated - Letter I emailed Samantha Nieuwenbroek, licensee designee/ administrator and requested resident records and employee files.
07/15/2026	Contact - Document Received I received an email reply from Ms. Nieuwenbroek.
08/11/2026	Contact - Telephone call made I conducted a phone conference with direct care staff TreAzhanee Murphy.
08/11/2026	Contact - Document Sent I requested additional documentation from Ms. Nieuwenbroek.
08/19/2026	Contact - Face to Face I conducted an onsite interview with Resident B.
08/19/2026	Contact - Face to Face I conducted an onsite interview with home manager Le'Chenia Felton I briefly spoke with Resident B's case coordinator Peg Thompson, Easter Seals/MORC that was visiting during my onsite. I interviewed Resident B.
08/19/2026	Contact - Face to Face I conducted an interview with Resident A at Life Enrichment Academy (LEA).

08/20/2026	Contact- Document sent I emailed former direct care staff Cindy Severe. No response to date.
08/26/2026	Contact - Telephone call made I conducted a phone interview with Relative B1.
09/02/2026	Contact - Telephone call made I left detailed voice message with former direct care staff Cindy Severe. I left a detailed message No return call to date.
09/02/2026	Contact - Document Received I reviewed the resident and employee records.
09/02/2026	Contact - Telephone call made I conducted a phone interview with Relative A1.
09/04/2026	Exit Conference I conducted an exit conference with Ms. Nieuwenbroek.

ALLEGATION:

Resident A had an aggressive episode and attacked staff. The staff ran to the porch for safety. As a result, Resident A assaulted Resident B, causing injuries.

INVESTIGATION:

On 07/14/2026, I received a complaint via email. In addition to the above allegation, it was reported on 05/02/2026 that Resident A attacked a staff member. The staff member attempted to get to safety, ran outside, and called the police/emergency. The staff member was terminated, and upper management terminated staff because she left the resident unsupervised. Additional information was received after the intake. It was also reported.

On 07/15/2026, I received an email reply from Ms. Nieuwenbroek. The Office of Recipient Rights (ORR) investigated, and findings with both staff, Cindy Server (resigned) and TreAzhanæe Murphy, were substantiated. Ms. Nieuwenbroek said that they terminated Ms. Murphy after the ORR investigation was completed. Adult Protective Services (APS) was not involved.

On 08/11/2026, I conducted a phone conference with direct care staff TreAzhanæe Murphy. Ms. Murphy has worked with the company for three years. On the day of the incident, Resident A and Resident C were sitting in the living room while direct care worker Cindy Severe was in the kitchen doing dishes after dinner. Resident A told Ms. Severe that she wanted to take a shower. Ms. Severe told Resident A that she would

shower after she finished in the kitchen. Resident A began screaming and stood up. Ms. Murphy said that she told Resident A to “sit down”. Miss Murphy was sitting in the office while this was occurring. Resident A charged at Ms. Severe in the kitchen and began swinging at her. Miss Murphy said she immediately told Resident A, “to stop and have a seat.” At that time, Resident A jumped and charged at her while she was sitting at the dining room table. Resident A then began to chase her around the table, and Ms. Murphy then ran out the front door to the porch where Ms. Severe was already standing. Ms. Murphy called the police and the home manager to report the incident. Ms. Murphy said that while they were on the porch, Resident A was still trying to come outside and was irate. Ms. Murphy went back inside because she could hear Resident B screaming upstairs. She witnessed Resident A dragging Resident B down the stairs. Before the screaming sounds, Ms. Murphy said that she could hear Resident A banging on the bedroom door upstairs, which she shares with Resident B. Ms. Murphy went back inside to remove Resident B from Resident A on the stairs and observed that Resident B's eye was bleeding. The police arrived at that time and intervened. Resident A was taken to the hospital. Resident B's family arrived shortly thereafter and took Resident B for medical treatment. Ms. Murphy said she had never observed Resident A have a behavior episode such as this; however, she was aware of the behavior because she was told by colleagues that Resident A had attacked her uncle in the past. Resident C is non-verbal and was not harmed during the incident.

Ms. Murphy believes that she was terminated from her job unfairly because she was not trained properly on how to address Resident A's behavior. Ms. Murphy said that she was never trained on Resident A's IPOS or Crisis Prevention and Safeguard Plan until after the incident. Ms. Murphy was terminated from her employment on June 29th. Before they terminated her, they had her work during the ORR investigation, and they promoted her from caregiver to medication coordinator. Ms. Severe resigned before the ORR investigation was completed. Ms. Murphy said she was told by corporate staff at termination that she shouldn't have left the inside of the home. Ms. Murphy said that she was afraid at the time and thought that running to safety to call the police was the right thing to do.

On 08/19/2026, I conducted an onsite. I interviewed Resident B and the home manager Le'Chenia Felton. I interviewed Resident B in her bedroom. Resident B and Resident A are roommates. Resident B recalled the incident vividly. She said that it started downstairs where she heard Resident A having an argument with staff. She's not sure what the argument was about but shortly after she heard Resident A yelling, she came upstairs and “barreled through the door” and punched her in the eye. Resident A then pulled her hair and began dragging her to the floor. She tried to get away by crawling down the stairs and Resident A began dragging her down the stairs. She heard the staff yelling at Resident A to stop the at that time Ms. Murphy came inside from the front porch and lifted her up and away from Resident A. Resident B reiterated that Resident A pulled her down the stairs as she was trying to go down the stairs. She screamed for help and both staff were outside on the front porch. Resident B said that she was crying and upset her mom took her to the emergency room. As a result, she spent two weeks at her parents' home because they had to get Resident A's medications adjusted before

she returned. Resident A "is ok now". She feels safe in the home at this point. According to Resident B this was the second time that Resident A hit. She did not elaborate on the first time. Resident B displayed a picture of her red eye via her cell phone. Resident B has lived in the home for two years.

I interviewed Ms. Felton, home manager. Ms. Felton was not at home at the time of the incident however, she became aware of it by receiving a phone call from Ms. Murphy. Ms. Felton said that Ms. and all staff were trained on Resident A's (Individual Plan of Service) IPOS in which she conducted the training. Ms. Felton said that Ms. Murphy was made medication coordinator prior to the incident. Still, it became official during the onset of the ORR investigation, so it was already in the works. Ms. Felton said that she was not the person that terminated Ms. Murphy and corporate office terminated her after the ORR investigation was completed. Ms. Felton did not become aware of the termination until it happened. Ms. Felton reiterated that all residents IPOS's and behavior plans are in-serviced with staff. Resident A and Resident B are still roommates and there are no issues between the two. Resident A at times has attacked others at program and is part of her behavior issues that are being addressed in her plan. When Resident A is agitated, she will attack anyone in the vicinity when she is having an episode. Resident A has not had any other physical attacks against staff or the other residents prior to this incident but is known to have had issues at program. Ms. Felton said that Resident A was currently at program and provided the address. I informed Ms. Felton that I would interview her at program.

I briefly spoke with Resident B's case coordinator Peg Thompson, Easter Seals/MORC that was visiting during my onsite. Ms. Thompson was aware of the incident but added no further details.

On 08/19/2026, I conducted an interview with Resident A at Life Enrichment Academy (LEA). Resident A was asked about the incident that occurred between her and the staff as well as Resident B. Resident A said, "I don't remember but I'm ok and better now." Resident A said that on the day of the incident had a bad headache. Resident A was able to provide her date of birth and her age, and she indicated that she went to a water park on her birthday recently. No other information was provided by Resident A.

On 08/26/2026, I conducted a phone interview with Relative B1. Relative B1 said she became aware of the incident when Resident B called her screaming that her roommate Resident A hit her in the face. Resident A is significantly taller and larger in size than Resident B. They share a room because they are the only two females in the home. Resident A is very intimidating when she's angry, she had done the same thing to the staff members that day before she attacked Resident B. The home is supposed to be a nonviolent home. According to information she received Resident A had an increased amount of agitation than normal around this time and she feels that the staff had done nothing about it until the incident. Relative B1 said that she is a very involved parent. Resident A's mom is not that involved and lives about an hour away. She feels the staff did not make it urgent to get Resident A meds changed after the incident. As a result, Resident B had to stay home for three weeks and miss her program as well as other

activities. She was informed by staff that when Resident A was sent to the ER on the day of the incident, they did nothing and sent her back home. We talked in detail about how this happens frequently. Relative B1 said that she was very disappointed that it took two weeks to get Resident A an appointment with her psychiatrist to get her medications adjusted. Relative B1 also said that she discovered that there had been police running calls to the home but could not specify the timeframes or who was involved. Relative B1 said that both Resident A and Resident B were close friends and many times she would take them both on outings outside of the home.

On 08/26/2026, I received an email reply from Ms. Nieuwenbroek. Ms. Nieuwenbroek said that she had one Incident Report (IR) in which she attached for regarding Resident A. Ms. Nieuwenbroek reiterated that there was a delay in Resident A getting an appointment with her psychiatrist and that she also called MORC and the caseworker to get an emergency appointment immediately after the May 2nd incident which she had on May 12, 2026. I reviewed the IR dated 03/06/2026 in which, Resident was returning from a family visit with her uncle. When she arrived home, she asked the uncle to give her some of the chips that they brought back. The uncle handed the bag to Cindy Severe to distribute to Resident A she then snatched the bag and attacked him, and they both fell to the floor, and the uncle was able to get Resident A off of him. He called Relative A1 to report the incident and left the home. Resident A did not have any injuries however; the uncle had a bloody face and broken glasses. Resident A was redirected.

On 09/02/2026, I reviewed the resident and employee records and ORR investigative report. Resident B admission date was 02/01/2025. According to Resident B IPOS. Resident B does not have any behavioral interventions documented in her IPOS. Resident B is diagnosed with ADHD and has a visual impairment. Resident B has a crisis plan to only address seizure activity. Resident B is to be checked on by staff every two hours.

Resident A's admission date is 01/24/2023. According to her IPOS her diagnosis is as follows: Moderate intellectual disability, Autism Spectrum Disorder, Bipolar 1 disorder, unspecified disruptive/impulse control and conduct disorder. Resident A receives behavioral support. The objectives are as follows: coping strategy when emotionally dysregulated as evidenced by an increase in verbal aggression. Resident A de-escalation techniques to be applied are deep breathing, private time and sensory. Resident A is to be given as a PRN for agitation Ativan .5 mg when de-escalation techniques are unsuccessful. Resident A becomes physically aggressive by pushing others, yelling, property destruction and pounding on tables and chairs. The deescalation strategies are as follows: avoid power struggles with Resident A; Try to keep her energy calm by deep breathing; slow request and demands down, less talk and more support; be respectful, treat her with mutual respect, and companionship; listen with an open mind; let some time pass before reengaging activities; remain present and available but don't crowd or hover. It is documented in Resident A's IPOS that situations to avoid is staff saying "no" firmly, harsh tone of voice, not enough structure, being left to problem solve simple situations and requests are not responded

to. Resident A does not like to be ignored. Resident A Crisis Prevention and Safeguard Plan outlines signs and symptoms of risk escalation. Resident A will switch quickly to an angered state, refuse to cooperate, shut down, push or throw objects, push or shove others, begin hitting or striking out and somatic complaints.

I reviewed the ORR investigative report dated 06/26/2026 specifically to review Ms. Severe's interview. On 05/27/2026, Recipient Rights Specialist interviewed Life center - Gilbert Group Home staff, Cindy Severe face to face and the following relevant statements were made regarding the events of 05/02/2026 at the Gilbert Group Home:

Ms. Severe said that she was present along with Tre'Azhanae Murphy, Resident A, Resident B and Resident C. She has worked in the home for about six months. After dinner on 05/02/2026, she told Resident A that after she was done cleaning that she would shower her. She usually showers Resident A at 6pm before leaving at 7pm on the weekends. Resident A said OK, and then went to sit in the front living room with Resident C. Staff, Ms. Murphy was in the room where they kept the med cart and resident files which is between the kitchen and front living room. Approximately 10-15 minutes later, Ms. Severe said that she heard Resident A screaming, therefore, she went to check on her; and Ms. Murphy was doing paperwork at the table by the medications. Ms. Severe stepped out of the kitchen to see what was going on and Resident A made eye contact with her and then started coming towards her. Ms. Severe said that she did not have enough time to move so put her my arms across her face to block Resident A's hits. Ms. Severe said that she had the cleaning cloth in my hand that I was using to clean the stove. Resident A hit her a couple of times on her arms. Ms. Severe said that she had never said anything to Resident A and everything happened so fast. Ms. Severe said that when staff Ms. Murphy asked Resident A to stop hitting her, then Resident A turned towards her and started running after her. Ms. Severe said that Ms. Murphy jumped on the table, and she ran outside of the home then Ms. Murphy ran out of the house behind her. Resident A took both of her fists and was banging on the front glass storm door. Resident C was still in the front living room and Resident B was upstairs. When Resident A banged on the glass storm door, she never opened the door to get to them on the porch. Neither of them was holding the door closed to prevent Resident A from exiting. Resident A then went to sit down in the front living room, by Resident C. Ms. Severe and Ms. Murphy were outside the front of the house, and we could see both Resident A and Resident C sitting in the living room. Resident A never bothered Resident C. Ms. Severe did not see Resident A go upstairs but suddenly, she heard crying and I thought it was Resident A, but when she looked through the front glass door to see Resident B crying and coming down the stairs. Ms. Severe did not see Resident A come down with Resident B and she did not see Resident A pull Resident A's hair. Ms. Severe said that she opened the front glass storm door and told Resident B to come outside. Ms. Severe denied hearing any more banging coming from upstairs after Resident B came outside. Resident A looked like she had been attacked, her face was red and above her eye was bleeding and scratched. Ms. Severe stayed outside with Resident B and Ms. Murphy went inside to get Resident A's paperwork because the police were on their way. The police officers arrived and they had to go in and get Resident A. Resident A came down the stairs with

the police and did not seem to be any distress, and she wasn't fighting with them. The police asked Resident A what happened and she said she didn't know what happened.

Resident A was taken to the hospital by ambulance. Relative B1 took Resident B to urgent care and then home with her that day. Ms. Severe said that there were no warning signs with Resident A's behavior to give her a PRN because she was sitting and happy at one moment and then she suddenly started screaming and started hitting her. Ms. Severe said that she has seen Resident A get violent before and she can usually be de-escalated or her PRN is offered. Resident A was not upset at dinner and seemed happy right before she screamed and came after her.

Ms. Murphy was trained in Resident A's IPOS and Crisis Prevention & Safeguard Plan on 04/09/2026 and Ms. Severe was trained on 04/11/2026- verified with their signatures. Both staff are fully trained. Ms. Murphy was terminated on 06/29/2026 for not following behavioral plan that resulted in injury and one individual. ORR substantiated Ms. Murphy and Ms. Severe for Neglect II.

On 09/02/2026, I conducted a phone interview with Relative A1. I interviewed relative A1 who was aware of the situation that occurred between resident A and staff prior to this issue there have been no concerns regarding resident a attacking staff. In her opinion the staff followed appropriate procedures and resident aid needed a medication change and things have been much better. Miss relative A1 doesn't know what transpired but sometimes resonant a will suddenly become agitated. She was very surprised by resident a attacking resident B because their best buds and auto character of her although resident a can be impulsive at times but all she recalls is that she wanted a shower and nap and staff never told her no or blew her off things have been better at the home since her medication change. She still talks about it to her and the staff and she understands that what occurred was not appropriate.

On 09/04/2026, I conducted an exit conference with Ms. Nieuwenbroek. Ms. Nieuwenbroek said that it is required that the home managers have a meeting every other month with staff and at the meeting they are to go over every residence IPOS and Crisis Prevention and Crisis Safeguard plans. Since the incident she has recommended that the managers review a plan in between meetings to encourage staff understanding and also provide refreshers here we miss Anne was informed of the tentative rule findings prior to supervisory approval.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(2) Interventions must be specified in the resident's assessment plan and performed in accordance with that plan. Interventions must ensure that the safety, welfare, and rights of the resident are adequately protected. If an intervention is needed to address the unique programmatic

	needs of a resident, the intervention must be developed in consultation with, or obtained from, a professional or professionals licensed, certified, or registered in that scope of practice.
ANALYSIS:	Based upon the Investigation there is sufficient evidence to support that direct care staff Ms. Murphy and Ms. Severe did not provide the safeguard interventions to deescalated Resident A on 05/02/2026 during a crisis episode. Resident A became aggressive and attacked Ms. Severe unwarranted and chased Ms. Murphy. According to Ms. Severe's interview with ORR, she did not have to deescalate and exited the home, and Ms. Murphy followed her outside to the porch. As a result, other the lack of deescalation techniques by staff leaving outside Resident A attacked Resident B causing her a bloody eye. Neither staff administered the PRN Ativan to calm her down instead removed themselves from the home leaving all residents at risk of harm. Moreover, Ms. Murphy said that she told Resident A to sit down prior to the episode, this could have been taken as a string demand to Resident A, which is a crisis trigger. Per Resident A's IPOS the staff are to remain present and available at the time of a crisis episode. Ms. Murphy and Ms. Severe were trained on Resident A's IPOS and Crisis Prevention and Safeguard Plan in April of 2026.
	VIOLATION ESTABLISHED

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 investigation there is sufficient evidence to support that Resident B was not protected on 05/02/2026 when her roommate Resident A attacked her. Resident A was having a crisis episode and staff members Ms. Murphy and Ms. Severe exited the home instead of intervening in Resident A's episode. As a result, Resident B received bruises and a black eye.

	Resident B had to leave the home for two weeks until Resident A's medications were adjusted by her psychiatrist.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, there is no change to the license status.

L. Reed

09/16/2026

LaShonda Reed
Licensing Consultant

Date

Approved By:

Denise Y. Nunn

09/17/2026

Denise Y. Nunn
Area Manager

Date