GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 29, 2026

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

RE: License #: AS820014616
Investigation #: 2026A0122032
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,



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

License #:	AS820014616
Investigation #:	2026A0122032
Complaint Receipt Date:	08/10/2026
Investigation Initiation Date:	08/10/2026
Report Due Date:	10/09/2026
Licensee Name:	New Life Services Inc
Licensee Address:	36022 Five Mile Road Livonia, MI 48154
Licensee Telephone #:	(734) 744-7334
Administrator:	Jason Schmidt
Licensee Designee:	Jason Schmidt
Name of Facility:	Kirkland Drive
Facility Address:	433 Buckingham Canton, MI 48188
Facility Telephone #:	(734) 397-6939
Original Issuance Date:	01/11/1994
License Status:	REGULAR
Effective Date:	03/08/2025
Expiration Date:	03/07/2027
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A is not being showered and as a result has skin break down issues.	Yes

III. METHODOLOGY

08/10/2026	Special Investigation Intake 2026A0122032
08/10/2026	APS Referral Allegations received from Adult Protective Services (APS)
08/10/2026	Special Investigation Initiated - Telephone Telephone call made to APS specialist Monique King
08/10/2026	Referral - Recipient Rights Forwarded allegations to Detroit Wayne Integrated Health Network (DWIHN) Office of Recipient Rights
08/12/2026	Onsite Inspection Observed Resident A and reviewed her file. Conducted interview with area supervisor, Shanita Turner.
08/21/2026 & 0/27/2026	Contact – Telephone call made Attempted to interview staff members, Nadia Lewis and Laura Tolbert
08/26/2026	Contact – Telephone call made Conducted interview with supports coordinator, Samakia Patmon.
09/29/2026	Contact – Telephone call made Conducted interviews with staff members, Laura Tolbert and Nadia Lewis.
08/31/2026	Contact – Telephone call made Conducted exit conference with licensee designee, Jason Schmidt.

ALLEGATION: Resident A is not being showered and as a result has skin breakdown issues.

INVESTIGATION: On 08/11/2026, I conducted an interview with adult protective services worker, Monique King. Ms. King reported that she conducted an inspection and found both Resident A and the facility to be clean. Resident A is verbal however; she did not participate in an interview with Ms. King. Per Ms. King, she did not observe skin breakdown on Resident A nor was there any report that Resident A had any issues with skin breakdown because of not being showered.

On 08/12/2026, I conducted an onsite inspection. Resident A was at the dining room table having lunch. I observed Resident A to be clean and appropriately dressed. Resident A did not participate in an interview with me.

I conducted an interview with area manager, Shanita Turner. Ms. Turner reported that Resident A does not have skin breakdown issues, however, she is not being bathed as documented in her assessment plan. Ms. Turner stated that Resident A should be bathed twice per day as written in her pan, however, she is showered at least twice per week.

Per Ms. Turner, it was reported to her by staff members, Nadia Lewis and Laura Tolber, that Resident A was left in bed for an entire shift, 7:00 a.m. – 3:00p.m. and she was found soiled.

On 09/29/2026, I conducted separate interviews with staff members, Laura Tolbert and Nadia Lewis. Both Ms. Tolbert and Ms. Lewis stated they Resident A is bathed once per day. Both reported they had not observed skin breakdown on Resident A. Ms. Tolbert and Ms. Lewis stated they did not remember reporting that Resident A was left in bed for an entire shift and found soiled.

I reviewed Resident A's assessment plan dated 01/07/2026 which documents that she is "totally incontinent, wears adult briefs, and requires checks and changes every two hours or as needed…she receives total care with showering twice per day unless accidents occur…"

I reviewed Resident A's consultation note dated 06/24/26 completed by her primary care physician. The note documented that Resident A was medically assessed on the date but did not mention that she had skin breakdown issues.

On 08/26/2026, I conducted an interview with supports coordinator, Samakia Patmon. Ms. Patmon confirmed that Resident A should be showered twice per day as written in her plan. Ms. Patmon stated that she had received no reports that Resident A had skin breakdown issues. Ms. Patmon stated that she had concerns regarding the amount of time Resident A is left in bed, however, her assessment

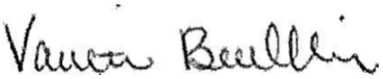
plan states that Resident A should be seated at the dining room table for meals but gives no other parameters for staff to follow. Ms. Patmon stated that an addendum to Resident A's assessment would be completed to address this issue.

On 08/31/2026, I conducted an exit conference with licensee designee, Jason Schmidt, and discussed my findings with him. Mr. Schmidt stated he agreed with my findings, and he would submit a corrective action plan to address the rule 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 upon my investigation, which consisted of multiple interviews with staff members, Laura Tolbert and Nadia Lewis, area supervisor, Shanita Turner, and supports coordinator, Samakia Patmon, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that Resident A is not being showered as outlined in her assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



Vanita C. Bouldin — Date: 08/31/2026
Licensing Consultant

Approved By:



Ardra Hunter — Date: 9/29/2026
Area Manager