GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 7, 2025

Rebirth Community Inclusion Program, LLC
16951 Maryland
Southfield, MI 48075

RE: License #: AS820396286
Investigation #: 2025A0116046
Rebirth Community Inclusion Program

Dear Ms. Jefferson:

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.

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 (313) 456-0439.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820396286
Investigation #:	2025A0116046
Complaint Receipt Date:	09/17/2025
Investigation Initiation Date:	09/19/2025
Report Due Date:	11/16/2025
Licensee Name:	Rebirth Community Inclusion Program, LLC
LicenseeAddress:	16951 Maryland Southfield, MI 48075
Licensee Telephone #:	(313) 778-3194
Administrator:	Linda Jefferson
Licensee Designee:	Linda Jefferson
Name of Facility:	Rebirth Community Inclusion Program
Facility Address:	811 Superior St Wyandotte, MI 48192
Facility Telephone #:	(734) 407-7390
Original Issuance Date:	07/22/2021
License **Status:**	REGULAR
Effective Date:	01/22/2024
Expiration Date:	01/21/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
The residents were assaulted by staff.	No
Resident A lived in the home for two months and reported he never received any of his medications.	No
The residents receive little food.	No
Additional Findings	Yes

III. METHODOLOGY

09/17/2025	Special Investigation Intake 2025A0116046
09/17/2025	APS Referral Received, denied for investigation.
09/19/2025	Special Investigation Initiated - On Site Staff, Cynthia Wells, and Residents B-D.
09/19/2025	Contact - Telephone call made Interviewed licensee designee, Linda Jefferson.
09/23/2025	Inspection Completed-BCAL Sub. Compliance
09/23/2025	Exit Conference Licensee designee, Linda Jefferson.

ALLEGATION:

The residents were assaulted by staff.

INVESTIGATION:

On 09/19/25, I conducted an unscheduled onsite inspection and interviewed staff, Cynthia Wells, and Residents B-D. Ms. Wells reported that the allegations are false and that she and the licensee designee, Linda Jefferson, are the only staff presently

working in the home. She reported that the residents are all verbal and could best answer any questions pertaining to how they are treated and cared for.

I interviewed Residents B-D separately and they all denied the allegation. They reported that they have never been hit, pushed, slapped or handled in an aggressive manner by the staff. They reported their belief that this allegation is coming from Resident A. Resident D reported that Resident A was a drug addict who lived in the home for a couple weeks and did nothing but try to cause problems.

On 09/19/25, I interviewed licensee designee, Linda Jefferson, and she reported that the allegations are not true. She reported that she and Ms. Wells are the only two staff employed presently, and that they have never assaulted any of the residents.

On 09/23/25, I conducted the exit conference with licensee designee, Linda Jefferson, and informed her of the findings of the investigation. Ms. Jefferson agreed with the findings.

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 the findings of the investigation, which included interviews with staff, Cynthia Wells, Residents B-D and licensee designee, Linda Jefferson, there is not a preponderance of evidence to substantiate the allegation. Ms. Wells denied that she or Ms. Jefferson have ever assaulted any of the residents. Residents B-D all denied that they had ever been hit, pushed, slapped, or assaulted in any way by staff. Ms. Jefferson denied that she has ever assaulted any of the residents and reported that the allegation is not true. This violation is not established, as the residents are treated with dignity and their personal needs, including protection and safety, are attended to in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A lived in the home for two months and reported he never received any of his medications.

INVESTIGATION:

On 09/19/25, I conducted an unscheduled onsite inspection and interviewed staff, Cynthia Wells, and reviewed Resident A's medication administration record (MAR). Ms. Wells reported that Resident A lived in the home for about two weeks and came to them from the hospital. Ms. Wells reported that when he came to the home he had two prescribed medications, Trazadone 100mg and Escitalopram 30mg. Ms. Wells reported the hospital only provided a few days of medication and it was administered as prescribed. Resident A started the medication on 08/04/25 and took his last dose on 08/08/25. Ms. Wells reported that they planned to get him connected to a primary care physician, however, he did not remain in the home long enough for them to do so. Ms. Wells reported while Resident A lived in the home he would get up early in the morning and stay gone all day, often not returning until late evening or at night. Ms. Wells reported after speaking to one of Resident A's children, she was informed that he is an addict and has been for over 50 years. Ms.

Wells reported that Resident A's daughter reported that she was just waiting on the call that he was dead.

I reviewed Resident A's MAR and confirmed that he received his first dose of Trazadone and Escitalopram on 08/04/25 and his last dose on 08/08/25.

On 09/19/25, I interviewed Residents B-D. They are reported that they receive their medications daily. They reported that Resident A received his medication when he was in the home too. They all reported that Resident A was hardly ever in the home when he did live there. Resident B reported he would get his morning medication and he would be gone until late evening. She reported she is glad he is gone.

On 09/19/25, I interviewed licensee designee, Linda Jefferson, and she reported that Resident A lived in the home from 08/04/25 until 08/18/25. She reported that he was not under the care of a doctor and came to the home from the hospital. Ms. Jefferson reported that the hospital sent him with a four-day supply of Trazadone and Escitalopram and reported it was administered to him. Ms. Jefferson reported her plans to get Resident A assigned to a primary care physician; however he was not in the home long enough to do so. Ms. Jefferson reported that Resident A needs drug treatment.

On 09/23/25, I conducted the exit conference with licensee designee, Linda Jefferson, and informed her of the findings of the investigation. Ms. Jefferson agreed with the findings.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Based on the findings of the investigation, which included interviews with staff, Cynthia Wells, Residents B-D, licensee designee, Linda Jefferson, and my review of Resident A's MAR, there is not a preponderance of evidence to substantiate the allegation. Ms. Wells reported that Resident A was given the four-day supply of medication he received from the hospital upon his admission into the home on 08/04/25. Residents B-D reported they get their medication daily and reported that when Resident A was in the home, he also received his medication. Ms. Jefferson reported that Resident A received the four-day supply of Trazadone and Escitalopram that the hospital sent with him. I reviewed Resident A's MAR and confirmed that both the Trazadone and Escitalopram was initialed as given from 08/04/25 through 08/08/25. This violation is not established as Resident A was given his medications as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The residents receive little food.

INVESTIGATION:

On 09/19/25, I conducted an unscheduled onsite inspection and interviewed staff, Cynthia Wells, and Residents B-D. Ms. Wells reported that the residents are fed three meals per day and have access to snacks. She reported that the cabinets, pantry, refrigerator and freezer have an abundance of food in them. Ms. Wells opened the cabinets, pantry, refrigerator and freezer and I confirmed that the food supply was more than adequate.

I interviewed Residents B-D, and they reported that they get plenty of food and have a part in creating the menu. They reported that they eat very well and can have seconds if they desire too. They reported that there is always plenty of food in the home. Resident D reported that during the short time Resident A lived in the home,

he was gone from sun-up to sun-down, however, the staff would always make a plate and put it up for him to eat whenever he returned.

On 09/23/25, I conducted the exit conference with licensee designee, Linda Jefferson, and informed her of the findings of the investigation. Ms. Jefferson agreed with the findings. Ms. Jefferson reported that the residents eat very well and enjoy meals because they as a group plan the weekly meals, and so they are able to eat the things that they enjoy.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the findings of the investigation, which included interviews with staff, Cynthia Wells, Residents B-D and my observation, there is not a preponderance of evidence to substantiate the allegation. Ms. Wells reported that the residents eat three meals per day and have access to snacks. She reported that they eat very well. Residents B-D reported that they eat three meals per day and can get seconds if they desire too. They reported that there is always plenty of food in the home. I observed the food supply in the home and found it to be more than adequate. This violation is not established as the residents are receiving three meals daily.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/19/25, I conducted an unscheduled onsite inspection and requested to review Resident A's records. Staff, Cynthia Wells, reported that Resident A did not have a

complete record containing all of the required forms, as they did not believe it was going to stay in the home for even a day. Ms. Wells reported that when Resident A came to the home from the hospital, he left and she and Ms. Jefferson, did not believe he would return. I informed Ms. Wells, that the licensing rules require that a record for each resident is completed at the time of their admission. Ms. Wells reported an understanding.

On 09/23/25, I conducted the exit conference with licensee designee Linda Jefferson and informed her of the findings of the investigation. Ms. Jefferson reported an understanding. Ms. Jefferson took responsibility for her failure to complete the required forms upon Resident A's admission. She reported that she did not believe that he would stay even one night in the home, based on his behavior. Ms. Jefferson reported, "I'm not going to make excuses, I know I should have completed the paperwork."

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident

	record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of the next of kin or the designated representative.** **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.** **(g) Weight record.** **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.**

ANALYSIS:	Based on the findings of the investigation, which included interviews with staff, Cynthia Wells, licensee designee, Linda Jefferson, and my observation, there is a preponderance of evidence to establish this violation. Ms. Wells and Ms. Jefferson reported that a record was not completed for Resident A as they did not believe that he would remain in the home for longer than a day. Ms. Jefferson took responsibility for not completing the required admission paperwork and reported she knows that she should have done it. This violation is established as Ms. Jefferson did not complete and maintain a record for Resident A as required by these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Pandrea Robinson
Licensing Consultant

10/07/25
Date

Approved By:

10/07/25

Ardra Hunter
Area Manager

Date