GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 4, 2026

Catherine Reese
Vibrant Life Senior Living, Superior Township, LLC
8100 Geddes Rd
Ypsilanti, MI 48198

RE: License #: AL810401931
Investigation #: 2026A0122014
Vibrant Life Senior Living, Superior 2

Dear Catherine Reese:

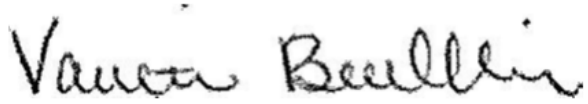
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL810401931
Investigation #:	2026A0122014
Complaint Receipt Date:	02/02/2026
Investigation Initiation Date:	02/02/2026
Report Due Date:	03/04/2026
Licensee Name:	Vibrant Life Senior Living, Superior Township, LLC
Licensee Address:	4488 Jackson Road Ste 2 Ann Arbor, MI 48103
Licensee Telephone #:	(734) 819-7790
Administrator:	Catherine Reese
Licensee Designee:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living, Superior 2
Facility Address:	1900 N. Prospect Road Ypsilanti, MI 48198
Facility Telephone #:	(734) 484-4740
Original Issuance Date:	12/23/2019
License Status:	REGULAR
Effective Date:	12/23/2024
Expiration Date:	12/22/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's personal care needs are not attended to as written in his assessment plan.	No
Additional Findings	Yes

III. METHODOLOGY

02/02/2026	Special Investigation Intake 2026A0122014
02/02/2026	APS Referral
02/02/2026	Contact – telephone call made Completed interview with Guardian A1 Special Investigation Initiated - On Site Completed an interview with Resident A1 and reviewed Resident A's file. Completed interviews with staff members, Bridget Allen and Rita Campbell.
02/03/2026	Exit Conference Discussed findings with licensee designee, Catherine Reese.

ALLEGATION: Resident A's personal care needs are not attended to as written in his assessment plan.

INVESTIGATION: On 01/30/2026, I conducted an interview with Guardian A1, who reported that while at a medical appointment on 01/26/26, Resident A was observed and described by medical personnel as disheveled/unkept, improperly dressed, and smelling of urine. Guardian A1 stated that Resident A attended the medical appointment independently. Guardian A1 does not know what assistance Resident A is to be given by the staff at Vibrant Life Senior Living, Superior 4, specifically if Resident A can attend medical appointments independently and/or what assistance should be given regarding personal hygiene tasks.

Guardian A1 reported that Resident A is a veteran and receives all of his medical care and follow-up from the Veterans Hospital of Ann Arbor, MI. Guardian A1 stated he has been issued a 30-day discharge notice on behalf of Resident A and is searching for a skilled nursing care facility for Resident A.

On 01/30/2026, Resident A was in his room, I observed him to be dressed in shorts and a shirt on but no brief, he had bandages on his legs, but he was pulling them down and scratching his legs. Resident A's room smelled of urine, and I observed dried feces on his toilet seat. Resident A agreed to participate in an interview with me. He stated he has lived in the facility for approximately 5 months, and he was not pleased with the personal care he receives from the staff members. I asked Resident A to expand upon his statement; he replied that the staff are "incompetent." I asked Resident A to give me examples of ways he felt the staff members were incompetent, and he began making a "spitting" sound with his mouth.

I asked Resident A what assistance staff give him and he reported the following: he will allow staff to assist him with dressing on occasion, he acknowledged that he needed assistance with toileting but does not allow staff to assist nor does he alert them to when he has to go as he stated, "it's none of their business." I asked Resident A if it was normal for him to travel to a medical appointment independently or if he needed staff assistance, to which he replied that his medical appointments were none of the staff members' business. I attempted to ask Resident A additional questions; however, he began making "spitting" sounds with his mouth and I ended the interview.

On 01/30/2026, I reviewed Resident A's file. Resident A's assessment plan dated 09/26/2025 documents that staff are to one-person assist with transfers with toileting and bathing, staff are to set-up grooming supplies and personal hygiene task. Staff are to dispense medications. Per my interview with Guardian A1, he is to attend medical appointments with Resident A, however, he stated he is not always able.

Resident A's file documents that he is to receive showers twice per week, Monday mornings and Thursday evenings. Resident A's bed sheets change/shower day dated from 1/15/2026 through 1/29/2026 documents that he received as he allows staff to complete them. During the previous listed dates, there were occasions Resident A refused showers and days that he allowed showers to be completed.

Resident A's file documented that on different occasions he has urinated on his bedroom floor and refused to use his personal bathroom.

On 01/30/2026, I conducted interviews with staff members, Bridget Allen and Rita Campbell. Both stated they provided personal care services to Resident A, including assistance with toileting and showering. Both reported Resident A refuses assistance with toileting and showering and also he can become combative when they attempt to assist as well. Ms. Allen and Ms. Campbell stated when Resident A" refuses assistance, they will give verbal prompts as a way to redirect but usually give time until he agrees to be assisted with the personal hygiene tasks.

On 02/03/2026, I conducted an exit conference with licensee designee, Catherine Reese and discussed my findings with her. Ms. Reese agreed with my findings and stated she would submit a corrective action plan to address the rule violation found during my investigation.

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 Guardian A1, Resident A, staff members, Bridget Allen and Rita Campbell, and a review of pertinent documentation relevant to this investigation, there is not enough evidence to substantiate the allegation that Resident A does not receive personal care as specified in his written assessment plan. On 01/26/2026, Resident A was observed to be disheveled/unkept, dirty, with urine-soaked brief on, however, after conducting interviews with Resident A and staff members and reviewing his file, staff members attempt to assist Resident A with personal hygiene tasks as documented in his assessment plan, however, Resident A sometimes refuses personal care assistance offered from staff members.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

INVESTIGATION: On 01/30/2026, I observed dried feces on Resident A’s toilet seat.

On 02/03/2026, I conducted an exit conference with licensee designee, Catherine Reese and discussed my findings with her. Ms. Reese agreed with my findings and stated she would submit a corrective action plan to address the rule violation found during my investigation.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based upon my investigation, which consisted of an onsite inspection and observation of Resident A's personal bathroom, there is enough evidence to substantiate the allegation that housekeeping standards were not met on 01/30/2026, as I observed dried feces on Resident A's toilet seat.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt and approval of a corrective action plan, I recommend no change in the license status.

Vanita C. Bouldin
Licensing Consultant
Date: 02/04/2026

Approved By:

Ardra Hunter
Area Manager
Date: 02/04/2026