



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 13, 2026

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

RE: License #: AS500379039
Investigation #: 2026A0617011
Mile End

Dear Ms. 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,

A handwritten signature in grey ink, appearing to be 'EJ', is positioned above the typed name.

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 #:	2026A0617011
Complaint Receipt Date:	02/12/2026
Investigation Initiation Date:	02/13/2026
Report Due Date:	04/13/2026
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?
On 02/10/2026, Resident A was hospitalized for a clogged feeding tube and was noted to have a significant bruise on her leg of unknown origin	Yes

III. METHODOLOGY

02/12/2026	Contact - Document Received email from APS
02/12/2026	Special Investigation Intake 2026A0617011
02/12/2026	APS Referral Referral received from Adult Protective Services- assigned worker is Debra Johns
02/13/2026	Special Investigation Initiated - Telephone TC to Ms. Debra Johns of Adult Protective Services
02/13/2026	Contact - Document Received I interviewed Ms. Debra Johns of Adult Protective Services.
02/19/2026	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, and I observed Resident A who is non-verbal.
04/10/2026	Contact - Telephone call made I interviewed staff Tracy Dunlap
04/10/2026	Contact - Telephone call made

	I interviewed Resident A's guardian
04/10/2026	Exit Conference I held an exit conference with administrator Samantha Nieuwenbroek informing her of the findings of the investigation

ALLEGATION:

On 02/10/2026, Resident A was hospitalized for a clogged feeding tube and was noted to have a significant bruise on her leg of unknown origin

INVESTIGATION:

On 02/12/26, 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 02/10/26, Resident A went to the hospital because her feeding tube was clogged and needed to be replaced. Resident A has a significant bruise on her leg. The bruise is dark purple with yellow spots. It is unknown where the bruise is located on Resident A's leg or how it occurred.

On 02/13/26, I interviewed Adult Protective Services worker Debra Johns. According to Ms. Johns, she completed a visit with Resident A and the group home manager. According to Ms. Johns, Resident A appears to be safe. Ms. Johns stated that the home manager Stacy admitted she forgot to document and complete an incident report. According to Ms. Johns, staff had no idea when or how Resident A obtained the bruise, however the staff concluded that Resident A sustained the bruise from being transferred to her wheelchair. Ms. Johns stated that she spoke to Resident A's guardians, and they had no safety concerns regarding Resident A remaining at the group home. Ms. Johns stated that Resident A was observed by her on 02/12/26 and Resident A was observed to be safe and stable. Ms. Johns stated her case will be closed with the case being substantiated for improper transfer and not timely documenting the bruise or reporting it to the guardians. Ms. Johns stated that staff reported they have no idea how Resident A substantiated the bruise, however staff admitted they observed it. Ms. Johns provided me with a copy of a picture of Resident A's hip with a large bruise on it. The bruise was deep purple and yellow and covered the majority of Resident A's hip.

On 02/19/26, I completed an unannounced investigation at the Mile End facility. During the onsite investigation, I interviewed home manager Stacey Williams Bey, staff Victoria Bartkowski, and I observed Resident A who is non-verbal.

During the onsite investigation, I interviewed Victoria Bartkowski. According to Ms. Bartkowski, on an unknown date, Resident A received a bruise on her leg from a transport from her wheelchair to the shower. It is not known how the injury occurred or who was the staff who transported her. Ms. Bartkowski stated that the bruise was not documented nor was an incident report completed until after Resident A went to the hospital for an unrelated cause on 02/10/26.

During the onsite investigation, I interviewed home manager Stacey Williams Bey. According to Ms. Williams Bey, on 01/29/26, she was made aware that Resident A had a bruise on her hip. According to Ms. Williams Bey, it is believed that the bruise happened during a transport from her wheelchair to the shower chair. The bruise started very small but over time became larger. Ms. Williams Bey stated that she forgot to complete an incident report at the time, but when Resident A went to the hospital for an unrelated issue on 02/10/26, she went back and completed an incident report. Ms. Williams Bey stated that Resident A is non ambulatory and requires staff assistance to move.

During the onsite investigation, I observed Resident A sitting in her wheelchair in the Livingroom of the home. Resident A appeared to be clean with no noticeable odor. With the assistance of staff, I observed Resident A's left hip with a small purple bruise. It appeared that the bruise was healing and reducing in color.

During the onsite investigation, I reviewed the incident report completed by Stacey Williams Bey and dated 2/10/26. According to the incident report, around January 30, 2026, staff brought it to Ms. Williams Bey's attention that Resident A had a small bruise on her left side. Over time the bruise got bigger and now it is a couple of inches long. The IR also stated that staff failed to document the bruise/incident, and it is assumed that the bruise came from transferring Resident A.

On 04/10/26, According to Resident A's guardian, she had no concerns at first regarding Resident A's injury. However, Resident A has been injured again from being transferred from her wheelchair to the shower chair and the family is now becoming concerned about the care Resident A is receiving in the home.

04/10/26, I interviewed staff Tracy Dunlap. According to Ms. Dunlap, on 01/29/26, Ms. Dunlap and Ms. Williams Bey transferred Resident A from her wheelchair to her bed using a Hoyer lift. While changing Resident A's brief, Ms. Dunlap observed a small mark/bruise on Resident A's hip/leg area. Ms. Dunlap told Ms. Williams Bey to write an incident report. Ms. Dunlap stated that the bruise looked fresh because it was small and red. It is unknown how the mark got there. It is assumed that the bruise came from one of the transports.

On 04/10/26, I held an exit conference with administrator Samantha Nieuwenbroek informing her of the findings of the investigation.

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 02/10/26, Resident A was observed with a significant bruise on her leg. The bruise is 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. On 02/13/26, Ms. Johns provided me with a copy of a picture of Resident A's hip with a large bruise on it. The bruise was deep purple and yellow and covered the majority of Resident A's hip. On 02/19/26, with the assistance of staff, I observed Resident A's left hip with a small purple bruise. It appeared that the bruise was healing and reducing in color. Resident A was not protected and kept safe.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



4/10/26

Eric Johnson
Licensing Consultant

Date

Approved By:



For

04/13/2026

Denise Y. Nunn
Area Manager

Date