



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 17, 2026

Karon Lee  
Michigan Community Services, Inc.  
PO Box 317  
Swartz Creek, MI 48473

RE: License #: AS090010213  
Investigation #: 2026A0576024  
Nebobish Road CLF

Dear Karon Lee:

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.
- 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. 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) 643-7960.

Sincerely,

A handwritten signature in cursive script that reads "C. Garza".

Christina Garza, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(810) 240-2478

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS090010213
<b>Investigation #:</b>	2026A0576024
<b>Complaint Receipt Date:</b>	02/24/2026
<b>Investigation Initiation Date:</b>	02/27/2026
<b>Report Due Date:</b>	04/25/2026
<b>Licensee Name:</b>	Michigan Community Services, Inc.
<b>Licensee Address:</b>	5239 Morrish Rd., Swartz Creek, MI 48473
<b>Licensee Telephone #:</b>	(810) 635-4407
<b>Administrator:</b>	Karon Lee
<b>Licensee Designee:</b>	Karon Lee
<b>Name of Facility:</b>	Nebobish Road CLF
<b>Facility Address:</b>	1405 W. Nebobish Road, Essexville, MI 48732
<b>Facility Telephone #:</b>	(989) 892-0948
<b>Original Issuance Date:</b>	08/07/1986
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	02/28/2025
<b>Expiration Date:</b>	02/27/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
<b>On 2/21/2026, Staff Elizabeth Licea pushed Resident A off the back of the van and the lift was down. Resident A fell off the van and hit her head requiring stitches.</b>	Yes

**III. METHODOLOGY**

02/24/2026	Special Investigation Intake 2026A0576024
02/24/2026	APS Referral
02/27/2026	Special Investigation Initiated - Telephone Left message for Case Manager to return call
04/16/2026	Inspection Completed On-site Interviewed Staff Diane Wraczynski, Susan Stevenson, and Resident A
04/16/2026	Contact - Document Received Reviewed AFC Assessment Plan
04/16/2026	Contact - Telephone call made Interviewed Case Manager Kerensa Hecht
04/16/2026	Contact - Telephone call made Interviewed Staff Elizabeth Licea
04/16/2026	Exit Conference Exit interview with Karon Lee

**ALLEGATION:**

**On 2/21/2026, Staff Elizabeth Licea pushed Resident A off the back of the van and the lift was down. Resident A fell off the van and hit her head requiring stitches.**

**INVESTIGATION:**

On February 27, 2026, I left a message for Kerensa Hecht, Case Manager from Bay Arenac Behavior Health to return call. On April 16, 2026, I interviewed Case Manager Hecht who reported she has been Resident A's case manager for 2 years and Resident

A has lived at Nebobish Road CLF for at least 5 years. Regarding the allegations, the staff member lowered the van lift to the ground and then went back in the van to push Resident A out. Resident A fell out of the van along with the staff person. The van was equipped with an alarm which was working so it is likely the staff person was not paying attention. Case Manager Hecht believes the incident to be an accident, and she has no concerns regarding Resident A's safety at the home.

On April 16, 2027, I conducted an unannounced on-site inspection at Nebobish Home CLF and interviewed Staff Diane Wraczynski who confirmed the allegations are true. Staff, Elizabeth Licea was out with Resident A and returned home. Staff Licea did not follow training resulting in the injury to Resident A. Staff Licea no longer works at the home.

During my on-site, Staff Wraczynski demonstrated how the van lift works. There is an alarm that sounds when staff step forward in the van when the lift is on the ground. According to the Staff Wraczynski, this should have alerted staff not to move Resident A prior to her fall.

On April 16, 2026, I interviewed Staff Susan Stevenson who was working on the day of the incident. Staff Stevenson reported that Staff Elizabeth Licea took Resident A out on an outing. When they came back Staff Licea came running into the home and said, "I need your help" and ran out of the home. Staff Stevenson followed Staff Licea out and saw Resident A on the ground with blood coming from her head. Staff Stevenson noticed that the lift on the van was down. Staff Stevenson immediately called 911 and staff were instructed to leave Resident A the way she was. The ambulance arrived and transported Resident A to the hospital where she received treatment for a wound on her head.

On April 16, 2026, I interviewed Resident A who was outside sitting in her wheelchair. Resident A appeared comfortable and was listening to music. Resident A confirmed there was an accident and she fell off the van. Resident A had to get stitches from falling off the van and today she is "fine". Resident A had never fallen from the van before, and Resident A believed this was an accident. Resident A denied any concerns about her home.

On April 16, 2026, I interviewed Staff, Elizabeth Licea who confirmed the allegations are true. Staff Licea reported she was coming back to the home with Resident A and Staff Licea was "in a rush". Staff Licea did not know why she had the van lift all the way down. Staff Licea stated "I don't know what happened that day" and "this was just an accident". Staff Licea tried to pull Resident A back up onto the van but was unable and both her and Resident A fell from the van. 911 was called and Resident A was taken to the hospital. Staff Licea was suspended and she no longer works at Nebobish Home CLF.

On April 16, 2026, I reviewed an AFC Licensing Division Accident / Incident Report (IR) authored by Staff Elizabeth Licea and dated for February 21, 2026. The IR documented

that on February 20, 2026, Resident A was returning home, and staff had the lift on the van all the way down. Staff pushed Resident A off the lift. By the time staff noticed staff tried pulling Resident A back in the van but staff fell off the lift with Resident A. Staff tried to hold the wheelchair but tipped over. Staff got help from another staff and 911 was called. The ambulance took Resident A to the hospital and staff held a towel on Resident A's head where it was bleeding.

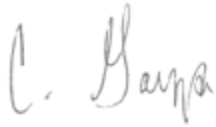
On April 16, 2026, I reviewed Resident A's AFC Assessment Plan which revealed Resident A is 49 years old and uses a wheelchair with a safety belt. Resident A requires staff assistance with mobility and hygiene needs including showering, dressing, and grooming.

On April 16, 2026, I conducted an exit interview with Licensee Designee (LD) Karon Lee. LD Karon reported that Staff Elizabeth Licea no longer works at Nebobish Home CLF and she was transferred to a home with residents that are mobile. LD Lee was provided with the findings of my investigation. I advised LD Lee I would be requesting a corrective action plan for the cited rule violation.

<b>APPLICABLE RULE</b>	
<b>R 400.681</b>	<b>Resident rights; licensee responsibilities.</b>
	<b>(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.</b>
<b>ANALYSIS:</b>	<p>It was alleged that staff pushed Resident A off the van with the van lift down causing injury to Resident A. Upon completion of investigative interviews and a review of documentation there is a preponderance of evidence to conclude a rule violation.</p> <p>Staff Elizabeth Licea reported that she was in a rush and put the van lift all the way down prior to Resident A being put onto the lift. Staff Licea pushed Resident A out of the van causing her to fall and obtaining a head injury. Resident A and two staff confirmed the allegations were true. Resident A was transported to the hospital for treatment as she obtained an injury to her head from the fall.</p> <p>There is a preponderance of evidence to conclude Resident A was not protected and safe given her fall and injury.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent upon receipt of an acceptable corrective action plan no change in the license status is recommended.



4/17/2026

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Christina Garza  
Licensing Consultant

Date

Approved By:



04/17/2026

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Mary E. Holton  
Area Manager

Date