GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 7, 2026

Julia Hill
Centered Care LLC
15945 Wood Rd
Lansing, MI 48820

RE: License #: AS190414185
Investigation #: 2026A0622048
Doe Acres

Dear Ms. Hill:

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) 335-5985.

Sincerely,

Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS190414185
Investigation #:	2026A0622048
Complaint Receipt Date:	06/26/2026
Investigation Initiation Date:	06/26/2026
Report Due Date:	08/25/2026
Licensee Name:	Centered Care LLC
Licensee Address:	15945 Wood Rd Lansing, MI 48820
Licensee Telephone #:	(517) 394-1234
Administrator:	Julia Hill, Designee
Licensee Designee:	Julia Hill, Designee
Name of Facility:	Doe Acres
Facility Address:	1920 Deerwood Circle A Dewitt, MI 48820
Facility Telephone #:	(517) 394-1234
Original Issuance Date:	05/06/2024
License Status:	REGULAR
Effective Date:	11/06/2024
Expiration Date:	11/05/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was hospitalized after staff allegedly grabbed her leg during an incident, resulting in a large hematoma and bruising.	Yes - No

III. METHODOLOGY

06/26/2026	Special Investigation Intake 2026A0622048
06/26/2026	Special Investigation Initiated - Telephone
06/26/2026	APS is also investigating
06/30/2026	Contact - Document Received from Nursing Director with Centered Care, Julia Hill
07/14/2026	Inspection Completed On-site, contact with adult protective services worker, Tom Hilla.
08/05/2026	Contact - Telephone call made to direct care worker, Bret Smith, Sabrelle Baker and Justin Deville.
08/10/2026	Exit conference with licensee designee, Julia Hill

ALLEGATION: Resident A was hospitalized after staff allegedly grabbed her leg during an incident, resulting in a large hematoma and bruising.

INVESTIGATION:
On 06/26/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. Per the referral, adult protective services is also investigating the allegations. According to the complaint, on the morning of 06/26/2026, Resident A complained of pain to staff and EMS was called. The complaint stated that Resident A has a large growing hematoma the size of a grapefruit and a bruise the size of a quarter on the inside of her right leg. According to the complaint, staff reported that Resident A had no trauma prior to going to bed on 6/26/26, however, Resident A stated that direct care worker, Sabrelle Baker was yelling and screaming in Resident A's face and did not want to get her out of bed. The compliant also stated that direct care worker Sabrelle Baker grabbed Resident A's leg and caused injury. According to the complaint, Resident A was sent to the emergency room after being evaluated by EMS.

On 06/26/2026, contact was made with adult protective services worker, Tom Hilla and additional information was obtained.

On 06/30/2026, I received documentation regarding Resident A and the allegations from Centered Care nursing director Julia Hill. According to documentation received, Resident A was admitted to Does Acres on 06/01/2026. On 06/30/2026, I received *AFC Licensing Division-Incident/Accident Report* regarding the allegations.
The *AFC Licensing Division-Incident/Accident Report* completed by nursing manger, Carrie Wolf stated the following*:*

Explain what happened:
"On 06/26/2026 at 6:47am, direct care worker, Bret Smith was changing [Resident A] when she noticed a large swollen lump on the inside of clients right upper thigh. Client was reporting it was painful and bruising was starting to appear."

Action Taken by Staff:
"Floor staff contacted on call nurse at 6:47am. On call nurse called OT Haley at 6:49am whom [sic] was on her way in. I requested that she stop at Deerwood first and evaluate [Resident A]. Haley contacted on call nurse at 7:22am and recommended we send her in for evaluation. Advised her to call 911 and send her to McLaren. Upon my arrival at 7:35ish, Bret, Haley and I were in the clients room. I observed a large hematoma medial right thigh, with skin discoloration. Client reported increased pain. It was warm to touch. I asked client to explain what happened and she reported she was being pinched every two hours by the overnight staff, Sabrelle Baker. EMS arrived and transported her to McLaren."

On 06/30/2026, I received additional written statements from direct care workers, that Does Acres obtained regarding the allegations.

Direct care worker, Bret Smith stated the following: *"Arrived for shift at 6am, completed shift change and walk through with direct care worker Sabrelle Baker. Eyes on client, no seen concerns. At 6:45am, client rang bell to use the bathroom. While uncovering her blankets, I noticed a raised bump on her right leg. I asked resident if this was painful and, she answered yes. [Resident A] stated staff working the night shift had been physical with her through the night and grabbed her leg aggressively, while be very demanding that she must stay in bed. Also stating to resident that she needed to stop calling so much, she checks on her every two hours. Immediately called on call nurse, Carrie Wolf to report the raised bump. OT Haley LaFave-Mendez and nurse Carrie Wolf arrived to assess and called 911."*

Direct care worker, Tamera Schueller stated the following: "*On 06/25/2026 at 6:05pm, I assisted direct care worker, Rebecca Miller do a check and change on the client at the end of our shift. At the time of the change there was no signs of swelling, bruising or complaints of pain at that time."*

Direct care worker, Rebecca Miller stated the following: *"On 06/25/2026 at 6:05pm, with the assistance of direct care worker, Tamera Schueller we did a check on [Resident A], we changed her before the end of the shift. At the time of the change I did not see any bruising, swelling or complaints of pain at the time."*

Direct care worker, Justin Deville stated the following: *"On 06/25/2026, I arrived at the home at 6am to help train a new employee. Upon arrival we completed shift rounds and counted medications. Everything was accounted for and there was no issues noted. [Resident A] appeared to be doing well and was in a good mood with no apparent concerns. [Resident A] woke up around 7am. We began getting her up around 7:40am. During personal care and while changing her, I carefully observed her body and I did not notice and bruising, swelling, redness or any other abnormalities."*

Occupational therapist, Haley LaFave-Mendez stated the following: *"I received a phone call at 6:49am, but was unable to answer, I received a second phone call at 6:51am and was asked if I would go to Deerwood to check on [Resident A] due to reports of a new leg mark. OT arrived at 7:18am. This OT gently woke up [Resident A] with voice and requested to look at her leg. She replied, "yes, please it's hurting me really badly." The OT removed the blanket to reveal large, raised hematoma on inside of right leg a few inches above knee and on medial side of leg. Concern for DVT, this OT checked for temperature, swelling, pain with palpitation. Noted no increase heat along lower leg, increased temperature noted along back of knee and directly over the hematoma, small bruise on inferior and proximal portion of hematoma. Patient initially reported to this OT that she was unsure where the injury came from, reports no new falls or injuries. She did then report to this OT, "that Saby has been pinching me." OT reported to the nurse and then the nurse approached patient in bed, patient then identified more specifics of how the night nurse had been getting heightened in her words and repeated 4 times that she has been being pinched by Saby. OT collaborated with nursing staff and it was decided to call 911. Nursing informed her that the Guardian A was requesting that Resident A be sent to McLaren Hospital."*

On 06/30/2026, I reviewed a copy of Resident A's *Discharge Instructions from McLaren Greater Lansing Emergency Department.* According to the *Discharge Instructions,* Resident A was seen on 06/26/2026 at 8:19am. The instructions stated that the reason for the visit was medical problem, minor. According to the *Discharge Instructions,* the final diagnosis was assault.

On 07/20/2026, I received a *Dewitt Township Police Department Incident/Investigation Report* regarding the allegations. The Incident/Investigation Report stated the following regarding their interview with Resident A: *"On 06/27/2026 at approximately 0920 hours, officers and APS Investigator Tom Hilla returned to the facility to interview [Resident A]. [Resident A] was alert, oriented, and answered questions appropriately. [Resident A] stated Sabrelle had been her caretaker for approximately five to six years. She explained that when she*

transferred to the current facility approximately one year ago, Sabrelle transferred with her. [Resident A] stated that prior to this incident she could not recall Sabrelle ever striking her. However, she stated she had been afraid of Sabrelle because Sabrelle frequently screamed at her whenever she needed assistance. [Resident A] stated there had been previous occasions where Sabrelle grabbed her, but this was the first time it resulted in visible injuries. [Resident A] stated that during the overnight shift on 06/25/2026 she requested assistance using the restroom. According to [Resident A], Sabrelle became upset and told her, "You can go in your pants," because she was wearing Depends. When specifically asked about being punched, [Resident A] stated she could not clearly remember being punched but distinctly remembered Sabrelle grabbing her right thigh, causing pain. [Resident A] consistently maintained that Sabrelle grabbed her multiple times throughout the shift. [Resident A] stated she is afraid of Sabrelle and expressed relief after learning Sabrelle would no longer be caring for her. [Resident A] stated she feels safe with the other caretakers currently assigned to her. When asked why she had never reported Sabrelle`s behavior previously, [Resident A] stated she was too afraid to say anything."

According to the Dewitt Township Police Department Incident/Investigation Report the following was documented regarding their interview with direct care worker, Sabrelle Baker:
"We advised Sabrelle we were investigating an incident that occurred at her workplace in DeWitt Township. She stated she believed this was why we were there because Carrie had contacted her the previous day, advised her she had been suspended, and provided limited information regarding the allegation. Officers advised Sabrelle that regardless of what was discussed during the interview she would not be taken to jail by DeWitt Township officers; however, because she had an active Lansing Police Department warrant, she was not free to leave. Using a Miranda warning card, I read Sabrelle her constitutional rights verbatim. Sabrelle stated she understood each of her rights and agreed to waive those rights and speak with officers. Sabrelle stated she worked from 1800 hours on 06/25/2026 until 0600 hours on 06/26/2026 and was the sole caretaker assigned to [Resident A], who was the only resident on that floor.

Sabrelle stated she has cared for [Resident A] for approximately three years, including two years at a previous facility and approximately one year at the current facility. Sabrelle stated [Resident A] has previously accused other caretakers of "acting some type of way," but she was unaware of any previous allegations involving physical assaults or injuries. Sabrelle described [Resident A] as occasionally being difficult during care because [Resident A] becomes upset when she must be repositioned or changed multiple times during the night. Sabrelle stated [Resident A] was already in bed when she arrived for her shift. Throughout the night she checked on [Resident A] approximately every two hours unless [Resident A] requested assistance sooner. Sabrelle estimated she changed [Resident A's] Depends approximately four times and repositioned her several additional times during the shift. Sabrelle explained that when repositioning [Resident A] she follows

the procedures she was taught by moving [Resident A's] legs to one side, having [Resident A] grasp the bedrail, assisting her in rolling, completing care, and then repeating the process from the opposite side. Sabrelle stated [Resident A] frequently complained that other staff did not reposition her as many times, but Sabrelle believed her methods were consistent with facility procedures. Sabrelle stated that during each interaction there was sufficient lighting to observe bruising, cuts, abrasions, fecal matter, or other abnormalities. She stated she did not observe any bruising or injuries to [Resident A's] leg during her shift. Sabrelle stated she completed shift report with Brett Smith at approximately 0600 hours and left work. She stated Carrie contacted her approximately five to six hours later and informed her she was suspended. Sabrelle stated that had she observed any injury she would have reported it to day shift staff. She also stated that no one contacted her afterward to ask about any bruising or injuries. Officers asked Sabrelle whether she ever grabbed [Resident A] in an inappropriate or unprofessional manner. Sabrelle denied doing so. Sabrelle denied punching [Resident A]. Sabrelle denied pinching [Resident A], either intentionally or accidentally. Sabrelle further denied yelling or screaming at [Resident A] during the shift. Sabrelle stated she had no explanation for how [Resident A] sustained the bruising and stated nothing occurred, either intentionally or accidentally, that could have caused those injuries. When asked whether she would want to continue caring for [Resident A] if the allegations were resolved today, Sabrelle advised she did not want to continue providing any sort of care for [Resident A]."

On 06/29/2026, I viewed the staff schedule for Doe Acres and confirmed that Sabrelle Baker was the only direct care worker on shift on 06/25/2026 during the overnight shift. I also confirmed that all direct care workers who provided statements were listed on the staff schedule for identified dates and times.

On 08/05/2026, I received documentation that direct care worker Sabrelle Baker was terminated from Doe Acres on 6/29/2026. According to nursing director, Julia Hill she stated that cameras are located in the main areas of the home and a camera was located outside of Resident A's bedroom. Ms. Hill reported that they reviewed the surveillance tapes and sound was available, but they were unable to view any care provided to Resident A during the shift. Ms. Hill reported that the videos were turned over to the Dewitt Police Department, therefore they were unable to be shared. On the performance correction notice dated 6/29/26 for Sabrelle Baker it stated that she terminated due to the following incident:

"6/25/26, 6pm-6am on 06/26/2026, she failed to check, change or turn client every two hours. From 10:30pm-4:30am, she did not enter [Resident A's] bedroom. During the 4:30am check and change, Sabrelle Baker was verbally aggressive, demanding and treated client with disrespect. It was a violation of standards of conduct of Centered Care LLC." The following statement was also documented on Sabrelle Baker's Performance correction notice regarding the review of video surveillance: "On 06/26/26 between the hours of 4:30am-4:44am, Sabrelle Baker was clearly upset. Her tone was incredibly demanding using phases such as "move your legs

over and open them up." During this incident, Sabrelle Baker told [Resident A] to open her legs up more than 10 times. Sabrelle Baker was very aggressive in her speech to [Resident A] and used phases like "can you hear?" Are you slow?" "What are you looking for?" Are you going to wipe your own self?" Later in the video, the tone became unsettling after what seemed to be the patient informed Sabrelle Baker that she was demanding. Sabrelle Baker stated to [Resident A] "wipe your own self since I'm ordering you around, the trash can is right here." Unable to hear the exact back and forth between Sabrelle Baker and [Resident A], Sabrelle Baker responded with "I don't have to clean you up, luckily I am. You stinking and some people wouldn't' do it." What I assume, the client was reaching for an item, Sabrelle Baker stated "don't touch these briefs no more, this is the 2nd time you touched it."

On 07/14/2026, I completed an unannounced onsite investigation to Doe Acres AFC. During the unannounced onsite investigation, Resident A was not available to be interviewed as she was currently at the hospital for a urinary tract infection. All direct care workers who were present when the injury was found on Resident A were unavailable to be interviewed in person. Resident A's bedroom was viewed and the location of the surveillance camera closest to her bedroom was also viewed.

On 07/14/2026, I had contact with adult protective services worker, Tom Hilla. He reported the following: "Detective Schaberg sent the police report to the prosecutor's office. Furthermore, APS will be closing the case as there is no longer a need for APS involvement."

On 08/05/2026, I left a voicemail for direct care worker Sabrelle Baker. She later returned my phone call and stated that she did not want to be interviewed.

On 08/05/2026, I interviewed direct care worker Bret Smith via phone. She reported that as soon as she found the raised bump on Resident A's leg, she called the on-call nurse to report it. DCW Smith stated that as time went on during the morning and throughout her time at the hospital the bruising became more prominent on Resident A's right leg. DCW Smith confirmed that Resident A told her that the night shift staff had been very aggressive with her, was talking rudely, made her stay in bed and grabbed her leg. DCW Smith reported that she went with Resident A to the hospital and they ruled out blood clots. She explained that the bruising became larger throughout the day, but the bump stayed about the same. DCW Smith reported that she has never worked a shift with Sabrelle Baker and most interaction with Sabrelle Baker was at shift change.

On 08/05/2026, I interviewed direct care worker Justin Deville via phone. He stated that he worked the day shift of 6/25/26 and observed no bruising, bumps or redness on Resident A's leg. She stated that Resident A did not report any pain either. DCW Deville stated that Resident A is easy to work with and is a very sweet lady. He explained that Resident A is able to tell you what she needs.

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:	Based upon documentation reviewed, it was found that direct care worker Sabrelle Baker did not treat Resident A with dignity and respect. Based upon documentation from Centered Care, they confirmed through a common area surveillance tape that DCW Baker was using an aggressive tone and used degrading comments towards Resident A during a brief changing at 4:30am. Resident A also confirmed that direct care worker, Sabrelle Baker was disrespecting her and was also physically grabbing/pinching her leg during her brief change on 6/26/26 at 4:30am. The physical grabbing/pinching to Resident A's right leg was confirmed through an emergency visit on 6/26/26 at McLaren Hospital. According to the *Discharge Instructions,* the final diagnosis was assault. Based upon the documentation from Centered Care regarding the surveillance cameras, Resident A's consistent statements and the discharge diagnosis from McLaren Hospital, a violation was established as direct care worker Sabrelle Baker did not treat Resident A with respect, dignity or make her feel safe and protected during her brief change on 06/26/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

08/06/2026

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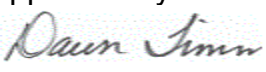
Amanda Blasius Date
Licensing Consultant

Approved By:



08/07/2026

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Dawn N. Timm Date
Area Manager