GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2026

Catherine Reese
Vibrant Life Senior Living Sterns Lodge
667 W. Sterns Road
Temperance, MI 48182

RE: License #: AH580353904
Investigation #: 2026A1027055
Vibrant Life Senior Living Sterns Lodge

Dear Licensee:

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 authorized representative 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH580353904
Investigation #:	2026A1027055
Complaint Receipt Date:	07/27/2026
Investigation Initiation Date:	07/30/2026
Report Due Date:	09/26/2026
Licensee Name:	Vibrant Life Senior Living, OC Temperance LLC
Licensee Address:	5720 Williams Lake Road Waterford, MI 48329
Licensee Telephone #:	(734) 847-3217
Authorized Representative/ Administrator:	Catherine Reese
Name of Facility:	Vibrant Life Senior Living Sterns Lodge
Facility Address:	667 W. Sterns Road Temperance, MI 48182
Facility Telephone #:	(734) 847-3217
Original Issuance Date:	02/20/2014
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	46
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents lacked protection.	Yes
Additional Findings	No

III. METHODOLOGY

07/27/2026	Special Investigation Intake 2026A1027055
07/30/2026	Special Investigation Initiated - On Site
07/30/2026	Inspection Completed-BCAL Sub. Compliance
07/31/2026	Exit Conference Conducted via email with Catie Reese

ALLEGATION:

Residents lacked protection.

INVESTIGATION:

On July 27, 2026, the Department received an anonymous allegation which read that, as of July 23, 2026, and for several weeks prior, a fingerprinting business had been operating within the facility's common living areas. The complainant reported an incident in which an individual visiting for fingerprinting became irate with staff and refused to leave, creating a potential safety risk for residents and staff. The complainant expressed concern that the presence of non-residents entering the home for fingerprinting services compromised resident safety and infringed upon their rights to a secure and predictable living environment. The complainant further stated that a resident felt unsafe following the incident.

On July 28, 2026, the Department received two additional anonymous allegations consistent with the original report. These allegations indicated that members of the public routinely entered and occupied the front porch and living room areas while waiting for fingerprinting services, preventing residents from using these spaces and creating ongoing safety and privacy concerns. The allegations read that both front desk staff and the administrator had acknowledged concerns regarding this arrangement.

On July 30, 2026, an on-site inspection was conducted. Employee #1 stated that visitors regularly entered the home to receive IdentoGo fingerprinting services. She reported receiving daily appointment lists and escorting visitors into a room located within the common living space where the IdentoGo machine was stationed. She stated that visitors frequently waited in the front entrance/porch area, with appointments scheduled every ten minutes.

Employee #2's statements were consistent with Employee #1. She stated the home served as an IdentoGo hub and was required to fingerprint members of the public, not solely employees. She reported that fingerprinting began on June 4, 2026, initially occurring Monday through Friday from 9:00 a.m. to 4:00 p.m., then shifting to Thursdays and Fridays from 12:00 p.m. to 4:00 p.m. She explained that visitors occasionally filled the porch, and when additional space was needed, they waited in the living room, as well as use the facility's restroom. She described an incident in which a visitor became aggressive in front of residents and families, resulting in a police report. Employee #2 reported that residents at times became agitated due to the increased public traffic, and that residents' families have also expressed concerns regarding the presence of visitors in these areas.

During the inspection, an IdentoGo logo was observed on the front window. The front entrance doors were locked, and access was granted by Employee #1. The porch area contained multiple seating arrangements and opened into the common living room area through unlocked interior doors. The IdentoGo room was located within this common living space, directly accessible to residents. Appointment lists for July 30 and July 31, 2026, documented fingerprinting visitors scheduled every ten minutes, representing various agencies and states.

APPLICABLE RULE	
MCL 333.21313	**Owner, operator, and governing body of home for aged; responsibilities and duties; good moral character; issuance of license by department; criminal history check and criminal records check required; renewal of license; storage of fingerprints in automated fingerprint identification system database; convictions.**
	(1) The owner, operator, and governing body of a home for the aged are responsible for all phases of the operation of the home and shall assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.

For Reference: 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.** **(g) A patient or resident is entitled to exercise his or her rights as a patient or resident and as a citizen, and to this end may present grievances or recommend changes in policies and services on behalf of himself or herself or others to the health facility or agency staff, to governmental officials, or to another person of his or her choice within or outside the health facility or agency, free from restraint, interference, coercion, discrimination, or reprisal. A patient or resident is entitled to information about the health facility's or agency's policies and procedures for initiation, review, and resolution of patient or resident complaints.**
ANALYSIS:	The allegations were consistent with staff statements and on-site observations. The facility permitted members of the public to routinely enter and utilize resident living areas for fingerprinting services. The home failed to maintain an organized system of protection and did not preserve residents' rights to a safe, private, and secure living environment.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/30/2026

Jessica Rogers Date
Licensing Staff

Approved By:

07/31/2026

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section