



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 17, 2026

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

RE: License #: AS630389328
Investigation #: 2026A0612033
Lake Orion

Dear Ms. 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.
- 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 (248) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Johnna Cade". The signature is written in a dark ink and is positioned to the left of the typed name and address.

Johnna Cade, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(248) 302-2409

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630389328
Investigation #:	2026A0612033
Complaint Receipt Date:	08/13/2026
Investigation Initiation Date:	08/17/2026
Report Due Date:	10/12/2026
Licensee Name:	Life Center Inc
Licensee Address:	Ste. 100 36975 Utica Rd. Clinton Twp., MI 48038
Licensee Telephone #:	(586) 739-9220
Administrator:	Samantha Nieuwenbroek
Licensee Designee:	Samantha Nieuwenbroek
Name of Facility:	Lake Orion
Facility Address:	1025 Orion Road Lake Orion, MI 48035
Facility Telephone #:	(248) 783-7068
Original Issuance Date:	05/03/2018
License Status:	REGULAR
Effective Date:	11/03/2024
Expiration Date:	11/02/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
- On 08/10/26, direct care staff, Ahman Dillard, was found with his arms wrapped around Resident A's neck. It was alleged that Mr. Dillard choked Resident A. - Resident B has been grabbing his neck as if trying to communicate that someone has touched his neck. Resident B's eyes have broken blood vessels. There is concern that Resident B was also choked.	Yes

II. METHODOLOGY

08/13/2026	Special Investigation Intake 2026A0612033
08/17/2026	APS Referral Referral received from Adult Protective Services (APS). Assigned APS worker, Donna Dennis
08/17/2026	Special Investigation Initiated – Letter Email sent to assigned APS worker Donna Dennis to coordinate.
08/17/2026	Referral - Recipient Rights I made a referral to Oakland Community Health Network - Office of Recipient Rights via email.
08/25/2026	Contact - Telephone call made Telephone call with APS worker Donna Dennis.
08/25/2026	Contact - Document Received Photos of Resident B received via text message from APS worker Donna Dennis.
08/25/2026	Contact - Telephone call made Telephone interviews completed with home manager Demitra Bonds, nurse practitioner Allison Laprise, and direct care staff Kaniyah Spears.
08/25/2026	Contact - Document Received Facility documentation received from home manager Demitra Bonds via text message.

08/25/2026	Document Received Photos of Resident B received via text message from direct care staff Kaniyah Spears.
08/26/2026	Contact - Telephone call made Telephone interview completed with direct care staff Ahman Dillard.
08/26/2026	Exit Conference I placed a telephone call to licensee designee Samantha Nieuwenbroek to conduct an exit conference.
09/01/2026	Inspection Completed On-site I completed an unscheduled onsite investigation. I interviewed Resident C. Home Manager Demetria Bonds was onsite at the time of the investigation.
09/01/2026	Contact - Face-to-Face Interviews completed with Resident A and Resident B (with assistance from Life Skills Staff Shantel Joyce).
09/02/2026	Exit Conference I emailed licensee designee Samantha Nieuwenbroek to conduct a second exit conference.

ALLEGATION:

- **On 08/10/26, direct care staff, Ahman Dillard, was found with his arms wrapped around Resident A's neck. It was alleged that Mr. Dillard choked Resident A.**
- **Resident B has been grabbing his neck as if trying to communicate that someone has touched his neck. Resident B's eyes have broken blood vessels. There is concern that Resident B was also choked.**

INVESTIGATION:

On 08/17/26, I received a referral from Adult Protective Services (APS) that in summary indicated Resident A resides at Lake Orion Group Home. Resident A is autistic and mostly non-verbal. He has a history of bladder cancer, he has a learning disability, dementia, and hypertension. Resident A has a guardian with Macomb Oakland Guardianship. On Monday 08/10/26, direct care staff, Ahman Dillard, was found with his arms wrapped around Resident A's neck. Resident A was facing the bedroom window, and Mr. Dillard was behind him. Resident A went to the ground but got back up. It is unknown how long Mr. Dillard had his arms around Resident A's neck. Mr. Dillard's story was that he was helping Resident A get out of bed. This story did not match since

Resident A was already out of bed. Mr. Dillard then followed Resident A around all day. Resident A was taken to his primary care physician, and he had no injuries. When asked if Mr. Dillard choked him, he said yes and put his hands to his throat. A police report has been made, and Mr. Dillard is off the schedule pending an investigation. There are also concerns that Mr. Dillard might be involved with another incident regarding Resident B.

Resident B is a 34-year-old male. Resident B is diagnosed with Down Syndrome and requires assistance with his activities of daily living. Resident B has been making motions of grabbing his neck as if trying to communicate that someone has touched his neck. Both of Resident B's eyes have so many blood vessels broken that the white of his eyes are red. There is concern that Resident B was choked to the point that he broke blood vessels in his eyes.

On 08/17/26, I initiated this investigation by emailing the assigned APS worker Donna Dennis to coordinate. On 08/25/26, I spoke to Ms. Dennis via telephone. Ms. Dennis stated Resident A and Resident B are nonverbal. She interviewed Resident B's guardian who indicated that they have no concerns he was choked by staff. Ms. Dennis stated Resident B had red marks on his neck and broken blood vessels in his eyes, however, it was reported to her that he had been straining to have bowel movements. Regarding Resident A, Ms. Dennis stated there was a witness to the alleged choking incident.

On 08/17/26, I made a referral to Oakland Community Health Network – Office of Recipient Rights via email. The investigation was assigned to Recipient Rights Specialist Rishon Kimble. Ms. Kimble stated she completed an onsite investigation on 08/14/26. Although Resident A is nonverbal when asked if something happened with direct care staff Ahman Dillard Resident A touched his neck.

On 08/25/26, I interviewed nurse practitioner Allison Laprise via telephone. Ms. Laprise stated Resident A was brought in for an appointment the day he was allegedly choked by a staff member. Resident A had no injuries at the time of the appointment. Ms. Laprise stated she has been working with Resident A for 5 -10 years and he has been agitated lately. He is typically very happy. Ms. Laprise stated she has concerns about the care this home is providing as she has had other another patient at this home who had unexplained bruises on their body.

Ms. Laprise stated Resident B came in for an appointment the same day as Resident A. Resident B's eyes were red and had broken blood vessels. Resident B was not sick or coughing. Ms. Laprise stated there were no reports that Resident B was constipated or having issues with bowel movements. There were no bruises observed on Resident B's neck, however, Ms. Laprise was informed by staff that Resident B had been making hand motions towards his neck, which raised suspicions that he was choked.

On 08/25/26, I interviewed home manager Demitra Bonds via telephone. Ms. Bonds stated on 08/05/26, direct care staff Kaniyah Spears took Resident A to workshop, and it was discovered that his eyes were bloodshot red and he had marks on his neck. Direct care staff, Ahman Dillard took Resident A to the emergency room. At the hospital Mr. Dillard reported that Resident A was constipated. It was therefore determined by the emergency room that Resident A had eczema on his neck and dermatitis. Ms. Bonds stated Mr. Dillards statement regarding Resident A being constipated was contradictory as he also informed group home staff that Resident A had diarrhea.

Ms. Bonds stated on Monday, 08/10/26, Ms. Spears reported that she found Mr. Dillard with his arms wrapped around Resident A's neck. Mr. Dillard stated he was trying to get Resident A out of bed. However, this did not make sense as Resident A was already out of bed. On 08/10/26, Resident A and Resident B were taken to nurse practitioner Allison Laprise for an appointment. Ms. Laprise was concerned. She suspects that both residents were choked. Additionally, Ms. Bonds stated she took Resident B to the dermatologist on 08/25/26, and the dermatologist said that he had eczema on his neck and the dermatitis healed. Ms. Bonds remarked that she would never have expected Mr. Dillard to do anything like this, however, she does believe what Ms. Spears reported is accurate and truthful.

On 08/25/26, in collaboration with Recipient Rights Specialist Rishon Kimble, and APS worker Donna Dennis I interviewed direct care staff Kaniyah Spears via telephone. Ms. Spears stated on 08/10/26 she was working a midnight shift with direct care staff Mr. Dillard. In the morning, Mr. Dillard provided personal care to the men and Ms. Spears provided personal care to the women. Ms. Spears stated she heard moaning coming from Resident A's bedroom, so she went to see what was going on. Ms. Spears stated she stood in front of Resident A's bedroom door, and she observed Mr. Dillard with his arms wrapped around Resident A's neck, as if he had him in a head lock, choking him. Resident A was facing the bedroom window, and Mr. Dillard was behind him. Ms. Spears stated she asked if everything was okay. Mr. Dillard released his arms, and Resident A went to the ground but got back up. Mr. Dillard said he was helping Resident A get out of bed. Ms. Spears stated Resident A was already out of bed. Ms. Spears stated Resident A is nonverbal; however, he was whining as if he was in pain and had just been choked. For the remainder of the morning Mr. Dillard followed Resident A around the house. Ms. Spears remarked the mood of the house was off and the morning did not go according to schedule. Mr. Dillard fed Resident A breakfast and gave him his medication before getting him dressed and ready, which is unusual. Then, without prompting Mr. Dillard told Ms. Spears he was assessing to see if Resident A needed a Xanax for a behavior. Ms. Spears remarked that this was an odd comment as Resident A did not present with any behaviors that would suggest he needed a Xanax at this time.

Ms. Spears stated following this incident she recalled an incident on 08/05/26, when she was working with Mr. Dillard on the midnight shift. That evening Mr. Dillard told her that Resident B was constipated and had diarrhea all night. The next morning Ms. Spears stated she drove Resident B to workshop and while she was taking him out of the van, she observed that his eyes were blood shot and he had red scratches on his neck. Mr. Dillard took Resident B to the emergency room. Mr. Dillard reported to the emergency room physician that Resident B was straining to use the restroom. Ms. Spears stated she is concerned that Mr. Dillard may have caused or contributed to Resident B's injuries as well. Ms. Spears stated she did not witness and/or hear any physical altercation between Resident B and Mr. Dillard that evening.

On 08/26/26, I interviewed direct care staff Ahman Dillard via telephone. Mr. Dillard stated on 08/10/26 he worked a midnight shift with direct care staff Ms. Spears. In the morning, Resident A was in bed. Mr. Dillard asked him to get up three times. Mr. Dillard remarked Resident A was being disobedient, which is a sign that he was going to have a behavior. Mr. Dillard stated when Resident A got up out of bed he started to make his bed. However, Mr. Dillard wanted Resident A to get dressed first. Mr. Dillard remarked, "I hugged him from behind and walked him to where I needed him to be" near his closet. Mr. Dillard explained while standing behind Resident A he put his right hand under Resident A's right hand across his stomach. Mr. Dillards left hand was over Resident A's shoulder and across Resident A's chest. Mr. Dillard remarked, "when I first grabbed him, he didn't move." Then, Ms. Spears came into the bedroom and said, "hey Ahaman." When Resident A heard Ms. Spears, he dropped all his weight to the floor. Mr. Dillard stated he was holding Resident A up by his armpits. He then had to assist Resident A into a standing position. Mr. Dillard stated he kept Resident A near him for the remainder of the morning to determine if he needed a Xanax for his behavior. He determined that no Xanax was needed.

Regarding Resident B, Mr. Dillard stated on 08/05/26, he worked with Ms. Spears on the midnight shift. That evening Resident B was constipated and had diarrhea all night. He was in and out of the bathroom repeatedly. While straining on the toilet Resident B was uncomfortable. He was pulling his hands back and forth on his cheeks and the side of his neck while applying pressure. Mr. Dillard stated the following morning he took Resident B to the emergency room because his eyes were blood shot red and he had scratches on his neck. It was determined that these injuries were a result of his straining due to constipation. Mr. Dillard denied causing the injuries to Resident B. Mr. Dillard denied choking Resident B and/or restraining his movement in any way.

On 08/25/26 I reviewed the Appointment Record from Resident B's dermatologist appointment on 08/25/26. The record indicates dermatitis improved, mild eczema.

On 08/25/26 I reviewed Resident B's Hospital Discharge paperwork following his ER visit on 08/05/26. Resident B was diagnosed with eczema, pruritus, and subconjunctival hemorrhage left eye— a small broken blood vessel on the surface of the eye.

On 08/25/26, I reviewed a photo of Resident B's eye sent via text message from Ms. Spears. The photo shows one of Resident B's eyes with broken blood vessels. Ms. Spears also provided a video of Resident B taken on 08/25/26. His eye appears to be clearing up. There is mild eczema seen on his neck/ behind his ear.

On 08/25/26, I reviewed five photos of Resident B taken on 08/12/26. They were sent via text message from APS worker Ms. Dennis. The photos show one of Resident B's eyes with broken blood vessels. There is mild eczema seen on his neck/ behind his ear.

On 09/01/26, I completed an unscheduled onsite investigation. I interviewed Resident C. Home Manager Demetria Bonds who was on site at the time of the investigation. Ms. Bonds confirmed the details that she reported during her telephone interview on 08/25/26. There was no additional information provided.

On 09/01/26, I observed Resident C sitting at the kitchen table eating lunch. Resident C returned today from the hospital where she had been admitted for five days due to a medical issue. Resident C stated she was tired and wanted to go take a nap. As such, Resident C was not interviewed. There were no other residents' home at the time of the unscheduled onsite investigation.

On 09/01/26, I interviewed Resident A at Life Skills workshop. Resident A is nonverbal. When asked about direct care staff Ahman Dillard, Resident A covered his eyes/face using both of his hands.

On 09/01/26, I interviewed Resident B at Life Skills workshop. Resident B was interviewed with Life Skills Staff Shantel Joyce present as Resident B is mostly nonverbal. Resident B did not respond to interview questions. Ms. Joyce stated on the day Resident B arrived at workshop with marks on his neck and bloodshot eyes he approached her, grabbed his neck, began to whine and gave her a hug. This behavior was unusual for Resident B. Ms. Joyce stated she has been working with Resident B for five years and she has never known him to have blood shot eyes or marks on his neck.

On 08/26/26, I placed a telephone call to licensee designee Samantha Nieuwenbroek to conduct an exit conference and review my findings. Ms. Nieuwenbroek was advised that a corrective action plan is required. Ms. Nieuwenbroek acknowledged. On 09/02/26, I emailed licensee designee Samantha Nieuwenbroek to conduct a second exit conference and confirm my findings that were discussed via telephone on 08/26/26.

APPLICABLE RULE	
R 400.641	Resident behavior interventions.
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: (c) Restrain a resident's movement for the purpose of immobilizing the resident.
ANALYSIS:	Based upon the information gathered during this investigation there is sufficient information to conclude that direct care staff Ahman Dillard restrained Resident A's movement for the purpose of immobilizing him. Although, Mr. Dillard denied choking Resident A he admitted that on 08/10/26, he felt that Resident A was being "disobedient." Therefore, he "hugged (Resident A) from behind" and walked him to where he wanted him to be. Mr. Dillard explained that he stood behind Resident A and put his right hand under Resident A's right hand across his stomach. His left hand was over Resident A's shoulder and across his chest. Mr. Dillard remarked, that when he first "grabbed" Resident A he did not move. Resident A eventually dropped all his weight to the floor and Mr. Dillard was holding Resident A up by his armpits. It has therefore been determined that Mr. Dillard restrained Resident A. Although it was further alleged that Resident B was observed grabbing his neck, which was interpreted as an attempt to communicate that someone had touched or grabbed his neck. It was also suggested that the broken blood vessels in Resident B's eyes may have resulted from someone choking him. However, there is insufficient evidence to substantiate these allegations. Resident B was evaluated in the emergency room and subsequently seen by his dermatologist. Neither provider documented or reported concerns of suspected abuse. Resident B was diagnosed with a subconjunctival hemorrhage in his left eye, dermatitis, and eczema. Additionally, there were no witness reports or other evidence indicating that Resident B had been restrained, choked, or harmed in any manner.
CONCLUSION:	VIOLATION ESTABLISHED

III. RECOMMENDATION

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

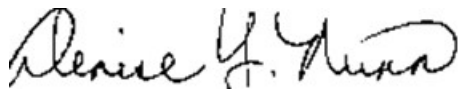


09/02/2026

Johnna Cade
Licensing Consultant

Date

Approved By:



09/17/2026

Denise Y. Nunn
Area Manager

Date