GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 13, 2026

Jason Schmidt
New Life Services Inc
36022 Five Mile Road
Livonia, MI 48154

RE: License #: AS820014616
Investigation #: 2027A0122001
Kirkland Drive

Dear Jason Schmidt:

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) 284-9720.

Sincerely,



Vanita C. Bouldin, Licensing Consultant
Bureau of Community and Health Systems
22 Center Street
Ypsilanti, MI 48198
(734) 395-4037

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820014616
Investigation #:	2027A0122001
Complaint Receipt Date:	09/28/2026
Investigation Initiation Date:	09/29/2026
Report Due Date:	10/28/2026
Licensee Name:	New Life Services Inc
Licensee Address:	36022 Five Mile Road Livonia, MI 48154
Licensee Telephone #:	(734) 744-7334
Administrator:	Jason Schmidt
Licensee Designee:	Jason Schmidt
Name of Facility:	Kirkland Drive
Facility Address:	433 Buckingham Canton, MI 48188
Facility Telephone #:	(734) 397-6939
Original Issuance Date:	01/11/1994
License Status:	REGULAR
Effective Date:	03/08/2025
Expiration Date:	03/07/2027
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
On 08/30/2026, Resident A did not receive his 7:00 a.m. medications.	Yes

III. METHODOLOGY

09/28/2026	Special Investigation Intake 2027A0122001
09/28/2026	APS Referral
09/29/2026	Special Investigation Initiated - Telephone Conducted interview with case manager, Lauren Weibe.
10/01/2026	Inspection Completed On-site Observed Resident A and reviewed his file.
10/05/2026	Contact – document received Resident A's documents.
10/12/2026	Contact – Telephone call made Conducted interview with staff member, Nadia Lewis.
12/12/2026	Exit Conference Discussed findings with licensee designee, Jason Schmidt.

ALLEGATION: On 08/30/2026, Resident A did not receive his 7:00 a.m. medications.

INVESTIGATION: On 09/29/2026, I conducted an interview with Resident A's case manager, Lauren Weibe. Ms. Weibe stated that she had been informed that Resident A missed his 7:00 a.m. medications on 08/30/2026. Ms. Weibe stated that she believed the proper protocol had been followed for medication error and she had no concerns at this time.

On 10/01/2026, I conducted an onsite inspection. I observed Resident A sitting in his bedroom, rocking peacefully in his rocking chair. I observed Resident A to be appropriately dressed, showing no signs of discomfort or distress. Resident A is non-verbal and therefore he was unable to participate in an interview.

On 10/01/2026, I conducted an interview with area supervisor, Shanita Turner. Ms. Turner confirmed that Resident A did not receive his 7:00 a.m. medication on 08/30/2026. Ms. Turner stated that staff member, Nadia Lewis, reported the incident and completed an incident report. Also, staff member, Kayla Banks, was responsible for the medication error. Per Ms. Turner, Kayla Banks no longer works for the company.

On 10/05/2026, I reviewed Resident A's incident report dated 08/31/2026, completed by staff member, Nadia Lewis. Ms. Lewis documented the following, "I was passing 4pm medications when I noticed a cup with medications in front of the medication bin…it was…7am medications." Ms. Lewis identified the medications that belonged to Resident A. Ms. Lewis further stated that Resident A did not receive his medications due to the amount of time that had passed. Resident A was monitored for rest of the evening without further incident.

On 10/12/2026, I conducted an interview with staff member, Nadia Lewis. Ms. Lewis confirmed what she had documented in the incident report dated 08/31/2026. Per Ms. Lewis, she administered Resident A's 4:00 p.m. medications and disposed of his 7:00 a.m. medications. Ms. Lewis stated she reviewed Resident A's standing missed/late/refused medication orders and did not administer his 7:00 a.m. medications as per protocol. Ms. Lewis reported she monitored Resident A without further incident on 08/30/2026.

Staff member, Kayla Banks, was assigned to administer Resident A's 7:00 a.m. medication on 08/30/2026. Per Shanita Turner, Ms. Banks was terminated on 09/24/2026 and therefore was unable to be interviewed.

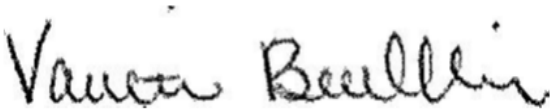
On 10/12/2026, I reviewed Resident A's file. His medication administration records document that Kayla Banks placed her initials on the following medications as if she had passed them to him, Amlodipine 5mg, Tamsulosin 0.4mg, and Memantine HCL 5mg. Resident A's standing missed/late/refused medication orders dated 03/26/26 documents that if his 7:00 a.m. medications are missed then staff are to "resume medication at next scheduled dose" signed by his primary care physician." Resident A's medication administration records documents that he was given his 7:00 a.m. on 07/31/2026.

On 10/12/2026, I conducted an exit conference with licensee designee, Jason Schmidt, and discussed my findings with him. Mr. Schmidt agreed with my findings and stated he would submit a correction action plan to address the rule violation found in my special investigation.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based upon my investigation, which consisted of multiple interviews with case manager, Lauren Weibe, supervisor, Shanita Turner, and staff member, Nadia Lewis, and a review of pertinent documentation relevant to this investigation, there is enough evidence to substantiate the allegation that on 08/30/2026, Resident A did not receive his medication his 7:00 a.m. medications as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



Vanita C. Bouldin
Licensing Consultant
Date: 10/12/2026

Approved By:



Ardra Hunter
Area Manager
Date: 10/13/2026