GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 4, 2022

Achal Patel
Divine Life Assisted Living Center 5 LLC
2045 Birch Bluff Drive
Okemos, MI 48864

RE: License #: AL230404954
Investigation #: 2022A0577012
Divine Life Assisted Living Center 5 LLC

Dear Mr. Patel:

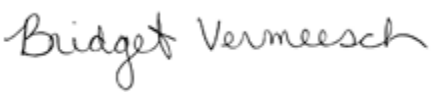
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (231) 922-5309.

Sincerely,



Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL230404954
Investigation #:	2022A0577012
Complaint Receipt Date:	12/08/2021
Investigation Initiation Date:	12/09/2021
Report Due Date:	02/06/2022
Licensee Name:	Divine Life Assisted Living Center 5 LLC
Licensee Address:	2045 Birch Bluff Drive Okemos, MI 48864
Licensee Telephone #:	(517) 708-8745
Administrator/Licensee Designee:	Achal Patel
Name of Facility:	Divine Life Assisted Living Center 5 LLC
Facility Address:	1020 Eastbury Drive Lansing, MI 48917
Facility Telephone #:	(517) 708-8745
Original Issuance Date:	11/20/2020
License **Status:**	REGULAR
Effective Date:	05/20/2021
Expiration Date:	05/19/2023
Capacity:	16
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Background checks and fingerprinting is not being completed when direct care staff members are hired.	No
Resident A requires the use of a Hoyer Lift as well as two direct care staff members to assist with transfers and mobility. There are insufficient direct care staff members scheduled during third shift to meet Resident A's needs and the needs of other residents.	Yes
Direct care staff members are smoking marijuana while at work and while providing care to residents.	No
Karleigh McNutt is taking photos of residents and posting the pictures on social media Snapchat.	No
Residents have unexplained bruises causing concern for mistreatment by direct care staff members	No
Direct care staff member Jeff Klaver yells at residents telling them to shut up.	No
Direct care staff are being asked to pass medications without proper training.	No
Additional Findings	Yes

III. METHODOLOGY

12/08/2021	Special Investigation Intake 2022A0577012
12/09/2021	Special Investigation Initiated – Telephone call to Shelly Stratz, Eaton Co APS.
12/09/2021	APS Referral made to APS Specialist Shelly Stratz.
12/09/2021	Contact - Document Received- Email from Shelly Stratz with documents attached.
12/09/2021	Contact - Document Received- Email from Shelly Stratz, attached documents of RR, Staff names/numbers, staff schedule and IR"s.
12/16/2021	Contact - Telephone call made to direct care staff member Janice White- Left Message.
12/17/2021	Inspection Completed On-site- Interviewed staff, residents, licensee, and reviewed files.

01/04/2022	Contact - Telephone call made to Matthew Sons, CEO of DNPH-Indiana Hospital.
01/04/2022	Contact - Document Sent- Email request of information to Matthew Sons.
01/05/2022	Contact - Telephone call made- Interviewed staff.
01/06/2022	Inspection Completed On-site- Reviewed paperwork, interviewed staff, residents, and family.
01/07/2022	Contact - Telephone call made- Left Messages for staff requesting a call back.
01/07/2022	Contact - Telephone call received- Interview with staff.
01/07/2022	Contact - Telephone call made- Interview with Relative A1.
01/11/2022	Inspection Completed-BCAL Sub. Compliance
01/12/2022	Contact-Telephone call made- Attempted interview with Karleigh McNutt and Anissa Nadeau.
01/13/2022	Exit Conference with licensee designee Achal Patel

ALLEGATION: Background checks and fingerprinting is not being completed when staff are hired.

INVESTIGATION:

On December 08, 2021 a complaint was received alleging Divine Life Assisted Living does not require fingerprinting for direct care staff members upon hire.

On December 17, 2021 I completed an unannounced onsite investigation and reviewed the 12 current direct care staff employee files and found criminal history checks and fingerprinting was completed on the 12 current direct care staff employees. I interviewed direct care staff (DCS) Sheila Martinez who reported she was fingerprinted upon hire and a criminal history check was completed. I reviewed and found all 12 employees files with eligibility notices to work from the Workforce Background Check Program, consent to fingerprint form completed and the IdentiGo Receipt for fingerprints.

On December 17, 2021 I interviewed owners Sam Patel, Achal Patel, and Vic Thakore who reported all direct care staff are fingerprinted and criminal history

checks are completed on all new hires. Mr. Sam Patel reported they try and complete these checks prior to the employee even working the floor.

On January 07, 2022 Shelly Stratz, Eaton County APS and I interviewed the following direct care staff, Jeff Klaver, Shaneese Brown, Janice White, and Candace Johnson who reported they were all fingerprinted and criminal history checks were completed upon hire.

APPLICABLE RULE	
MCL 400.734	**400.734b. This amended section is effective January 9, 2009 except Section 734b(1)(e)(iv) after the word "or" which will not be effective until October 31, 2010.** **Employing or contracting with certain employees providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; failure to conduct criminal history check; automated fingerprint identification system database; report to legislature; costs; definitions.**
	3) An individual who applies for employment either as an employee or as an independent contractor with an adult foster care facility and has received a good faith offer of employment or independent contract from the adult foster care facility shall give written consent at the time of application for the department of state police to conduct an initial criminal history check under this section. The individual, at the time of initial application shall provide identification acceptable to the department of state police.
ANALYSIS:	It has been found the facility did conduct a criminal history check and had the current 12 direct care staff fingerprinted to be in compliance as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A requires the use of a Hoyer Lift as well as two direct care staff members to assist with transfers and mobility. There are insufficient direct care staff members scheduled during third shift to meet Resident A's needs and the needs of other residents.

INVESTIGATION:

On December 08, 2021 a complaint was received alleging Resident A requires a Hoyer Lift but the facility does not have one. The complaint reported it takes two or three direct care staff members to transfer Resident A and there is only one direct care staff scheduled during third shift.

On December 09, 2021 I received an email from Shelly Stratz, Eaton County Adult Protective Service Specialist (APS) who visited the facility today and received copies of staff names and numbers, staff schedule, *Resident Register*, *AFC Licensing Division Incident/Accident Report* and provided me with copies of this information. The staff schedule provided was for the week of December 05, 2021, documenting one direct care staff being scheduled from 10:00pm-6:00am in the facility. Ms. Stratz reported Liza Hobbins, home manager reported to Ms. Stratz there is only one staff scheduled for third shift.

On December 17, 2021 during my onsite investigation, I reviewed the *Assessment Plan for AFC Residents* for the 13 residents currently living in the facility and received a copy of Resident A's *Assessment Plan for AFC Residents* that was completed on November 27, 2021. Resident A's *Assessment Plan for AFC Residents* documented "[Resident A] requires 1-2 person assist for toilet transfer, occasional Hoyer Lift, 1-2 person assist for shower transfer, 1 person assist for shower, and special equipment used documents wheelchair and Hoyer lift." I also reviewed Resident B's *Assessment Plan for AFC Residents,* completed on September 16, 2021, which documented "[Resident B] is a 1-2 person assist with mobility, toileting, and showering." During my onsite investigation, I observed a Hoyer lift in Resident A's bedroom.

On December 17, 2021, during my onsite investigation, I interviewed Achal Patel, Licensee Designee and Administrator who reported most of the residents only need one direct care staff member to assist with mobility and activities of daily living but at times there are a few residents who do require the help of two direct care staff members with mobility and activities of daily living. Mr. Patel reported while Resident A was hospitalized, the hospital staff determined it would be best for the hospital to use a Hoyer lift when transferring Resident, A, but once Resident A was returned to the facility there was no need for a Hoyer lift to be used for all transfers. Mr. Patel reported the hospital advised the facility for the safety of staff and Resident A; the Hoyer lift should be used. Mr. Patel reported there is a Hoyer lift in the Resident A's bedroom but no physician's orders were received when Resident A was discharge from the hospital.

On December 17, 2021, I interviewed DCS Sheila Martinez who reported there is currently one resident who requires two direct care staff members to assist with transferring along with a Hoyer lift and an additional resident who sometimes needs two direct care staff members to assist when transferring. Ms. Martinez reported the facility has a Hoyer lift but staff rarely use it. Ms. Martinez reported there is supposed to be two staff assisting when using the Hoyer lift. Ms. Martinez reported there is currently one direct care staff scheduled to work third shift and usually two direct care staff scheduled during waking hours.

On January 04, 2022 I interviewed Matthew Sons, Chief Executive Officer of Doctors Neuro Psychiatric Hospital who reported Resident A was admitted into the hospital on October 23, 2021 due to suicidal ideations caused by neurocognitive disorder, dementia, and behavioral disturbances. Mr. Sons reported Resident A received physical therapy while at the hospital and was discharged from the hospital on November 24, 2021. Ms. Sons provided me with a copy of the Interdisciplinary Discharge Plan and physicians orders documenting "[Resident A's] need of a medical bed, Hoyer Lift, wheelchair and is a two person assist from bed to wheelchair." Mr. Son's also provide me with a copy of the *Provider Order Form* completed on November 22, 2021. The *Provider Order Form* documented an order for a medical bed, Hoyer Lift and wheelchair for Resident A and ordered the equipment be delivered to Resident A's current residence Divine Life Assisted Living Center 5 LLC. Mr. Sons reported this was not a recommendation to the facility for the safety of staff and Resident A but was a physician order/requirement due to Resident A's needs and inability to transfer or assist in a transfer due to Resident A's medical decline.

On January 07, 2022, Shelly Stratz from Eaton County APS and I interviewed the following direct care staff members Jeff Klaver, Shaneese Brown, Janice White, and Candace Johnson who reported Resident A needs two direct care staff members to assist with transferring or requires the use of a Hoyer lift with two direct care staff assisting. Ms. White and Mr. Klaver reported they work third shift from 10:00pm-6:00am and when working each direct care staff member stated they work alone. Ms. White reported there was an incident when Resident A fell and Ms. White had to call the facility next door requesting for a staff to come over and assist with lifting Resident A up off of the floor. Both staff reported the Hoyer Lift was rarely used but at times the Hoyer Lift was not available in the building.

On January 07, 2022 I interviewed Relative A1 who reported Resident A was placed at the facility in October 2021 due to becoming combative at home and family not able to provide the care Resident A required. Relative A1 reported Resident A was hospitalized many times while at the facility due to falls, agitation, and medical decline. Relative A1 reported family did not visit Resident A while he was the facility because this caused him to become agitated and inconsolable. Relative A1 reported knowing a Hoyer Lift was ordered upon discharge from the hospital and due to Resident A's medical decline, Relative A1 was also aware Resident A required two direct care staff members to assist with transferring. Relative A1

reported being told by a staff (name unknown) the Hoyer Lift was not being used to transfer Resident A due to Resident A refusing to allow direct care staff to use the lift.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professionals with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	On November 24, 2021, Resident A's physician ordered Resident A receive the following level of care: "a medical bed, Hoyer Lift, wheelchair and is a two person assist from bed to wheelchair." However, based on interviews with various direct care staff members and licensee designee Achal Patel, a review of staff schedules, and an interview with Relative A1, facility direct care staff members and administration did not follow these physician instructions nor assure the required number of direct care staff members were scheduled during the nighttime shift to assure Resident A could be safely transferred.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Direct care staff are smoking marijuana while at work and providing care to residents.**
- **Karleigh McNutt is taking photos of residents and posting the pictures on Snapchat.**
- **Residents have unexplained bruises causing concern for mistreatment.**

INVESTIGATION:

The complaint received on December 08, 2021 reported direct care staff Karleigh McNutt, Anissa Nadeau, Candace Johnson, Shaneese Brown and Janice White smoke marijuana on their breaks, residents are found with unexplained bruises and Karleigh McNutt, staff is taking photos of residents and posting the photos on Snapchat.

On December 09, 2021 Shelly Stratz, Eaton County Adult Protective Service Specialist (APS) who visited the facility reported she observed the residents in care and only found Resident A with a bruise on his forehead. Ms. Stratz received an

AFC Licensing Division-Incident Report/Accident Report documenting, “December 01, 2021 at 10:00pm by Janice White, DCS involving Resident A, explaining Ms. White went to check on Resident A and Resident A was found on the floor, Ms. White called the staff in the building next door to come and assist with getting Resident A back into bed. Got Resident A back into bed. Checked on Resident A more often and request bed rails as corrective measures.”

On December 17, 2021 during my onsite investigation, I observed the 11 residents who were at the facility and did not observe any unusual bruising. I interviewed Sheila Martinez who reported she is not aware of any staff smoking marijuana while at work and does not have any concerns of this happening. Ms. Martinez denied she smokes marijuana while at work. Ms. Martinez reported she is not aware of DCS Karleigh McNutt or any other direct care staff taking photos of residents and posting them on their social media accounts such as Snapchat.

During my second unannounced onsite investigation on January 06, 2022 with Shelly Stratz from Eaton County APS we reviewed *AFC Licensing Division-Incident Report/Accident Report* for the current residents living at the facility and observed all residents for a second time. I found no unusual bruising on the residents or incidents reports to cause concern. We attempted to interview residents but due to their dementia and cognitive limitations the residents were not able to provide us with any detailed information regarding the concerns of the complaint.

On January 06, 2022 I interviewed Relative C1 who reported he has not witnessed or had concerns regarding direct care staff being under the influence of marijuana or any other substances. Relative A1 reported he has not witnessed direct care staff being on their phone while he has been at the facility visiting and is not aware of any pictures being posted on direct care staff’s personal social media accounts. Relative A1 reported he is at the facility multiple times a week and at all different times and has not seen direct care staff be rough with residents and has not noticed any unusual bruising on Resident C, nor suspected mistreatment.

On January 07, 2022, Shelly Stratz from Eaton County APS and I interviewed direct care staff members Jeff Klaver, Shaneese Brown, Janice White, and Candace Johnson who all denied the allegations of smoking marijuana while at work. Mr. Klaver reported there are times when some staff arrive for their shift and smell of marijuana, but there is no evidence the staff smoked on the property of the facility. Mr. Klaver, Ms. Brown, Ms. White, and Ms. Johnson all reported being unaware of Karleigh McNutt or any other staff posting pictures of residents on Snapchat. Mr. Klaver, Ms. Brown, Ms. White, and Ms. Johnson all denied observing any unexplained bruises on residents and all stated direct care staff are usually good about completing incident reports if any resident falls or has an accident resulting in a visible injury.

I left messages with DCS Karleigh McNutt and DCS Anissa Nadeau on January 07, 2022, and January 12, 2022 with no return call.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	There was insufficient evidence found to support the allegations of direct care staff smoking marijuana while at work, DCS Karleigh McNutt or any staff taking photos of residents and posting the pictures on their social media account, or that residents having unexplained bruises. It has been found the residents are treated with dignity and their personal needs including protection and safety are being attended to at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff member Jeff Klaver yells at residents and tells them to “shut up.”

INVESTIGATION:

On December 08, 2021 the complaint reported DCS Jeff Klaver yells at all of the residents, tells them to “shut up”, and is generally mean to them.

During my onsite investigation on December 17, 2021, I interviewed Sheila Martinez who reported she does not work with DCS Jeff Klaver and has not witnessed Mr. Klaver yelling at residents. Ms. Martinez reported she has not heard any direct care staff members talk about Mr. Klaver being mean or yelling at residents. I attempted to interview residents, but due to the residents’ dementia diagnoses and their cognitive decline the residents were not able to provide any information regarding direct care staff member Jeff Klaver or any staff yelling at them.

On January 07, 2022 I interviewed DCS Jeff Klaver who reported he no longer is employed at the facility after he quit about two weeks ago. Ms. Klaver denied swearing at residents or yelling at them. Mr. Klaver reported there was a time when a resident was heading into the kitchen and Mr. Klaver yelled, “stop” to prevent the resident from entering the kitchen due to the stove being on.

On January 07, 2022 I interviewed direct care staff members Shaneese Brown and Janice White who both reported direct care staff member Jeff Klaver was rude to residents and was not very empathetic when talking with the residents as he spoke in a very matter of fact tone of voice. Ms. Brown and Ms. White both reported hearing Mr. Klaver swear and yell at the residents. Ms. Brown and Ms. White reported they heard Mr. Klaver tell the residents to “shut up and go back to bed.”

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(ii) Verbal Abuse.**

ANALYSIS:	Direct care staff members Janice White and Shaneese Brown both reported hearing Jeff Klaver speak rudely and loudly residents yet direct care staff member Sheila Martinez denied witnessing this behavior. Further, direct care staff member Jeff Klaver denied yelling and/or swearing at residents and no residents could provide any information regarding the allegation. Consequently, there is not enough evidence to support that DCS Jeff Klaver yells at or is mean to residents. Mr. Klaver reported he is no longer employed at the facility which removed the cause of concern.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff are being asked to pass medications without proper training.

INVESTIGATION:

The complaint received on December 08, 2021 alleged direct care staff are being asked to pass medications without proper training.

On December 17, 2021 I completed an unannounced onsite investigation and reviewed the 12 current direct care staff employee files and found all 12 staff had been trained in medication administration.

On December 17, 2021 during my onsite, DCS Sheila Martinez reported all staff are trained on medication administration prior to being able to administer medications. Ms. Martinez reported the training consists of being trained by the facility pharmacy and shadowing a trained direct care staff, then the direct care staff member being trained is shadowed by a trained direct care staff member as the trainee passes medications. Ms. Martinez reported she is not aware of any staff passing medications that has not been trained.

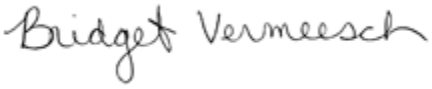
On December 17, 2021 I interviewed licensee designee and administrator Achal Patel, and who verified the medication administration direct care staff training process described above. Mr. Patel added the shadowing process occurs for a few days to ensure the trainee is fully competent in medication administration.

On January 07, 2022 I interviewed the following direct care staff, Jeff Klaver, Shaneese Brown, Janice White, and Candace Johnson who reported they received medication administration training prior to administering medications.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident he or she shall comply with all of the following provisions: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	There was no evidence found to support the allegations of direct care staff passing mediations without being properly trained. On December 17, 2021, during my onsite investigation I reviewed and verified all 12 employee had been properly trained in medication administration.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended the current status of the license remains unchanged.



01/13/2022

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

02/04/2022

_____

Dawn N. Timm Date
Area Manager