GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 28, 2025

Achal Patel & Vivek Thakore
Divine Life Assisted Living Center 3 LLC
2045 Birch Bluff Drive
Okemos, MI 48864

RE: License #: AL330404952
Investigation #: 2025A1033016
Divine Life Assisted Living Center 3 LLC

Dear Mr. Patel & Vivek Thakore:

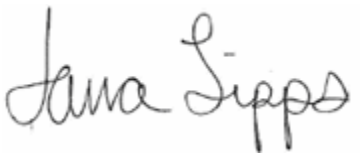
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 284-9730.

Sincerely,



Jana Lipps, 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 #:	AL330404952
Investigation #:	2025A1033016
Complaint Receipt Date:	02/11/2025
Investigation Initiation Date:	02/13/2025
Report Due Date:	04/12/2025
Licensee Name:	Divine Life Assisted Living Center 3 LLC
Licensee Address:	2045 Birch Bluff Drive Okemos, MI 48864
Licensee Telephone #:	(517) 339-2390
Administrator:	Cheri Lynn Weaver
Licensee Designee:	Achal Patel & Vivek Thakore
Name of Facility:	Divine Life Assisted Living Center 3 LLC
Facility Address:	2077 Haslett Road Haslett, MI 48840
Facility Telephone #:	(517) 339-2390
Original Issuance Date:	11/09/2020
License Status:	REGULAR
Effective Date:	05/09/2023
Expiration Date:	05/08/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has been sexually assaulted by Resident B. Direct care staff did not provide adequate supervision and protection for Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/11/2025	Special Investigation Intake- 2025A1033016
02/12/2025	Contact - Telephone call made Attempt to interview Complainant. Voicemail message left, awaiting response.
02/13/2025	Contact - Telephone call made Attempt to interview Complainant. Voicemail message left, awaiting response.
02/13/2025	Special Investigation Initiated - Letter Email correspondence with Complainant.
02/21/2025	Inspection Completed On-site Interviews conducted with direct care staff/home manager, Camie Fisher, direct care staff/assistant home manager, Amanda Maran, & Resident B. Review of Resident A's & Resident B's resident records initiated on-site.
02/21/2025	Contact - Telephone call made Interview conducted with Emily Daubert, LMSW with Heart to Heart Hospice.
02/27/2025	Contact - Face to Face Interview conducted with Administrator, Cheri Lynn Weaver.
03/07/2025	APS Referral Referral made per protocol.
03/12/2025	Contact – Telephone call made Interview conducted with direct care staff, Blake Pruitt, via telephone.

03/13/2025	Contact – Telephone call made Interview conducted with Careline Health Group, nurse practitioner, Jessica Bates, via telephone.
03/27/2025	Exit Conference Attempt to conduct exit conference with licensee designee, Achal Patel. Voicemail message left and email correspondence sent to co-licensee designees, Achal Patel & Vivek Thakore. Awaiting a response.
03/28/2025	Contact – Telephone call received Conducted exit conference conversation with Administrator, Cheri Lynn Weaver, as Mr. Patel & Mr. Thakore are currently unavailable. Findings were discussed.

ALLEGATION: Resident A has been sexually assaulted by Resident B. Direct care staff did not provide adequate supervision and protection for Resident A.

INVESTIGATION:

On 2/11/25 I received an online complaint regarding the Divine Life Assisted Living Center 3 LLC, adult foster care facility (the facility). The complaint alleged that Resident A had been sexually assaulted by Resident B, at the facility, due to direct care staff not providing adequate supervision. On 2/12/25 and 2/13/25 I attempted to interview Complainant, via telephone. On 2/13/25, Complainant responded to my inquiries for an interview through email correspondence. Complainant reported, via email, that she has a working relationship with Resident B and that he moved into the facility on 1/9/25. She reported that on 1/30/25, an email correspondence was received from Resident B's hospice provider (name not disclosed), noting Resident B was having increased behaviors and had been targeting another resident (name not disclosed) and had been entering this resident's bedroom. Complainant reported that the hospice provider noted that Resident B's medications would be increased. She reported she did not hear any further information concerning the issue until 2/4/25, when she received a follow up call from the same hospice provider. Complainant reported that on this date the hospice provider informed Complainant that Resident B was having "hypersexual behaviors" and they were in the process of altering his medications to see if this would alleviate the issue. Complainant reported that also on 2/4/25 she received a telephone call from direct care staff/home manager, Camie Fisher, who reported to Complainant that Resident B had touched Resident A's vagina and this was nonconsensual. Complainant reported that on 2/4/25 she additionally received a telephone call from the hospice social worker (name not disclosed) and this individual reported that Resident A did not wish to press charges against Resident B but she wanted him to be moved from the facility. Complainant reported that during this conversation the hospice social worker had reported that it was decided that Resident B required one-to-one supervision and

this could not be provided at the facility. Complainant reported that a request was made to send Resident B to the hospital for a mental health evaluation. Complainant reported that this permission was granted by Guardian B1, but on 2/6/25 Complainant was informed by the hospice social worker that the decision was made not to send Resident B for a mental health evaluation as it was felt his behaviors were due to a progression of his disease process. Complainant reported that an alternate placement was located for Resident B, permission was granted by Guardian B1 on 2/10/25 to move Resident B to another location, but Resident B was not moved until 2/14/25. Complainant reported that she feels Resident B should have been sent out for a mental health evaluation for the safety of Resident A and this did not happen.

On 2/21/25 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/assistant home manager, Amanda Maran. Ms. Maran reported that Resident B had been a resident at the facility and moved to another location on 2/14/25. Ms. Maran reported that she is aware of the allegations of Resident B assaulting Resident A. She reported that these allegations are accurate, and this did occur while at the facility. Ms. Maran reported that the first instance of this unwanted contact from Resident B toward Resident A occurred in the dining room at the facility. Ms. Maran reported that she did not know the date of this occurrence, but she knew that direct care staff, Blake Pruitt, had been working on this date. Ms. Maran reported that she was present on this date but did not witness the occurrence. She reported that Mr. Pruitt reported to her that Resident B was observed to have his hand on Resident A's inner thigh near her vagina. She reported that Mr. Pruitt separated the two residents and then reported the event to Ms. Maran. Ms. Maran reported that she spoke with Resident B and explained to him that his behavior was inappropriate and then she made a telephone call to Resident B's hospice provider, Heart to Heart Hospice. Ms. Maran reported that when she was discussing the inappropriateness of Resident B's actions, with him, Resident B stated, "I'm still going to do it till I get it." She reported he was referring to having sex with Resident A. Ms. Maran reported that after this the hospice team instructed the direct care staff to utilize his as needed medications for behavior management, such as Ativan and Haldol. She reported direct care staff were instructed to conduct regular safety checks on Resident B and Resident A. She reported, "the staff were constantly watching."

On 2/21/25 during the on-site investigation, I interviewed Ms. Fisher regarding the allegations. Ms. Fisher reported that Resident B was previously a resident at the facility and moved from the facility on 2/14/25 related to the allegations. Ms. Fisher reported that it was initially reported by Mr. Pruitt that Resident B had touched Resident A, near her vagina, in the dining room area of the facility. She reported that the two residents were in their wheelchairs when this occurred. Ms. Fisher reported that she then met with Resident A who reported that Resident B's behaviors made her feel "uncomfortable" and "sad". Ms. Fisher reported direct care staff spoke with the Heart to Heart Hospice team, Guardian B1, Resident B's medical provider, and Tri County Office on Aging (who works with Resident B) to develop a plan to address Resident B's behaviors. Ms. Fisher reported that Resident B was placed on hourly checks from direct care staff. She reported that at the beginning of each shift, direct care staff sign into the QuickMar

system and check a box which acknowledges that they are aware of the requirement to conduct hourly checks for Resident B and that they will follow through with this requirement. She reported that this is how the facility determined direct care staff understand the requirement for hourly checks for Resident B. Ms. Fisher reported that each involved party was surprised by Resident B's behaviors of sexual aggression toward Resident A. She reported that he had no prior history of these types of behaviors. Ms. Fisher reported that Resident B had transferred from another adult foster care facility, operated by the same co-licensee designees, Achal Patel & Vivek Thakore. She reported that Resident B had resided at the previous adult foster care facility for a lengthy period and did not exhibit any such behaviors while at that placement. Ms. Fisher reported that Resident B's sexually inappropriate behaviors were first reported to her on 1/21/25. Ms. Fisher reported that Resident B's medical provider and hospice team members made the determination to treat Resident B's sexually aggressive behaviors with medications. She reported that this was identified as a short-term solution, but the result of this was Resident B became sedated due to these medications. Ms. Fisher reported that at one point in time the Heart to Heart social worker, Emily Daubert, made the statement that Resident B required one-to-one supervision from direct care staff. Ms. Fisher reported that Resident B's physician did not order a one-to-one supervision for Resident B. She further reported that Guardian B1 stated that Resident B could not afford the cost of one-to-one supervision at the facility. Ms. Fisher further stated that the facility could not be staffed with one-to-one supervision for Resident B due to staffing limitations.

During the on-site investigation on 2/21/25 I interviewed Resident A regarding the allegations. Resident A reported that on multiple occasions Resident B had attempted to touch her in a sexual manner, against her will. She reported that she could not recall the dates of these encounters with Resident B. Resident A reported that during one of these assaults she had been sitting in her electric power chair, in the living room area of the facility, which connects to the dining room. She reported that Resident B was also in a wheelchair and positioned himself adjacent to her wheelchair. Resident A reported that she told Resident B, "get back" and Resident B stated to her, "I'm going to get you no matter what". Resident A reported that Resident B grabbed her on her breasts and at her vagina, on top of her clothing. Resident A reported that Resident B never got under her clothing because she was wearing layers, and he could not get under her clothing. Resident A reported that there were occasions when Resident B would try to come into her resident bedroom, but the direct care staff would stop him. Resident A reported that each instance of Resident B touching her against her will occurred in the dining room. She reported that this happened about 3-4 times. When asked if Resident A felt the direct care staff were doing enough to provide for her safety at the facility she reported, "sort of, kind of." Resident A reported that it depended on which direct care staff member was working as to whether she felt safe at the facility. She reported that she felt some direct care staff, such as Mr. Pruitt, did a good job making sure Resident B did not touch her in an inappropriate manner. Resident A reported that she did not feel safe at the facility when Resident B was residing there. She reported that she now feels safe at the facility again. Resident A reported that she does have a call button to call for assistance and the direct care staff did start doing regular safety checks to ensure

Resident B was not near her. Resident A reported that she did not want to press criminal charges against Resident B.

During the on-site investigation on 2/21/25 I reviewed the following documentation:

- *Charting Notes for [Resident B]*, reviewed for the dates 1/28/25 – 2/13/25. The following information was observed in these notes:
    - 1/29/25, documented by Ms. Fisher at 9:11pm. The report reads, “This writer noticed today that resident was getting close to another female resident and attempting to hold her hand. This writer redirected him as female resident did tell him to “getaway”. Resident seemed to understand the boundary that female resident put in place but still continued to sit right next to her at table.”
    - 1/29/25, documented by Ms. Fisher at 9:13pm. The report reads, “It has been stated by staff that resident is stealing other residents clothes and personal belongings. Residents roommate was upset because resident had been “eating all his private snacks”. While cleaning residents room today, this writer did find other residents socks and underwear. Resident is often times found coming in and out of others rooms but stated “he is checking on them”. Staff continue to redirect him and encourage him to stay out of others rooms unless he is invited.”
    - 1/29/25, documented by direct care staff, Shaye Hadley at 9:26pm. The report reads, “[Resident B] seemed a bit more antsy today. He’s been all over the place and has been talking to anyone and about anything he can think of. Seems to want to get my attention anytime I pass him. Usually just to say hello or ask how I am doing.”
    - 1/30/25, documented by Ms. Fisher at 12:36pm. The report reads, “Resident was in another female residents room while she was in bed. This writer prompted him to please exit the room as the female was half asleep. When resident left the room, I asked the female resident is she was uncomfortable. She stated “no, but it is beginning to be too much”. Residents hospice nurse was here today and the behavior was discussed. They did a UA to test for UTI and also increased his Ativan intervals. This writer will notify staff to continue to encourage resident to only be in rooms that he is asked to visit in. This writer also requested to hospice that resident begin seeing behavioral health again.”
    - 2/3/25, documented by Ms. Hadley at 946pm. The report reads, “[Resident B] has been a little difficult recently. He’s been back talking the staff quite a bit [sic]. He also will not stay out of [Resident A’s] personal space even though we have told him multiple times it makes her uncomfortable. He did not eat his dinner.”
    - 2/4/25, documented by Ms. Fisher at 3:50pm. The report reads, “Resident was in common area and staff member walked over and observed resident to be touching a female residents vagina area. Resident was upset when staff redirect him and removed him from the area. Resident was told that the female resident did not want to be touched and that he was making her feel uncomfortable. Resident became verbally aggressive

cussing and swearing. This writer contacted facility director, Sherry Martin, Residents PCP through Hospice, and Guardian. Company COO, Cheri Weaver will be contacting APS to present information. Per hospice, PRN Haldol and Ativan need to be utilized during this time. Staff members are reminded to be vigilant about the 1 hour safety checks to ensure that these 2 residents stay separated. Resident was administered PRN Ativan and is currently sleeping."

- 2/5/25, documented by direct care staff, Erica Pierce, at 5:02am. The report reads, "Resident still unable to follow directions pertaining to other peoples personal space. Resident had to be removed from dining room this evening due to attempting to grab at other resident [Resident C]. Staff corrected him and removed him from the situation."
- 2/7/25, documented by Ms. Fisher at 11:04am. This writer spoke with NP, Jessica Bates, this morning. After consulting with his care team, they are going to be starting him on cimetidine 2x daily to address the hypersexual behavior. Resident is also being treated for UTI. At this time, Careline is not petitioning resident. Resident is presenting tired but has not seeked out the female resident in 2 days. This writer spoke with facility nurse, Kortney Hammil this morning, we are hoping to plan a coordination of care meeting with his entire to team to see what the steps are regarding placement and to continue to closely monitor symptoms. Staff are reminded to continue to monitor behavior, complete safety checks, and utilize PRNs."
- 2/7/25, documented by direct care staff, Brenda Gonzalez, at 5:52pm. The report reads, "Was ok earlier today until dinner time after he eat he started toward [Resident A] and wanting to touch her we redirect him to go the other way and if he continue we are going to take him to his room. He did stay away."
- 2/8/25, documented by direct care staff, Kaylynn Mitchell, at 3:37am. The report reads, "[Resident B] had to be removed from the dining room again tonight he just cannot leave the female residents alone took all meds slept all night all safety and toileting checks done no issues to report at this time."
- 2/9/25 through 2/12/25, there were no documented incidents of Resident B attempting to assault Resident A or any other resident at the facility.
- 2/13/25, documented by direct care staff, Turquoist Fletcher, at 8:04pm. The report reads, "[Resident B] was hanging off the bed when staff went to check on him. Staff tried to assist him back into bed but he became aggressive. This staff asked another staff to assist with putting him to bed and [Resident B] grabbed him around the neck. This staff tried to change his brief but he also declined. Bed checks were done."

- *AFC Licensing Division Incident/Accident Report*, for Resident A & Resident B, dated 2/4/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "[Resident B] was sitting near [Resident A] in common area. When staff member, [Mr. Pruitt], walked over, [Resident B] had his hand on [Resident A's] vagina area. [Resident A] confirmed that his hand was on her vagina. She stated

she was uncomfortable and did not want that." Under section, *Action Taken by Staff/Treatment Given*, it reads, "Staff member, [Mr. Pruitt], removed [Resident B] from area near [Resident A]. [Ms. Fisher] contacted company director (Sherry Martin), [Resident B's] hospice physician and guardian. Tri County representative of both residents were made aware also. [Resident A] states that "she does not want him here and she is sad"." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Staff members were directed to ensure they know both residents whereabouts and do frequent safety checks. [Ms. Fisher] met with [Resident B] to let him know that [Resident A] requests that he not touch her. [Ms. Fisher] encouraged [Resident A] to continue to voice her concerns."

- *Medication Administration Record* (MAR) for Resident B for the month of January 2025 and February 2025. I made the following observations on these documents:
    - Resident B was ordered Lorazepam 0.5mg tablet three times daily, on a routine basis on 12/16/24. This order was discontinued on 1/31/25 at 9am. A new order for Lorazepam 0.5mg tablet every four hours, routinely, was ordered on 1/30/25 and administration began on 1/31/25 at 8am. This medication was routinely administered from 1/31/25 through 2/3/25 at 12pm. This order was discontinued on 2/3/25. The Lorazepam order was updated on 2/3/25 to, Lorazepam 0.5mg, "take 1 tablet by mouth every 6 hours during waking hours".
    - Resident B was prescribed Olanzapine 5mg tablet "Take 1 tablet by mouth in evening". This medication is documented as being administered 1/8/25 through 2/7/25, with missed doses on 2/4/25 and 2/6/25. A second order for Olanzapine 5mg was added on 2/5/25, reading, "take 1 tablet by mouth every morning". This dosage is marked as being administered 2/6/25 through 2/14/25 at 8am. A third order for Olanzapine 10mg was added on 2/5/25 and states, "Take 1 tablet by mouth every evening". This dosage is documented as being administered on 2/5/25 and 2/7/25 through 2/13/25 at 8pm.
    - Resident B was prescribed Trazadone 50mg tablet to be routinely administered 1 time per day. This medication is documented as being administered 1/8/25 through 2/13/25, with a missed dose on 2/6/25.
    - Resident B was ordered Haloperidol Con 2mg/ML, "take 0.5 ML by mouth every 6 hours as needed for agitation". This medication is documented as being administered on 2/5/25, one time. The order for the Haloperidol was updated to a routine medication with instructions, "take 0.5ml by mouth three times a day" on 2/5/25. This medication is documented as being administered as ordered from 2/5/25 through 2/14/25 at 8am. There were missed doses on 2/6/25, 2/12/25, and 2/13/25, all at 8pm. There was a third order for Haloperidol Con 2mg/ml was ordered on 2/5/25 with the direction, "Take 1ml by mouth every 4 hours as needed". This medication is documented as being administered one time on 2/10/25.
    - Resident B was ordered Lorazepam 0.5mg tablet, "take 1 tablet by mouth every 2 hours as needed for anxiety". This medication is documented as being administered on 2/5/25, 2/9/25, 2/10/25, 2/12/25.

- Resident B was ordered Morphine Sul Sol 100/5mg, “take 0.25ml by mouth or sublingually every hour as needed for pain & shortness of breath *prefilled syringe8.” This medication is not documented as being administered to Resident B during the month of January 2025.
- Resident B was ordered Bupropn HCL Tab 150mg XL, “take 1 tablet by mouth daily”. This medication is documented as being administered 1/8/25 through 2/14/25.
- Resident B was ordered Cimetidine Tab 300mg, “take 1 tablet by mouth twice daily *Take 30 minutes prior to breakfast and dinner*”. This medication was ordered on 2/7/25 and was documented as being administered 2/8/25 through 2/14/25.
- Resident B was ordered Fluoxetine CAP 40mg, “take 1 capsule by mouth daily”. This medication is documented as being administered 2/1/25 through 2/4/25. This dosage was discontinued on 2/4/25 and a new dosage of 60mg was ordered 2/3/25 and documented as being administered 2/5/25 through 2/14/25.

- *Admin History for [Resident B] – 1 Hour Safety Check.* This document was reviewed for the period, 2/5/25 through 2/13/25. Ms. Fisher reported that this document is utilized as part of the electronic record to document direct care staff acknowledgement that they are required to perform one-hour safety checks on Resident B. It was demonstrated to this licensing consultant that there is a button the direct care staff are required to click with a disclaimer that reads, “By clicking off on this prompt, you acknowledge that you are aware of and will do 1 hour safety checks on resident for the entirety of your shift”. I made the following observations in reviewing this document:
  - 2/5/25: direct care staff, Shaye Hadley signed off on the safety check at 10:24pm. Direct care staff, Amanda Maran signed off on the safety check at 9:33am.
  - 2/6/25: Ms. Maran signed off on the safety check at 10:17am. Direct care staff, McKenna Wilkins signed off on the safety check at 9:45pm.
  - 2/7/25: Direct care staff, Brenda Gonzalez, signed off on the safety check at 12:36pm. Direct care staff, Kaylynn Mitchell signed off on the safety check at 3:38am.
  - 2/8/25: Direct care staff, Bobbi Snider, signed off on the safety check at 12:10pm. Ms. Mitchell signed off on the safety check at 8:47pm.
  - 2/9/25: Ms. Gonzalez signed off on the safety check at 1:02pm. Ms. Mitchell signed off on the safety check at 3:02am.
  - 2/10/25: Ms. Maran signed off on the safety check at 7:41am. Direct care staff, Turquoist “Marie” Fletcher, signed off on the safety check at 8:43pm.
  - 2/11/25: Ms. Maran signed off on the safety check at 7:29am. Ms. Mitchell signed off on the safety check at 9:41pm.
  - 2/12/25: Ms. Snider signed off on the safety check at 1:02pm. Ms. Fletcher signed off on the safety check at 8:11pm.
  - 2/13/25: Ms. Snider signed off on the safety check at 1pm. Ms. Fletcher signed off on the safety check at 8:07pm.

- *Assessment Plan for AFC Residents* document for Resident B, dated 1/1/25. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *J. Controls Sexual Behavior*, the document is marked, “yes”. Under subsection, *I. Controls Aggressive Behavior,* the document is marked, “no”, with the narrative, “Needs redirection and medication”. There were not any notations on this assessment plan indicating Resident B was receiving one-hour safety checks, or that he had sexually aggressive behaviors.
- *AFC – Resident Care Agreement* for Resident B, dated 1/1/25. On page one of this document, under the section, *License Number*, it reads, AL330404951. Under the section, *Name of Home*, it reads, “Divine Life ALC 2” The “2” has a strike through it and a “3” is written next to the “2”. Under the section, *The basic fee includes the following basic services*, it reads, “Room and board, assist with ADL’s, general supervision, all meals, housekeeping, laundry, medication passing”.
- *Health Care Appraisal* for Resident B. Under section, *Resident Name*, it listed Resident B. Under the section, *AFC Facility Name,* it reads, “Divine Life ALC 2”. Under the section, *Facility License Number*, it reads, “AL330404951”. The rest of the document is blank. There was a yellow sticky note found on this document which read, “Have Lauren fill out for you.” I inquired of Ms. Fisher whether she had a completed *Health Care Appraisal* for Resident B. She reported that she did not have a completed *Health Care Appraisal* for Resident B.
- *Resident Register.* In reviewing this document, Resident B is listed as a resident of the facility but there is no “Date of Admission” listed for Resident B. Resident B’s “Date of Discharge” is recorded as 2/14/25. There is also no “Date of Admission” listed for Resident D, E, & F.
- *Assessment Plan for AFC Residents* document for Resident A, dated 2/3/25. On page one, under the section, *I. Social/Behavioral Assessment*, subsection, *B. Communicates Needs*, it reads, “yes, speech is slow and mumbled”. On page two, under the section, *II. Self Care Skill Assessment*, the document identifies that Resident A is a “2 person full assist” and uses a Hoyer lift, with *Toileting*, *Bathing and Personal Hygiene*. This section also identifies that Resident A requires the use of an electric wheelchair for mobility purposes.

On 2/21/25 I interviewed Ms. Daubert, via telephone, regarding the allegations. Ms. Daubert reported that she provides social work services to Resident B through the Heart to Heart hospice program. She reported that Resident B did not previously have a history of sexually aggressive behaviors prior to this incident with Resident A. Ms. Daubert reported that she never witnessed Resident B acting in this manner when visiting with him at the facility. Ms. Daubert reported that Resident B has diagnoses of Dementia, Bipolar Disorder, and a generally poor cognitive state. Ms. Daubert reported direct care staff at the facility did a good job communicating the concerns about Resident B’s behaviors with the hospice team members. She reported that the decision was made to try to medicate Resident B for the behaviors until an alternate option could be found for him. Ms. Daubert reported that Resident B moved to another adult foster care facility on 2/14/25 and she visited him at the facility on 2/17/25. She reported that he has been weaned off from the medications administered due to his behavior and he

has not exhibited any of the sexually aggressive behaviors in his new placement. Ms. Daubert reported that Resident B's medical provider, nurse practitioner, Jessica Bates, had encouraged one-to-one supervision for Resident B during his stay at the facility related to sexually aggressive behaviors. Ms. Daubert reported that to her knowledge the one-to-one supervision was not provided due to a lack of available staffing at the facility. Ms. Daubert reported that there were multiple providers involved trying to determine the best course of action for Resident B and for Resident A's safety. She reported that the hospice team, the Tri County Office on Aging members, the direct care staff, and Guardian B1 were all involved in trying to work through this situation. Ms. Daubert reported that she had wanted to file a petition to have Resident B involuntarily committed for mental health evaluation, but Ms. Bates indicated that this was not necessary as she felt his behaviors may be a result of his disease progression. Ms. Daubert reported that she was informed of the behaviors on 2/4/25 and everything escalated quickly from that point with Resident B's behaviors increasing and the communication regarding how to manage these behaviors and keep Resident A safe.

On 2/27/25 I interviewed Administrator, Cheri Lynn Weaver, in person, regarding the allegations. Ms. Weaver reported that Resident B had not been reported to have a prior history of sexually aggressive behaviors. She reported that Resident B had previously resided at another adult foster care facility for about one year and he did not exhibit any sexually aggressive behaviors at that residence. Ms. Weaver reported that she was first informed of Resident B touching Resident A in an inappropriate manner by Ms. Fisher. She reported that there was discussion of having Resident B involuntarily committed for a mental health evaluation, but it was determined by a medial provider that this was not going to be the correct course of action due to his disease progression. Ms. Weaver reported that the direct care staff, hospice staff, Guardian B1, and Resident B's medical staff were all working together to develop a plan for Resident's continued care and Resident A's safety. Ms. Weaver reported that Ms. Fisher placed Resident B on hourly checks by direct care staff and the medical providers had ordered medications for Resident B to treat his behaviors. Ms. Weaver reported that the hospice team did talk about the option of a one-to-one sitter for Resident B but this was never ordered by a medical provider. Ms. Weaver reported that Resident A stated she did not want Adult Protective Services contacted regarding the incident.

On 3/12/25 I interviewed Mr. Pruitt regarding the allegations, via telephone. Mr. Pruitt reported that he does work at the facility and usually works the 6pm to 6am shift. He reported that a few weeks ago he had been working a day shift and witnessed Resident B with his hands on Resident A's "private area". He reported that Resident B was grabbing at Resident A's leggings and trying to "rip through" them. Mr. Pruitt reported that this event occurred in the dining room, and he quickly separated Resident B from Resident A and took Resident B to his bedroom. Mr. Pruitt stated that he reported the event to Ms. Fisher. He reported that going forward the direct care staff were instructed to keep watch over Resident B to ensure he did not demonstrate these behaviors again. Mr. Pruitt reported that he only observed this behavior one time. Mr. Pruitt reported that the idea of one-on-one supervision for Resident B was not discussed to his knowledge.

He reported that the management took immediate action and Resident B was moved from the facility within days of the event.

On 3/13/25 I interviewed Careline Health Group, nurse practitioner, Jessica Bates. Ms. Bates reported that she is Resident B's primary care provider and has been his provider since prior to his admission at the facility. She reported that she was his provider at his previous placement and continues to provide services to Resident B at his current location. Ms. Bates also reported that she is the medical provider for Resident A. She reported that she spoke with Resident A and Resident A confirmed that Resident B had touched her in a sexual manner, without her consent. Ms. Bates reported that Resident B had no prior history of sexually aggressive behaviors. She reported that when Resident B moved to the facility, he became anxious and agitated. She reported that he has been in an adult foster care setting, previously, which was an all-male facility. She reported that she was unsure if this is what triggered Resident B's behaviors, but he was not adjusting well and his anxiety was increasing. She reported that she received notification from the direct care staff that Resident B had sexually assaulted by inappropriately touching Resident A over her clothing at the facility. She reported she made a visit to the facility and did observe Resident B to be acting in a sexually aggressive manner and seeking out Resident A. She reported she met with Ms. Fisher and Ms. Daubert, at the facility, to discuss what options were available to keep Resident A safe. Ms. Bates reported she recommended a one-on-one staffing for Resident B and was told by Ms. Fisher that the facility could not afford to staff a one-on-one for Resident B. She reported she asked Ms. Daubert whether the hospice team had the ability to place a sitter at the facility to provide a one-on-one for Resident B. Ms. Bates reported Ms. Daubert stated this was not an option hospice could assist with for this situation. Ms. Bates reported that she had inquired whether anyone had reported the assault against Resident A to Adult Protective Services (APS) or the police. Ms. Bates reported that Ms. Fisher made a telephone call to The Director of Nursing/direct care staff, Courtney Hamill, who reported to Ms. Fisher that Ms. Weaver had made a referral to APS. Ms. Bates reported that there was a conversation about sending Resident B to the emergency department to remove him from the facility, but Ms. Bates objected to this idea as she did not think this would be an adequate solution as there was nothing physically wrong with Resident B for the emergency department to keep him. Ms. Bates reported that the consensus of the meeting was to attempt to medicate Resident B for the behaviors and find him another placement. She reported that the hospice team ordered Haldol and Lorazepam to be administered to Resident B and she ordered Cimetidine. Ms. Bates reported that the Cimetidine was ordered as she had researched medications that may be effective in controlling sexually aggressive impulses and this medication had history of being used for this symptom. Ms. Bates reported that she is aware direct care staff stepped up their supervision of Resident B and were watching him more closely, but she would have preferred they had been able to provide a one-on-one supervision to provide better safety for Resident A. Ms. Bates reported that to her knowledge there was only one incident of Resident B touching Resident A in an unwanted, inappropriate, sexual manner.

On 3/17/25 I sent email communication to Ms. Fisher and Ms. Weaver requesting to review the direct care staff schedule for the dates 1/21/25 through 2/14/25. Ms. Fisher sent the requested documentation view email on 3/18/25. I reviewed the direct care staff schedule for the dates, 2/5/25 through 2/13/25, and compared it to the findings from the document, *Admin History for [Resident B] – 1 Hour Safety Check.* I observed the following information:

- On 2/5/25 the following direct care staff were scheduled to work:
    - 6am to 2pm: Amanda Maran (signed the safety check)
    - 6am to 2pm: Blake Pruitt (did not sign the safety check)
    - 2pm to 10pm: McKenna Wilkins (did not sign the safety check)
    - 2pm to 10pm: Shaye Hadley (signed the safety check)
    - 6pm to 6am: EJ Pierce (did not sign the safety check)
    - 10pmto 6am: Andre Fizer (did not sign the safety check)
      *There is a time frame from 10pm to 12am on this date where the safety check has not been signed as being completed.
- On 2/6/25 the following direct care staff were scheduled to work:
    - 6am to 2pm: Brenda Gonzalez (did not sign the safety check)
    - 6am to 2pm: Amanda Maran (signed the safety check)
    - 2pm to 10pm: McKenna Wilkins (signed the safety check)
    - 2pm to 10pm: Shaye Hadley (did not sign the safety check)
    - 6pm to 6am: Brooke Washburn (did not sign the safety check)
    - 10pm to 6am: Andre Fizer (did not sign the safety check)
      *There is a time frame from 10pm to 12am on this date where the safety check has not been signed as being completed.
- On 2/9/25 the following direct care staff were scheduled to work:
    - 6am to 2pm: Brenda Gonzalez (signed the safety check)
    - 6am to 2pm: Alyssa Davis-Zielke (did not sign the safety check)
    - 2pm to 10pm: McKenna Wilkins (did not sign the safety check)
    - 2pm to 6:30pm: Turquoist “Marie” Fletcher (did not sign the safety check)
    - 6pm to 6am: Kaylynn Mithcell (signed the safety check)
    - 6pm to 6am: Blake Pruitt (did not sign the safety check)
      *There is a time frame from 2pm to 6pm on this date where the safety check has not been signed as being completed.
- On 2/10/25 the following direct care staff were scheduled to work:
    - 6am to 6pm: Brenda Gonzalez (did not sign the safety check)
    - 6am to 3pm: Amanda Maran (signed the safety check)
    - 2pm to 10pm: McKenna Wilkins (did not sign the safety check)
    - 5:15pm to 10pm: Turquoist “Marie” Fletcher (signed the safety check)
    - 6pm to 6am: Kaylynn Mitchell (did not sign the safety check)
    - 10pm to 6am: Andre Fizer (did not sign the safety check)
      *There is a time frame from 3pm to 5:15pm and 10pm to 12am on this date where the safety check has not been signed as being completed.
- On 2/12/25 the following direct care staff were scheduled to work:
    - 6am to 6pm: Jamie Brownlee (did not sign the safety check)
    - 6am to 2:30pm: Bobbi Snider (signed the safety check)
    - 2pm to 6am: McKenna Wilkins (did not sign the safety check)

- 4:45pm to 10:20pm: Turquoist “Marie” Fletcher (signed the safety check)
- 8pm to 6am: Blake Pruitt (did not sign the safety check)
- 10pm – 6:30am: Andre Fizer (did not sign the safety check)
  *There is a time frame from 2:30pm to 4:45pm and 10:20pm to 12am on this date where the safety check has not been signed as being completed.

- On 2/13/25 the following direct care staff were scheduled to work:
  - 6am to 2pm: Brenda Gonzalez (did not sign the safety check)
  - 6:30am to 4pm: Bobbi Snider (signed the safety check)
  - 2pm to 10pm: McKenna Wilkins (did not sign the safety check)
  - 10am to 8pm: Annalisa Hewitt (did not sign the safety check)
  - 5:30pm to 10pm: Turquoist “Marie” Fletcher (signed the safety check)
  - 6pm to 6am: Blake Pruitt (did not sign the safety check)
  - 10pm to 6am: Andre Fizer (did not sign the safety check)
    *There is a time frame from 4pm to 5:30pm and 10pm to 12am on this date where the safety check has not been signed as being completed.

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:	Based upon the multiple interviews conducted, review of resident records and direct care staff schedules, it can be determined direct care staff did not adequately meet the needs of Resident A's protection and safety at the facility. It is noted by multiple individuals that direct care staff communicated the situation and the needs appropriately to the care providers involved in Resident B's care plan. However, it was also noted by Complainant, Ms. Daubert, Ms. Fisher, Ms. Weaver, and Ms. Bates, that a one-to-one staffing was suggested for Resident B, until a proper solution could be identified for Resident A's safety, and this intervention was not instituted. Ms. Fisher reported direct care staff were advised to put Resident B on one-hour safety checks to ensure proper supervision and safety for the other residents. When I reviewed the one-hour safety check log against the direct care staff schedule, there were six out of nine days reviewed where direct care staff had failed to sign off, during different shifts, that they had followed through with the one-hour safety checks that were scheduled for Resident B. In reviewing the *Charting Notes for [Resident B]* document, there were also multiple entries of direct care staff members finding Resident B invading the personal space of other female residents in the facility. Ms. Fisher reported that the first instance she was informed of Resident B having these behaviors was 1/21/25, Resident A reports that Resident B sought her out on multiple occasions and at least 3-4 times physically grabbed her breasts and private regions, and Resident B was not moved from the facility until 2/14/25. It is the finding of this investigation that the suggestion for a one-to-one staffing for Resident B was not instituted by the direct care staff and the implementation of the one-hour safety checks for Resident B was documented as being inconsistently conducted, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the on-site investigation on 2/21/25 I interviewed Ms. Fisher. I requested to review the *Resident Register* document at the facility. Ms. Fisher provided the *Resident Register* and reported that she had not yet updated Resident B's date of admission on the document. The date of admission for Resident B was blank when I reviewed this document. The date of discharge for Resident B was recorded as 2/14/25. Resident B's forwarding address was noted to be, "Solan Rd. location". She also noted that Resident

E & F did not have date of admission or date of discharge dates listed as they were "respite admissions". I observed Resident E and F to be listed on the *Resident Register* with no date of admission or date of discharge dates recorded. I also observed Resident D to not have a date of admission date recorded.

APPLICABLE RULE	
R 400.15210	**Resident register.**
	Rule 210. A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: (a) Date of admission. (b) Date of discharge. (c) Place and address to which the resident moved, if known.
ANALYSIS:	Based upon the interview with Ms. Fisher and the review of the *Resident Register* provided to me during the on-site investigation, it can be determined that the *Resident Register* was not updated to demonstrate accurate dates of admission or dates of discharge. As a result, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the on-site investigation on 2/21/25 I interviewed Ms. Fisher. Ms. Fisher reported that Resident B was admitted to the facility on 1/8/25. Ms. Fisher provided Resident B's resident record for review on this date. In reviewing Resident B's record I made the following observations:

- *AFC – Resident Care Agreement* for Resident B, dated 1/1/25. On page one of this document, under the section, *License Number*, it reads, AL330404951. Under the section, *Name of Home*, it reads, "Divine Life ALC 2" The "2" has a strike through it and a "3" is written next to the "2".
- *Health Care Appraisal* for Resident B. Under section, *Resident Name*, it listed Resident B. Under the section, *AFC Facility Name,* it reads, "Divine Life ALC 2". Under the section, *Facility License Number*, it reads, "AL330404951". The rest of the document is blank. There was a yellow sticky note found on this document which read, "Have Lauren fill out for you." I inquired of Ms. Fisher whether she had a completed *Health Care Appraisal* for Resident B. She reported that she did not have a completed *Health Care Appraisal* for Resident B.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following:
ANALYSIS:	Based upon the interview conducted with Ms. Fisher as well as review of the *Resident Care Agreement* document, it can be determined that this document was labeled as the RCA for Resident B's previous admission to a different adult foster care facility, as the license number and name of the adult foster care facility do not match this facility's license number and name. Furthermore, the document is dated 1/1/25 which is prior to the stated admission date of 1/8/25. A violation has been established as the information on this document does not match the identifying information for this facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

ANALYSIS:	Based upon the interview conducted with Ms. Fisher and review of Resident B's resident record it can be determined that the *Health Care Appraisal* found in Resident B's record was not completed as required. The document was blank and was labeled with an incorrect adult foster care license number and name. A *Health Care Appraisal* was not completed and in Resident B's resident record within the 90-day period prior to Resident B's admission to the facility. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the license recommended at this time.

3/18/25

_____

Jana Lipps Date
Licensing Consultant

Approved By:

03/24/2025

_____

Dawn N. Timm Date
Area Manager