GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 8, 2025

Achal Patel
Divine Life Assisted Living of Dewitt 3 Inc.
2045 Birch Bluff Dr
Okemos, MI 48864

RE: License #: AL190418056
Investigation #: 2025A1029020
DIVINE LIFE ASSISTED LIVING OF DEWITT 3 INC

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,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190418056
Investigation #:	2025A1029020
Complaint Receipt Date:	02/19/2025
Investigation Initiation Date:	02/19/2025
Report Due Date:	04/20/2025
Licensee Name:	Divine Life Assisted Living of Dewitt 3 Inc.
Licensee Address:	2045 Birch Bluff Dr, Okemos, MI 48864
Licensee Telephone #:	(517) 898-2431
Administrator:	Cheri Lynn Weaver
Licensee Designee:	Achal Patel
Name of Facility:	DIVINE LIFE ASSISTED LIVING OF DEWITT 3 INC
Facility Address:	1177 SOLON RD, Ste. 3 DEWITT, MI 48820
Facility Telephone #:	(517) 484-6980
Original Issuance Date:	06/03/2024
License Status:	REGULAR
Effective Date:	12/02/2024
Expiration Date:	12/01/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Direct care staff members are not able to respond in case of emergencies because they are sleeping on shift and smoking marijuana in the parking lot while on shift.	No
There are not enough direct care staff members to meet resident needs because residents are not provided personal care and they fall often.	No
There are multiple medication errors at Divine Life Assisted Living of Dewitt 3.	Yes
Divine Life Assisted Living Dewitt 3 does not have supplies such as toilet paper, wipes, wash cloths to clean residents with, laundry soap, dish soap, or personal protection equipment (PPE).	No

III. METHODOLOGY

02/19/2025	Special Investigation Intake 2025A1029020
02/19/2025	Special Investigation Initiated – Letter - B. Vermeesch emailed complainant for more information.
02/27/2025	Contact - Telephone call made to administrator Lynn Weaver
03/04/2025	Contact - Telephone call made Lauren Hanna left message
03/07/2025	Inspection Completed On-site - Face to Face with Cynthia Johnson, Nakisha Walker, Resident A, Relative A1 at Divine Life Assisted Living of Dewitt 3
03/12/2025	APS Referral made online to Centralized Intake – complaint assigned to Tom Hilla.
03/13/2025	Contact - Telephone call made to licensee designee Achal Patel
03/13/2025	Contact - Telephone call made to Director of Nursing RN Hamill
03/13/2025	Contact - Telephone call received APS Tom Hilla
03/13/2025	Contact - Document Received Email from Tom Hilla
03/19/2025	Contact - Telephone call made to direct care staff members Jessica Clark, Kayden McCan, Malas Jones, no answer, Evelyn Kabura left message, Jamiah Morgan, left message

03/25/2025	Contact - Telephone call made to Sally Gerow, Tri County Office on Aging
03/26/2025	Contact - Telephone call made to Nakisha Walker
03/27/2025	Contact - Telephone call made Nakisha Walker
03/31/2025	Contact - Telephone call made to administrator Lynn Weaver
04/02/2025	Contact - Document Sent - Email to Tom Hilla
04/02/2025	Contact - Telephone call made to licensee designee Mr. Patel
04/03/2025	Contact – Telephone call to APS Tom Hilla, email to Nakisha Walker and Lynn Weaver.
04/07/2025	Contact – Voice mail received and email from administrator, Lynn Weaver
04/08/2025	Contact – Document received from APS Tom Hilla.
04/08/2025	Exit conference with licensee designee Achal Patel and administrator Lynn Weaver

ALLEGATION: Direct care staff members are not able to respond in case of emergencies because they are sleeping on shift and smoking marijuana in the parking lot while on shift.

INVESTIGATION:

On February 19, 2025, a complaint was received via Bureau of Community and Health Systems online complaint system with concerns there are direct care staff members sleeping or smoking marijuana on shift and then coming into work under the influence of marijuana.
I
On February 27, 2025, I interviewed Divine Life Chief Operating Officer and administrator, Cheri Lynn Weaver. Ms. Weaver stated she heard this occurred however she does not know if this was true because it was just mentioned in a group chat on January 29, 2025, only and not observed. Ms. Weaver stated it was made clear to direct care staff members this was not permitted and they would be terminated if marijuana was used on the property. Ms. Weaver stated direct care staff members had to acknowledge they read this policy. Ms. Weaver stated she was not aware of any direct care staff member falling asleep on shift recently. Ms. Weaver stated there was one direct care staff member who fell asleep about a year ago however that was because of a medical condition and this was addressed.

On March 7, 2025, I completed an unannounced on-site investigation and interviewed direct care staff member whose current role is home manager Nakisha Walker. Ms. Walker stated she found out in the past there were two direct care staff members sleeping on separate shifts and she terminated them but this was last year and she has not had an issue with direct care staff members sleeping on their shift since that time. Ms. Walker has never had concerns a direct care staff members was going into the parking lot to use marijuana during work hours.

On March 13, 2025, I interviewed licensee designee Achal Patel. Mr. Patel stated he did not have specifics regarding direct care staff members sleeping on the job or using marijuana on the premises.

On March 19, 2025, I contacted direct care staff member Jessica Clark. Ms. Clark stated she has smelled marijuana on some of her coworkers in the past but she had no information when they were smoking marijuana or if it was outside of work time. Ms. Clark stated she did not have a date or a specific example when direct care staff members were sleeping, if they were asleep at the same time, or if residents did not receive care.

On March 20, 2025 I interviewed direct care staff member Jamiah Morgan. Ms. Morgan stated there have been no concerns of direct care staff members sleeping at night or smelling like marijuana. Ms. Morgan stated she has had no concerns of people using drugs in the parking lot and then coming into work.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based on my interviews with Ms. Morgan, Ms. Clark, and licensee designee Mr. Patel there is no indication direct care staff members have not been able to handle an emergency situation because they were sleeping or using marijuana during their shift. Although it was mentioned in a group chat that marijuana was smelled, I found no evidence direct care staff members were using marijuana while working.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There are not enough direct care staff members to meet resident needs because residents are not provided personal care and they fall often.

INVESTIGATION:

On February 19, 2025, a complaint was received via Bureau of Community and Health Systems online complaint system with concerns there are residents who are "bed bound" not receiving the proper care because they are left in urine soaked bedding all day. There were also allegations in the complaint that residents fall often and there are no "repercussions" after they fall.

On February 27, 2025, I interviewed Chief Operating Officer and administrator Ms. Weaver. Ms. Weaver stated she has no concerns there are not enough direct care staff members to perform the job duties and the residents who need to be changed are assisted often. Ms. Weaver stated she has no concerns residents are not tended to when they fall.

On March 7, 2025, I completed an unannounced on-site investigation and interviewed direct care staff member whose current role is home manager Ms. Walker. Ms. Walker stated Resident B is rotated every two hours because her family does not want her out of bed often. Ms. Walker stated Resident B had a sore they were trying to heal and it is almost gone after almost two years. Ms. Walker stated there has never been a time when a direct care staff member worked alone in this facility. Ms. Walker stated there are always two direct care staff members listed on the schedule for Divine Life Assisted Living of Dewitt 3 and when someone calls in or is mandated, she updates the schedule. I reviewed the schedule for the weeks of January 19 – March 8, 2025 and verified there was always two direct care staff members assigned. Ms. Walker stated currently there are four residents, Resident A, Resident B, Resident C and Resident D who require a Hoyer lift. Ms. Walker stated the Hoyer lift requires two direct care staff members to operate. Ms. Walker stated there are 15 residents at Divine Life Assisted Living of Dewitt 3 and two direct care staff members always working along with the home manager on first shift. Ms. Walker stated there is also an additional direct care staff member working from 2-10 PM to help residents with dinner and getting ready for bed. Ms. Walker stated she has never had concerns that residents were left in urine-soaked bedding or not provided care.

During the onsite investigation, I reviewed Resident A, Resident B, and Resident C's resident records and reviewed the following information:

1. Resident A's *Assessment Plan for AFC Residents* which included documentation that she requires two-person assistance for bathing, dressing, and for walking / mobility because she has a Hoyer lift and transferring in and out of her electric wheelchair.

2. Resident B's *Assessment Plan for AFC Residents* which included documentation that she requires two-person assistance with briefs, Hoyer lift, grooming, dressing, personal hygiene, walking/mobility.

3. Resident C's *Assessment Plan for AFC Residents* which included documentation that she requires two-person assistance Hoyer to Broda chair because she has pain and this is difficult for her. Resident C also has a Hoyer lift she relies on for an assistive device. According to Resident C's *Health Care Appraisal* she was bedbound and not in apparent distress but had decreased strength.

4. I reviewed the staffing schedule for the time period of January 19 – March 8, 2025 and confirmed there was always at least two direct care staff members working at Divine Life Assisted Living of Dewitt 3.

5. I reviewed Resident A, Resident B, and Resident C's e-MAR for February 2025 and there is a notation every two hours confirming Resident A and Resident B were turned and repositioned by a direct care staff member as ordered by their physician.

6. There were two *AFC Incident / Accident Reports* for January – February 2025 that documented resident falls. Both incidents were handled by direct care staff members who assisted the resident and made follow up calls as necessary.

I observed Resident A and Resident B however due to their dementia diagnosis they were unable to complete an interview regarding the allegations.

I interviewed Resident C and Relative C1 who was visiting at the time. Relative C1 stated she has no concerns Resident C is not changed regularly and provided personal care. Relative C1 stated Resident C has a history of urinary tract infections and has had three in the last six months. Relative C1 stated she has no concerns Resident C or any of the other residents are neglected in the facility and stated she always observes at least two direct care staff members working at a time when she visits at least twice per week.

On March 13, 2025, I interviewed licensee designee Mr. Patel. Mr. Patel stated he did not have specifics regarding inadequate staffing. Mr. Patel stated he feels there is adequate staffing to meet the resident needs and had no concerns regarding frequent falls or residents not being provided with personal care.

On March 19, 2025, I interviewed direct care staff member Ms. Clark. Ms. Clark stated she is concerned there are some residents who are not provided care as they should be because when she works with Resident B and has noticed she has had bed sores in the past. Ms. Clark stated Resident B has told her before she "hates her butt" because it's sore and based on this information, she does not think she is turned timely. Ms. Clark stated she believes having two direct care staff members on at a time is adequate to meet the resident care needs. Ms. Clark stated she has been told she can work by herself on third shift and that if they cannot find coverage they will tell her she's on her own, however, she did not recall a date when she worked alone. Ms. Clark stated it "is possible" to use a Hoyer lift with one person however there are some direct care staff

members who are small in stature/size who would not be able to do this task on their own.

On March 20, 2025 I interviewed direct care staff member Jamiah Morgan. Ms. Morgan stated she has no concerns of the residents not being changed. Ms. Morgan stated there are always two direct care staff members working at Divine Life Assisted Living of Dewitt 3 and she felt this was adequate to meet resident needs.

On April 3, 2025 I interviewed Mr. Hilla and he stated that he did not have concerns there was not enough direct care staff members while there. Mr. Hilla stated he was able to confirm there was at least two direct care staff members on per shift. Mr. Hilla stated he has been to the facility for several other investigations and did not have concerns regarding staffing coverages or the residents not receiving their required personal care.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Ms. Walker stated there were at least four residents who required two-person direct care staff member assistance for grooming, dressing, and mobility. I reviewed Resident A, Resident B, and Resident C's resident record and they all require the assistance of two direct care staff members. I reviewed the staffing schedule for the time period of January 19 – March 8, 2025 and ensured there was always at least two direct care staff members working at Divine Life Assisted Living of Dewitt 3. According to the e-MAR for Resident A, Resident B, and Resident C, they are all turned and repositioned as ordered and there is no indication based on the interviews completed they are not provided personal care as necessary.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: There are multiple medication errors at Divine Life Assisted Living of Dewitt 3.

INVESTIGATION:

On February 19, 2025, a complaint was received via Bureau of Community and Health Systems online complaint system with concerns there are multiple medication errors in the e-MAR system and when this occurs managers go in and change the medication entry. The complaint did not include a resident name who had multiple medication errors, dates when this occurred, or concerns any resident who was required to have medical treatment as a result of a medication error. APS specialist Tom Hilla was also assigned to investigate the allegations.

On February 27, 2025, I interviewed Chief Operating Officer and administrator, Ms. Weaver. Ms. Weaver stated there has not been any communication regarding medication errors and they have Director of Nursing Kortney Hamill, RN who assures orders are in and completes medication audits to make sure there are no errors.

On March 7, 2025, I completed an unannounced on-site investigation and interviewed direct care staff member whose current role is home manager Ms. Walker. Ms. Walker stated many residents now have over the counter medications and family members are responsible to provide over-the-counter medications because these family members do not want to use the pharmacy used by the facility. Ms. Walker stated there are also concerns with Resident A's medications because Relative A1 does not bring Resident A's medications to the facility in a timely manner. Ms. Walker stated there has not been any recent medication errors at Divine Life Assisted Living of Dewitt 3 because she would be informed if this was occurring and all direct care staff members have been medication trained in medication administration. Ms. Walker stated if there is a medication error, they are able to notice it because audits are done on Mondays and Thursdays on each medication cart. Ms. Walker stated RN Hamill would have a listing of any recent medication errors. Ms. Walker stated she can go in and change the medication but only if there is an order for it however she can go in and add the mediation in the system but they do not change to document it was administered when it was not administered.

I observed Resident B however due to their dementia diagnosis they were unable to complete an interview regarding the allegations.

I interviewed Resident C and Relative C1 who was visiting at the time. Relative C1 stated she had no concerns for medication errors for Resident C and states she receives her medications as scheduled.

During the on-site investigation, I reviewed the medications and the e-MAR for Resident A, Resident B, and Resident C with direct care staff member whose current role is home manager, Lakisha Baldwin. There were no missing medications or concerns with

Resident B or C's medications, however, there were missing medications from Resident A that have not been administered to her.

I reviewed Resident A's e-MAR for February 2025 and the medications available in the medication cart. The following medications were missing for Resident A because Ms. Baldwin stated Relative A1 was supposed to bring them to the facility but had not:

1. Levocetirizi Tab 5 mg – Listed on e-Mar starting on February 26, 2025 as "Med not available"
2. Magnesium tab 250 mg - Listed on e-Mar starting on February 27, 2025 as "med not available"
3. Oxybutynin tab 10 mg – Ms. Baldwin stated they were out of this medication during the on-site however according to her February e-MAR she did receive this throughout February 2025.
4. Stool Softener tab 8.6-50 mg - Listed on e-Mar starting on February 27, 2025 as "med not available"
5. Ketorolac Tromethamine 10 mg tablets - Listed as a PRN and this medication was not administered during the month of February 2025.
6. Lidocaine Patch 4% - Listed on e-Mar starting on February 27, 2025 as "awaiting med arrival from pharmacy"
7. Mag Citrate Sol Lemon – Listed as a PRN and this medication was not administered during the month of February 2025.
8. Pain Reliever Pad 3.1-6-10 - Listed as a PRN and this medication was not administered during the month of February 2025.
9. Polyeth Glyc Powder - Listed as a PRN and this medication was not administered during the month of February 2025.
10. Silver Sulfa Cream 1% - Listed as a PRN and this medication was not administered during the month of February 2025.
11. Metformin 500 mg was not present in the facility. Ms. Baldwin stated they did have Metformin 1000 mg and they were just cutting the medication in half. The instructions on the bottle and the medications did not match.

During my on-site, I did observe Resident A however she was eating lunch and not able to complete an interview regarding the allegations. APS Mr. Hilla interviewed her during his on-site on March 13, 2025, and Mr. Hilla sent the following interview notes from his visit with Resident A:

"Met with [Resident A] regarding the allegations and she reports she has been here since October 2023. She disclosed she was a nurse for BCBS. She expressed concern for the facility not having a nurse or LPN. Reminded [Resident A] that Kortney Hamill is the facility's nurse. In addition, she does not want to switch doctors. Confirmed her current PCP is dr. Kathryn Baumgartner. Confirmed she orders her own medication. APS suggested she complete a medication review due to her current medication list being such a mess. APS expressed concern for her doctor and all her specialist's ordering medication and no one communicating. APS suggested a medical appointment with Dr. Baumgartner and addressed other issues. She states cousin is not also available to assist her picking up her medication at Meijer. Attempted to contact Allison, RN at Dr. Baumgartner's Office, regarding the medical appointment for a med review,

but no answer. Left a message requesting she contact APS when she is able. Provided a resource guide and developed a Plan of Care. It was agreed to follow up with any further updates."

On March 13, 2025, I interviewed RN Hamill who stated there are issues with Resident A's medications. RN Hamill stated they are using Express Scripts and when they are running low, direct care staff member will let her know and she orders them herself. RN Hamill stated there are times this does not happen but Resident A is her own guardian and they allow her to do this. RN Hamill stated when the medications do not come, then they will call Relative A1 and she will send them to the facility because they cannot force her to use the facility pharmacy. RN Hamill stated in the future they are planning to use their pharmacy and then have them pay the bill. RN Hamill stated this has been going on for months. RN Hamill stated there are several specialists she sees who order various medications but the family does not inform facility direct care staff of the changes. RN Hamill stated they have a new order but need to complete a profile for Resident A with their pharmacy and it will go into the QuickMAR. RN Hamill stated she does have an email for Allison Clawson at Resident A's physician's office and they will email back and forth to get the medications.

On March 13, 2025, I was copied on an email that was sent from the RN Hamill to Ms. Clawson which stated they needed clarification for Resident A's medications:

"We're needing clarification on some of [Resident A's] meds, below is the list:

1. *Metformin should be 500 mg, we only have 1000mg caps*
   we do not have Oxybutynin for her, I thought this may have been prescribed by Urologist?
2. *Omeprazole has been changed to 40 mg, we have 20 mg caps only*
3. *She also has multiple pain patch/ointment orders, please clarify what to continue & what to DC:*
4. *Diclofenac, Lidocaine patch 4%, Biofreeze gel 4%, icy hot max*

- *Can we get a dc for the following due to non-use: Hydrocortisone cream, Abreva, Toradol?"*

On March 13, 2025, I received a call from APS specialist Tom Hilla regarding Resident A's missing medications. Mr. Hilla was informed of the medications which were not in the facility during the on-site and informed that the family was supposed to bring the medications to the facility last week. Ms. Hilla stated he interviewed Resident A and she was able to answer all his questions and he was able to verify there were several of the medications she has not been receiving. Mr. Hilla stated he did not review the medication cart while at the facility but that he was going to contact the physician's office and get an updated medication list to see what she should be taking. Mr. Hilla also noticed she had several different pain creams and patches prescribed and he would check to see if she needed to be prescribed several similar medications. Mr. Hilla stated Relative A1 is not the power of attorney or guardian at this time and she was opposed to getting someone in that role at this time.

On March 13, 2025, I interviewed licensee designee Achel Patel who stated he was unaware of any concerns regarding Resident A's medications or that her family was providing medications. I informed Mr. Patel that there were several medications that were not present in the facility for Resident A.

On March 19, 2025, I contacted direct care staff member Ms. Clark. Ms. Clark stated she was unaware of any medication errors at Divine Life Assisted Living of Dewitt 3.

On March 20, 2025 I interviewed direct care staff member Ms. Morgan. Ms. Morgan stated she was unaware of any medication errors at Divine Life Assisted Living of Dewitt 3.

On April 3, 2025 I interviewed Mr. Hilla who stated Resident A's medications have been updated and the facility has the updated medications. Mr. Hilla stated when he interviewed Resident A initially she didn't want to use their pharmacy as she was receiving medications from Meijer and through mail order. Mr. Hill stated moving forward, Resident A and RN Hamill are going to order the medications together through the facility pharmacy.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Although there were no concerns with Resident B and Resident C's medications, there were several missing medications for Resident A upon reviewing her medication administration record and medications. The following medications were missing for Resident A because Ms. Baldwin stated Relative A1 was supposed to bring them to the facility but had not: • Levocetirizi Tab 5 mg • Magnesium tab 250 mg • Oxybutynin tab 10 mg – Ms. Baldwin stated they were out of this medication. • Stool Softener tab 8.6-50 mg • Ketorolac Tromethamine 10 mg tablets • Lidocaine Patch 4% • Mag Citrate Sol Lemon • Pain Reliever Pad 3.1-6-10 • Polyeth Glyc Powder • Silver Sulfa Cream 1% I also observed the Metformin 500 mg was not present in the facility. Ms. Baldwin stated they did have Metformin 1000 mg and they were just cutting the medication in half. The instructions on the bottle and the medications did not match. Resident A has not been receiving the above medications as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Divine Life Assisted Living Dewitt 3 does not have supplies such as toilet paper, wipes, wash cloths to clean residents with, laundry soap, dish soap, or personal protection equipment (PPE).

INVESTIGATION:

On February 19, 2025, a complaint was received via Bureau of Community and Health Systems online complaint system with concerns the facility not having toilet paper, wipes nor wash cloths to clean residents with, no laundry soap, dish soap, personal protection equipment (PPE) for direct care staff members when residents had RSV and COVID.

On February 27, 2025, I interviewed Chief Operating Officer and administrator, Ms. Weaver. Ms. Weaver stated they have lots of PPE for COVID and RSV. Ms. Weaver stated the facility does not run out of laundry soap or dish soap and home managers are

responsible for ordering supplies as needed. Ms. Weaver stated J&B Medical Supply also sends supplies for some of the residents to the facility.

On March 7, 2025, I completed an unannounced on-site investigation and interviewed direct care staff member whose current role is home manager Ms. Walker. Ms. Walker stated there are two rooms for PPE and she didn't have any concerns they were low on PPE supplies. Ms. Walker stated she also has a business account card in case they do run out so she can always run out and get more. Ms. Walker stated she has never witnessed the direct care staff members using body wash to wash dishes and there is a detergent powder they use in the dishwasher.

On March 7, 2025 I observed Resident B however due to their dementia diagnosis they were unable to complete an interview regarding these allegations.

On March 7, 2025 I interviewed Resident C and Relative C1 who was visiting at the time. Relative C1 stated she had no concerns regarding the direct care staff members not having PPE and stated she has always observed the residents to wear gloves in the facility. Relative C1 stated the facility did have COVID-19 within the last year and she observed the direct care staff members to wear masks during this. Relative C1 stated there have been times where Resident C was low on hand towels and toilet paper however these are always restocked.

On March 13, 2025, I interviewed licensee designee Achal Patel. Mr. Patel stated he has no concerns there is a lack of PPE supplies at Divine Life Assisted Living of Dewitt 3 because they order on a regular basis. Mr. Patel stated the home managers are responsible for making sure the orders are in for supplies.

On March 19, 2025, I contacted direct care staff member Ms. Clark. Ms. Clark stated they went under new management and it's been a few times they ran out of supplies but they are ordered quickly. Ms. Clark stated one time the washer broke and she had to go to the building next door to do the laundry. Ms. Clark stated in one of the buildings ran out of toilet paper they will get it from another building so it is always available. Ms. Clark stated there are plenty of masks but sometimes the direct care staff members may not know where the supplies are.

On March 20, 2025 I interviewed direct care staff member Ms. Morgan. Ms. Morgan stated she never ran out of supplies or PPE while working at Divine Life Assisted Living of Dewitt 3. Ms. Morgan stated there are several supply cabinets where you can get additional supplies if needed while working.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(8) Hand-washing facilities that are provided in both the kitchen and bathroom areas shall include hot and cold water, soap, and individual towels, preferably paper towels.

ANALYSIS:	Based on my interviews with Ms. Johnson, Ms. Clark, and Ms. Morgan along with my observations of the supply closets during my on-site investigation, there are no concerns direct care staff members do not have the necessary supplies to provide care and services to residents at Divine Life Assisted Living of Dewitt 3.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

_ _____04/08/2025_____

Jennifer Browning Date
Licensing Consultant

Approved By:

04/08/2025

_____

Dawn N. Timm Date
Area Manager