GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 5, 2025

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

RE: License #: AL190418056
Investigation #: 2025A1033042
Divine Life Assisted Living of Dewitt 3

Dear Mr. Patel & Mr. Thakore:

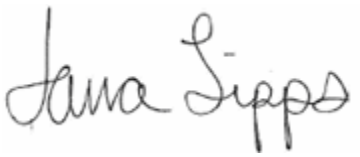
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 335-5985.

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 #:	AL190418056
Investigation #:	2025A1033042
Complaint Receipt Date:	06/27/2025
Investigation Initiation Date:	06/27/2025
Report Due Date:	08/26/2025
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 & Vivek Thakore
Name of Facility:	Divine Life Assisted Living of Dewitt 3
Facility Address:	STE 3 1177 SOLON RD 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?
There is not adequate food available for resident consumption and nutrition.	No
Additional Findings	Yes

III. METHODOLOGY

06/27/2025	Special Investigation Intake 2025A1033042
06/27/2025	Special Investigation Initiated - Telephone Interview conducted with Adult foster care licensing consultant, Jennifer Browning, via telephone.
07/07/2025	Inspection Completed On-site Interviews conducted with direct care staff, Lakeisha Baldwin, Cynthia Johnson, Jackie Milton, Resident A, Resident B. Review of the food supply available in the kitchen and pantry areas as well as review of menus.
07/08/2025	Contact - Telephone call made Interview conducted with Citizen 1, via telephone.
07/08/2025	Contact - Telephone call made Interview conducted with Kitchen Manager, Mohammad Redha-Abdulkarim, via telephone.
07/08/2025	Contact - Document Sent Email correspondence sent to co-licensee designees, Achal Patel & Vivek Thakore, & Administrator, Cheri Lynn Weaver, requesting resident register and resident weight records.
07/10/2025	Inspection Completed On-site Interview conducted with kitchen manager, Mohammad Redha-Abdulkarim. Inspection of available food items on the campus, completed today.
07/16/2025	Contact - Document Received Resident weight records received via email.
07/17/2025	Contact - Document Received Resident Register received via email.

07/28/2025	Contact – Document Sent Email correspondence sent to Administrator, Cheri Lynn Weaver, regarding clarification on resident weight records reviewed.
08/05/2025	Exit Conference Conducted via telephone with licensee designee, Achal Patel.

ALLEGATION: There is not adequate food available for resident consumption and nutrition.

INVESTIGATION:

On 6/27/25 I received a complaint regarding the Divine Life of Dewitt 3, adult foster care facility (the facility). The complaint alleged that the facility does not have adequate food available for residents and that there is only a $400 monthly food budget to feed all residents. I interviewed adult foster care licensing consultant, Jennifer Browning, who reported she had a telephone conversation with Citizen 1. Ms. Browning reported that Citizen 1 made claims that the shelves in the pantry are bare and that food at the facility was in a scarce supply. Ms. Browning reported that Citizen 1 stated that she had photographs she had taken of the empty shelves.

On 7/7/25 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/facility manager, Lakeisha Baldwin. Ms. Baldwin reported that she manages the direct care staff at the facility. She reported that there is a kitchen manager, Mohammad Redha-Abdulkarim, who oversees the day-to-day operations in the kitchen. Ms. Baldwin reported that this campus houses three licensed adult foster care facilities. She reported that the kitchen at the facility mentioned in the complaint is where all the meals are prepared for all three licensed adult foster care facilities on this campus. Ms. Baldwin reported that Mr. Redha-Abdulkarim orders food deliveries which arrive every two weeks. She reported that there are times when they do run low on bread, milk, eggs prior to the next delivery arriving and when this occurs the direct care staff will go to Meijer and pick up additional food items to supplement until the next delivery arrives. Ms. Baldwin reported that the facility currently has a census of 18 residents. She reported that building #2 on the campus has a census of 15 residents and building #1 has a census of 9 residents. Ms. Baldwin stated that the food deliveries arrive every other Wednesday. Ms. Baldwin reported that the residents at the facility do enjoy toast for breakfast and sandwiches for lunch, so they do go through about 24 loaves of bread in a week. She further reported that they also go through a large quantity of milk and that they will frequently run low on these items and need to go to the nearby grocery store to supplement while they wait for the next food delivery truck. Ms. Baldwin reported that there have been complaints from some of the residents as they do not like the food being prepared by Mr. Redha-Abdulkarim. She reported that Resident A and Resident B have made verbal complaints noting that the facility is

running low or out of bread and that they do not like the food being offered and want different menu items.

On 7/7/25, during the on-site investigation, I interviewed the facility manager for building #1 and #2 on this campus, Cynthia Johnson. Ms. Johnson reported that meals for all three facilities are prepared in the facility identified in this complaint. She reported that each facility does have a small supply of items, such as milk and bread, that they keep on hand in those kitchens for resident use. She reported that Mr. Redha-Abdulkarim is the kitchen manager for the campus and is responsible for preparing menus, ordering food for deliveries, and managing kitchen staff. Ms. Johnson reported that there have been occasions when food supplies have run short, such as bread, milk, eggs. She reported that when this happens the director of the campus, Nakisha Walker, or Mr. Redha-Abdulkarim will pick up these items from the local grocery store the day they are found to be running low. Ms. Johnson reported that the food deliveries are set to be delivered every other Wednesday. She reported that there have been some resident complaints about the types of food that are being prepared and offered to residents and that the residents had a meeting and came up with some alternate suggestions for the menu. She reported that this meeting occurred the week prior. Ms. Johnson reported that Mr. Redha-Abdulkarim was receptive to these suggestions. Ms. Johnson reported that Mr. Redha-Abdulkarim is responsible for creating the menus and distributing them to the residents each week.

During the on-site investigation on 7/7/25, I interviewed Resident A regarding the allegation. Resident A reported that the menu items they are served for the meals at the facility tend to have very little, to no meat in them. She reported that the food is not prepared well and is often dry, unrecognizable, and tough to chew. Resident A reported that the facility is “constantly running out of food”. She reported that the facility is consistently running low on bread and gave the example that this morning almost every resident wanted toast for breakfast, and they did not have enough bread to supply toast to everyone unless each resident only received one piece. Resident A reported that when there is something on the menu that a resident does not like they are able to substitute the item for a sandwich. She reported that a few days prior she wanted to substitute for a ham sandwich and she was told that the facility was all out of ham, turkey, and bread. Resident A reported that there have been times when the facility is out of bread for weeks. She reported that she has resorted to buying her own bread and keeping it in the refrigerator in her resident room. Resident A reported that there have also been occasions when the facility has run out of milk. Resident A reported that when they are served eggs, “it does not even look like eggs”. She reported, “they make up food that looks like eggs.” Resident A reported that since February she has been on a steady weight loss, and she attributes this to the poor quality of food at the facility and the lack of food at the facility. Resident A reported that previously they would receive a menu each week, but the menu was not accurate and rarely had the correct meals listed. She reported that she has not received an updated menu in weeks.

During the on-site investigation on 7/7/25 I interviewed Resident B regarding the allegations. Resident B reported, “I’m always hungry”. She was referring to the lack of

food at the facility. Resident B stated that the portions of meat the residents are given are too small to be considered a meal. She reported that the menu is too repetitive and the food is not prepared well. She reported that the kitchen staff always make complaints that there is not enough food to prepare meals. Resident B reported that the facility is often running low on bread and milk and some days neither item is available. Resident B reported that the eggs that are being prepared are, “nasty and too hard”.

During the on-site investigation on 7/7/25 I interviewed kitchen staff, Jackie Milton. Ms. Milton reported that she has worked at the facility for about 1.5 years. She reported that there is not a menu available for her to follow when she works. She reported that she will come into the facility and look at what is available in the refrigerator, freezer, and pantry and make up the meals as she goes based on the food available. Ms. Milton reported that the facility was previously receiving a food delivery every week. She reported that since Mr. Redha-Abdulkarim took over as kitchen manager, the deliveries have been cut to every two to three weeks. Ms. Milton reported that the facility is frequently running low on milk, eggs, and bread. She reported that there is very little in terms of snack items, such as crackers. Ms. Milton reported that sometimes it can be days before milk and bread are delivered to the facility. Ms. Milton reported that working with such limited supplies and without a menu to work from is difficult for her.

During the on-site investigation on 7/7/25, I conducted a walk-through of the dining area, pantry area, and kitchen at the facility. I observed the following:

- In the dining area there was a posted menu on the wall, which was dated for the week of 3/9/25 through 3/15/25. There was another menu posted above this menu which was not dated.
- In the kitchen office, Ms. Milton provided me with a paper menu that was not dated. Ms. Milton reported that she does not prepare foods listed on this menu as the facility is frequently not stocked with the menu items listed. On this date Ms. Milton was preparing lasagna, muffins, and a vegetable (the menu provided listed tuna sandwiches, chips, cookie, juice). She reported that the food I observed was for the 18 residents at the facility as she had already fed the residents at building #1 and #2 on the campus. The lasagna was prepared in a baking dish that appeared to be slightly larger than a 9x13 inch pan. The pan was not completely full of lasagna and the dish seemed loose and not in a formed consistency.
- In the pantry I observed the following:
    - Multiple packets of Jello
    - At least four boxes of pancake mix
    - Several boxes of brownie mix
    - Multiple packs of flour tortillas
    - 6 cans of chicken noodle soup
    - Two bags of spaghetti noodles
    - Ten or more packets of gravy mix
    - A couple cans of tomato sauce
    - One large can of red beans
    - One large can of baked beans
    - Two large bags of elbow macaroni

    - 12 bags of Cheese Sauce Mix
    - Multiple bottles of ketchup and mustard
    - Italian Dressing, Vegetable Oil, Olive Oil
    - Dry Cereal, Cream of Wheat, Oatmeal
    - Multiple boxes of tea bags
    - Multiple small cans of vegetable soup
    - Boxes of cake mix and muffin mix
    - Two large cans of fruit
    - Multiple cans of cream of mushroom soup
    - Two large containers of peanut butter
    - Two large containers of canned corn
    - Two large jars of jelly
    - 1.5 large bags of tortilla chips
    - 1.25 large bags of potato chips
    - A loaf of bread with 12 pieces of bread
- In the freezer I observed the following:
    - Three large rolls of ground hamburger
    - One medium size box of ground pork sausage
    - Multiple packages of frozen chicken
    - Two large packages of cheese slices
    - A 5lb package of frozen diced ham
    - Three large packages of frozen French fries
    - Three large packages of frozen vegetables
- In the refrigerator I observed the following:
    - A medium size package of ham lunchmeat
    - A large box of lemons
    - A package of cheese slices
    - A half-used jar of pickles
    - A large jar of jelly
    - A gallon of milk which was ¾ used.
    - One head of lettuce

On 7/8/25 I interviewed Citizen 1, via telephone, regarding the allegation. Citizen 1 reported that she previously worked at the facility. She reported that she found it concerning that there was little to no food in the pantry or the refrigerator when she worked there. Citizen 1 reported that she had asked Ms. Milton about the limited supply of food and was told that the food budget had been cut to $400 per month for the campus. Citizen 1 reported that she was responsible for serving food to residents and she was appalled by how small the portion sizes were. She reported that the residents were also not allowed a second helping of the food, even though the portion sizes they were given were so small. Citizen 1 reported that she found the lack of food on-site concerning and noted, “the residents were hungry.”

On 7/8/25 I interviewed Mr. Redha-Abdulkarim via telephone regarding the allegations. Mr. Redha-Abdulkarim reported that he began working as the kitchen manager for the campus in April 2025. He reported that he is responsible for submitting food delivery

orders, preparing menus, and managing kitchen staff. Mr. Redha-Abdulkarim reported that the campus currently has a census of 45 residents and the food for these residents is all prepared in the facility's kitchen. He reported that he is given a dietary budget of $5.42 per day per resident. Mr. Redha-Abdulkarim reported that when he began working as the kitchen manager, the food delivery orders were delivered every week. He reported that he has since moved this to every two weeks because he feels he has a good handle on how much to order to make the food deliveries last for two weeks. Mr. Redha-Abdulkarim reported that he submits his food orders to Gordan Food Service. He reported that if the facility runs low on milk, bread, eggs, or other fresh items, someone will go to the local grocery store to purchase those items. He reported that there are three licensed adult foster care facilities on the campus and each facility does have a small supply of bread, milk, and other items. He reported that bread and milk are items that are popular and tend to run low faster. Mr. Redha-Abdulkarim reported that when he first started he would produce a menu and provide a copy to all residents, weekly. He reported that menus have not been readily available for residents lately and he is working on correcting this issue. Mr. Redha-Abdulkarim reported that he feels the food at the facility is adequately stocked and feels that previously unnecessary items were being purchased and he has refined the food order to reflect what is essential. Mr. Redha-Abdulkarim further reported that he has reduced purchasing items such as boxed brownie and cake mixes as he can make these items from scratch and save money for the facility.

On 7/10/25 I conducted a follow-up, on-site investigation at the facility to observe the food supply available on this date. I observed that a shipment of food had been delivered to the facility on 7/9/25. I observed the following:

- Four gallons of milk
- A large case of eggs
- A large box of Roma tomatoes
- A large box of iceberg lettuce
- Four loaves of bread
- Two large boxes of potatoes
- 6 large cans canned peaches
- Several boxes of biscuit mix
- Four large cans of tuna
- One large box of bananas
- Multiple large bags of shredded cheddar cheese
- Six containers of lunch meat
- Breakfast sausage patties
- Chicken breast
- Bacon
- Two large bags of shredded mozzarella cheese
- At least nine large bags of frozen green beans

On 7/10/25, I also did an on-site inspection of the refrigerators in building #1 and #2 on this campus and observed the following:

- Building #2 had a full gallon of milk, multiple large containers of yogurt, and no bread.
- Building #1 had a full gallon of milk, a large container of yogurt, a large container of cottage cheese, and half a loaf of bread.

On 7/10/25, during the follow-up, on-site investigation, I spoke with Mr. Redha-Abdulkarim. He reported that he had served tuna salad sandwiches for lunch today. He presented me with a menu and this menu listed chicken soup for lunch. Mr. Redha-Abdulkarim reported that he had to change the menu based on the food that was available on-site. Mr. Redha-Abdulkarim reported that the menu he provided me today has not been distributed to the residents and he has not routinely been distributing a menu to the residents.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based upon the interviews conducted, documents reviewed, and two on-site investigations conducted including walkthroughs of the food storage areas, it can be determined that there is not adequate evidence to suggest that the facility is not equipped with adequate food supplies to provide three nutritious meals per day for the current residents. Even though, there were resident complaints that portion sizes were small and the facility is frequently depleted of milk, eggs, and bread, it was addressed by Mr. Redha-Abdulkarim, Ms. Johnson, and Ms. Baldwin, that the administration does make frequent trips to the local grocery store to obtain these items when the facility is in low supply. While I was on-site on 7/7/25 I did observe several food items that were in low supply, including milk, bread, and eggs, but was told that a food delivery was scheduled for 7/9/25. When I returned to the facility on 7/10/25, I did find that a food delivery had been received and bread, milk, and eggs were all replenished and available for consumption on this date. The two residents interviewed reported that they do not like the meals being prepared and stated they have requested additional menu items be added to the weekly rotation. They reported that this request was taken seriously by Mr. Redha-Abdulkarim, and he was willing to make these changes to the menu. Based upon the information collected, there is not adequate information to cite a violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	Based upon interviews conducted with Resident A, Resident B, Ms. Milton, Ms. Baldwin, Ms. Johnson, & Mr. Redha-Abdulkarim, as well as observations made during the on-site investigations on 7/7/25 & 7/10/25, it can be determined that a written menu is not being posted in advance at the facility. It can also be concluded that changes or substitutions in the menu are not being recorded on the menu itself. The menu observed while on-site on 7/725, was dated for March 2025. Both Resident A & Resident B reported that a menu is not provided to residents to review. Ms. Milton reported that she works in the kitchen at the facility and is not given a menu to follow. She reported she decides what to cook based on the products available at the facility on that day. Mr. Redha-Abdulkarim reported that he has been writing menus but has not distributed or posted menus for the residents in several weeks. Based upon this information a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 7/7/25, during the on-site investigation, I interviewed Ms. Milton. Ms. Milton stated that I should watch where I step so I don't step on any "roaches." I asked Ms. Milton what she was referring to and she reported that the facility had a recent cockroach infestation and that someone had been to the facility over the weekend of 7/5/25-7/6/25 to spray for bugs. Ms. Milton pointed to the floor in the kitchen where I could see multiple bug carcasses on the ground. I also observed a bottle of Bug Stop pesticide sitting on the kitchen floor by the kitchen sink. I walked around the kitchen and found dead bugs lying along the floorboards of the entire kitchen, in the windowsill of the kitchen window, near stacked pots and pans, on shelving containing clean dishes, and on the floor in the foyer of the facility.

When I returned to the facility on 7/10/25 these bug carcasses had been removed, and the floors had been cleaned.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based upon the observations made during the on-site investigation on 7/7/25, it can be determined that the housekeeping standards did not provide a clean and comfortable appearance at the facility. The bug carcasses were plentiful and had not been disposed of prior to food production in the kitchen as Ms. Milton was preparing food during my on-site investigation. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 7/16/25 I received email correspondence from Administrator, Cheri Lynn Weaver, and Director of Nursing, Kortney Hamill, containing documentation of weight records for each of the current residents. I made the following observations:

- Resident A:
  - 3/1/25 – 105lbs
  - 4/1/25 – 106.1lbs
  - 5/2/25 – 104lbs
  - 6/1/25 – 101.5lbs
  - 7/1/25 – 130lbs
    - Weight increase of 25lbs since March 2025.
- Resident B:
  - 3/1/25 – 176lbs
  - 4/1/25 – 182lbs
  - 5/1/25 – 193lbs
  - 6/1/25 – 189lbs
  - 7/1/25 – 187.1lbs
    - This resident is weighed daily per doctor's order.
    - Resident B's weights fluctuate between 176 – 196lbs.
- Resident C:
  - 3/2/25 – 137.5lbs
  - 4/1/25 – 138.7lbs
  - 5/1/25 – 136lbs
  - 6/1/25 – 138.7lbs
  - 7/1/25 – 125lbs
    - Weight decrease of 12.5lbs since March 2025.
- Resident D:
  - 3/1/25 – 126lbs
  - 5/2/25 – 119lbs

    - 6/1/25 – 107lbs
    - 7/1/25 – 120lbs
        - Weight decrease of 6lbs since March 2025.
- Resident E:
    - 3/1/25 – 188.5lbs
    - 4/1/25 – 189.3lbs
    - 5/2/25 – 185lbs
    - 6/1/25 – 180lbs
    - 7/1/25 – 189lbs
        - Weight increase of 0.5lbs since March 2025.
- Resident F:
    - 3/3/25 – 175.5lbs
    - 4/1/25 – 151.1lbs
    - 5/2/25 – 186.8lbs
    - 7/1/25 – 280lbs
    - 7/1/25 – 290lbs
        - Weight decrease 24.4lbs from March to April 2025.
        - Weight increase 35.7lbs from April to May 2025.
        - Weight increase of 93.2lbs from May to July 2025.
- Resident G:
    - 3/2/25 – 95.8lbs
    - 4/1/25 – 102.9lbs
    - 5/2/25 – 100.3lbs
    - 6/9/25 – 99.1lbs
    - 7/1/25 – 93lbs
        - Almost 3lb weight increase since March 2025
- Resident H:
    - 3/2/25 – 174.8lbs
    - 4/1/25 – 173.3lbs
    - 5/2/25 – 171.8lbs
    - 6/1/25 – 172.7lbs
    - 7/15/25 – 174.1lbs
        - Maintained stable weights since March.
- Resident I:
    - 5/2/25 – 360.2lbs
    - 6/13/25 – 347.6lbs
    - 7/15/25 – 352.1lbs
        - Weight decrease of 12.6lbs from May to June 2025.
- Resident J:
    - 3/2/25 – 175.7lbs
    - 4/1/25 – 205.4lbs
    - 5/2/25 – 199.4lbs
    - 6/1/25 – 201.6lbs
    - 7/1/25 – 205.9lbs
        - Weight increase of 30.2lbs since March 2025.
- Resident K:

    - 3/1/25 – 184lbs
    - 4/1/25 – 191.4lbs
    - 5/1/25 – 185lbs
    - 6/1/25 – 186lbs
    - 7/1/25 – 186lbs
        - Weight increase of 2lbs since March 2025.
        - This resident is weighed daily per medical order.
- Resident L:
    - 3/1/25 – 0.00lbs
    - 5/1/25 – 0.00lbs
    - 5/5/25 – 235.8lbs
    - 7/1/25 – 288lbs
    - 7/15/25 – 264.4lbs
        - Weight increase of 52.2lbs recorded from May to July 2025.
        - Weight decrease of 23.6lbs recorded from 7/1/25 to 7/15/25.
- Resident M:
    - 3/2/25 – 136lbs
    - 4/1/25 – 144.5lbs
    - 5/2/25 – 141.8lbs
    - 6/1/25 – 144.8lbs
    - 7/1/25 – 141lbs
        - Weight increase of 5lbs since March 2025.
- Resident N:
    - 6/11/25 – 179.4lbs
    - 7/15/25 – 182lbs
        - Weight increase of 2.6lbs since March 2025.
- Resident O:
    - 3/3/25 – 184lbs
    - 4/1/25 – 183.9lbs
    - 5/1/25 – 161.2lbs
    - 6/1/25 – 179lbs
    - 7/1/25 – 155.7lbs
        - Weight decrease of 22.7lbs from April to May 2025.
        - Weight increase of 17.8lbs from May to June 2025.
        - Weight decrease of 23.3lbs from June to July 2025.
- Resident P:
    - 3/27/25 – 185lbs
    - 4/1/25 – 189.3lbs
    - 5/2/25 – 190.2lbs
    - 6/10/25 – 190lbs
    - 7/15/25 – 192.2lbs
        - Weight increase of 7.2lbs since March 2025
- Resident Q:
    - 3/1/25 – 208lbs
    - 4/1/25 – 178lbs
    - 5/1/25 – 235lbs

    - 7/15/25 – 157.8lbs
        - Weight decrease of 30lbs from March to April 2025.
        - Weight increase of 57lbs from April to May 2025.
        - Weight decrease of 77.2lbs from May to July 2025.
- Resident R:
    - 3/2/25 – 171.5lbs
    - 4/1/25 – 173.5lbs
    - 5/2/25 – 171.9lbs
    - 6/1/25 – 174lbs
    - 7/15/25 – 176.1lbs
        - Weight increase of 4.6lbs since March 2025.

On 7/28/25 I sent email correspondence to Ms. Weaver & Ms. Hamill requesting clarification on the weight records for Resident A, D, F, L, & Q as each of these residents have large weight fluctuations recorded on their weight records. I received a response back reporting that the plan is to have each of these residents weighed again this week. The email correspondence reported that it is a potential that the direct care staff who recorded the monthly weights did not subtract the weight of the resident wheelchairs when calculating the weight of the resident. The email noted that Resident A & Resident Q have weight fluctuations related to a diuretic medication they take daily.

On 7/30/25 I received email correspondence from Ms. Hamill, reporting the updated weights for Resident A, D, F, L, & Q. This information is as follows:

- Resident A, 7/28/25, 100.4lbs. The following response was received from Ms. Hamill, “[Resident A] has intermittent edema with dosing changes to her diuretics, causing fluctuations.”
    - Reviewing Resident A’s weight record she had a recorded weight of 105lbs on 3/1/25. This would account for a 4.6lb weight loss.
- Resident D, 7/28/25, 103.9lbs. The following response was received from Ms. Hamill, “[Resident D] is also wheelchair bound, on Hospice services, partly because of her weight loss. Staff was also not consistently subtracting wheelchair weight.”
    - Reviewing Resident D’s weight record she had a recorded weight of 126lbs on 3/1/25. This would account for a 22.1lb weight loss.
- Resident F, 165.8lbs. The following response was received from Ms. Hamill, “[Resident F] on hospice with loss of appetite, she is now a 1:1 feed, staff were not subtracting her Gerri-chair consistently with previous weights.”
    - Reviewing Resident F’s weight record she had a recorded weight of 175.5lbs on 3/3/25. This would account for a 9.7lb weight loss.
- Resident L, 239.1lbs. The following response was received from Ms. Hamill, “Staff were not consistently subtracting her wheelchair weight.”
    - Reviewing Resident L’s weight record she had a recorded weight of 235.8lbs on 5/5/25. This would account for a 3.3lb weight gain.
- Resident Q, 157.8lbs. The following response was received from Ms. Hamill, [Resident Q] has had several hospitalizations and is End of Life, history of edema

with medication changes and inability to eat, diet changes over the past couple of months due to Parkinson's."

- Reviewing Resident Q's weight record he had a recorded weight of 208lbs on 3/1/25. This would account for a 50.2lb weight loss.

This email correspondence from Ms. Hamill on 7/30/25 reported that Ms. Hamill had the maintenance staff calibrate the scale as they had several issues with discrepancies and the scale itself would not "zero out". She further reported that she has educated the direct care staff and managers at the facility on the importance of accuracy and to notify maintenance if there appears to be extreme fluctuations in resident weights so that the scale can be calibrated. I requested that Ms. Hamill provide information regarding the weight of each resident's wheelchair/Gerri chair.

On 7/31/25 Ms. Hamill reported, via email the following information:

- Resident F Gerri-chair weighs 64lbs
- Resident D wheelchair weighs 48.8lbs
- Resident Q wheelchair weighs 58.5 lbs
- Resident L wheelchair weighs 46.2lbs

On 8/1/25 I received email correspondence from Ms. Hamill. On 7/31/25 I had requested Ms. Hamill provide information regarding the discrepancies observed in the resident weight records for Resident I, Resident J, and Resident O. Ms. Hamill provided the following information:

- Ms. Hamill reported that Resident I requires a Hoyer lift for transfers. She reported that it is difficult for direct care staff to get an accurate reading for Resident I due to her wheelchair having difficulty balancing on the scale. She reported that she reviewed the weight record for Resident I and observed the fluctuations and believes this is a calibration issue with the scale. Ms. Hamill reported that Resident I's wheelchair weighs around 56lbs.
- Ms. Hamill reported that Resident J has been fairly stable. She reported that she observed one low weight on Resident J's weight record and believes this to be a calibration issue with the scale. She reported that Resident J eats 100% of her meals.
- Ms. Hamill reported that Resident O requires a Hoyer lift for transfers. She reported that Resident O is "difficult to weight". She reported that the direct care staff have notified Resident O's provider of her weight decline and she supplied documentation to support this information. Ms. Hamill reported that Resident O's electric wheelchair weights 356.6lbs and the standard wheelchair weights 33.9lbs. Ms. Hamill reported that a hospice program was consulted on 7/31/25 regarding Resident O's decline.
    - Ms. Hamill provided a note from Resident O's medical provider, Kathryn Baumgartner, DO, dated 7/24/25. This note reads, "I am concerned about [Resident O's] weight loss. I think it has to do with calorie intake. Please make sure there is an alternative option for meals when there is something she doesn't like, this could be something such as a sandwich, but she needs to have a suitable option to her in order to increase caloric

intake. Please also allow her to have protein shakes if she does not want to eat a meal or between meals as desired."

- Ms. Hamill provided a speech therapy evaluation for Resident O, dated 2/20/25, completed by Jameley Becker, MS, CCC-SLP/L. This evaluation noted tips and strategies to assist Resident O with her dietary intake and to reduce dysphasia risk.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(d) Personal care, supervision, and protection.**
ANALYSIS:	Based upon interviews conducted and resident weight records reviewed it can be determined that the direct care staff responsible for weighing residents monthly, were not competent in completing this assigned task. Eighteen resident weight records were reviewed and at least eight of these records identified inconsistencies in resident weights, and fluctuations in resident weights recorded from February 2025 through July 2025. When I requested that Ms. Weaver and Ms. Hamill identify the reasoning for these inconsistencies it was identified that the direct care staff were forgetting to subtract the weight of the resident wheelchairs and that the scale was not accurately calibrated to obtain accurate weight measurements for each resident. Ms. Hamill reported that she has since requested that the scale be recalibrated due to the inconsistencies in these weight records identified within this investigation. The direct care staff taking the weights did not bring these inconsistencies to the attention of the leadership at the facility for resolution, even though from month to month these weights demonstrated fluctuations from 10 to 50lbs at a time. Based upon the reported error of direct care staff not subtracting the weight of resident wheelchairs and the lack of follow-through regarding inconsistent weights being measured, a violation has been established at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Based upon review of the resident weight records for Residents A, D, F, I J, L, O, & Q, and reports from Ms. Hamill, it can be determined that each of these residents had significant fluctuations, either increase or decrease, in their weights, recorded on their monthly weight records. These fluctuations were not reported to their medical providers by the direct care staff recording their monthly weights or reweighed to ensure accuracy. On 7/30/25 Ms. Hamill reported that it is believed that the fluctuations occurred due to a wheelchair scale which required a maintenance professional to recalibrate the scale and that direct care staff were not properly subtracting the weights of the resident wheelchairs. Ms. Hamill reported that as of 8/1/25 the wheelchair scale has been recalibrated, and the staff have been educated to report significant fluctuations in resident weights in the future. Based upon the fact that the direct care staff recorded these inconsistencies in resident weights for at least a five-month period and did not inform medical providers or leadership at the facility about a potential medical issue these residents could have been experiencing a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

8/4/25

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Jana Lipps Date
Licensing Consultant

Approved By:

08/05/2025

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Dawn N. Timm Date
Area Manager