GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 16, 2026

Achal Patel
Divine Life Assisted Living of Dewitt 2 Inc
2045 Birch Bluff Dr
Okemos, MI 48864

RE: License #: AL190418069
Investigation #: 2026A0577009
Divine Life Assisted Living of Dewitt 2 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 (517) 335-5985.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, 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 #:	AL190418069
Investigation #:	2026A0577009
Complaint Receipt Date:	12/16/2025
Investigation Initiation Date:	12/17/2025
Report Due Date:	02/14/2026
Licensee Name:	Divine Life Assisted Living of Dewitt 2 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 2 Inc
Facility Address:	1177 Solon Rd, Ste 2 DeWitt, MI 48820
Facility Telephone #:	(517) 484-6980
Original Issuance Date:	06/03/2024
License Status:	REGULAR
Effective Date:	12/03/2024
Expiration Date:	12/02/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On two separate occasions, Resident A was not ready for a medical appointment upon the arrival of transportation.	Yes
Resident B was mistakenly taken to a medical appointment in place of Resident A.	Yes
Resident A was not provided breakfast.	Yes
Resident A was not appropriately dressed as her clothing was too big, dirty and not appropriate for the weather.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/16/2025	Special Investigation Intake, 2026A0577009
12/17/2025	Special Investigation Initiated - Letter Email to Complainant.
12/18/2025	Contact - Document Received Andrea Barry, via email a copy of Resident A's Plan of Care.
12/18/2025	APS Referral, Tom Hilla, Clinton Co APS.
12/18/2025	Contact - Document Sent, Guardian A1, email exchanges.
12/18/2025	Contact - Telephone call made, Interview with Guardian A1
12/22/2025	Contact - Telephone call made, U of M-Sparrow Cardiovascular.
12/22/2025	Inspection Completed On-site
12/22/2025	Contact - Telephone call made Rhonda Reeves, LBSW with TCOA.
12/22/2025	Contact - Document Received Via Email, critical incident reports from TCOA.
12/29/2025	Contact - Telephone call made, DCS Salome Nahibije.
12/29/2025	Contact-Telephone call made, Attempted, left messages to interview DCS who are no longer employed at the facility but worked on March 18, 2025. No return calls were received
12/29/2025	Contact - Telephone call made, U of M-Sparrow Cardiovascular.

12/29/2025	Contact - Document Sent Camie Fisher, Community Manager, email requesting information.
12/29/2025	Contact - Telephone call received, U of M-Sparrow Cardiovascular.
12/29/2025	Contact - Document Received Camie Fisher, Community Manager, sent requested information via email.
12/29/2025	Contact - Telephone call made, Cynthia Johnson.
12/29/2025	Contact - Telephone call made Dawn's Early Light Transportation.
01/16/2026	Achel Patel, Licensee Designee.

ALLEGATION:

- **On two separate occasions, Resident A was not ready for a medical appointment upon the arrival of transportation.**
- **Resident B was mistakenly taken to a medical appointment in place of Resident A.**

INVESTIGATION:

On December 16, 2025, a complaint was received alleging that on March 18, 2025, and November 20, 2025, direct care staff members got the wrong resident ready for a medical appointment. The complaint stated that instead of getting Resident A ready for a medical appointment on the dates listed above, direct care staff members got a different resident ready for those appointments. This was not realized until the scheduled transportation arrived. The complaint reported that on March 18, 2025, Resident B was transported to Resident A's cardiology appointment instead of Resident A and on November 20, 2025, Resident C was transported to Resident A's cardiology appointment.

On December 17, 2025, I emailed Complainant requesting contact information for Guardian A1 and the Supports Coordinator for Tri County Office on Aging (TCOA). I also requested copies of Resident A's *Person Centered Service Plan* and any supporting documents Complainant may be able to provide.

On December 18, 2025, Complainant emailed a copy of Resident A's *Person Centered Service Plan (PCSP)* with TCOA- Mi Choice Waiver*,* completed on October 27, 2025. The PCSP documented that Resident A needs supervision around the clock due to dementia. Resident A's *PCSP* also documented that Resident A needs assistance with personal daily care needs, incontinence care, medical/financial decisions, and transportation.

On December 18, 2025, I interviewed Guardian A1 who reported the first incident occurred on March 18, 2025, when Guardian A1 arrived at the cardiologist office to attend Resident A's appointment only to find Transporter, name unknown, was attempting to check Resident A in and Guardian A1 heard the conversation. Guardian A1 reported that she interrupted the conversation and asked Transporter who the name of the resident was they had transported and Transporter said, "[Resident A]." Guardian A1 stated she told Transporter the resident that was transported was not Resident A. Guardian A1 reported she contacted the facility to find that Resident A was at the facility, and direct care staff had sent Resident B to the appointment. Guardian A1 reported the second incident occurred on November 20, 2025, the transportation company arrived and told direct care staff they were there to transport Resident A and direct care staff reported they were told Resident C had a cardiology appointment not Resident A. Guardian A1 reported direct care

staff had the wrong resident ready to be transported to the cardiologist while Resident A remained in bed. Guardian A1 reported direct care staff were able to get Resident A ready and sent to the appointment on November 20, 2025.

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On December 22, 2025, I interviewed Rhonda Reeves, Social Work Supports Coordinator with TCOA, who reported the most recent incident occurred on November 20, 2025, when Resident A was sent to a cardiologist appointment disheveled and not properly prepared for the medical appointment. Ms. Reeves reported that for the November 20, 2025, appointment Dawns' Early Light Transportation arrived at the facility to transport Resident A to this doctor appointment only to find that Resident C, the wrong resident, was prepared to attend the cardiology appointment. Ms. Reeves stated, "this is the second time this has occurred, with the first being on March 18, 2025, when the wrong resident was actually transported to the cardiology appointment in place of [Resident A]." Ms. Reeves reported the first incident caused Resident A to miss her cardiology appointment which was rescheduled for March 27, 2025. Ms. Reeves reported the only reason it was discovered that the wrong resident was taken in place of Resident A was because Guardian A1 attended the appointment and identified the incorrect resident at the appointment. Ms. Reeves reported there is an upcoming meeting in January 2026 with TCOA in conjunction with direct care staff and Guardian A1, with the purpose to ensure that Resident A is properly prepared and sent to medical appointments moving forward and all appropriate tests are completed. Ms. Reeves emailed me a copy of a *Critical Incident Report* completed by TCOA on March 18, 2025, documenting when Transporter arrived at Resident A's cardiology appointment on March 18, 2025, the wrong resident, Resident B, had been transported to the appointment in place of Resident A, so the appointment was rescheduled for March 27, 2025. Per the *Critical Incident Report,* TCOA contacted direct care staff member Cynthia Johnson, whose role was Community Manager, who stated, "I know exactly who they sent, both residents, [Resident A] and [Resident B] have the same initials."

On December 22, 2025, I completed an unannounced onsite investigation and attempted to interview Resident A however Resident A was not oriented to date and time. Resident A was not able to provide specific information about the allegations due to Resident A's dementia diagnosis and cognitive decline.

On December 22, 2025, during the onsite investigation, I interviewed direct care staff Camie Fisher, current Community Manager, who reported she started her position as Community Manager in August 2025 and was not aware of the incident in March 2025. Ms. Fisher reported she was aware of the incident that occurred on November 20, 2025. Ms. Fisher reported direct care staff and administration has an application on their phones for communication amongst management and direct care staff. Ms. Fisher stated the phone application is used by management and direct care staff to communicate the needs and appointments of the residents. Ms. Fisher reported that on November 20, 2025, Resident A had an appointment with the cardiologist so on the evening of November 19, 2025, Ms. Fisher stated she sent a message to direct

care staff notifying them of the appointment and that Resident A needed to be ready to leave by 7:30am for an 8:00am transportation pick up. Ms. Fisher reported the message also included a reminder to direct care staff that Resident A needed to be dressed in clean clothes, hair combed, shoes, coat, and medications passed. Ms. Fisher reported in her correspondence with direct care staff through the application, she misspoke and put Resident C's name as having the medical appointment instead of Resident A. Ms. Fisher reported Resident A was late for the transportation driver on November 20, 2025, due to Resident C being ready for the appointment instead of Resident A. On December 29, 2025, Ms. Fisher emailed me screenshots of the correspondence between management and direct care staff in the application which verified what she reported on December 22, 2025. The correspondence from Ms. Fisher to direct care staff stated, "Please remind 1st shift when they arrive [Resident C] has to be ready by 7:30am, she is getting picked up at 8:00am." A second correspondence by Ms. Fisher stated, "this is my fault, I had the wrong resident."

On December 29, 2025, I interviewed DCS Salome Nahibije, who reported she worked on November 20, 2025, and had been notified originally that Resident C had a cardiology appointment. DCS Nahibije reported when transportation arrived at the facility and reported they were there to transport Resident A to the cardiology appointment not Resident C. DCS Nahibije stated Resident A was not dressed and ready to be transported, since direct care staff had mistakenly gotten Resident C ready to be transported to the appointment. DCS Nahibije reported Resident A was still sleeping at 8:00am when transportation arrived and needed to be rushed to get ready to be transported to the cardiology appointment. DCS Nahibije reported that she cannot remember the incident that occurred in March 2025.

On December 29, 2025, I received a call from Laura Shapter, U of M-Sparrow Cardiovascular, Diagnostic Laboratory Manager who reported per their system, Resident A was scheduled for an initial cardiology appointment on March 18, 2025, which was rescheduled for March 27, 2025, due to a transportation issue. Ms. Shapter reported their system did not document the specifics of the transportation issue.

On December 29, 2025, I interviewed Cynthia Johnson, previous Community Supervisor who reported on March 18, 2025, she received a call from TCOA, explaining the wrong resident was taking to Resident A's cardiology appointment. Ms. Johnson reported when she looked into the incident, direct care staff (names unknown) reported when the transporter arrived at the facility on March 18, 2025, the transporter said they were there to transport a resident with the same initials as Resident A and Resident B was ready for the day, so direct care staff assumed it was Resident B who had the appointment. Ms. Johnson reported TCOA and Guardian A1 both notified Ms. Johnson that direct care staff members sent the wrong resident to the cardiology appointment.

On December 29, 2025, I interviewed Cameron Samuel with Dawn's Early Light Transportation who reported Resident A was transported by their company on November 20, 2025, to a cardiology appointment with U of M Sparrow Cardiovascular. Mr. Samual reported they arrived at the facility at 8:00am and told a direct care staff, name unknown, they were there to transport Resident A but was told it was supposed to be Resident C. Mr. Samuel reported they provided the direct care staff with the transportation request from TCOA documenting the request for transportation for Resident. A

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on the information gathered during the investigation, on March 18, 2025, and again on November 20, 2025, direct care staff members transported the wrong resident to Resident A's cardiology appointments. By the time these two errors were discovered, Resident A was not ready to be transported in a timely manner to her cardiology appointments. Both errors occurred due to direct care staff being told to get the wrong resident ready for the appointments. Fortunately, Guardian A1 recognized that the wrong resident was brought to the appointment and no harm came to either Resident A or Resident C. However, the licensee is responsible for assuring the correct resident arrives for scheduled, important medical appointments.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was not provided breakfast.

INVESTIGATION:

A complaint was received on December 16, 2025, alleging that Resident A was not served breakfast prior to attending a medical appointment on November 20, 2025. The complaint reported that Resident A was given a package of saltine crackers to eat on the way to the appointment as a replacement for breakfast.

During the interview with Guardian A1 on December 18, 2025, Guardian A1 reported upon meeting Resident A at the cardiologist on November 20, 2025, at 8:45am, Resident A reported to Guardian A1 that she was not fed breakfast prior to the appointment and was provided three small restaurant packages of saltine crackers for breakfast. Guardian A1 reported she observed the three packages of saltine crackers. Guardian A1 reported later in the day Guardian A1 spoke with direct care

staff Camie Fisher, Community Manager, who acknowledged Resident A was not fed breakfast on the morning of November 18, 2025, due to time restraints.

On December 22, 2025, during the onsite investigation, I interviewed direct care staff Camie Fisher, Community Manager, who reported Resident A had not been served breakfast prior to her cardiology appointment due to Resident A not being ready for her appointment prior to the transportation company arriving.

On December 29, 2025, I interviewed DCS Salome Nahibije who reported she got Resident A ready for her cardiology appointment later than expected and Resident A was not fed breakfast. DCS Nahibije reported that she was not aware of Resident A being provided saltine crackers to eat, stating, “I cannot remember if this happened.”

On December 29, 2025, I interviewed Cameron Samuel with Dawn’s Early Light Transportation who reported due to direct care staff getting the wrong resident ready for the medical appointment on November 20, 2025, Resident A was not ready to be transported to her appointment. Mr. Samuel reported direct care staff quickly got Resident A ready but Resident A did not have time for breakfast prior to her cardiology appointment.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(3) Not more than 14 hours must elapse between the evening and morning meal.
ANALYSIS:	Based on the information provided during the investigation, it was found on November 20, 2025, Resident A was not provided with breakfast prior to being transported to a medical appointment at 8:00am. This allowed more than 14 hours to elapse between the evening meal and morning meal.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was not appropriately dressed as her clothing was too big, dirty and was not appropriate for the weather.

INVESTIGATION:

The complaint received on December 18, 2025, alleged that Resident A had an appointment with the cardiologist and was sent to the appointment wearing a shirt that was too big, with no bra or coat. The complaint reported that Resident A was observed wearing a robe in place of a winter coat.

On December 18, 2025, I interviewed Guardian A1 who reported that on March 25, 2025, Resident A arrived at the cardiologist appointment wearing what Guardian A1

assumed was another resident's dirty shirt and blue jeans that were too big. Guardian A1 reported Resident A had a follow-up cardiologist appointment on November 20, 2025, and arrived wearing a top, with no bra, and sweatpants that were too big. Guardian A1 reported Resident A did not have a winter coat on but was dressed in a robe. Guardian A1 reported Resident A told Guardian A1 she did not want to wear a coat.

On December 22, 2025, I interviewed DCS Camie Fisher, whose role is Community Manager, who reported she spoke with Guardian A1 about the concerns that Resident A's clothing was disheveled, her hair was not brushed, and Resident A was not wearing a winter coat to the cardiology appointment on November 20, 2025. Ms. Fisher reported Resident A told direct care staff she did not want to wear a winter coat, instead Resident A wanted to wear her bathrobe. Ms. Fisher reported to her knowledge no winter coat was sent to the appointment with Resident A. Ms. Fisher reported she cannot specifically report what Resident A wore to the cardiology appointment on November 20, 2025, because she did not observe Resident A. Ms. Fisher stated that the information about what Resident A wore was relayed to her from direct care staff Salome Nahibije. Ms. Fisher reported that she told direct care staff to get the wrong resident ready, Resident A became upset because she was being rushed to get ready for the appointment. Ms. Fisher provided me with a screenshot of communication from the phone application between Ms. Fisher and Director of Nursing Hamill, documenting per Ms. Hammill, "[Resident A] was sent out in a robe and matted-uncombed hair?" and Ms. Fisher responded, "I will call and apologize on behalf of the facility, this was my fault-I had the wrong resident."

On December 29, 2025, I interviewed DCS Salome Nahibije who reported she attempted to get Resident A dressed appropriately, but due to Resident A being rushed to get ready for the medical appointment, Resident A became agitated. DCS Nahibije reported she cannot specifically remember what Resident A wore for the medical appointment, but believes Resident A was provided a bra to wear. DCS Nahibije reported Resident A refused to wear a winter coat and wanted to wear her robe. DCS Nahibije reported Resident A was already upset, so Resident A wore the robe, but DCS Nahibijie stated she did not think to send Resident A's winter coat. DCS Nahibije stated "this was too long ago to remember exactly what [Resident A] was wearing or if [Resident A]'s hair was brushed."

During my interview with Cameron Samuel, with Dawns Early Light Transportation, Mr. Samuel reported Resident A was not ready at the time he came to pick her up for the appointment on November 20, 20025. Mr. Samuel stated direct care staff rushed to dress Resident A for the appointment. Mr. Samuel reported Resident A's clothes were wrinkled and dirty, her hair was not combed, and Resident A was wearing a robe in place of a winter coat. Mr. Samuel reported direct care staff reported Resident A did not want to wear a winter coat.

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(3) A licensee shall assist the resident in obtaining clothing that fits, is clean, and is seasonally appropriate.
ANALYSIS:	It has been found, on November 20, 2025, Resident A attended a cardiology appointment in clothes that were ill fitting, dirty, and with no winter coat. Even though Resident A reported she did not want to wear a winter coat, direct care staff did not send one with her as needed due to the colder temperatures.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On December 18, 2025, I interviewed Guardian A1 who reported that on May 06, 2025, Resident A was prescribed a heart event monitor by U of M-Sparrow Cardiology to be worn for seven days and then returned to the Cardiology Lab to be read. Guardian A1 reported she went to the facility to pick up the heart event monitor to return cardiologists office for download, and the heart monitor could not be located in the facility. Guardian A1 reported she was told by a direct care staff, name unknown, that the heart monitor had been missing for five days, and direct care staff think another resident took the monitor or it was thrown away.

On December 29, 2025, I received a call from Laura Shapter, U of M-Sparrow Cardiovascular, Diagnostic Laboratory Manager, who reported that on May 06, 2025, Resident A was prescribed a heart event monitor to be worn for seven days and returned to the office on May 14, 2025, to be read. Ms. Shapter reported the office received a call from Guardian A1 reporting direct care staff misplaced Resident A's heart monitor, so the heart monitor was not returned to be read and the test has gone uncompleted.

On December 29, 2025, I interviewed former direct care staff member Cynthia Johnson, the previous Community Manager, who reported Resident A was prescribed the heart event monitor and wore the monitor for seven days and on the last day, after Resident A's shower, the monitor became missing. Ms. Johnson reported all direct care staff, and management searched the building for Resident A's heart event monitor and the monitor could not be located. Ms. Johnson reported she contacted Guardian A1 to notify Guardian A1 of the missing monitor.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Based on the information gathered during the investigation, on May 06, 2025, Resident A was prescribed a heart event monitor to be worn for seven days and returned to the cardiologist to be read. However, the heart event monitor could not be located by direct care staff. Due to Resident A's heart event monitor being misplaced by direct care staff, the test was not able to be completed as prescribed by Resident A's cardiologist, due to no heart event monitor being returned for reading. Therefore, it has been found that the licensee did not follow the instructions and recommendations of Resident A's cardiologist to complete the heart event monitor test.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains unchanged.

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

01/16/2026

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Dawn N. Timm Date
Area Manager