GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 29, 2026

Prabhjot Singh
Park Place OPCO LLC
PO BOX 1568
Portage, MI 49081

RE: License #: AL390418619
Investigation #: 2026A0581008
Park Place Senior Living D

Dear Prabhjot Singh:

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390418619
Investigation #:	2026A0581008
Complaint Receipt Date:	12/23/2025
Investigation Initiation Date:	12/23/2025
Report Due Date:	02/21/2026
Licensee Name:	Park Place OPCO LLC
Licensee Address:	4218 S Westnedge Ave Kalamazoo, MI 49008
Licensee Telephone #:	(269) 329-8187
Administrator:	Prabhjot Singh
Licensee Designee:	Prabhjot Singh
Name of Facility:	Park Place Senior Living D
Facility Address:	4222 S Westnedge Ave Kalamazoo, MI 49008
Facility Telephone #:	(269) 329-8187
Original Issuance Date:	06/04/2025
License Status:	REGULAR
Effective Date:	12/04/2025
Expiration Date:	12/03/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION

	Violation Established?
Direct care staff forcibly handled Resident A.	Yes

III. METHODOLOGY

12/23/2025	Special Investigation Intake - 2026A0581008
12/23/2025	APS Referral - Kalamazoo APS received the complaint and are investigating.
12/23/2025	Special Investigation Initiated – Telephone - Interview with APS specialist, Lauren Drake.
12/23/2025	Referral - Law Enforcement - APS confirmed law enforcement was involved.
12/30/2025	Inspection Completed On-site - Interview with staff and residents. Obtained documentation.
12/30/2025	Contact - Telephone call made - Contact with APS, Lauren Drake.
12/30/2025	Contact - Document Received - Email from Licensee Designee,
12/30/2025	Contact - Telephone call made - Follow up phone call with KDPS
01/06/2026	Contact - Telephone call received - Interview with licensee designee
01/06/2026	Contact - Document Sent - Requested police report
01/06/2026	Contact - Telephone call made - Interview with direct care staff, Desirae McDaniels
01/06/2026	Contact - Telephone call made - Attempted contact with direct care staff, Deon Lockett
01/06/2026	Contact - Telephone call made - Interview with direct care staff, Chaleigh Lewis
01/06/2026	Contact - Telephone call made - Left voicemail with licensee designee.

01/07/2026	Contact - Telephone call received - Interview with the licensee designee.
01/12/2026	Contact - Document Sent - Email to licensee designee
01/13/2026	Contact - Document Received - Email from the licensee designee
01/14/2026	Contact - Document Received - Email from Desirae McDaniels
01/21/2026	Inspection Completed-BCAL Sub. Compliance
01/21/2026	Contact – Telephone call made – Attempted contact with direct care staff, Devon Holder.
01/26/2026	Exit conference with licensee designee, Prabhjot Singh.

ALLEGATION: Direct care staff forcibly handled Resident A.

INVESTIGATION: On 12/23/2025, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on an unknown date, third shift direct care staff, Isabelle Sanhou and Desirae McDaniels, requested Resident A get out of a chair in the facility's TV room. The complaint alleged Resident A requested she finish reading her book first, but the staff told her no and then forced Resident A to get out of the chair. The complaint alleged direct care staff threw Resident A to the floor and dislocated her shoulders. The complaint also alleged the direct care staff up and pulled her to her room by her arms.

On 12/23/2025, I interviewed Adult Protective Services specialist, Lauren Drake, who stated she also received the allegations and was investigating. She also stated Kalamazoo Department of Public Safety (KDPS) visited the facility regarding the allegations. She stated Resident A has mental health issues and has assaulted residents in the past. Lauren Drake stated the alleged incident occurred on or around 12/13 or 12/14. She stated she interviewed Resident A who reported to her other residents and staff were around when the alleged incident occurred; however, Resident A reported staff were covering for one another. Lauren Drake stated Isabelle Sanhou denied the allegations. She stated she had not yet interviewed direct care staff, Desirea McDaniels.

On 12/30/2025, I conducted an unannounced investigation at the facility. Based on my knowledge of the facility, cameras are installed throughout the building, which was confirmed by the Licensee Designee and Administrator, Prabhjot Singh, during my investigation. Prabhjot Singh stated he was not aware of any significant incidents in the facility involving Resident A with staff the weekend of 12/12 through 12/15;

however, he stated incidences involving Resident A being aggressive with staff were frequent given her significant behavioral issues. He reviewed Resident A's electronic record for any relevant staff notes from that weekend and identified a chart note by direct care staff, Kanika Steele, requesting HomeMD assistance relating to Resident A's behaviors. There were no notes available for review regarding any type of incident between Resident A and staff from 12/13 -12/14.

I interviewed direct care staff, Isabelle Sanhou, who denied being forceful with Resident A the weekend of 12/13-12/14. She also stated she was not aware of any incident occurring on or around 12/13-12/14 whereas staff dislocated Resident A's shoulders after forcibly removing her from a chair in the facility's TV room. Isabelle Sanhou stated Resident A "makes things up" and displays significant behaviors. Isabelle Sanhou described multiple incidents where Resident A has taken resident's belongings and has been both physically and verbally aggressive with staff.

I interviewed Resident A who stated the incident involving Isabelle Sanhou and Desirea McDaniel occurred on 12/08 rather than 12/13. Resident A denied any incident with staff assaulting her on 12/13. Resident A stated on 12/08 she had been sitting in the facility's TV room at approximately 11:30 pm when a direct care staff told her she needed to get up and move because she needed to clean the chair Resident A was sitting in. Resident A could not recall the name of the staff, but stated the staff requested Isabelle Sanhou's assistance. Resident A stated Desirae McDaniels, Isabelle Sanhou and other staff pulled her out of her chair and put her on the facility's floor. She stated these staff dragged her by her arms all the way to her bedroom with her face against the floor. Resident A stated her legs hurt as a result and she dislocated her shoulders. Resident A stated the staff also laughed at her. She stated there were no other residents around when the incident occurred.

Upon Resident A identifying a new date of the alleged incident, I requested Prabhjot Singh review the facility's camera footage for 12/08 at approximately 11:30 pm. He stated the camera in the facility's TV room (i.e. living room) was not working; however, he stated the cameras in the hallway and by the medication cart were working properly.

We reviewed the footage from multiple cameras and determined based on the audio from the video footage that Desirea McDaniels and Deon Lockett, who were identified as second shift staff, were attempting to leave the facility at the end of their shift, but could not because Deon Lockett could not locate his keys. Based on the audio captured from the video footage, these staff believed Resident A not only took Deon Lockett's keys, but was also hiding them. The audio from the video footage confirmed staff requested Isabelle Sanhou's assistance in retrieving the keys from Resident A. The audio from the video footage captured Resident A repeatedly denying she took staff's keys; however, based on the audio, staff assisted Resident A out of her seat and patted her down in an attempt to locate the keys. Resident A was heard throughout the audio telling staff not to touch her. Prabhjot Singh

confirmed staff, Desirea McDaniels, said to Resident A during the encounter, “Nobody likes you.”

Video footage of the facility hallway showed Desirea McDaniel and Chaleigh Lewis each holding onto one of Resident A’s arms as they escorted her down the hallway. Video footage showed Deon Lockett walking behind them. The video footage then showed Resident A intentionally lowering herself to the floor. Review of the video footage showed Desirae McDaniels then grasping Resident A’s legs and dragging her down the hallway for approximately 10 seconds. Desirea McDaniel was heard in the audio telling Resident A, “If you hit me, I’ll hit you back.” Resident A was seen kicking at Desirea McDaniel, but only after Desirea McDaniel stopped dragging Resident A. Review of the footage indicates that no other staff, including Chaleigh Lewis or Deon Lockett, attempting to intervene or stop Desirea McDaniel while she was dragging Resident A. The video footage showed Isabelle Sanhou coming into the hallway only after Desirea McDaniel stopped dragging Resident A. The video footage then showed Desirea McDaniel, Chaleigh Lewis and Isabelle Sanhou assisting Resident A with standing. Desirea McDaniel and Chaleigh Lewis each held onto one of Resident A’s arms while escorting her down the hallway while Isabelle Sanhou walked behind her.

I conducted a follow up interview with Isabelle Sanhou after watching the video footage of the incident. Her statement to me was consistent with the initial portion of the video footage. Isabelle Sanhou stated she could not recall if Resident A stood up on her own or if staff assisted Resident A with standing up prior to patting Resident A down. She stated she also could not recall which staff patted Resident A down. She stated Resident A was verbally assaultive throughout the whole incident, which is also consistent with the audio from the initial portion of the video footage. She also stated Resident A was physically assaultive during the incident by swinging at Isabelle Sanhou and throwing a book at her. Isabelle Sanhou stated Resident A was asked to go to her room because of “the time of night”. She stated staff were instructed to put their hands out to direct Resident A to her room. Isabelle Sanhou stated Resident placed herself on the facility floor and denied any staff pushed Resident A on the floor. Isabelle Sanhou stated staff only held onto Resident A’s arms while they were assisting her from getting up from the floor; however, she also stated it was possible staff held onto her while they escorted her to her bedroom.

I reviewed an electronic “Observation Note” created by Chaleigh Lewis, dated 12/09/2025, as part of Resident A’s electronic file. According to this note, Chaleigh Lewis documented Resident A was asked to relocate to a different seat because a staff lost their keys. The note documented Resident A yelled, cussed at and called staff racial slurs. The note documented Resident A threw her book at staff and attempted to hit them. The note documented Resident A was asked to relocate to her room, but she refused and continued swearing at staff. The note did not contain any additional information.

I reviewed Resident A's Initial Assessment (assessment plan), dated 09/22/2025, which documented Resident A, "Frequently displays aggressive/combative behaviors from the resident. Has an issue with staff at least a couple time a week usually in Evenings she likes to monitor job duties of staff and sometimes interferes with care [sic]". The assessment plan documented staff were to monitor and intervene; however, it did not document any additional information regarding how staff should address or handle Resident A's aggressive or combative behaviors. Resident A's assessment plan also documented Resident A can walk and ambulate independently.

On 12/30/2025, I provided the information about Resident A being dragged across the facility's floor on 12/08/2025 to KDPS and APS specialist, Lauren Drake.

On 01/06/2025, Prabhjot Singh stated Resident A was given a 30 day discharge notice due to her significant behaviors and Desirea McDaniel was suspended pending the investigation. He stated Desirea McDaniel reported to him that Resident A tried kicking her and she blocked the kick.

On 01/06/2026, I interviewed direct care staff, Desirae McDaniels. Her statement to me was consistent with Isabelle Sanhou's statement to me. She stated she and Deon Lockett worked 2nd shift in the facility on 12/08. She stated Deon Lockett left his coat in a chair in the same room as Resident A for approximately one to two hours. She stated at approximately 10:45 pm until 11:10 pm, she and Deon Lockett attempted to locate his keys, but were unable to find them. Desirea McDaniel stated Resident A has a history of taking items that are not hers; therefore, they questioned her about taking the keys, but she denied it. She stated Resident A then started screaming and became verbally aggressive towards her and staff by cursing and calling them names. Desirea McDaniel stated Isabelle Sanhou also assisted staff with questioning Resident A about the lost keys. Desirea McDaniel stated Resident A hit Isabelle Sanhou while she patted Resident A down in search of the missing keys. Desirea McDaniel stated she told Resident A she could not attack or hit people. She stated Resident A also hit her on her left hand and tried biting her. Desirea McDaniel stated Resident A is paranoid, has Dementia and belongs in a psychiatric facility.

Desirea McDaniel stated she and Chaleigh Lewis escorted Resident A back to her room because Resident A "was a threat." Desirea McDaniel stated she and Chaleigh Lewis each took one of Resident A's arms and said, "let's go to your room". Desirea Lewis stated she did not apply any pressure to Resident A's arms while escorting her to her bedroom. She stated Resident A sat on the facility's floor a couple times while they were escorting her to her room. She stated Resident A "plopped down like a kid at Disney." She stated she asked Resident A to stand up, but she and Chaleigh Lewis had to assist her with getting back up. She stated while Resident A was on the floor, Resident A attempted to kick her in the knee. Desirea McDaniel stated she had a knee replacement and has frequent pain in the knee Resident A attempted to kick. She stated when Resident A attempted to kick her in the knee she blocked the kick

by putting her right hand down. She stated she was not aggressive in handling Resident A and denied dragging her as she stated this type of behavior was inappropriate. Desirea McDaniel stated she did not complete an incident report or any observation note regarding the incident because she was “depleted” at the end of her shift.

On 01/06/2026, I interviewed direct care staff, Chaleigh Lewis. Her statement was consistent with Isabelle Sanhou’s and Desirea McDaniel’s statements to me. Chaleigh Lewis stated Desirea McDaniels and Isabelle Sanhou both searched Resident A’s person by patting her down. She stated both she and Desirea McDaniel escorted Resident A down the facility’s hallway. She stated Resident A wound up on the floor, but she could not recall how she got there. She stated both she and Desirea McDaniel held onto Resident A’s arms as they escorted her down the hall. She stated while on the ground, Resident A kicked Desirea McDaniel who then grabbed Resident A’s foot. She stated she could not recall what happened after Desirea McDaniel grabbed Resident A’s foot, but she recalled telling Desirea McDaniel not to pull Resident A. She stated Resident A was swearing and calling staff derogatory names and being verbally abusive. Chaleigh Lewis stated she could not recall what Desirea McDaniel said to Resident A while the situation was taking place. Chaleigh Lewis stated Desirae McDaniel let go of Resident A’s foot and they both assisted Resident A up off the ground. She stated once they got Resident A to her bedroom, she immediately came out and continued swearing at them. Chaleigh Lewis denied any of the staff grabbing Resident A by the shoulders or knocking her over. She also could not recall if Resident A was dragged.

On 01/06/2026, I attempted to contact and interview direct care, Deon Lockett; however, I was unable to leave a voicemail as the automated message stated the number I contacted was a non working number.

On 01/07/2026, I interviewed Prabhjot Singh who stated Desirae McDaniel’s employment was terminated on 01/06/2026.

On 01/13/2026, I received KDPS Incident/Investigation Report Case Number # 25-015820; however, the report only referenced an incident involving Resident A being assaultive towards staff on 12/04/2025.

On 01/14/2026, I reviewed a letter forwarded to me by Desirea McDaniels, dated 01/02/2026. The letter was purportedly written on behalf of Relative A1; however, it was not notarized, and I was therefore unable to verify the identity of the author. The letter documented Relative A1’s support for Desirae McDaniels by describing her as professional, trustworthy, and respectful toward residents and families. Relative A1 documented in the letter that she had not observed misconduct by Desirae McDaniels and believed the concerns being evaluated do not reflect Desirae McDaniels’ character.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	Based on review of video footage and audio from the video footage provided by the licensee, on 12/08/2025, at approximately 11:30 pm, multiple direct care staff proceeded to pat Resident A down looking for a staff's keys and proceeded to escort her down the facility's hallway by holding her arms. Throughout the incident, Resident A requested staff not to touch her. The video footage also documented Desirea McDaniel mistreated Resident A by dragging her across the facility's hallway for approximately 10 seconds.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(b) Use any form of restraint without an order from an appropriately licensed heath care professional or physical force, other than physical restraint for crisis intervention.**
ANALYSIS:	On 12/08/2025, direct care staff, Desirea McDaniel and Chaleigh Lewis escorted Resident A from the facility's living room area to her bedroom by holding onto her arms; despite Resident A being ambulatory. Audio of Resident A and video footage of the incident determined Resident A did not want to be touched or escorted by direct care staff back to her bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** ***(ii) Verbal abuse.*** **(iii) Derogatory remarks.** ***(iv) Threats.***
ANALYSIS:	On 12/08/2025, direct care staff, Desirea McDaniel, told Resident A “No one likes you” and “If you hit me, I’ll hit you back”. This type of language is not appropriate to use towards a resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/26/2026, I conducted my exit conference with the licensee designee, Prabhjot Singh. He acknowledged the significance of the findings and anticipated additional training for staff regarding resident rights.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

01/28/2026

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Cathy Cushman Date
Licensing Consultant

Approved By:

01/29/2026

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Dawn N. Timm Date
Area Manager