GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 9, 2026

Happiness Nwaopara
Divine Care Inc.
6400 Royal Pointe Drive
West Bloomfield, MI 48322

RE: License #: AS820380402
Investigation #: 2026A0116008
Divine Care:Dunning

Dear Ms. Nwaopara:

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 (313) 456-0439.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820380402
Investigation #:	2026A0116008
Complaint Receipt Date:	12/03/2025
Investigation Initiation Date:	12/04/2025
Report Due Date:	02/01/2026
Licensee Name:	Divine Care Inc.
Licensee Address:	6400 Royal Pointe Drive West Bloomfield, MI 48322
Licensee Telephone #:	(248) 346-4397
Administrator:	Happiness Nwaopara
Licensee Designee:	Happiness Nwaopara
Name of Facility:	Divine Care:Dunning
Facility Address:	26239 Dunning Street Inkster, MI 48141
Facility Telephone #:	(313) 722-4167
Original Issuance Date:	08/04/2016
License Status:	REGULAR
Effective Date:	02/04/2025
Expiration Date:	02/03/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A got out of the van seat, sat in his wheelchair, removed the wheelchair lock without staff assistance, causing him to roll out of the van and fall out of his wheelchair. Resident A was not hurt.	Yes

III. METHODOLOGY

12/03/2025	Special Investigation Intake 2026A0116008
12/03/2025	Referral - Recipient Rights Received.
12/04/2025	APS Referral Received. APS denied the complaint for investigation.
12/04/2025	Special Investigation Initiated - On Site Home manager, Kevin Delleh, Residents A-B, and reviewed Resident A's Individual Plan of Service (IPOS) and health care appraisal.
12/10/2025	Contact - Telephone call made Catherine Cato, Lincoln Behavioral Services.
12/16/2025	Contact - Telephone call received Charles Carter, Recipient Rights investigator.
12/16/2025	Contact - Document Received Copy of internal policy re: van safety.
12/16/2025	Inspection Completed-BCAL Sub. Compliance
01/05/2026	Exit Conference With licensee designee, Happiness Nwaopara.

ALLEGATION:

Resident A got out of the van seat, sat in his wheelchair, removed the wheelchair lock without staff assistance, causing him to roll out of the van and fall out of his wheelchair. Resident A was not hurt.

INVESTIGATION:

On 12/04/25, I conducted an unscheduled onsite inspection and interviewed home manager Kevin Delleh, Residents A-B and reviewed Resident A's IPOS and health care appraisal. Mr. Delleh reported that on 11/27/25, he and Residents A-C returned home from Thanksgiving dinner at one of their other licensed AFC homes. He reported that he assisted Residents B and C out of the van as they use walkers and are able to ambulate up the ramp and into the house. He reported that he had set up Resident A's fold-up wheelchair and locked the wheels so that he could assist him in getting into the wheelchair, once he saw that Resident B and C were in the house. Mr. Delleh reported while he was outside of the van helping them, Resident A got out of the van seat, into his wheelchair, took the brakes off, rolled out of the van onto the sidewalk and fell out of the wheelchair. Mr. Delleh reported that Resident A has multiple sclerosis (MS) and uses a walker and a wheelchair. Mr. Delleh reported that Resident A knows that staff assist in all transfers due to his MS and lower extremity weakness and he is unsure why he decided to transfer himself into the wheelchair and unlock the wheels on the wheelchair. Mr. Delleh reported that thankfully Resident A was not hurt, however, he still called 911 so that emergency medical services (EMS) could evaluate him. Mr. Delleh reported that the EMS technicians evaluated Resident A and reported that he did not require medical treatment at this time. I asked Mr. Delleh to take me outside to the van and show me where Resident A was seated in the van and where the wheelchair was once he opened it and locked it. Mr. Delleh opened the back of the van and showed me the seat that Resident A was sitting in as well as the position of the wheelchair. The wheelchair was facing the front of the van locked and the ramp was extended from the back of the van. Mr. Delleh reported that Resident A rolled backwards down the ramp and fell out of the chair. I observed areas in the van that are used to tie down wheelchairs so that they are secure. I asked Mr. Delleh why Resident A's wheelchair was not tied down and he reported that because he uses a fold-up wheelchair and does not sit in the wheelchair during transport it is not required to be tied down.

I interviewed Resident A, and he reported that after returning home from Thanksgiving dinner, home manager, Mr. Delleh, was assisting Resident B and C out of the van so that they could go into the house. He reported that he was still in the van, so he unbuckled his seat belt and got in his wheelchair. Resident A reported that he was unsure if he unlocked the brakes or if they weren't locked by Mr. Delleh. Resident A reported the wheelchair rolled down the van ramp onto the sidewalk. Resident A reported that he fell out of the wheelchair onto the driveway. Resident

reported that he is still independent and doesn't want to always wait on staff to help him. He reported that he was not hurt and did not require any treatment. Resident A reported that Mr. Delleh called 911 and EMS came to the home, evaluated him and left. Resident A reported that moving forward when he is in the van, he will try to wait on staff to assist him.

I interviewed Resident B, and he reported that all he remembers about the incident is Resident A falling out of his wheelchair onto the ground. He reported that he and Resident C were walking up the ramp heading into the house when he heard a noise and saw Resident A on the ground. Resident B reported that staff always help Resident A from the van seat into his wheelchair and reported being unsure as to why Resident A tried to get out of the van without staff.

I reviewed Resident A IPOS effective 07/28/25. The plan documents that Resident A has MS and the potential for falls due to MS and leg weakness and documents that staff should monitor him. I also reviewed Resident A's health care appraisal dated 06/10/25, and it documents that Resident A uses a walker and wheelchair due to MS and lower extremity weakness.

On 12/10/25, I interviewed Catherine Cato, Resident A's case manager with Lincoln Behavioral Services. Ms. Cato reported that Resident A struggles to accept help, wants his independence and is having a difficult time accepting the fact that due to his MS diagnosis he is requiring more help from staff. Ms. Cato reported that she has no concerns regarding the care provided in the home and reported that the home manager is exceptional. She reported that the staff are also great and she couldn't ask for a better placement for Resident A. Ms. Cato reported that she will be having another conversation with Resident A regarding the need to allow staff to assist him to prevent an incident like this from happening again.

On 12/16/25, I interviewed Charles Carter, recipient right investigator. Mr. Carter reported that he will be substantiating the allegations after reviewing the homes internal policy that requires all wheelchairs to be strapped/tied down while in the van. Mr. Carter reported had the wheelchair been properly secured, regardless of Resident A deciding to independently transfer himself into the wheelchair, it would not have rolled out of the van, causing Resident A to fall out of it. Mr. Carter reported that the policy also documents that Residents are never left unattended in the van. Mr. Carter reported that he spoke with licensee designee, Happiness Nwwaopara, and informed her that the home manager violated their internal policy and that the allegations would be substantiated and require the submission of a corrective action plan. Mr. Carter reported that he would forward the internal policy to my review.

On 12/16/25, I received and reviewed the internal van safety policy and procedures for Divine Care Corporation. The policy documents that wheelchairs must be secured using all tie-down points. The policy does not distinguish the type of

wheelchairs, it simply states “wheelchairs.” The policy also states that residents must never be left unattended in the van.

On 01/05/26, I conducted the exit conference with licensee designee, Happiness Nwaopara, and informed her of the findings of the investigation. Ms. Nwaopara reported understanding that the home manager was in violation of the corporation’s internal policy, however, reported he had no ill intent and was assisting other residents out of the van and into the home. I informed Ms. Nwaopara that based on her internal policy, if the wheelchair had been tied down and secured to the van floor, Resident A would not have rolled out of the van after transferring himself from the van seat into his wheelchair. I also informed Ms. Nwaopara that Resident A’s IPOS instructs staff to monitor Resident A due to him being a fall risk due to his MS diagnosis that causes lower extremity weakness. Ms. Nwaopara reported understanding but did not agree. Ms. Nwaopara reported that she has already rein-serviced all staff regarding van safety and proper procedures and will submit an acceptable corrective action plan upon receipt of the report.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

ANALYSIS:	Based on the findings of the investigation, which included interviews of home manager, Kevin Delleh, Residents A-B, recipient rights investigator, Charles Carter, and review of Resident A's IPOS, health care appraisal and the corporation's internal policy on van safety, there is a preponderance of evidence to substantiate the allegation. Home manager, Kevin Delleh, did not properly tie down/secure Resident A's wheelchair to the van floor as documented and required by the corporation's internal policy. Subsequently Resident A rolled out of the van and fell out of the wheelchair onto the ground while being left alone in the van. Resident A's IPOS also documents that he is monitored for potential fall risks due to his MS and lower extremity weakness. This violation is established as the home manager, Mr. Delleh did not provide supervision and protection as specified in Resident A's IPOS and the corporation's internal policy.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Pandrea Robinson
Licensing Consultant

01/07/26
Date

Approved By:

Ardra Hunter
Area Manager

01/09/26
Date