GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 3, 2026

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

RE: License #: AL190418056
Investigation #: 2026A0577018
Divine Life Assisted Living of Dewitt 3

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 #:	AL190418056
Investigation #:	2026A0577018
Complaint Receipt Date:	01/27/2026
Investigation Initiation Date:	01/27/2026
Report Due Date:	03/28/2026
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 Weaver
Licensee Designee:	Achal Patel
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?
Direct care staff are not provided with training in Alzheimer care.	Yes
Resident are not being supervising while medications are administered.	Yes
Residents are not being bathed at least weekly.	No

III. METHODOLOGY

01/27/2026	Special Investigation Intake, 2026A0577018
01/27/2026	Special Investigation Initiated - Telephone Interview Relative A1
01/27/2026	APS Referral
02/05/2026	Contact - Document Received Jana Lipps, AFC Licensing Consultant.
02/13/2026	Inspection Completed On-site
02/16/2026	Contact - Document Sent Camie Fisher, HM, via email requested documentation.
02/17/2026	Contact - Telephone call made, Interview with DCS.
02/17/2026	Contact - Document Received Camie Fisher, HM, via email, resident documents.
02/18/2026	Contact - Document Received Camie Fisher, HM, via email, documentation received.
02/23/2026	Contact - Telephone call made, Sensations Wellness Manager.
02/23/2026	Contact - Telephone call made Interviews with Resident A's family.
02/24/2026	Inspection Completed On-site, Observed forms.
02/24/2026	Exit Conference, Achel Patel, LD & Cheri Weaver, Admin.

ALLEGATION: Direct care staff are not provided with training in Alzheimer disease care.

INVESTIGATION:

On January 27, 2026, the complaint received alleged that direct care staff do not understand Alzheimer's disease or how to communicate and treat residents diagnosed with Alzheimer's disease. Complainant stated direct care staff argue with residents when residents refuse to take a bath/shower.

The complaint also alleged that residents were not being fed. This allegation was previously investigated under SIR# 2026A1029012 with no violations cited.

On January 27, 2026, I interviewed Relative A1 who reported direct care staff were not trained in how to communicate and provide care to residents diagnosed with Alzheimer's disease. Relative A1 reported direct care staff come into Resident A's room to ask Resident A if Resident A would like a shower and if Resident A responds by saying "no", Relative A1 stated direct care staff say "okay" and walk out of the room. Relative A1 reported witnessing direct care staff arguing with Resident A about taking a shower or changing her clothes. Relative A1 reported Resident A became upset and aggressive with direct care staff who then left the room without providing Resident A with a shower or assisting with changing her clothes. Relative A1 reported inquiring with direct care staff about training received about caring for residents diagnosed with Alzheimer's disease and the direct care staff reported they did not receive any special training.

On January 27, 2026, I reviewed the facility file and confirmed the facility is licensed to provide care for the following program types: Aged, Physically Disabled, and Alzheimer's Disease.

On January 27, 2026, I contacted Cheri Weaver, Chief Operating Officer and requested and received a copy of Divine Living Centers Alzheimer's/Dementia Program Statement. The Alzheimer's/Dementia Program Statement documented training will be provided for direct care staff in proper ways to approach and care for residents diagnosed with Alzheimer/Dementia through regular training and continuing education. The Alzheimer's/Dementia Program Statement documented that all direct care staff are trained in the individual needs of the residents upon hire and are reviewed regularly. A log of staff training will be managed. The Alzheimer's/Dementia Program Statement documents the following:

"Behavioral/Crisis Intervention:
The Company supports a proactive and positive approach to dealing with resident behaviors. Serious challenging behaviors are behaviors which may cause harm or could potentially cause harm to the person themselves, or to others around them. These behaviors include but are not limited to anxiety, agitation, verbal aggression, physical aggression, wandering, sundowning. Staff should follow these steps:

1.REMAIN CALM - Staff must communicate before, during and after the behavior that their presence represents safety and reward. Remaining calm takes practice. A good plan can help you learn to remain calm. If you are upset, the individual you are working with is likely to become upset as well. Actively listen to, respond and reassure the resident.
2. REDIRECT - Staff need to redirect the focus of the interaction to another activity or subject. Ignore inappropriate behavior, but not the person. Identify and reduce triggers.
3. REWARD - Reward should begin immediately. Do not wait for the person to calm down or engage in another activity. The individual should get the message you still value them as a person, even though they have just had a problem.
4. RE-GROUP - Think about what happened before, during and after the situation. Discuss the situation with other staff. Make a plan for how to interact with this individual in the future. What will you do differently?"

Ms. Weaver also provided me with a copy of a Dementia Effective Communication PowerPoint developed by Careline Health Group. This consisted of a list of talking points when communicating with residents diagnosed with Alzheimer's disease and a pamphlet titled, "*113 Things to do While Visiting Your Older Adult*." Ms. Weaver reported these are the documents used to train direct care staff upon hire regarding the needs of residents diagnosed with Alzheimer's disease.

On February 12, 2026, I interviewed direct care staff (DCS) Joslyn Hofstetter who reported being provided with three days training, but did not recall anything specific to caring for residents diagnosed with Alzheimer's disease upon hire. DCS Hofstetter denied being provided any pamphlets about specialized training regarding the care and communication with resident's diagnosed with Alzheimer's disease upon hire or since being employed.

On February 13, 2026, I completed an unannounced onsite investigation and interviewed DCS Camie Fisher, whose role is as home manager, and Zize Gashi, Director of Facility Operations, who both reported all direct care staff upon hire receive basic Alzheimer's disease training. Ms. Fisher and Ms. Gashi both reported there has not been any continuing education or trainings provided to direct care staff specifically about residents diagnosed with Alzheimer's disease. Ms. Fisher and Ms. Gashi reported Hospice Care Agencies used to provide trainings to direct care staff about Alzheimer's disease care, but this has not happened in a while.

On February 17, 2026, DCS Breanna Johnson reported upon hire, seven months ago, she was provided a basic overview of Alzheimer's disease and care of residents, but nothing in depth. DCS Johnson reported she has not received any additional trainings specific to the care of residents diagnosed with Alzheimer's disease since being hired.

On February 17, 2026, I interviewed DCS Tatyana Smith, who reported she has worked at the facility for four years. DCS Smith reported upon hire there was a basic overview of caring for residents diagnosed with Alzheimer's disease provided in the initial

trainings. DCS Smith reported she has not received any additional trainings or continued educations specific to the care of residents diagnosed with Alzheimer's disease since being hired.

On February 17, 2026, I interviewed DCS Shana Horsley who reported that she has worked at the facility for about 5 weeks and upon hire received an overview training about Alzheimer's disease and caring for residents diagnosed with Alzheimer's disease.

APPLICABLE RULE	
MCL 400.726b	**Adult foster care; description of services to patients or residents with Alzheimer's disease; contents; "represents to the public" defined.**
	(1) Beginning not more than 90 days after the effective date of the amendatory act that added this section, an adult foster care large group home, an adult foster care small group home, or an adult foster care congregate facility that represents to the public that it provides inpatient or residential care or services, or both, to persons with Alzheimer's disease or related conditions shall provide to each prospective patient, resident, or surrogate decision maker a written description of the services provided by the home or facility to patients or residents with Alzheimer's disease or related conditions. A written description shall include, but not be limited to, all of the following: **(d) Staff training and continuing education practices.**
ANALYSIS:	Divine Life Assisted Living of Dewitt 3 Program Statement for Alzheimer's Disease documented that training will be provided direct care staff about the proper ways to approach and care for residents diagnosed with Alzheimer/Dementia residents. This will be accomplished both through trainings conducted upon hire and continuing education and training. Based on the information gathered during the investigation, direct care staff are provided with a basic overview of Alzheimer's disease upon hire but are not provided proper training in ways to approach and care for the residents diagnosed with Alzheimer's Disease nor is continuing education about caring for residents diagnosed with Alzheimer's disease provided as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident are not being supervising while medications are administered.

INVESTIGATION:

On January 27, 2026, the first complaint received alleged that resident medications were being left in residents bedrooms with the expectation that residents will take them without direction or guidance from direct care staff. The second complaint received on January 27, 2026, reported resident medications were found in resident bedrooms. A third complaint was received on February 03, 2026, alleged that medications were found in Resident B's room after Resident B was discharged from the facility.

On January 27, 2026, I interviewed Relative A1 who reported upon moving Resident A from the facility, Relative A1 found medication pills and tablets on the floor of Resident A's bedroom and in the nightstand drawer in Resident A's bedroom. Relative A1 reported there were times when direct care staff brought Resident A's medication cup into Resident A's bedroom, sat it on Resident A's nightstand and said, "[Resident A] here is your medicine, time to take it." Complainant stated direct care staff walked away and did not supervise Resident A taking the medication. Relative A1 reported making sure that Resident A took the medication whenever this happened. Relative A1 was not able to provide names of direct care staff who were witnessed not supervising while Resident A took her medications.

On February 05, 2026, Jana Lipps, Adult Foste Care (AFC) Licensing Consultant provided me with documentation from her interviews with direct care staff on February 05, 2026, from her SIR#2026A033016 which documented the following:

- Jana Lipps, AFC Licensing Consultant interviewed DCS Brooke-Lynn Ketchum, via telephone, on February 05, 2026. DCS Ketchum reported that Resident B had been hiding medications in her dresser drawer at the facility. Ms. Lipps inquired whether DCS Ketchum directly observed this or if this was reported to DCS Ketchum by another party. DCS Ketchum reported that Relative B1 reported finding a bunch of dumped pills in Resident B's dresser drawer. DCS Ketchum reported that she watches residents take their medications and makes sure they swallow the medications before she leaves the room. DCS Ketchum reported that there are multiple new employees and she is not sure everyone is following this protocol. DCS Ketchum had no further information regarding this allegation.

- Jana Lipps, AFC Licensing Consultant interviewed DCS Ila Gebott on February 05, 2026. DCS Gebott reported that she has administered medications to Resident B. DCS Gebott reported that she makes sure residents swallow medications prior to leaving the room. DCS Gebott reported that she has no knowledge of Resident B pocketing pills in her mouth or being left to self-

administer medications. DCS Gebott reported that she has never seen medications in Resident B dresser drawers.

On February 12, 2026, I interviewed DCS Joslyn Hofstetter who reported there have been a couple of times when DCS Hofstetter has entered a resident bedroom and found a cup of medication sitting in the resident's bedroom that the resident had not taken.

On February 12, 2026, I interviewed DCS Kim Morgan who denied ever observing any resident medications sitting unattended in resident bedrooms, any medication on resident bedroom floors or in the resident's nightstand.

On February 13, 2026, during the onsite investigation DCS Camie Fisher and Zize Gashi reported that was brought to their attention that some direct care staff were not monitoring residents to assure medications were administered. Ms. Fisher and Ms. Gashi denied ever observing any resident medications being left in resident bedrooms for residents to self-administer. However, since this was brought to their attention, they have had conversations and trainings with direct care staff regarding the requirement to supervise residents during medication administration.

On February 17, 2026, I interview DCS Shana Horsley, Tatyana Smith, and Breanna Johnson who all denied ever observing any resident medications being left in the resident bedrooms unattended.

On February 23, 2026, I attempted to interviewed Relative B1, left a voicemail requesting a return call with no returned call.

On February 23, 2026, I interviewed Relative B2 who reported during a few visits Relative B2 observed direct care staff leaving Resident B's medications in the bedroom without supervising their administration. Relative B2 reported they did not see any loose medications in Resident B's bedroom and stated, "but I did not look in [Resident B's] dresser drawers either."

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(3) Giving, taking, or applying prescription medications must be supervised by a licensee, administrator, or direct care staff unless otherwise directed by an appropriately licensed health care professional in writing.

ANALYSIS:	Based on the information gathered during the investigation, there was sufficient evidence that Resident A and Resident B were not supervised while taking their medications causing direct care staff and family members to find loose medications in Resident A and Resident B's rooms.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are not being bathed at least weekly.

INVESTIGATION:

On January 27, 2026, two complaints were received a alleging that Resident A was not being bathed. Specifically, one of the complaints reported Resident A was found with black build up between her toes due to not being bathed. On February 10, 2026, a third complaint was received that Resident B was not being bathed causing Resident B to develop a yeast infection under her breast.

On January 27, 2026, I interviewed Relative A1 who reported Resident A has since moved to a different facility due to the decline in care. Relative A1 reported the day Resident A was moved, the new facility was able to get Resident A to take shower immediately. Relative A1 reported Resident A has taken three showers in the first week since being placed at a new facility. Relative A1 reported upon Resident A taking a shower, Resident A's toes, in between the toes and under the nails was a black mold like substance. Relative A1 reported that when Resident A moved into her new facility, Resident A was found to have dried fecal matter on her buttocks, that was hard and crusty. Relative A1 reported the fecal matter looked like it had been there for a couple of days. Relative A1 reported receiving calls from direct care staff notifying Relative A1 of Resident A refusing to bathe. Relative A1 reported direct care staff did not reapproach Resident A at a different time or in a different manner after Resident A refused to take a shower. Relative A1 reported there were times direct care staff argued with Resident A and said, "you need to take a shower now, oh well we cannot make you." Relative A1 reported not believing that Resident A took a shower during the time she was at the facility. Relative A1 reported Resident A has dementia, anxiety and depression and needs to be encouraged and offered multiple times to bathe. Relative A1 stated, "the direct care staff were a one and done offer, then move on to the next resident."

On February 12, 2026, I interviewed DCS Tiffany Hofstetter and Kim Morgan who both reported a resident shower chart is available for review next to the medication cart. DCS Hofstetter and DCS Morgan reported residents are offered showers at least twice a week. DCS Hofstetter and DCS Morgan both reported Resident A often refused to be showered and became aggressive towards direct care staff when being encouraged to shower. DCS Hofstetter reported she personally bathed Resident A at least three times in the past couple of months. DCS Morgan reported she has showered Resident A in the past but could not specify times and dates.

On February 13, 2026, during the onsite investigation I interviewed Resident C, Resident D, Resident E, and Resident F who all reported being bathed a minimum of twice a week and then peri care is provided the other days. Resident C, Resident D, Resident E, and Resident F denied the allegations of residents not being bathed.

On February 17, 2026, I interview DCS Shana Horsley, Tatyana Smith, and Breanna Johnson who all reported residents are provided showers twice a week and helped with peri care daily. DCS Breanna Johnson reported Resident A often refused to be bathed or showered. DCS Johnson reported she tried to encourage Resident A to take a shower or at least let DCS Johnson assist Resident A with washing herself but Resident A refused. DCS Johnson reported they cannot make a resident take a shower so she documented Resident A's refusals.

On February 18, 2026, I received an email correspondence from DCS Camie Fisher containing the *Activities of Daily Living Logs* for Resident A and Resident B which documented daily hygiene and weekly showers. I made the following observations per the logs:

Resident A:

- January 2026: Resident A refused daily hygiene on: 1/1/26, 1/2/26, 1/3/26, 1/4/26, 1/5/26, 1/7/26, 1/9/26, 1/12/26, 1/14/26.
- January 2026: Resident A refused showers on 1/1/26. Resident A was showered on 1/5/26, 1/8/26, 1/12/26.

- Resident B:
  - January 2026: Resident B received assistance with daily hygiene except on: 1/13/26, 1/21/26, 1/27/26.
  - January 2026: Resident B was offered but refused a shower on 1/5/26, 1/19/26 but was showered on other Mondays and Thursdays throughout the January 2026.

On February 23, 2026, I interviewed Lisa French from Resident A's current facility who reported Resident A was admitted into their facility on January 14, 2026. Upon admission, Resident A was found to have dirty finger and toenails, black buildup between and under her toes. Ms. French reported Resident A's skin was intact and healthy in the peri area.

On February 23, 2026, I interviewed Relative B2 who reported Resident B was offered showers on a regular basis but often refused them.

APPLICABLE RULE	
R 400.677	**Resident hygiene, clothing.**
	(2) A licensee shall ensure the resident receives or has access to all of the following: **(a) Bathing at least weekly.**

ANALYSIS:	Based on the information provided through documentation and interviews, there was insufficient amount of evidence found to support the allegations of Resident A and Resident B not being bathed weekly. Resident A's *Activities of Daily Living Log* documented that Resident A was offered and provided access to a shower two times a week but often refused. Per Resident B's *Activities of Daily Living Log ,* Resident B refused a shower on January 5 and January 19, 2026, but was provided a shower on the other Mondays and Thursdays of the month of January 2026.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the current status of the license remains unchanged.

Bridget Vermeesch

03/02/2026

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm

03/03/2026

_____

Dawn N. Timm Date
Area Manager