



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2026

Laura Esese
Dignified Care LLC
3640 Brambleberry DR Nw
Comstock Park, MI 49321

RE: License #: AM410411953
Investigation #: 2026A0357014
Dignified Care

Dear Ms. Esese:

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 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 (616) 356-0100.

Sincerely,

A handwritten signature in cursive script, appearing to read "Toya Zylstra".

Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM410411953
Investigation #:	2026A0357014
Complaint Receipt Date:	12/08/2025
Investigation Initiation Date:	12/08/2025
Report Due Date:	02/06/2026
Licensee Name:	Dignified Care LLC
Licensee Address:	3640 Brambleberry DR Nw Comstock Park, MI 49321
Licensee Telephone #:	(616) 856-9191
Administrator:	Laura Esese
Licensee Designee:	Laura Esese
Name of Facility:	Dignified Care
Facility Address:	1675 3 Mile Rd. NW Grand Rapids, MI 49544
Facility Telephone #:	(616) 784-6197
Original Issuance Date:	10/05/2023
License Status:	REGULAR
Effective Date:	04/05/2024
Expiration Date:	04/04/2026
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED, AGED, ALZHEIMERS, DEV DISABLED, MENTALLY ILL, TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Staff did not administer Resident A's medications as prescribed.	Yes

III. METHODOLOGY

12/08/2025	Special Investigation Intake 2026A0357014
12/08/2025	Special Investigation Initiated - Letter to Melissa Gekeler, Recipient Rights, network 180.
12/10/2025	Contact - Document Received Melissa Gekeler said it is very complex, with many moving parts, Rehab, pharmacy, and AFC staff.
03/09/2026	Contact - Document Received (Toya Zylstra) Recipient Rights Melissa Gekeler
03/10/2026	Inspection Completed On-site (Toya Zylstra)
03/11/2026	APS Complaint (Toya Zylstra)
03/11/2026	Exit Conference Licensee Designee Laura Esese

ALLEGATION: Staff did not administer Resident A's medications as prescribed.

INVESTIGATION: On 12/08/2024 complaint allegations were received from Recipient Rights and stated that on 10/26/2025 Resident A was administered Oxycodone 5 MG PRN at 3:56 AM for pain and Diazepam 5 MG PRN for agitation at 3:57 AM. The complaint stated that the medications were not administered as prescribed. This complaint was assigned for my investigation 03/09/2026.

On 03/09/2026 I emailed Recipient Rights staff Melissa Gekeler. Ms. Gekeler confirmed that she was assigned to investigate the complaint allegations and substantiated the investigation with a violation.

On 03/09/2026 I received Ms. Gekeler's "Report of Investigative Findings" signed 12/11/2025. The report indicated the following: "*Recipient (Resident A) guardian Daphne Welton was interviewed over the phone on 11/4/25 and the complaint was reviewed with her. Daphne said she contacted Registered Nurse Monica Huesing on*

10/27/25 because (Resident A) had been sent to the Emergency Room four times over the weekend. Daphne said Monica told her (Resident A) was given both Valium prescribed by Dr. Plattner and Oxycodone within a minute of each other. Daphne reported that she didn't know (Resident A) had been prescribed Oxycodone, and she didn't give consent for it to be given to (Resident A). Daphne said (Resident A) fell and tore her meniscus in July 2025 and was in a rehabilitation facility for a couple of weeks. Daphne stated that (Resident A) would not be able to answer interview questions. She was not interviewed".

"Psychiatrist Dr. Plattner was interviewed via Microsoft Teams on 12/3/25 and the complaint was reviewed with him. Dr. Plattner reported that he didn't know that (Resident A) was prescribed Oxycodone until Monica brought it to his attention on 10/27/25. Dr. Plattner stated that the Oxycodone was not on (Resident A's) October 2025 MAR that he reviewed during her medication review on 10/15/25. Dr. Plattner said staff should have given (Resident A) Visteril first for anxiety and then Valium if the Visteril didn't work. Dr. Plattner said Visteril and Oxycodone would have been okay to give together because Visteril is not a central nervous system depressant. Dr. Plattner stated that (Resident A) could have died from getting Oxycodone and Valium within a minute of each other".

"Optalis Health and Rehabilitation Admission paperwork for Recipient (Resident A) dated 7/24/25 was received and reviewed on 11/5/25. It indicates that her diagnoses were left knee pain and difficulty walking. She was prescribed Oxycodone for knee pain as needed every eight hours on 7/24/25".

"Medication Reviews for Recipient (Resident A) dated 7/16/25 and 10/15/25 were received and reviewed on 12/8/25 and 12/10/25. Both medication reviews indicate that Walker Home staff were present for the reviews, and Visteril PRN should be continued and Valium given if the Visteril is not helpful.

On 03/10/2026 I completed an unannounced onsite investigation at the facility and privately interviewed staff Sinenhlanhla Nkabinde. Ms. Nkabinde stated that Resident A no longer resides at the facility. Ms. Nkabinde stated that on 10/26/2026 Resident A had been transported to the emergency department multiple times due to agitation which included "saying someone was bothering her, when no one was, and dropping and picking up items continuously". Ms. Nkabinde stated that Resident A was returned to the facility after evaluation at approximately 6:00 PM. Ms. Nkabinde stated that Resident A continued to display agitation and could not sleep later in the evening. Ms. Nkabinde stated that she telephoned Resident A's guardian, Daphne Welton, at approximately 3:00 AM and requested permission to transport Resident A to the emergency department. Ms. Nkabinde stated that Ms. Welton refused. Ms. Nkabinde stated that Resident A's Network 180 Behavior Support Plan mandates the steps staff must take prior to administering Resident A's PRN Diazepam. Ms. Nkabinde stated that she attempted to assist Resident A with practicing her coping skills including redirection and verbal deselection however Resident A continued to exhibit agitation. Ms. Nkabinde stated that she asked Resident A if she was in pain,

and Resident A reported that her back and knee were painful. Ms. Nkabinde stated that she completed all the requirements of said plan before administering Resident A's Diazepam. Ms. Nkabinde stated that Resident A was prescribed Oxycodone 5 MG PRN for pain and Diazepam 5 MG PRN for agitation. Ms. Nkabinde stated that she administered Oxycodone 5 MG PRN at 3:56 AM for pain and Diazepam 5 MG PRN for agitation at 3:57 AM. Ms. Nkabinde stated that Resident A did not appear over medicated and went to sleep approximately one hour later. Ms. Nkabinde stated that Resident A woke later in the morning and did not appear to have sustained ill effects from the medication administration.

While onsite I observed Resident A's MAR. The document stated in typed font that Resident A was prescribed Diazepam 5 MG by Dr. Aaron Plattner "TAKE ONE TABLET BY MOUTH THREE TIMES DAILY AS NEEDED FOR ANXIETY OR AGITATION, CAN GIVE WITHIN 30 MINUTES OF NEEDED". I observed in handwritten font that Resident A was prescribed "OXYCODONE TAB 5 MG TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED FOR PAIN". The document indicated that on 10/26/2025 Ms. Nkabinde administered Oxycodone 5 MG for "Back Pain" at 3:56 AM and Diazepam 5 MG for "Agitated" at 3:57 AM. The document indicated in typed font that Resident A is prescribed Hydroxyzine 50 MG (Vistaril) by Dr. Aaron Plattner "TAKE ONE CAPSULE BY MOUTH FOUR TIMES DAILY AS NEEDED FOR ANXIETY".

While onsite I reviewed Resident A's Network 180 Behavior Support Plan dated 12/04/2024, with the plan in effect until 12/2025. The document stated that Resident A's "PRN Protocol" indicates that before a PRN medication is administered staff must determine if the behavior is due to a medical condition (headache, toothaches, etc), and if so, "use appropriate medical treatment". Resident A's "PRN Protocol" indicates that before a PRN medication is administered staff must attempt "to have Resident A use a non-medication coping skill (i.e. watching tv, talking with staff, etc.)". Resident A's "PRN Protocol" indicates that before a PRN medication is administered Resident is to request for the use of the PRN.

On 03/11/2026 I completed an Adult Protective Services complaint via the online portal.

On 03/11/2026 I completed an exit conference via telephone with licensee designee Laura Esese. She stated that she did not dispute the findings and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	<p>Resident A's MAR indicated that Resident A was prescribed Diazepam 5 MG by Dr. Aaron Platther "TAKE ONE TABLET BY MOUTH THREE TIMES DAILY AS NEEDED FOR ANXIETY OR AGITATION, CAN GIVE WITHIN 30 MINUTES OF NEEDED". Resident A's MAR indicated in handwritten font that Resident A was prescribed "OXYCODONE TAB 5 MG TAKE ONE TABLET BY MOUTH EVERY 8 HOURS AS NEEDED FOR PAIN". The document indicated that on 10/26/2025 Ms. Nkabinde administered Oxycodone 5 MG for "Back Pain" at 3:56 AM and Diazepam 5 MG for "Agitated" at 3:57 AM.</p> <p>Resident A's Network 180 Behavior Support Plan dated 12/04/2024 stated that Resident A's "PRN Protocol" indicates that before a PRN medication is administered staff must determine if the behavior is due to a medical condition (headache, toothaches, etc), and if so, "use appropriate medical treatment".</p> <p>Based upon my investigation, which includes interviews and a review of pertinent documentation, a preponderance of evidence does support that a violation of the applicable rule occurred.</p> <p>In accordance with the 07/16/2025 and 10/15/2025 medication review, staff should have administered Resident A's Hydroxyzine 50 MG and observed the effectiveness before administering the 10/26/2026 3:57 AM dose of Diazepam 5 MG.</p> <p>In accordance with Resident A's Network 180 Behavior Support Plan dated 12/04/2024, staff should not have administered the 10/26/2026 3:57 AM dose of Diazepam until after observing the effectiveness of the 10/26/2026 3:56 AM dose of Oxycodone.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.



03/11/2026

Toya Zylstra
Licensing Consultant

Date

Approved By:



03/11/2026

Jerry Hendrick
Area Manager

Date