



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 22, 2026

Daniela Marit
Selah Senior Living LLC
1825 Hiller Rd
West Bloomfield, MI 48324

RE: License #: AS630410571
Investigation #: 2026A0626021
Ahava of White Lake

Dear Mr. Marit:

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 (248) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Sara E. Shaughnessy". The signature is fluid and includes a long horizontal flourish at the end.

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 320-3721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630410571
Investigation #:	2026A0626021
Complaint Receipt Date:	05/04/2026
Investigation Initiation Date:	05/05/2026
Report Due Date:	07/03/2026
Licensee Name:	Selah Senior Living LLC
Licensee Address:	1825 Hiller Rd West Bloomfield, MI 48324
Licensee Telephone #:	(248) 860-3101
Administrator:	Daniela Marit
Licensee Designee:	Daniela Marit and Claude Marit
Name of Facility:	Ahava of White Lake
Facility Address:	760 Robar Circle White Lake, MI 48324
Facility Telephone #:	(248) 860-3101
Original Issuance Date:	09/23/2022
License Status:	REGULAR
Effective Date:	03/23/2025
Expiration Date:	03/22/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell out of bed around 4:00 am on 05/02/2026. She did not receive immediate medical attention and was found with swelling and bruising to her face and a head injury.	Yes
Additional Findings	No

III. METHODOLOGY

05/04/2026	Special Investigation Intake 2026A0626021
05/05/2026	APS Referral A referral was not made to APS due to them already being involved.
05/05/2026	Special Investigation Initiated - Telephone I initiated the special investigation by completing a telephone interview with Adult Protective Services investigator, Tracey Anderson.
05/06/2026	Contact - Face to Face I completed an unannounced onsite investigation at Ahava of White Lake. I completed face to face interviews with care manager, Amanda Beeler, licensee, Claude Marit, and Relative A1.
05/08/2026	Contact - Telephone call received I received a telephone call from Detective Salwell of White Lake Township Police Department regarding the investigation.
05/13/2026	Contact - Telephone call received I received a telephone call from APS investigator, Tracey Anderson, informing me that Resident A had passed away on 05/08/2026.
05/14/2026	Contact - Telephone call received I received a telephone call from Detective Swalwell providing me an update on his investigation.

05/19/2026	Contact - Telephone call received I received a telephone call from APS investigator, Tracey Anderson, informing me of her disposition.
05/20/2026	Contact - Telephone call made I completed telephone interviews with direct care staff members, Chantiya Coleman and Chamiya Curby, and registered nurse, Breonna Robinson.
05/21/2026	Exit conference I completed an exit conference, via telephone, with licensee designee, Claude Marit. The findings were discussed.

ALLEGATION:

Resident A fell out of bed around 4:00 am on 05/02/2026. She did not receive immediate medical attention and was found with swelling and bruising to her face and a head injury.

INVESTIGATION:

On 05/05/2026, I received a complaint, via email, alleging Resident A had fallen out of her bed at Ahava of White Lake, and did not receive medical attention for approximately four hours. When she received medical attention, there was significant bruising and swelling to right side of her face.

On 05/05/2026, I initiated the special investigation by completing a telephone interview with Adult Protective Services (APS) investigator, Tracey Anderson. Ms. Anderson informed me that she went to the home to see Resident A and she does not look good; she is barely alive. Resident A is back at Ahava of White Lake and is now on hospice care, per her daughter's wishes. She explained that Resident A fell out of her bed, onto a hardwood floor around 3 or 4 am and the direct care staff member just picked her up and put her back into bed. Resident A has a bed alarm and that is how the staff member knew she had fallen. When the next shift came on duty, they checked on Resident A and saw the bruising, so she called the nurse, Breonna Robinson, who went to the home to assess her, then called 911. She stated the EMT who arrived on the scene was appalled and Resident A's daughter would not really talk to her. Ms. Anderson sent me a photograph of Resident A's face. It appeared to be deep purple/blue in color on the right side of her face.

On 05/06/2026, I completed an unannounced, onsite investigation at Ahava of White Lake. I completed an in-person interview with care manager, Amanda Beeler. Ms. Beeler stated she was not at the home at the time of the fall but was told that it occurred around 4am when Resident A tried to get out of bed. The direct care staff member had assessed Resident A, did not see any visible injuries, then got her back into her bed. The next shift started and at around 8:20 am, they contacted their nurse, Breonna Robinson due to observing bruises on Resident A's face. Ms. Robinson came to the home to assess Resident A, then immediately contacted Relative A1 and 911. Resident A had bruises and swelling and is now in hospice care. She stated Resident A is 97 years old and she has appeared to have declined since the fall. Resident A is comfortable now and her daughter just wants her to be as comfortable as possible. Ms. Beeler does not believe Resident A is in pain. Ms. Beeler informed me that management is still trying to decide what to do about the direct care staff member who was working and they have had meetings regarding it, as their protocol is to contact management or 911 immediately after a fall.

On 05/06/2026, during my onsite investigation, licensee, Claude Marit arrived and I completed a private, in-person interview with him. Mr. Marit showed me the phone application he designed to make communication more efficient for staff. He showed me how incident reports are created on the application and how it provides immediate access for the management team to know what is going on. He explained that the protocol for falls is to contact management immediately, or 911, depending on the severity of the fall. Regarding the fall, it occurred between 3 and 4 am, the direct care staff member did not see any injuries and put Resident A back into bed. Shift change took place at 7am and he received the report at 8:27 am. He requested photographs and sent his nurse to the home right away and she contacted 911 after seeing the bruises. Mr. Marit stated that his employees are all trained to call him or 911 right away after a fall occurs and he does not know why the staff member did not follow the protocol. He has had management meetings to decide how to handle the situation. He employs a nursing director who does the training and he is already planning on having her re-train all staff regarding fall protocol. He has a bed alarm on all of the residents' beds and chairs and Resident A had never fallen from bed before, so this was surprising. Mr. Marit appeared to be genuinely concerned about the situation and to be taking this incident seriously. He explained that he wants to do right by his residents.

On 05/06/2026, during my onsite investigation, I completed a private, in-person interview with Relative A1 in the bedroom of Resident A. Relative A1 stated that she had been informed of the fall by text, around 8:50 am, but the nurse had called her about one minute before she sent the text, she had missed the call. She called the nurse back and was informed that Resident A was being taken to the hospital where she was diagnosed with a hematoma and some cracked ribs. She explained that Resident A was not doing well before this; she is 97 years old and has dementia. According to Relative A1, the staff and Mr. Marit were amazing and wonderful. Mr. Marit is an amazing businessman, and it is obvious he cares. She believes Resident A, who she described as having severe dementia, tried to climb over her bedrails

and fell. She is not mad at any of the staff and thinks they would have reacted if they had seen the bruising or thought Resident A was in pain. She trusts that they are providing amazing care. She does not believe Resident A is coming back from this and may die by the weekend. Some of the aides are sitting with Resident A, all night, even while off duty to ensure Resident A is not alone and to keep her safe. She reiterated that they have treated Resident A amazingly and she has no complaints or concerns regarding the care Resident A has received.

On 05/06/2026, during my onsite investigation, I was able to view Resident A. She appeared to be in a deep sleep, breathing heavily. Resident A had her head turned to the right, so I could not view the bruising to her face. Relative A1 offered to move her so I could see it, but I insisted she did not have to, as she appeared to be comfortable and I did not want to disturb her.

At the onsite investigation, I was provided with a copy of the incident report. The report was completed by Chamiya Curby and lists Chantiya Coleman as a witness. It indicates the incident occurred on 05/02/2026 at 4am. The explanation of what happened read:

"Caregiver found resident on floor, next to bed, alert and oriented to baseline. Resident as assessed by caregiver with no evidence of bruising or pain, vitals stable. Resident was transferred back to the bed. Day shift caregiver observed resident with bruising and swelling forming to the head."

I also received a copy of Resident A's assessment plans. There was one dated 02/29/2026 and one dated 05/06/2026, after she returned to the home from the hospital. Both assessment plans reference her use of bedrails. The one dated 02/29/2026 references that she will be supervised and the one dated 05/06/2026 indicates routine checks will be needed at least every two hours.

On 05/08/2026, I received a phone call from Detective Swalwell from the White Lake Police Department. He stated that he received a complaint regarding Ahava of White Lake and the fall that happened with Resident A. He stated that he was going to go to the home and investigate the next week.

On 05/13/2026, I received a phone call from APS investigator, Tracey Anderson. Ms. Anderson informed me that she had just found out that Resident A had passed away on 05/08/2026. She stated that the cause of death was blunt force trauma to the head and chest. She also informed me that Chamiya Curby had been terminated from her job at Ahava White Lake.

On 05/14/2026, I received a phone call from Detective Swalwell. He stated that he went to the home and was informed that Resident A had passed away. He is going to continue his investigation.

On 05/19/2026, I received a phone call from APS investigator, Tracey Anderson. Ms. Anderson requested an update on my investigation and informed me that she is substantiating her allegations against Ms. Curby, regarding Resident A.

On 05/20/2026, I completed a telephone interview with direct care staff member, Chantiya Coleman. Ms. Coleman came onto shift on 05/02/2026, around 7:30 am. When she came in, night shift provided their report and told her about Resident A falling out of bed. She went to check on Resident A and noticed her face was bruised, she contacted the nurse and she requested photographs. She sent the photographs to the nurse, and the nurse came to the home to assess Resident A. Ms. Coleman stated that Resident A was awake and yelled at her, "Let me go, Goddammit! My back hurts!". She left Resident A alone until the nurse arrived. She denied having any concerns regarding the work of Chamiya Curby and stated that she was good with all of the residents.

On 05/20/2026, I completed a telephone interview with Chamiya Curby. Ms. Curby was the direct care staff member who was on shift when Resident A fell out of bed. Ms. Curby stated that Resident A had tried getting out of bed around 3am and she got her back to bed without incident. Ms. Curby then went to assist another resident and heard Resident A's bed alarm go off. She put her back into bed and she appeared fine. She checked her vitals and they were normal. Resident A seemed good until around 7 or 8am, when the day shift came in and saw her bruising. She was gone at that time. She denied calling and reporting the fall to anyone when it happened. She denied Resident A falling out of bed before but stated she did fall at least one time going to the bathroom on her own. Ms. Curby confirmed that she is no longer employed at Ahava White Lake.

On 05/20/2026, I completed a telephone interview with Breonna Robinson. Ms. Robinson is a registered nurse employed with the company. Ms. Robinson responded to the call regarding Resident A's fall. She had received a text message from Ms. Coleman, informing her of the fall, around 8:22 am. She requested photographs of Resident A and when she received them, she immediately contacted Relative A1, got ready, and went to the home. She stated she arrived a little bit before 10 am. She assessed Resident A to be bruised, swollen, and to have slurred speech, so she contacted 911. Paramedics assessed Resident A and transported her to the hospital for treatment. She informed me that Resident A's official cause of death is listed as blunt force head and chest trauma with complications, resulting from the fall. She stated the protocol when there is a fall is for direct care staff members to contact the licensee, if they cannot reach him, they are to contact her or the other nurse, if they are not able to reach the nurses, they are to contact the care manager. She explained that one of the nurses will be sent to the home to assess the resident and determine if other care is needed. She stated that they have re-trained the direct care staff members on fall protocol.

On 05/21/2026, I completed an exit conference, via telephone, with licensee designee, Claude Marit. Mr. Marit was informed of the findings and indicated an

understanding of them. Mr. Marit confirmed the termination of employment of Ms. Curby, due to her not following the rules of the home regarding fall protocol. Mr. Marit stated that all employees have been re-trained on the fall protocol for the home and he is going to institute quarterly re-training to ensure it is fully understood. He already has his employees sign a paper indicating they have been trained in, and understand, fall protocol and he will continue to do that.

After the exit conference took place, Mr. Marit emailed me a copy of the paperwork that was signed by Ms. Curby at the time of her being hired. In the paperwork, it states the following regarding any incidents or accidents:

For each accident or incident involving a resident, staff member, or visitor, I will prepare an accident record or incident report, which will include:

- The name of the person involved.
- The date, time, place, and cause of the accident or incident.
- The effect on the person involved and the care given.
- The names of the individuals notified and the time of notification.
- A statement on the extent of the injuries, treatment ordered, and the disposition of the person involved.
- The corrective measures taken to prevent a recurrence.
- If I cannot get ahold of Claude, I will try to get ahold of:
 - Daniela Marit
 - Amanda Beeler
 - Noel Hancock

APPLICABLE RULE	
R 400.689	Resident health care.
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	Based on the information gathered during the special investigation, there is enough evidence to establish that Resident A did not receive needed health care immediately. Resident A fell out of bed on 05/02/2026 at approximately 4:00 am and the direct care staff member on duty put her into bed and did not obtain care for her. After 8:00 am, when the next shift arrived, she was found with significant bruising to her face. The licensee was informed of this around 8:22 am and he went the nurse to the home to assess Resident A. Resident A was found with swelling and bruising to her face and slurred speech. She was treated at the hospital and later passed away.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective plan, I recommend no changes to the status of the license.

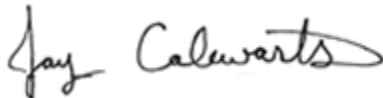


05/21/2026

Sara Shaughnessy
Licensing Consultant

Date

Approved By:



For

05/22/2026

Denise Y. Nunn
Area Manager

Date