GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 8, 2026

Achal Patel
Divine Life Assisted Living Center 3 LLC
2045 Birch Bluff Drive
Okemos, MI 48864

RE: License #: AL330404952
Investigation #: 2026A1029036
Divine Life Assisted Living Center 3 LLC

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated by the licensee designee.

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. 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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

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

I. IDENTIFYING INFORMATION

License #:	AL330404952
Investigation #:	2026A1029036
Complaint Receipt Date:	04/13/2026
Investigation Initiation Date:	04/14/2026
Report Due Date:	06/12/2026
Licensee Name:	Divine Life Assisted Living Center 3 LLC
Licensee Address:	2045 Birch Bluff Drive, Okemos, MI 48864
Licensee Telephone #:	(517) 339-2390
Administrator:	Cheri Weaver
Licensee Designee:	Achal Patel
Name of Facility:	Divine Life Assisted Living Center 3 LLC
Facility Address:	2077 Haslett Road, Haslett, MI 48840
Facility Telephone #:	(517) 339-2390
Original Issuance Date:	11/09/2020
License Status:	REGULAR
Effective Date:	05/09/2025
Expiration Date:	05/08/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her medications as prescribed while she was at Divine Life Assisted Living Center 3.	Yes
The residents were yelled at and direct care staff members did not respond to requests from the residents.	No
Additional Findings	Yes

III. METHODOLOGY

04/13/2026	Special Investigation Intake 2026A1029036
04/14/2026	Special Investigation Initiated – Email to Cheri Weaver
04/15/2026	Contact - Telephone call made Resident A. Left message
04/15/2026	Inspection Completed - Face to Face with Cheryl Long, Resident B, Resident C at Divine Life Assisted Living Center 3
04/16/2026	Contact - Telephone call received from Resident A
04/21/2026	Contact - Document Sent - Cheri Weaver, email exchange
05/07/2026	Contact - Document Sent to Cheri Weaver and RN Kortney Hamill and Resident A.
05/07/2026	Contact - Telephone call made to Resident A, Left message
05/08/2026	Contact – Email from Resident A
05/20/2026	APS referral made to Centralized Intake
05/22/2026	Email to Kortney Hamill, R.N and administrator, Cheri Weaver
05/29/2026	Contact – Telephone call to administrator Cheri Weaver
06/02/2026	Contact – Email sent to RN Hamill and Cheri Weaver, direct care staff members Angela Brooks (Left message), Teasia Wilson, Doniesha Martin (Left message.), April (Left message), Darvieon (Left message), Brenda (wrong number), and licensee designee Achal Patel
06/02/2026	Exit Conference with licensee designee Achal Patel

ALLEGATION: Resident A did not receive her medications as prescribed while she was at Divine Life Assisted Living Center 3.

INVESTIGATION:

On 04/13/2026, a complaint was received via Bureau of Community and Health Systems alleging that Resident A did not receive her medications as prescribed while residing at Divine Life Assisted Living Center 3 for a respite stay.

On 04/15/2026, I conducted an unannounced on-site investigation at Divine Life Assisted Living Center 3 LLC and interviewed direct care staff member and home manager Cheryl Long. Ms. Long reported she began her role in August 2025. She stated that Resident A was admitted for a short rehabilitation stay and was expected to remain for two weeks but elected to leave early to stay with her sister. Ms. Long initially reported that Resident A’s stay was from 03/27/2026 to 04/03/2026. However, the facility’s electronic medication administration record (eMAR) contained no entries for 03/27–03/30/2026. The eMAR reflected medication administration beginning on 03/30/2026, and it was later confirmed that Resident A moved in on that date. Ms. Long stated the absence of entries on 04/04/2026 was due to Resident A moving out that morning. She acknowledged she did not know why no entries appeared for the initial days and stated that although the facility typically uses Advanced Pharmacy services for new admissions from Tri-County Area Agency on Aging or PACE, Resident A declined to use that pharmacy and arrived with her own medications. Ms. Long indicated she entered the medications into the eMAR based on the instructions on Resident A’s medication bottles. She also stated Resident A frequently refused medications or reported that her physician discontinued them, though the facility did not have corresponding physician orders to verify these claims. Ms. Long reported that Resident A did not have a case manager but did have a relative involved.

I reviewed Resident A’s *Assessment Plan for AFC Residents* (assessment plan), which indicated that Dr. Vanderjagt prescribed Gabapentin 300 mg; however, the eMAR listed two separate Gabapentin dosages. The assessment plan also indicated a prescribed dose of Synthroid/Levothyroxine 175 mcg, while the eMAR listed Levothyroxine 200 mcg. I reviewed discharge documentation dated 03/29/2026 from McLaren Greater Lansing Main Hospital. The documents showed Resident A was hospitalized from 03/27/2026 to 03/29/2026 following a fall and ongoing lower extremity infections requiring multiple hospitalizations and rehabilitation stays. The discharge instructions listed the following Gabapentin dosages:
- 300 mg orally every morning
- 600 mg (two 300 mg capsules) orally at bedtime

I interviewed Resident B and Resident C, both of whom reported that direct care staff members administer their medications appropriately and stated they had never received incorrect medications.

Because Resident A had discharged from the facility, I reviewed the active medication listings for Resident D and Resident E. All medications for these residents were present at the facility, and no concerns were identified regarding medication administration.

On 5/07/2026 I received an email from Resident A who included the following statement about her medications.
“Gabapentin was my main concern because of the potential for abuse. I was asked to bring in my own meds so they had each bottle with dosing information. I was told it was entered into their computer and it informed them when and how many to give me. Some pills were given at the wrong time, or morning and evening pills mixed together. I take Synthroid every day and it has to be taken in the morning on an empty stomach at least one hour before breakfast. Not once did I get it early instead being mixed with my morning pills. The morning prescriptions were not consistently given at a set time. Earliest was between 10 am to 11 am. One day it was noon. I am of sound mind and could see the errors but what about those who can't talk or be aware of what they are being given.”

After receiving this, I reviewed the Levothyroxin tablet medication administration times to see if the instructions were followed. According to the medication listing the instructions are to *“Take 1 tablet by mouth daily every morning (half hour to one hour before any meal / medications).”* According to the eMAR Resident A received Levothyroxin 200 mcg at the following times:

- 03/30/2026 – Refused at 8:10 AM
- 03/31/2026 –No initials indicating Resident A was administered the medication.
- 04/01/2026 – Administered at 6:57 AM.
- 04/02/2026 – Administered – no time noted
- 04/03/2026 - Administered at 8:18 AM. Other medications were given within 10 minutes of this medication so the instructions were not followed.

I reviewed Resident A’s eMAR for the time period of 03/30/2026- 04/03/2026 and found the following:

- 03/30/2026 – Resident A refused her medication 21 times. All other medications were administered as prescribed.

- 03/31/2026 – Resident A refused two of her medications. Resident A was not administered the following medications as prescribed:
    1. Levothyroxine 200 mcg – 7 AM dose
    2. Bumetanide tab .5 mg – 8 AM and 8 PM dose
    3. CA Citrate tab 250 mg – 2 PM and 8 PM dose
    4. Ferrous Sulfate 325 – 8 AM dose
    5. Gabapentin 300 mg – 8 PM dose
    6. Hydroco / APAP tab 325 mg – 8 AM, 2 PM, and 8 PM doses
    7. Pantoprazole tab 40 mg – 8 AM dose
    8. Polyeth Glyc Pow. 3550 NF – 8 AM and 8 PM dose
    9. Pot CL Micro tab 20 MEQ ER – 8 AM dose
    10. Atorvastatin tab 80 mg 8 PM dose

11. Senna-time tab 8.6 mg – 8 PM dose

- 04/01/2026 and 04/02/2026 – Resident A did not refuse any medications. All medications were given as prescribed.

- 04/03/2026 - Resident A was administered all medications as prescribed for the morning. According to Resident A she moved out at noon 04/03/2026 so the evening medications would not have been administered.

On 05/29/2026, I interviewed administrator Cheri Weaver. Ms. Weaver stated that when a resident moves in, the facility typically receives a medication list from the prescribing physician. However, in some cases, families bring medications from home, and direct care staff members enter the medications into the system directly from the prescription labels on the original bottles. Ms. Weaver reported that the facility does not routinely rely on hospital discharge summaries because they may not reflect updates from the resident's primary care physician. She stated she was unsure whether the primary care physician was contacted for Resident A due to the short, three-day admission. Ms. Weaver reported no complaints from Resident A's family or Resident A during her stay. She explained that the facility follows a two-hour medication administration window (one hour before and one hour after scheduled time) and that any administration outside this window is referred to RN Hamill. Ms. Weaver also stated that the facility implemented an electronic eMAR system around 04/01/2026, and it is possible direct care staff member did not document correctly during the transition.

On 06/02/2026, I interviewed former direct care staff member Teasia Wilson. Ms. Wilson stated she recalled Resident A but did not recall Resident A ever receiving incorrect medication. Ms. Wilson stated she did not verify prescriptions at admission because the home manager entered them, but direct care staff ensured medications matched the prescription labels on the bottles while administering medications. Ms. Wilson stated she does not recall Resident A refusing medications but acknowledged that it had been a long time since working with Resident A.

On 06/02/2026, I also interviewed licensee designee Achal Patel. Mr. Patel stated he has no concern regarding respite residents receiving incorrect medications.

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:	Interviews and documentation reviewed during the investigation confirmed that direct care staff members at Divine Life Assisted Living Center 3 did not ensure Resident A's medications were administered as prescribed during Resident A's admission. Ms. Long reported that Resident A's medications were entered into the eMAR based on the labels on the bottles brought from home, rather than verified physician orders. Ms. Long was unsure why initials on eMAR entries were missing but acknowledged the errors could be a result of the recent transition to an electronic system. Ms. Weaver confirmed that she was unsure whether Resident A's primary care physician had been contacted to confirm medication instructions and/or to report medication refusals. Resident A did not receive her Levothyroxin as scheduled on 03/31/2026. On 04/03/2026 Resident A's Levothyroxin was administered at 8:18 AM and her other medications were given within 10 minutes of this medication which is not according to the label instructions. There were also several medications on 03/31/2026 that were not initialed confirming they were administered as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The residents were yelled at and direct care staff members did not respond to requests from help from the residents.

INVESTIGATION:

On 04/13/2026 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns that Resident A and other residents were not treated with respect and direct care staff members did not respond to requests for help from the residents at Divine Life Assisted Living Center 3 LLC.

On 04/15/2026, I conducted an unannounced on-site investigation and interviewed direct care staff member whose role is home manager Ms. Long. Ms. Long stated she had no concerns regarding direct care staff members speaking disrespectfully or failing to respond to residents' needs.

I interviewed Resident B and Resident C, both of whom reported that staff treat them with respect and respond promptly when assistance is needed. Neither resident reported concerns about staff ignoring calls or failing to address their needs. Resident B described the staff as supportive and stated that at times staff speak loudly due to residents' hearing impairments. Both residents stated they feel safe living in the home. Resident C noted that nighttime noise from other residents can make it difficult to sleep but did not indicate concerns about staff responsiveness. Resident B stated, "the staff love me and I love them" and said that anything she needs assistance with is provided by direct care staff members.

On 05/07/2026, I received an email from Resident A stating that she did not observe compassion from direct care staff members and reported hearing loud voices, swearing, and a dismissive tone toward residents. She also stated that direct care staff members had conflicts with one another and with the home manager.

On 05/29/2026, I interviewed administrator Ms. Weaver, who stated she has no concerns about direct care staff members attentiveness or resident treatment. Ms. Weaver reported that direct care staff members provide respectful care and that she has never observed them ignoring residents or speaking inappropriately.

On 06/02/2026, I interviewed former direct care staff member Ms. Wilson. Ms. Wilson stated she had no concerns about how the direct care staff members treated Resident A or other residents and did not observe disrespectful interactions during her employment.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Based on my interviews with Ms. Weaver, direct care staff member Ms. Wilson, Resident B, and Resident C there was no evidence residents were treated with disrespect or yelled at while residing at Divine Life Assisted Living 3. All residents indicated the direct care staff members respond promptly to requests for assistance.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

During the on-site investigation, I attempted to verify the dates Resident A resided at Divine Life Assisted Living Center 3 for respite care. Resident A was not listed on the facility's *Resident Register*, and home manager Ms. Long initially provided incorrect dates, stating Resident A was present from 03/27/2026 to 04/03/2026. However, the eMAR contained no medication entries from 03/27/2026 through 03/29/2026 and Resident A did not appear on the *Resident Register* so the correct admission and discharge dates could not be verified.

On 05/07/2026 I received an email from RN Hamill confirming that Resident A moved in on 03/30/2026 and moved out 04/03/2026.

On 05/29/2026, I interviewed administrator Ms. Weaver. Ms. Weaver reported that Ms. Long was aware that respite residents must be included on the *Resident Register* and

was unsure how Resident A was omitted. Ms. Weaver stated she would address this with Ms. Long to ensure all respite residents are documented appropriately going forward.

On 06/02/2026 I interviewed licensee designee Mr. Patel who stated he was unaware that Resident A was not on the *Resident Register* but he would make sure respite residents were documented moving forward.

APPLICABLE RULE	
R 400.615	**Resident register.**
	A licensee shall maintain a chronological register of all residents admitted that includes the following information for each resident: **(a) Resident full name.** **(b) Resident date of birth.** **(c) Date of admission.** **(d) Date of discharge and location, if known, where the resident moved.**
ANALYSIS:	During the on-site investigation, I attempted to verify the dates Resident A resided at Divine Life Assisted Living Center 3 for respite care; however, she was not listed on the *Resident Register*, and Ms. Long initially provided incorrect dates. Ms. Weaver and Mr. Patel stated all respite resident will be included on the *Resident Register* moving forward.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

_ ____________06/02/2026__________________
Jennifer Browning
Licensing Consultant

Approved By:

06/08/2026

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Dawn N. Timm Date
Area Manager