



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 1, 2026

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

RE: License #: AS410417331
Investigation #: 2026A0009033
Amelia AFC Home

Dear Ms. Esese:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- Specific time frame 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, reading "Adam Robarge".

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410417331
Investigation #:	2026A0009033
Complaint Receipt Date:	08/14/2026
Investigation Initiation Date:	08/14/2026
Report Due Date:	09/13/2026
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:	Amelia AFC Home
Facility Address:	1854 Glenvale DR SW Wyoming, MI 49519
Facility Telephone #:	(616) 341-9050
Original Issuance Date:	10/03/2023
License Status:	REGULAR
Effective Date:	04/03/2026
Expiration Date:	04/02/2028
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED, TRAUMATICALLY BRAIN INJURED & ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not administer Resident A's medication properly after her stay at a psychiatric hospital.	Yes
Staff did not respond quickly enough when Resident A's behavior continued to be aggressive and self-injurious.	No

III. METHODOLOGY

08/14/2026	Special Investigation Intake 2026A0009033
08/14/2026	APS Referral
08/14/2026	Special Investigation Initiated – Telephone call made to Kristen Ranson, Trinity Health social worker, left message
08/19/2026	Inspection Completed On-site Interview with home manager Destiny Willis and licensee designee Laura Esese Face to face with Resident A
08/20/2026	Contact – Telephone call made to Resident A's Guardian
08/20/2026	Contact – Document (email with attachment) received from Resident A's Guardian
08/24/2026	Contact – Telephone call made to Resident A's Guardian
08/24/2026	Contact – Document (forwarded text message) received from Resident A's Guardian
09/01/2026	Exit conference with licensee designee Laura Esese

ALLEGATION: Staff did not administer Resident A's medication properly after her stay at a psychiatric hospital.

INVESTIGATION: I conducted an unannounced site visit at the Amelia AFC Home on August 19, 2026. The staff who were present promptly put me on a telephone call with home manager Destiny Willis. I asked her about Resident A not receiving her medication properly following her stay at a psychiatric hospital. She reported that Resident A was at the hospital for about two weeks but they were not notified of her medication changes when she was discharged. Ms. Willis said that typically any medication changes are sent directly to the pharmacy they use for their residents. In

this case, the pharmacy did not receive any new medication orders from the hospital. For a week after Resident A returned from the hospital, her behavior was unchanged from before she had gone. Resident A was still acting aggressively and punching holes in the walls. They asked Resident A's guardian to take her back to the hospital at that point. When she got back to the hospital, they asked to see her most recent medication administration record (MAR). They then discovered that they were continuing to give Resident A's medication that had been prescribed before the hospital stay. Ms. Willis said that she had not seen the discharge papers for Resident A immediately following the initial hospital visit and they did not, at that time, have access to her medical record application system (MyChart). Ms. Willis said that she called Resident A's guardian and told her that she had never seen Resident A's discharge papers and that no new medication orders had been sent to the pharmacy that Resident A uses. The psychiatrist at the hospital had confirmed that the new orders had not been faxed to the pharmacy.

I asked what the procedure is for gathering the discharge papers from hospital stays. Ms. Willis said that staff are supposed to ask for them. She said that Resident A's guardian dropped her off at the home on July 22, 2026 and staff should have asked then for the discharge papers. Any change in medication is supposed to go straight to the pharmacy. Ms. Willis said that if she had seen the discharge papers, she would have known that several of her medications had changed. She said that she had wondered what was going on because the pharmacy did deliver a large package of medication for Resident A on July 23, 2026, which did not seem to make sense. Ms. Willis said that she went to the pharmacy herself on that day and met with pharmacist Erin West. She brought Resident A's medications so they could make sure she was taking the current and correct medications. The pharmacist confirmed that she was taking the right medications. Ms. Willis wanted to prove to me that she had done this and included pharmacist Erin West on our telephone call. The person who identified herself as Ms. West confirmed that Ms. Willis had come in on that day and they had gone over what they knew of Resident A's medications at that time. Ms. West also confirmed to me that they had not received an email from the hospital, which is standard procedure, when new medication orders are created.

Licensee designee Laura Esese showed up to the home while I was present and I spoke with her about the complaint. She confirmed that all medication changes are sent directly to the pharmacy. She said that Resident A's guardian had dropped off Resident A from the hospital. Their staff did not pick her up. Ms. Esese said that Ms. Willis did go to the pharmacy and confirmed that they had not received anything new from the hospital after Resident A's initial stay there. She also reported personnel from the hospital had called both her and Ms. Willis about Resident A and never mentioned any medication changes. When they got a package of medication that didn't seem to match what they thought Resident A was taking, she suggested to Ms. Willis that she go directly to the pharmacy and make sure they had the correct medication administration information.

I spoke with Resident A's guardian by telephone on August 20, 2026. I asked her

what she knew about Resident A not being administered her prescribed medication for at least one week after her initial hospital stay in July of 2026. Resident A's guardian explained that she had not realized that had happened until she took Resident A to the hospital for the second hospital later in July of 2026. The hospital asked the home to provide them with Resident A's MAR for the last week. Resident A's guardian said that she looked at it and realized they had been administering her previous medications that were prescribed before the initial hospital visit. It looked to her as if they had made none of the changes indicated in the discharge papers. She said she then provided Ms. Willis with the discharge papers from the initial hospital visit which showed all the medication changes, which were significant. I asked how it was that the home had not been provided with the discharge papers in the first place which showed all the changes. Resident A's guardian said that she did provide them with the discharge papers when she dropped Resident A off from the hospital after the initial visit. I asked if there was a staff person who had met them at that time. She said yes, there were two. Resident A's guardian said that she remembered going over the discharge instructions with them including the medication changes. She then left the discharge papers in a packet on the counter of the home.

I received an email with an attachment from Resident A's guardian on August 20, 2026. The attachment was the "After Visit Summary" from Trinity Health for Resident A dated July 22, 2026. It listed that Resident A "Start Taking" three medications/supplements, "Change how you take" four medications/supplements and "Stop Taking" nine medications/supplements.

I spoke again with Resident A's guardian by telephone on August 24, 2026. She provided me with a forwarded text message between her and home manager Destiny Willis. The text message was dated July 22, 2026. It read, "Call me if you have any questions about the discharge. The number for the unit is highlighted in the discharge packet. They should have called in 45 days worth of meds to the pharmacy for you guys to pick up. Lmk if you need anything else from me." It appeared from the forwarded text that Ms. Willis had then tapbacked a thumbs up icon to the guardian's message.

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:	Resident A was discharged from a psychiatric hospital on July 22, 2026. She was dropped off at the home by Resident A's guardian on that day. The guardian reported that she spoke with two staff and went over the discharge instructions with them, including the medication changes. She said that she left

	the discharge packet on the counter of the home. If the packet was misplaced, there should have been a process in place for another copy of the discharge papers to be obtained and any orders contained therein quickly put into practice. It was confirmed through this investigation that Resident A was not given the correct medications after her discharge from a hospital on July 22, 2026.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Staff did not respond quickly enough when Resident A's behavior continued to be aggressive and self-injurious.

INVESTIGATION: I spoke with both home manager Destiny Willis and licensee designee Laura Etese about Resident A still being aggressive and hitting the walls for a week after her initial hospital visit. Ms. Willis stated that Resident A was still exhibiting the same behavior she had exhibited before her initial hospital visit. She had continued to bang on the walls which she had done before. She was also itching a lot and removing her clothing. They monitored her closely to try to prevent her from hurting herself. When it became obvious after a week that her behavior was not changing, they called the guardian and asked her to take Resident A back to the hospital.

Ms. Etese showed me the home including the stairwell, hallway and Resident A's bedroom. She showed me several areas in the drywall that had been repaired from past holes. I observed several areas that had been repaired leading to and in Resident A's room. There was one hole that hadn't been repaired. We surmised that the remaining hole had likely been made during the week between Resident A's initial and subsequent hospital visit. Ms. Etese told me that the staff were administering Resident A's as-needed (PRN) medications and monitoring her as closely as they could during that week. Ms. Etese stated that when they realized that Resident A's behavior was not changing for the better, they contacted her guardian and asked her to take Resident A back to the hospital.

I spoke with Resident A's guardian by telephone on August 24, 2026. I asked her what she thought about Resident A going back to the hospital after a week back at the Amelia AFC Home. She confirmed that they called her about a week later and asked her to take Resident A back to the hospital. Resident A had hit her head intentionally against the wall which was a new behavior for her. Resident A's guardian said that she wished she would have known sooner that had happened but did feel it was reasonable for them to wait to see after her initial hospital visit whether her behavior would improve. She felt that it makes sense that they would want to monitor her for a while before asking her to go back to the hospital. She said that she thought if they had asked that Resident A go back after only two days

or so, the hospital probably would not have taken her back. Ms. Willis reported that they were giving Resident A “a transition period” after the initial hospital stay. They were monitoring her and giving her as-needed (PRN) medications to see if her behavior would stabilize. Resident A’s guardian wanted me to know that besides the recent medication issue, she feels that the home does a good job with Resident A. She has no other concerns for Resident A’s care at the home.

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:	Resident A returned to the home after a two-week stay at a psychiatric hospital. She continued to exhibit the same behaviors that led to her initial stay at the hospital. The staff reportedly used her as-needed (PRN) medication and monitored her closely to try to prevent her from harming herself. After about one week, they did contact Resident A’s guardian and asked that she return Resident A to the hospital. Resident A’s guardian reported that she felt it was appropriate that the home monitored Resident A for a short time after her hospital stay to see if she improved. Information was not discovered that would indicate the licensee had failed to obtain needed health care immediately in the case of an accident or sudden adverse change. Resident A was experiencing chronic behaviors of at least several weeks duration and staff were monitoring her and trying to provide her with as-needed (PRN) medications to alleviate the condition.
CONCLUSION:	VIOLATION NOT ESTABLISHED

An exit conference was conducted by telephone with licensee designee Laura Esese on September 1, 2026. She was told of the findings of the investigation and given the chance to ask questions.

IV. RECOMMENDATION

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



09/01/2026

Adam Robarge
Licensing Consultant

Date

Approved By:



09/01/2026

Jerry Hendrick
Area Manager

Date