GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 12, 2026

Jenice Choate
Ebenezer Care Center
16013 Middlebelt Road
Livonia, MI 48170

RE: License #: AL330418806
Investigation #: 2026A0622061
Ebenezer Care Center

Dear Ms. Choate:

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.

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,



Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

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

I. IDENTIFYING INFORMATION

License #:	AL330418806
Investigation #:	2026A0622061
Complaint Receipt Date:	09/09/2026
Investigation Initiation Date:	09/10/2026
Report Due Date:	10/09/2026
Licensee Name:	Ebenezer Care Center
Licensee Address:	16013 Middlebelt Road Livonia, MI 48170
Licensee Telephone #:	(716) 704-9185
Administrator:	Jenice Choate
Licensee Designee:	Jenice Choate
Name of Facility:	Ebenezer Care Center
Facility Address:	2447 N. Williamston Road Williamston, MI 48895
Facility Telephone #:	(517) 230-6276
Original Issuance Date:	01/21/2025
License Status:	REGULAR
Effective Date:	07/21/2025
Expiration Date:	07/20/2027
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Emergency plan is not specific and instructs staff to listen to the weather for Wayne County. Only two flashlights were available for lighting during the overnight shift of 9/3/26.	Yes
The gas-powered generator was a couple of feet from the front window and the front door on the porch. The window was open enough for the cord to the generator to go inside the house. Extension cords were running through the home, proposing a tripping hazard.	Yes
Resident B had an Oxygen cannula in her nose attached to the oxygen concentrator, but there was no electricity for the concentrator to work.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/09/2026	Special Investigation Intake 2026A0622061
09/10/2026	Special Investigation Initiated – Email contact with complainant.
09/18/2026	Inspection Completed On-site and phone interview with licensee designee, Jenice Choate
09/22/2026	Contact- phone interviews with direct care workers, Kalista Towsley, Unique Lewis, Hollie Speer and Guardian E1.
09/28/2026	Inspection Completed-BCAL Sub. Compliance
10/08/2026	Contact- phone interview with Residential hospice nurse, Alicia Zacek
10/09/2026	Contact- phone interview with direct care worker, Emily Grosheng
10/09/2026	Exit conference with licensee designee, Jenice Choate

ALLEGATIONS:

- **Emergency plan is not specific and instructs staff to listen to the weather for Wayne County. Only two flashlights were available for lighting during the overnight shift of 9/3/26.**
- **The gas-powered generator was a couple of feet from the front window and the front door on the porch. The window was open enough for the cord to the generator to go inside the house.**
- **Resident B had an Oxygen cannula in her nose attached to the oxygen concentrator, but there was no electricity for the concentrator to work.**

INVESTIGATION:

On 09/09/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint Ebenezer Care Centers emergency plan is not specific and instructs staff to listen to the weather for Wayne County rather than the county in which the facility is located. The complaint also stated that staff only had two flashlights available and licensee designee had bought candles during the second day of the power outage. According to the complaint, Complainant went out and bought battery powered lanterns due to the concern of using candles and having oxygen running in the home. As indicated in the complaint, the generator was a couple of feet from the front window and front door on the porch, and the window was open enough for the cord to the generator to go inside the house. The complaint described cords in front of egresses and across the hallways. According to the compliant, one resident had an Oxygen cannula in her nose attached to the oxygen concentrator, but no electricity for the concentrator to work. As detailed in the complaint, Complainant instructed licensee designee, Jenice Choate that she could not use the generator there due to the potential for CO poisoning of residents or staff, therefore she called and had someone move it away from the building. Per the complaint, Resident A was only taken to the bathroom once during the night, although she gets up frequently to use the bathroom.

On 09/10/2026, I emailed Complainant and received pictures regarding the power outage and concerns noted in the complaint. Complainant confirmed that she arrived on 9/4/26 around 9:30am and was informed that the home automatic generator did not work, therefore a small gas-powered generator was connected. Complainant stated that the small generator would not power emergency lighting and had just run out of gas before she arrived.

On 09/10/2026, I viewed the pictures sent from Complainant. I viewed a picture of the generator, which was located right next to the house on the front porch. An extension cord was connected to the generator, came through the front window and into the house. The front window was observed to be cracked open in the picture. I also viewed pictures of an extension cord running across a main hallway that was preventing residents from safely moving through the hallway. I viewed a picture of two additional extension cords running through the building to power recliners.

On 09/18/2026, I completed an unannounced onsite investigation to Ebenezer Care Center. During my unannounced onsite investigation, I interviewed direct care workers and viewed documentation.

On 9/18/2026, I viewed Ebenezer Care Centers' emergency preparedness plan. The plan listed the address of the facility and stated that it was reviewed on 11/21/2024 by Regional Director of Operations Matt Cortis. I viewed the procedures for a Thunderstorm warning and Tornado watch/warning. Both sections stated the following: "The administrative person in charge will listen to the Wayne County central dispatch. The weather channel, or the local news for updated information." It should be noted that Ebenezer Care Center is located in Ingham County. The emergency preparedness plan did not discuss a plan if there is an extended utility outage. The emergency preparedness plan stated that if residents needed to receive care at another location, local motels and other local licensed homes or long term care facilities would be considered. Within the emergency preparedness plan, no information was available on where additional lights or emergency supplies were located.

On 9/18/2026, I interviewed direct care worker (DCW), Madelelin Kabimany in person. She reported that she was working the second day after the power went off which was 9/4/2026. She stated that she arrived at 7am and the generator was hooked up on the front porch. DCW and the residents received cereal for breakfast. She stated that staff were able to provide care to residents during the day and they kept most of the residents in the living room because resident call lights were not working. DCW Kabimany stated that her manager worked on 9/4/2026 because the power was out until around 6pm that day.

On 09/18/2026, I interviewed DCW Consuela Banks in person. She stated that she worked on 9/4/26 from 7am-7pm. DCW Banks explained that the power was out when she arrived and a generator was running in the front of the house. DCW Banks reported that the generator was close to the home when she arrived, but later in the day it was moved farther away from the home. She stated that she observed managers adding gas to the generator and also observed extension cords running through the home. DCW Banks reported the power came on around 5pm, therefore she had enough light during her shift. DCW Banks explained that the generator powered oxygen tanks, a feeding tube, TV, fridge and recliners. DCW Banks stated that for lunch residents were served McDonalds and dinner they were served pizza.

On 09/18/2026, I interviewed DCW Adrianna Gutierrez in person. She reported that she worked on 9/3/26 from 7am-7pm, which was the first day the power went out. DCW Gutierrez reported that the power went out right before dinner and they brought all residents into the pantry and some were outside the pantry, away from the windows. She stated that staff kept the residents sheltered in place for a few hours until the storm passed. DCW Gutierrez explained that Resident D was on a feeding tube, but his battery was working even after the power went out. She reported that two other residents were on oxygen but none of the staff that were

working knew where the backup oxygen tanks were because these residents always use oxygen concentrators that plug into the wall. DCW Gutierrez stated that she was checking the resident's oxygen during her shift and made licensee designee Janice Choate aware. DCW Gutierrez stated that staff onsite had two flashlights available for lighting. She reported that during her shift maintenance arrived to hook up a small generator.

On 09/18/2026, I interviewed licensee designee (LD), Jenice Choate via phone and received information via email. LD Choate reported that the power went out on 9/3/26 at 3:30pm and came back on at 4:32pm on 9/4/26. LD Choate reported that two residents who use oxygen, both of whom have backup E-tanks for emergencies, as well as one resident who receives tube feeding. LD Choate stated a portable generator was brought to the facility around 7:00 PM on 9/3/26, and the oxygen concentrators and feeding tube equipment were plugged in at that time. She explained that the following morning, on 9/4, she arrived on-site with additional gas, longer cords, and additional flashlights and lanterns. She explained that she reached out to families who were not present at the home and informed them that they were considering relocation if the power was not restored by the evening of 9/4/26. LD Choate reported that they provided sandwiches for lunch, ordered food for dinner, breakfast and lunch on 9/4/26. LD Choate provided names of staff members who were working during the power outage.

On 09/22/2026, I interviewed DCW Kalista Towsley via phone. She reported that she worked on 9/3/26 when the power went out. She explained that the power went out between 2pm and 3pm due to a storm. She stated residents were moved to a safe place in the home until the storm passed. DCW Towsley explained that they informed managers that the power went out. She stated that the generator arrived around the end of her shift at 7pm but was not hooked up when she left. DCW Towsley stated she heard it was put on the porch but did not observe it on the porch. She explained that the resident with the feeding tube had a battery backup to keep it running and there were portable oxygen tanks for residents who use oxygen. DCW Towsley stated that there was enough light to pass medications and they fed the residents sandwiches and chips for dinner.

On 09/22/2026, I interviewed DCW Unique Lewis via phone. She reported that she worked on the night shift on 9/3/26 through 9/4/26. She arrived at 7pm on 9/3/26 and reported that the power was out and the generator was not hooked up yet. DCW Lewis stated that the generator was hooked up and running about an hour after her shift started. DCW Lewis stated that the generator only ran the oxygen tanks and feeding tube for three residents. She explained that the generator was placed in the front of the house. DCW Lewis reported that she worked with one other person and the only lights they had were two flashlights and the flashlights on their personal phones. She explained that she tried to do the best she could during her shift, but the building was pitch dark and they informed all residents they would be checking on them more and to wait for assistance with using the bathroom. DCW Lewis stated the decision was made based on safety for one resident who likes to get up

frequently during the night and is also a high fall risk to use an adult incontinence brief through the night. DCW Lewis stated this resident was upset by this but stated it was safer than trying to navigate to the bathroom in the dark. She reported that portable oxygen tanks did not arrive until around 8:30pm. DCW Lewis stated that two residents are on oxygen 24/7. She explained that she did not observe a manager during her shift. DCW Lewis reported that extension cords were everywhere and were running down hallways, which was causing a tripping hazard. She explained that no residents were injured on her shift and they did their best with the lack of light and resources to care for the residents. DCW Lewis reported that she did not observe a window to be open.

On 9/22/2026, I interviewed DCW Hollie Speer via phone. She stated that she worked on 9/3/26 from 7am-7pm and the power went out between 2pm and 3pm. She explained that they started hearing sirens, therefore they moved all the residents to the pantry area away from the windows. DCW Speer explained that generators were arriving on her shift but were not hooked up yet. She explained that they did have oxygen backups on her shift and Resident B uses oxygen while sleeping whereas Resident C uses oxygen but not during meals. DCW Speer reported that Resident D had a battery backup for his feeding tube. DCW Speer explained that she had to use her phone flashlight as there was no lighting in the home.

On 09/22/2026, I interviewed Guardian E1 via phone. Guardian E1 confirmed that she visited the home on 9/4/26 during the power outage. She stated that the generator as being located out on the front porch. Guardian E1 stated that extension cords were everywhere and it was a tripping hazard. She explained that the generator was powering the fridge, freezer, oxygen tanks and feeding tube. Guardian E1 stated that staff were trying their best to care for residents and mainly had them all in the dining room to provide supervision and meet resident needs more quickly. She stated that there was some discussion about transferring residents to other homes if the power was not restored by the evening. Guardian E1 stated that her sister visited Resident E the night prior on 9/3/26 when the power was out and she mentioned she was concerned about how dark the facility was and Resident E needing assistance in the middle of the night, as the call lights did not work and Resident E is non-verbal.

On 10/09/2026, I interviewed DCW Emily Grosheng via phone. She stated that the two senior staff on shift when the power went out knew where the backup oxygen tanks were and Resident B was provided with back up oxygen until the generator could be installed. DCW Grosheng stated that she arrived on 9/4/26 at 6:30am and assisted staff with caring for the residents.

On 09/22/2026, I requested *Assessment Plan for AFC Residents* for Resident B, C and D. I also requested documentation for the prescribed oxygen for Resident B and C.

I reviewed Resident B's *Assessment Plan for AFC Residents.* According to the document, she has a walker, hospital bed, wheelchair, bed alarm, shower chair, fall mat, nebulizer and Oxygen as needed. I received a document labeled *Client Medication Report* for Resident B. The report documented Resident B prescribed Oxygen Gas for Inhalation. No documentation was provided for how often Resident B should be given oxygen; therefore, I called Residential Hospice who prescribed oxygen. On 10/8/2026, I confirmed via phone with nurse, Alicia Zacek that Resident B should be on oxygen 24/7, but can often handle short periods of time without it, such as toileting or bathing. Resident B's *Assessment Plan for AFC Residents* was dated 5/29/2026.

I reviewed Resident C's *Assessment Plan for AFC Residents.* According to the document, Resident C is a wheelchair user who requires two direct care staff members to assist with the Hoyer lift for transfers when needed. According to the document, Resident C also has a nebulizer and oxygen. I received a document labeled *Client Medication Report* for Resident C. The report documented Resident C prescribed Oxygen Gas for Inhalation due to shortness of breath. Resident C is prescribed oxygen when she is in bed, and her oxygen is prescribed as a PRN when out of bed. Resident C's *Assessment Plan for AFC Residents* was dated 5/25/2025.

I reviewed Resident D's *Assessment Plan for AFC Residents.* According to the document, Resident D requires 24/7 supervision, has tube feeding; Nutren 1.5 cal @ 50cc and hour X 24/7. The document stated that Resident D is unable to walk and requires full assistance with toileting and bathing. Resident D's *Assessment Plan for AFC Residents* was dated, 6/5/2026.

APPLICABLE RULE	
R 400.619	**Emergency preparedness plan.**
	(1) A licensee shall have a written emergency preparedness plan in case of fire, medical, weather, extended utility outage, or other emergencies. The plan must include where residents will receive care in the event the facility is no longer habitable.

ANALYSIS:	Based on the emergency preparedness plan provided during the unannounced onsite investigation, the plan did not reflect the correct county where the facility is located to ensure staff received the most accurate weather information for that county. Additionally, upon review of Ebenezer Care Center's emergency preparedness plan, no procedures were established for an extended utility outage including where residents will receive care. Interviews with direct care workers indicated that some staff were not adequately prepared for a utility outage and were unaware of the locations of essential emergency supplies, including backup oxygen tanks and additional lighting. A violation was established due to inaccuracies within the emergency preparedness plan regarding the home's location and the absence of a written plan addressing extended utility outages.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

ANALYSIS:	Based on interviews and photographs provided by the complainant, it was determined that Ebenezer Care Center was not adequately prepared or maintained to safely support residents during a power outage. A generator was positioned on the front porch next to the home for a minimum of 14 hours, and a nearby window was left partially open, increasing the risk of carbon monoxide entering the facility from generator exhaust. The facility is equipped with emergency lighting; however, it was not functioning properly during the outage. According to interviews with direct care worker Unique Lewis, who worked the overnight shift on 9/3/26, as well as with Guardian E1 and Complainant, the home had only two flashlights available for lighting along with personal cell phone flashlights. This created significant safety concerns for residents receiving care during the overnight hours because of low or no visibility to safely move about the facility. Additionally, the use of the generator included having multiple extension cords running through resident hallways which created an additional tripping hazard for residents. A violation was established, as Ebenezer Care Center was not maintained in a manner that adequately protected the health, safety, and well-being of occupants during an extended power outage.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	During interviews and a review of documentation, it was determined that two residents, Residents B and C, require oxygen and primarily use electric concentrators. Due to the power outage that occurred on 9/3/26 at approximately 3:30 p.m., neither resident was able to use the electric oxygen concentrators from 3:30pm until 8:00pm when the generator was fully connected. However, two direct care workers on duty on 9/3/26 confirmed that Resident B was provided with a backup oxygen tank until the generator was connected and Resident C's *Client Medication Report* confirmed that Resident C only requires oxygen while in bed. Oxygen was available to Resident C due to the generator being connected at 8pm which then allowed Resident C's electric concentrator to be connected. A violation was not established, as two direct care workers confirmed that Resident B was provided with back up oxygen before the generator could be fully hooked up and Resident C did not require oxygen during the periods of 3:30pm-8pm per her prescribed orders.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 09/22/2026, I reviewed Resident C's *Assessment Plan for AFC Residents* which was last completed 5/25/2025. There was no updated Assessment Plan for AFC Residents for Resident C as required.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.

ANALYSIS:	A violation was established as Resident C's *Assessment Plan for AFC Residents* was not updated for the annual period of 2026 and was last completed on 5/25/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 09/18/2026, I interviewed LD Jenice Choate via phone and received information via email. During my interview, I requested staff contact information for direct care workers who worked during the power outage. Due to some phone numbers and last names not provided, I reviewed Ebenezer Care Centers work force background system to review the seven direct care workers provided to me via email. Upon review of Ebenezer Care Centers work force background system, the following direct care workers had not been fully cleared: Adrianna Gutierrez, Consuela Banks and Emily Grosheng.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under

	independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	A violation was established as three of the seven direct care workers' names provided had no background clearance completed within Ebenezer Care Centers work force background system.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.



10/09/2026

_____

Amanda Blasius — Date
Licensing Consultant

Approved By:



10/12/2026

_____

Dawn N. Timm — Date
Area Manager