GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 6, 2026

Prabhjot Singh
Park Place OPCO LLC
PO BOX 1568
Portage, MI 49081

RE: License #: AL390418617
Investigation #: 2026A0581045
Park Place Senior Living A

Dear Prabhjot Singh:

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 (517) 335-5985.

Sincerely,



Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390418617
Investigation #:	2026A0581045
Complaint Receipt Date:	08/14/2026
Investigation Initiation Date:	08/14/2026
Report Due Date:	10/13/2026
Licensee Name:	Park Place OPCO LLC
Licensee Address:	4218 S Westnedge Ave Kalamazoo, MI 49008
Licensee Telephone #:	(269) 329-8187
Administrator:	Prabhjot Singh
Licensee Designee:	Prabhjot Singh
Name of Facility:	Park Place Senior Living A
Facility Address:	4214 S Westnedge Ave Kalamazoo, MI 49008
Facility Telephone #:	(269) 329-8187
Original Issuance Date:	05/28/2025
License Status:	REGULAR
Effective Date:	11/28/2025
Expiration Date:	11/27/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATIONS

	Violation Established?
Residents are not being fed.	No
Residents are being neglected.	No
Residents are administered medications prescribed for other residents.	No
Additional findings.	Yes

III. METHODOLOGY

08/14/2026	Special Investigation Intake - 2026A0581045
08/14/2026	Special Investigation Initiated – Telephone - Interview with Complainant.
08/27/2026	APS Referral - referral made online.
08/27/2026	Referral - Law Enforcement - KDPS - case number 26-011331
08/27/2026	Inspection Completed On-site - Interviewed staff, observed residents and obtained documentation
08/28/2026	Contact - Telephone call made - Interview with Tabatha Watts.
08/28/2026	Contact - Document Received - Email from Tabatha Watts.
09/30/2026	Contact – Document Sent – Email to Tabatha Watts.
09/30/2026	Contact – Telephone call made – Interviews with direct care staff, Joanna Sanchez and Quintana Knox.
09/30/2026	Contact – Telephone call made – Left voicemail with direct care staff, Edith Zanou.
10/01/2026	Inspection Completed On-Site – Observed lunch. Interviewed facility staff, hospice staff, and management.
10/06/2026	Exit conference with licensee designee, Prabhjot Singh.

ALLEGATION: Residents are not being fed.

INVESTIGATION: On 08/14/2026, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged residents are not being fed, but no additional information was provided.

On 08/14/2026, I interviewed Complainant. Complainant stated residents do not have enough food to eat. Complainant stated residents do not always have enough food available at the facility and residents are sometimes provided only small portions. Complainant stated when residents request additional food, there is not always enough food available to provide additional servings. Complainant stated there have also been occasions when the facility has run out of food.

On 08/27/2026, I conducted an unannounced onsite inspection at Park Place Senior Living D, as the complaint was initially received identifying that as the facility involved in the complaint. During interviews with residents and staff at Park Place Senior Living D, I obtained information indicating the allegations pertained to Park Place Senior Living A rather than Park Place Senior Living D. While at Park Place Senior Living D, I observed residents eating lunch. I interviewed multiple residents regarding the food and meals provided at Park Place Senior Living D and none of them indicated any concerns they were not being fed, that food wasn't available, or that the facility was running out of food. It should be noted that Park Place Senior Living A and Park Place Senior Living D have meals prepared in the same commercial kitchen.

I subsequently conducted an unannounced inspection at Park Place Senior Living A regarding the allegations. Upon my arrival, the lunch meal had concluded; therefore, I was unable to directly observe the meal or portion sizes served to residents.

I attempted to interview multiple residents regarding the allegations; however, residents did not appear to be able to understand and respond to questions sufficiently enough to complete interviews regarding the allegations. Resident A was sleeping and did not awake when I attempted to speak with him. Resident B, Resident C, and Resident D were neither able to provide sufficient responses to my questions nor demonstrated an understanding of my questions. Resident E was visiting with family and was unavailable for an interview.

I interviewed direct care staff, Alexis Sanchez, Alexandria Lynch, and Hayley Shook. All the staff stated residents are fed three meals a day. They indicated that some residents may refuse to eat, but they still offered meals and meal alternatives. None of the staff indicated concerns such as not enough food being available to residents to eat or that the facility ran out of food to serve residents.

On 09/01/2026, I interviewed direct care staff, Atsou Agouze. His statement was consistent with other staff's statement regarding residents being served sufficient meals three times daily.

On 09/30/2026, I interviewed direct care staff, Joanna Sanchez and Quintana Knox. Their statements were consistent with other staff's statements regarding residents being served sufficient meals three times daily.

On 10/01/2026, I conducted a follow-up unannounced inspection at the facility. During the inspection, I observed residents eating lunch. I did not observe concerns with the amount of food available or the portions served. Residents appeared to have sufficient food available during the meal.

I interviewed direct care staff, Gloria Kabaseke and Glenda George. Their statements were consistent with those of previously interviewed staff. Both stated residents may receive additional servings, if requested, and that alternative food options are available when a resident does not want the meal being served.

I reviewed resident weight records for August and September 2026. The records did not identify any significant weight loss among residents during the period reviewed. I noted that several residents demonstrated a slight increase in weight from August to September 2026.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Based on my investigation, which included interviews with multiple direct care staff, observations made during unannounced inspections, and review of resident weight records, there is insufficient evidence to establish residents are not being provided a minimum of three nutritious meals daily and not receiving additional servings or alternative food options upon their request. During an unannounced inspection, I observed residents being served and eating lunch and did not observe concerns with the amount of food available or portions served. Additionally, my review of resident weight records for August and September 2026 did not identify significant weight loss among residents with several residents demonstrating a slight increase in weight during the period reviewed.
	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents are administered medications prescribed for other residents.

INVESTIGATION: The complaint alleged residents are being given other residents' medications; however, no additional information was provided.

Complainant subsequently identified Resident F as having been prescribed a medication to "calm him down", which Complainant believed was Lorazepam. Complainant stated staff, Atsou Agouze, was administering this medication to Resident A. Complainant was unable to explain why Atsou Agouze was reportedly administering Resident F's medication to Resident A or whether Resident A was prescribed the same or a similar medication.

During an unannounced onsite inspection on 08/27/2026, I reviewed residents' controlled medications, including their narcotic medications. I determined Resident A, Resident B and Resident G were each prescribed Lorazepam while Resident F did not have a prescription for Lorazepam. I did not identify concerns with the Lorazepam prescribed to Resident B or Resident G; however, I identified concerns regarding the administration and documentation of Resident A's Lorazepam.

During the inspection, I reviewed Resident A's Lorazepam 1 mg controlled medication count sheet and corresponding medication bubble pack. The pharmacy label on the bubble pack documented the medication was filled on 07/28/2026 for 30 tablets and directed Resident A to receive one tablet by mouth once daily as needed (PRN). The controlled medication count sheet documented 29 tablets as administered, with one tablet remaining at the time of my inspection. The count sheet documented two separate one tablet administrations on 07/30 at approximately 7 am and 8 pm, 08/01 at approximately 8 am and 8 pm, 08/02 at approximately 8 am and 5:50 pm, and 08/08 at approximately 8 am and 8 pm, despite the pharmacy directions specifying one tablet once daily as needed. The last administration documented on the count sheet was 08/24/2026, at which time one tablet was documented as remaining.

I reviewed Resident A's June, July, and August 2026 electronic Medication Administration Records (eMARs). The June and July eMARs identified Lorazepam 2 mg as a scheduled medication beginning 06/26/2026, with directions to administer one tablet by mouth once daily. The July 2026 eMAR also identified Lorazepam 1 mg as an as needed medication beginning 07/07/2026, with directions to administer one tablet by mouth once daily as needed. The July eMAR documented administration of the Lorazepam 1 mg PRN only once on 07/30/2026.

I reviewed a physician order dated 08/13/2026 directing that Resident A's Lorazepam 2 mg be discontinued while Lorazepam 1 mg PRN for agitation be continued.

Resident A's August eMAR documented PRN administrations of Lorazepam 1 mg on 08/15, 08/16, 08/20, 08/21 and 08/24 and identified agitation as the reason for administration. The eMAR entries did not account for all administrations documented on the controlled medication count sheet.

I interviewed the administrator, Tabatha Watts, regarding the discrepancy. She stated that, based on her review, it appeared staff continued administrating Resident A's Lorazepam 1 mg PRN as though it were the previously scheduled daily Lorazepam 2 mg medication.

Tabatha Watts provided additional controlled medication records for Resident A. An earlier controlled medication county identified Lorazepam 1 mg as a PRN medication and documented a starting quantity of 30 tablets. The count sheet documented administration beginning 06/30/2026 and continuing regularly through 07/26/2026, when the remaining quantity reached zero. Additionally, the count sheet documented two separate one tablet administrations on 07/11 at approximately 8 am and 8 pm, 07/19 at approximately 8 am and 8 pm and 07/20 at approximately 8 am and 8 pm, despite the pharmacy directions specifying one tablet once daily as needed. These administrations were not consistently reflected on Resident A's June and July eMARs.

Tabatha Watts also located and provided a separate controlled medication count sheet for Resident A's Lorazepam 2 mg among unfiled facility records. The pharmacy label directed Resident A receive one tablet by mouth once daily. The count sheet documented administration of one tablet on 06/27/2026. Resident A's June and July 2026 MARs identified Lorazepam 2 mg as a scheduled once daily medication.

Direct care staff, Alexis Sanchez's, Alexandria Lynch's, Joanna Sanchez's, Hayley Shook's, Quintana Knox's, and Atsou Agouze's statements were generally consistent. They all denied knowledge of staff administering medications prescribed for one resident to another resident, including Resident F's medication being administered to Resident A. Hayley Shook stated she attempts to audit the medication carts weekly; however, she stated she did not audit the cart the week of 08/27/2026 because she was working third shift. Atsou Agouze acknowledged Resident A's Lorazepam PRN medication. He stated he administered this medication daily because Resident A was experiencing "episodes." He stated he documented the daily administration on the narcotic count sheet and in the eMAR system. He denied administering Resident A's Lorazepam medication to other residents.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based on my investigation, there is insufficient evidence to establish that Resident A was administered medication prescribed for another resident. Although Complainant alleged Resident A was administered a Lorazepam medication prescribed for Resident F, a review of Resident F's medications determined Resident F was not even prescribed this medication, while Resident A had his own prescriptions for Lorazepam. Additionally, multiple direct care staff denied knowledge of medication prescribed for one resident being administered to another resident, including Resident F's medication being administered to Resident A.
CONCLUSION:	**VIOLATION NOT 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:	Based on my investigation, Resident A's Lorazepam 1 mg medication was prescribed to be administered as needed; however, a review of the controlled medication records documented two separate administrations of Lorazepam 1 mg on 07/11, 07/19, 07/20, 07/30, 08/01, 08/02, and 08/08.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.**
ANALYSIS:	Based on my investigation, which included a review of Resident A's controlled medication count records and eMARs for June, July and August 2026, there were multiple administrations of Lorazepam 1 mg PRN documented on the controlled medication count records that were not documented on Resident A's eMAR. Consequently, Resident A's individual medication log did not contain a complete record of the administration of his Lorazepam 1 mg PRN medication, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are being neglected.

INVESTIGATION: The complaint alleged residents were being neglected, including an allegation that "maggots" were discovered on a resident's vaginal area and that residents experienced frequent falls. The complaint did not identify specific residents or provide additional information regarding these allegations.

Complainant subsequently identified Resident B as the resident allegedly being neglected and stated staff were not changing her incontinence briefs. Complainant stated Resident B had sores on her buttocks and vaginal area and that flies had been observed in Resident B's room and landing on her sores. Complainant denied personally observing bugs or maggots on or around Resident B's vaginal area but stated Resident B complained of vaginal itching.

Complainant also stated that Resident C, Resident D, and Resident E had recently fallen. Complainant stated staff assisted residents following falls, but alleged the assistance was not immediate.

I interviewed direct care staff, Alexis Sanchez, Alexandria Lynch, Hayley Shook, Atsou Agouze, Quintana Knox, Gloria Kabaseke, and Glenda George. Their statements were generally consistent. They denied that Resident B or other residents were being neglected and stated residents' toileting and incontinence needs were routinely addressed. They stated residents were generally checked and toileted approximately every two hours. Hayley Shook stated Resident B receives showers from hospice staff two to three times per week and stated no concerns had been communicated by the hospice agency regarding Resident B's care.

Alexis Sanchez, Alexandria Lynch, Hayley Shook, Atsou Agouze, Quintana Knox Gloria Kabaseke, and Glenda George acknowledged residents occasionally experience falls, but denied the falls resulted from staff neglect or that residents were not assisted following a fall.

The facility's administrator, Tabatha Watts, stated she did not have any concerns regarding Resident B's hygiene or staff not addressing her incontinence. She also stated hospice visits weekly with Resident B to assist bathing her. She also did not have concerns residents were frequently falling without staff assisting residents following the falls.

During my inspection, I observed Resident B in the facility's living room. I attempted to interview Resident B; however, she was unable to provide responses sufficiently to complete an interview. I did not observe flies on or around Resident B or apparent signs that Resident B required incontinence care. I also did not detect a noticeable odor associated with incontinence.

I reviewed Resident B's *Health Care Appraisal*, dated 04/21/2026, which documented that she has an overactive bladder. Her assessment plan, completed on 03/03/2026, documented Resident B is incontinent and requires physical assistance from staff.

I also reviewed all August Incident Reports (IRs) for the facility with only three pertaining to resident falls. According to my review of the IRs, Resident A experienced two unwitnessed falls on 08/26/2026 and 08/27/2026, but staff assisted Resident A in getting up. The IR, dated 08/28/2026, documented medical attention was sought for Resident A's fall. An IR, dated 08/08/2026, documented Resident E also experienced an unwitnessed fall with staff seeking medical treatment.

During a follow-up inspection on 10/01/2026, I interviewed Interim Hospice nurse, Jessica Bancroft. She stated she was not aware of any concerns relating to Resident B's hygiene such as maggots being observed on or around her vaginal area. She stated she interviewed Resident B's hospice aid, Alex Foster, who confirmed with her Resident B is bathed approximately twice weekly and who was unable to identify any concerns relating to Resident B's hygiene or care.

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:	There is insufficient evidence that residents are being neglected in the facility. Based on my investigation, which included interviews with multiple staff, my own observations of residents during multiple unannounced inspections, and review of the facility's August Incident Reports, there is insufficient evidence Resident B's hygiene is not addressed, or that she has maggots on or around her vaginal area. Resident B is bathed approximately twice weekly by a hospice aid who also reported no concerns. Additionally, though it was reported by Complainant that residents had fallen in the facility in August, there is insufficient evidence residents are falling because of staff neglect or that staff are not addressing residents once they were observed after their fall.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/06/2026, I conducted my exit conference with the licensee designee, Prabhjot Singh and discussed my findings, which Prabhjot Singh acknowledged and understood. I discussed the need to retrain staff regarding medication administration and documentation, including the purpose of controlled medication count records and the requirement to accurately document medication administration on the eMAR. Prabhjot Singh stated the facility is in the process of changing its medication administration system to incorporate medication scanning, which he anticipates will assist in reducing medication administration and documentation errors.

IV. RECOMMENDATION

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



10/06/2026

Cathy Cushman Date
Licensing Consultant

Approved By:



10/06/2026

Dawn N. Timm Date
Area Manager