STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

July 13, 2021

Achal Patel
Divine Life Assisted Living Center 4 LLC
2045 Birch Bluff Drive
Okemos, MI 48864

RE: License #: AL230404953
Investigation #: 2021A1029012
Divine Life Assisted Living Center 4 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.
- 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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL230404953
Investigation #:	2021A1029012
Complaint Receipt Date:	05/21/2021
Investigation Initiation Date:	05/25/2021
Report Due Date:	07/20/2021
Licensee Name:	Divine Life Assisted Living Center 4 LLC
Licensee Address:	2045 Birch Bluff Drive Okemos, MI 48864
Licensee Telephone #:	(517) 580-8291
Administrator:	Achal Patel
Licensee Designee:	Achal Patel
Name of Facility:	Divine Life Assisted Living Center 4 LLC
Facility Address:	1038 Eastbury Drive Lansing, MI 48917
Facility Telephone #:	(517) 580-8291
Original Issuance Date:	11/09/2020
License Status:	REGULAR
Effective Date:	05/09/2021
Expiration Date:	05/08/2023
Capacity:	19
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
The home manager stole Resident A's watch and is wearing it.	No
Resident A is not receiving the proper medications because she is not receiving her Dilantin for seizures and she is receiving heart medications without having a heart condition.	Yes
Resident A is fed minimal food for meals with only water and no snacks.	No

III. METHODOLOGY

05/21/2021	Special Investigation Intake 2021A1029012
05/21/2021	Contact - Telephone call made to complainant. Voice mail full
05/25/2021	Special Investigation Initiated - On Site - Face to face with Victoria Ramirez, Resident A, Kenyana, Crusoe, home manager Liza Hobbins
06/15/2021	Contact - Document Sent Emailed to Liza Hobbins, home manager
06/16/2021	Contact - Telephone call to Liza Hobbins.
06/18/2021	Contact - Tele phone call to Guardian A1.
06/18/2021	Contact - Telephone call to PACE – Spoke with Kristen Ball, RN
06/18/2021	Contact - Telephone call to Neya Jackson, direct care staff member and left a voice mail.
06/22/2021	Contact - Telephone call to Neya Jackson Jones.
06/22/2021	Contact - Telephone call from Guardian A1.
06/24/2021	Contact - Telephone call from Kristen Ball, RN
06/24/2021	Contact - Telephone call from Vivek Thakore, CEO Divine Life

06/25/2021	Contact - Telephone call to CareKinesis Pharmacy, Dana Palmer
06/29/2021	Contact – Telephone call to Joanne Campbell, NP at PACE.
06/29/2021	Contact – Telephone call to Vivek Thakore
06/29/2021	Exit conference with licensee designee, Achal Patel.

ALLEGATION:
The home manager stole Resident A's watch and is wearing it.

INVESTIGATION:

On May 21, 2021, a complaint was received via a rejected adult protective services referral from Centralized Intake stating concern Resident A had her watch stolen while she was in the hospital and the home manager was wearing it.

On May 25, 2021, I conducted an unannounced on-site investigation to Divine Life Assisted Living Center 4. I interviewed direct care staff member, Victoria Ramirez. She stated she is familiar with Resident A falling, knows she had a seizure, and was hospitalized for a period of time. She has never observed the home manager Liza Hobbins wearing a watch or any items of the residents. She had no knowledge of any of Resident A's items being stolen.

Direct care staff member, whose role is as home manager, Liza Hobbins was also interviewed at that time and she denied having information regarding Resident A's missing watch. Ms. Hobbins stated that it was likely lost due to the conditions of Resident A's bedroom. I observed pictures of the conditions of Resident A's bedroom taken at the time of Resident A's hospitalization and before direct care staff members assisted in cleaning the space during her hospital stay from May 11 - May 13, 2021. Based on a review of the photographs, Resident A's bedroom was cluttered with various items such as trash, food, and empty toilet paper rolls which was a safety concern considering Resident A is at risk for falling. The direct care staff members have been working with Resident A since then to keep a clean and safe space for her.

Ms. Hobbins was not wearing a watch at the time of the on-site inspection and denied that she took a watch or any item from Resident A.

I interviewed Resident A in her bedroom. Resident A was frustrated because the staff cleaned out her bedroom and stated that she was missing items from the room. She was upset that they may have thrown out a survey from PACE she wanted to fill out. She had no concerns that the home manager or any of the direct care staff member would have stolen her watch. At the time of the on-site inspection, her room was very organized and clean.

On June 16, 2021, I interviewed Liza Hobbins. She stated that Resident A will bring up the watch occasionally but tells Ms. Hobbins that it is likely the hospital has the watch. When Ms. Hobbins asked her if she wanted her to call the hospital, she tells her "not to worry about it." Ms. Hobbins stated she is not aware of any family that has contact with her. Ms. Hobbins stated Resident A has not had any more falls since her seizure despite Resident A regularly refusing to use her walker or wheelchair to assist with mobility.

On June 22, 2021, I interviewed Guardian A1 who stated she has never had a concern direct care staff at Divine Life were taking Resident A's belongings but she knows that Resident A was upset that her room was cleaned out. Guardian A1 went to visit with Resident A last week and Resident A was upset that her items were moved. Guardian A1 stated Resident A was upset that her CDs were put in a drawer because she felt that they should not be stored there. Guardian A1 stated she believed Resident A should have been involved in the process of cleaning out her room and it should not have been done while she was in the hospital. However, despite this Guardian A1 stated she understood why it was necessary for direct care staff members to clean Resident A's bedroom due to the conditions.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(1) A resident shall be assured privacy and protection from moral, social, and financial exploitation.
ANALYSIS:	There is no indication that Ms. Hobbins or any other direct care staff members at Divine Life Assisted Living 4 stole Resident A's watch or is currently wearing it. Resident A has made several statements that she feels it was misplaced when she went to the hospital but has declined wanting to call the hospital to find it. Direct care staff at Diving Life Assisted Living 4 cleaned her room while she was in the hospital which caused some distress for Resident A; however, her room conditions were unsafe for her.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Resident A is not receiving the proper medications because she is not receiving Dilantin for seizures and she is receiving heart medications without having a heart condition.

INVESTIGATION:

On May 21, 2021, a complaint was received via a rejected adult protective services referral from Centralized Intake. There were concerns Resident A was not receiving her Dilantin.

On May 25, 2021, I conducted an unannounced on-site investigation to Divine Life Assisted Living 4 and interviewed home manager, Liza Hobbins. Ms. Hobbins stated there were some changes to Resident A's medications but Resident A was not on a heart medication. She stated Resident A was worried about her medication, Dilantin, which had been changed to the generic version called Phenytoin. Resident A has had more confusion and behaviors since experiencing a seizure and fall. Ms. Hobbins stated direct care staff members have been documenting each day how Resident A is acting. Resident A is not supposed to walk on her own and utilizes a walker or wheelchair for assistance, however at times, she will refuse to use them.

I interviewed Resident A in her bedroom. She stated the week prior she had a seizure and ended up in the hospital for three days. She was walking out of her bedroom door and fell. Resident A stated that around this time, some of her medications were changed. Resident A said that her Dilantin used to be a light and dark blue in color pill but Resident A stated she is no longer getting pills of this color. Resident A was upset that she is now receiving pills that are yellow in color. Resident A stated she takes her medications as scheduled and sees a nurse from PACE. Resident A stated the direct care staff members give her the medication but she still likes to be aware of what she is taking.

I interviewed direct care staff member, Kenyana Crusoe who was at the medication cart during the on-site investigation. She was able to show me the current medications for Resident A along with her Medication Administration Record (MAR) and they matched up for the week of May 25, 2021. Ms. Crusoe stated that it is not often that Resident A will refuse her medications but she does make comments about not getting her Dilantin. Ms. Crusoe stated when there are changes to the color or type of medications, Resident A thinks that she is no longer getting the medication. Ms. Crusoe stated she has explained to Resident A that she is getting the medication even though it looks different and that the name has been changed to Phenytoin.

According to Resident A's MAR, the following notes are documented for her Dilantin/ Phenytoin 100 mg tablet in the beginning of May 2021.

Phenytoin Ex Cap 100 mg (Equivalent to Dilantin)
RX1100806
Originated: 4/29/21 and stop date of 5/13/21
May 1-3 – No documentation in the MAR.
May 4-6 – Documentation that Resident A received the medication as prescribed and the dates were initialed from the direct care staff member to indicate she took the medication.
May 7-10 – Documentation that they are waiting on the pharmacy to refill.
May 10-13 – Resident A was admitted to the hospital after a seizure.

Resident A’s May 2021 MAR also documented Resident A was scheduled to start Phenytoin 200 mg on May 13, 2021, along with Phenytoin 50 mg to start on May 21, 2021.

On June 16, 2021, I interviewed home manager, Liza Hobbins who stated resident medications are not changed without a physician order. Ms. Hobbins stated Resident A was taking the Dilantin before she fell and had the seizure. Ms. Hobbins stated starting March 1, 2021, Resident A’s prescription Dilantin (200 mg) was one capsule by mouth daily. Ms. Hobbins stated there was a script for April 29, 2021, that was discontinued and that is when she started to take the Phenytoin which is a generic for Dilantin. Currently Resident A takes Phenytoin (200 mg) and Phenytoin (50 mg) at nighttime. Ms. Hobbins did not believe Resident A was on any specific heart medications but knows that Resident A does take medication for cholesterol and blood pressure which could affect her heart.

On June 18, 2021, I contacted the PACE program at Senior Community Care of Michigan. Resident A’s case worker through PACE is Stephanie Dosser. I spoke to the nurse Kristen Ball, RN. Ms. Ball agreed to have the current medication list sent over for June 2021. Ms. Ball stated Resident A did have her dose increased of the Dilantin and the medications changed to a generic, Phenytoin. Ms. Ball sees her every other month and has never had any concerns regarding her care at Divine Life Assisted Living 4.

On June 22, 2021, I interviewed direct care staff member, Neya Jackson-Jones. She stated Resident A is on Dilantin (or the generic Phenytoin) for her seizures. She said Resident A will question her medication if one changes or if it looks different. Ms. Jackson-Jones stated that she was getting the Dilantin before she had her seizure on May 10, 2021, but she was not sure what the dosage was without referring to Resident A’s medication administration record.

On June 22, 2021, I interviewed Guardian A1. She stated that she did not know about the medications other than PACE is the one that makes sure the facility has the correct medications. Guardian A1 has not had any concerns in the past that Resident A is not receiving the correct medications at Divine Life Assisted Living 4.

On June 22, 2021, I spoke with Kristen Ball, RN from PACE who stated Resident A should have had enough Dilantin/Phenytoin medication until she was admitted into the hospital on May 10, 2021. According to her records, Resident A should have been receiving the Phenytoin until her hospital admittance. Ms. Ball confirmed that not having this medication for five days could have caused Resident A to have a seizure resulting in the fall and hospital admittance.

On June 23, 2021, I spoke with Kristen Ball, RN from Pace. She stated that she was able to get into the EPIC system for Sparrow Hospital to determine what Resident A’s Dilantin levels were and how this affected Resident A’s seizures. According to the Sparrow records:

- April 12, 2021- Resident A had a breakthrough seizure and her Dilantin level was at 5. Normal levels are supposed to be between 10-20.
- April 24, 2021 - After the seizure, the levels were increased and when checked again on April 24, 2021, the level was at 24. She had another fall and altered mental status on April 25, 2021 and was again admitted to the hospital.
- April 26, 2021 - Dilantin level was 33.1 and Resident A was discharged with a lower dose. The Dilantin was held at this time until May 3, 2021, so her levels could decrease.
- May 2, 2021 - Dilantin level was 6.2. Dose was returned to the original 200 mg on May 4, 2021.
- May 10, 2021- Resident A was admitted to the hospital and her level was only at 2.5 resulting in a seizure and a fall. There is a note in the hospital records that Divine Life Assisted Living staff were questioned if she was receiving the Dilantin and hospital staff was told by staff at Divine Life Assisted Living facility that Resident A was receiving the medication.
- May 13, 2021 – Resident A's Dilantin level was up to 11 before she was discharged.

Ms. Ball stated that she should have had the medications because the new cycle of medications starts on the fifteenth of the month. Ms. Ball stated Resident A should have been getting the Phenytoin the whole month of May.

On June 23, 2021, I received a phone call from Vivek Thakore, co-owner of Divine Life Assisted Living 4. He stated that he has copies of the medication orders that he will send. Mr. Thakore stated they did not receive the Phenytoin (100 mg) tablet. Resident A never received the medication so the entries for May 4-6, 2021, in her MAR were in error. The order of Phenytoin (100 mg) was canceled by PACE on the same day that it was ordered (April 29, 2021) because a new order was received of Phenytoin (200 mg). Mr. Thakore sent over the following medication orders from PACE:

- April 29, 2021, Phenytoin 100 mg capsule – 1 capsule by mouth daily prescribed by Joanne Campbell, NP and Elizabeth Hengsteback, MD. The same day, on April 29, 2021, there was a visit and a request to hold Phenytoin until May 4, 2021.

Mr. Thakore also submitted records from CareKinesis Pharmacy that Dilantin 200 mg was sent to the facility.

- April 15, 2021 – 7 capsules RX# 7814453
- April 22, 2021 – 56 capsules RX # 7814454
- May 20, 2021 – 28 capsules RX # 7843153

Upon review of Resident A's May 2021 MAR, there was no documentation these 100 mg capsules were sent to Divine Life Assisted Living 4. I also noted the RX numbers also did not match up with the RX numbers in listed in Resident A's May 2021 MAR.

On June 25, 2021, I contacted CareKinesis pharmacy for clarification. Dana Palmer answered and confirmed that CareKinesis has never delivered Phenytoin (100 mg) capsules to Divine Life Assisted Living 4 for May 2021. Ms. Palmer confirmed the Phenytoin 200 mg was added to the medication cycle on May 12, 2020. According to Ms. Palmer, Diving Life Assisted Living 4 received the following medication delivery of Phenytoin for Resident A:

- April 16, 2021 – 56 capsules of Phenytoin (200 mg) were delivered.

- April 29, 2021 – There was an order placed for Phenytoin (100 mg). However, that order was discontinued the same day so it was never dispensed. Ms. Palmer confirmed the Phenytoin 100 mg was never received by the facility.

- May 13, 2021 - Phenytoin (200 mg) delivered. 1 x daily – Dose decreased and those were delivered to the facility on 5/18/2021.

Ms. Palmer confirmed that Resident A should have been on the Phenytoin (200 mg) dosage from May 3-10, 2021, and the facility should have had this medication available to administer to Resident A. The medications that were delivered on April 16, 2021, even if they were giving it twice daily, would have lasted until May 14, 2021. Ms. Palmer stated according to Resident A's most current physician order, Resident A should have been giving a dosage of Phenytoin 200mg once daily starting from May 3, 2021. According to Ms. Palmer, it is a possibility that not getting this medication caused the seizure on May 10, 2021.

May 21, 2021, There was a new order to add Phenytoin (50 mg) which was sent to a local pharmacy by CareKinesis to be filled so Resident A could start it the same day. At the time of the on-site inspection, she was receiving the correct dosage on May 25, 2021.

On June 29, 2021, I spoke with Vivek Thakore, owner / CEO of Divine Life. Ashel Patel, licensee designee, was also present at this time and on speaker phone. Mr. Thakore stated he stated that he was upset about the medication error and is going to remedy the situation. Although he was not sure how the medication was mixed up, he stated again that Resident A did not receive the Phenytoin medication during the time frame of May 4-10, 2021. He was aware that due to not having the correct Phenytoin medication, Resident A had a seizure and hospital admittance. Mr. Patel and Mr. Thakore both stated they are going to work more closely with PACE and CareKinesis pharmacy to ensure this does not occur again.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A was not administered the Dilantin medication correctly from May 4-10, 2021. Interviews with Ms. Palmer from CareKinesis Pharmacy and email documentation shows that this order was canceled on 4/29/2021 however that was not received by PACE. The medication administration record (MAR) is incorrect since it shows a stop date of May 13, 2021, for this medication. The facility direct care staff member documented in error that she had the medication for three days even though the Dilantin 100 mg was not available to give. Ms. Palmer from CareKinesis confirmed she should have been on the Phenytoin (200 mg) during this time but Resident A did not receive any Dilantin from May 4-10, 2021, which led to her seizure and hospital admittance.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:
Resident A is fed minimal food for meals with only water and no snacks.

INVESTIGATION:

On May 21, 2021, a complaint was via a rejected adult protective services referral from Centralized Intake. There were concerns that Resident A was not receiving adequate food and only getting water with meals. There was also a concern that the direct care staff members at Divine Life Assisted Living 4 was not offering any snacks to the residents.

On May 25, 2021, I conducted an unannounced on-site investigation to Divine Life Assisted Living 4. I interviewed direct care staff member, Victoria Ramirez. When asked about the meals, she stated there is a menu that is always posted. She said the direct care staff members cook the meals and the residents can always have water, juice, coffee to drink. During the on-site inspection, the residents were eating lunch. They had soup and grilled cheese sandwiches. There was a variety of drinks including coffee, tea, water, and juice for the residents.

Resident A was interviewed in her room. She stated that she gets plenty of food to eat at the facility. They were serving grilled cheese and soup the day of the interview and

she liked that meal. She did not have any complaints regarding what she was given to drink with her meal. Resident A stated if she were hungry, she could ask someone for a snack and they would provide that to her.

Resident B was also interviewed. She did not have any concerns regarding the food at the facility and felt that she received enough to eat. They can usually have coffee or water but they are not limited to those options.

On June 22, 2021, I interviewed Neya Jackson-Jones. Ms. Jackson-Jones stated that there are no concerns that the residents are not getting enough food. The home manager, Ms. Hobbins, will go out and buy their favorite snacks and they are able to have a variety of drinks with their meals.

On June 22, 2021, I interviewed Guardian A1. She has not had any concerns regarding the meals at Divine Life. She has not been there during a mealtime recently, but stated that since the new owners started, Resident A has not complained about the meals or drinks offered.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	All residents at Divine Life are given three regular nutritious meals daily. There is no indication from the interviews and observing the food supply during the on-site inspection on May 25, 2021, that the residents are not receiving adequate meals or snacks. They are able to choose between a variety of drinks to have with the meals.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

_________________7/9/21_______________________
Jennifer Browning Date
Licensing Consultant

Approved By:

07/13/2021

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Dawn N. Timm Date
Area Manager