GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2024

Achal Patel
DIVINE LIFE ASSISTED LIVING OF DEWITT 1 INC
2045 Birch Bluff Dr
Okemos, MI 48864

RE: License #: AM190418054
Investigation #: 2024A0577001
DIVINE LIFE ASSISTED LIVING OF DEWITT 1 INC

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 (517) 284-9727.

Sincerely,

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

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM190418054
Investigation #:	2024A0577001
Complaint Receipt Date:	07/12/2024
Investigation Initiation Date:	07/16/2024
Report Due Date:	09/10/2024
Licensee Name:	DIVINE LIFE ASSISTED LIVING OF DEWITT 1 INC
Licensee Address:	2045 Birch Bluff Dr Okemos, MI 48864
Licensee Telephone #:	(517) 898-2431
Administrator:	Cheri Lynn Weaver
Licensee Designee:	Achal Patel
Name of Facility:	DIVINE LIFE ASSISTED LIVING OF DEWITT 1 INC
Facility Address:	1177 SOLON RD DEWITT, MI 48820
Facility Telephone #:	(517) 484-6980
Original Issuance Date:	06/03/2024
License **Status:**	TEMPORARY
Effective Date:	06/03/2024
Expiration Date:	12/02/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED

	AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's wheelchair was forcefully moved by a direct care staff causing Resident A to fall out of the wheelchair and hit her head.	Yes
Direct Care Staff yelled and swore at Resident A after falling.	Yes

III. METHODOLOGY

07/12/2024	Special Investigation Intake 2024A0577001
07/16/2024	Special Investigation Initiated - Telephone call with Tom Hilla, Clinton County APS.
07/16/2024	APS Referral- Open Investigation Currently, no referral needed.
07/16/2024	Referral to Law Enforcement- Officer Stump, Dewitt Township Police Department.
07/17/2024	Contact - Document Received- Email from Tom Hilla, Clinton Co APS, emailed contacts from his investigation.
07/23/2024	Inspection Completed On-site- Interviewed resident and administration. Reviewed and received documents.
07/24/2024	Contact - Telephone call made- Interviews with DCS.
07/24/2024	Contact - Document Sent- Email to Kortney Hamill, Director of Nursing requesting a copy of the physician's orders for the chair alarm, copy of Resident A's assessment plan,
07/25/2024	Contact - Telephone call made- Interviews with DCS.
07/26/2024	Exit Conference with administrator CheriLynn Weaver.
07/26/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

- **Resident A's wheelchair was forcefully moved by a direct care staff causing Resident A to fall out of the wheelchair and hit her head.**
- **Direct Care Staff yelled and swore at Resident A after falling.**

INVESTIGATION:

On July 12, 2024, a complaint was received with allegations that Resident A fell on two separate occasions on July 10, 2024. The complaint alleged the first fall occurred when Resident A fell out of her wheelchair while attempting to pick something up on the floor. The complaint alleged the second fall was caused by direct care staff member Janice Carter forcefully pushing Resident A causing Resident A to fall out of her wheelchair. The compliant alleged after the second fall, direct care staff members Janice Carter and Michelle Winchell-Baum, treated Resident A improperly by swearing and yelling at Resident A.

On July 16, 2024, I interviewed Tom Hilla, Clinton County Adult Protective Service Specialist (APS) who reported he has an opened investigation. Mr. Hilla reported he has been in contact with Officer Bob Stump from the Dewitt Township Police Department regarding a criminal investigation being completed. Mr. Hilla reported he attempted to interview Resident A but was unsuccessful due to Resident A not being able to provide specific details regarding the falls that occurred on July 10, 2024. Mr. Hilla reported he was informed there was surveillance video of the falls but stated he has not been able to review the video at the time of our interview.

On July 17, 2024, Tom Hilla, Clinton County APS provided me with the contact information of the alleged direct care staff involved in the incidents.

On July 23, 2024, I completed an unannounced onsite investigation and interviewed Cheyanne Rodriguez, direct care staff (DCS) and facility manager. Ms. Rodriguez reported she received a message from Michelle Baum, DCS on July 10, 2024, reporting Resident A had thrown herself out of her wheelchair on two separate occasions. Ms. Rodriguez stated that Hospice and Resident A's family were notified. Ms. Rodriguez reported she came to the facility later in the morning of July 10, 2024, and observed Resident A had a significant bump and bruise on the right side of her forehead, above her right eye. Ms. Rodriguez reported Careline Hospice came to the facility to evaluate Resident A with no further instructions regarding Resident A's care. Ms. Rodriguez reported she received a message from Kerri Wheeler Human Resource Director on July 11, 2024, notifying Ms. Rogriguez of direct care staff, Michelle Baum, Janice White, and Brooklyn Winchell will be terminated immediately due to incidents surrounding Resident A falling on two separate occasions on July 10, 2024, and what Ms. Wheeler observed on the surveillance video. Ms. Rodriguez reported she has since reviewed the surveillance video. Ms. Rodriguez provided copies of two *AFC Licensing Division-Incident/Accident Reports (IR)* completed on July 10, 2024, by staff member Michelle Baum which documented the following:

- 07/10/2024 Date of Incident; Time: 6:20am; Person Involved-[Resident A]; Other Persons involved/witnessed: Michelle Baum and Brooklyn Winchell; Explain what happened: [Resident A] was observed on the floor on her left side, [Resident A] reported she did not hit her head, no visible injuries; Actions taken by staff/treatment: vitals, ROM, called hospice and daughter in law, picked Resident A off of floor; Corrective measures: remind [Resident A] to stay sitting in wheelchair unless someone was there to help.
- 07/10/2024 Date of Incident; Time: 6:30am; Person Involved-[Resident A]; Other Persons involved/witnessed: Michelle Baum, Janice White, and Brooklyn Winchell; Explain what happened: Staff removed [Resident A] from med room, [Resident A] threw herself forward out of her chair, hitting her head first on the floor; Actions taken by staff/treatment: vitals, ROM, called hospice and daughter in law, picked [Resident A] off of floor; Corrective measures: none provided.

On July 23, 2024, I interviewed Kerri Wheeler Human Resource Director who reported on July 11, 2024, she was watching surveillance video due to someone losing their wallet and while watching video observed the two falls Resident A had on July 10, 2024. Ms. Wheeler reported she contacted administration immediately to explain what she observed and then terminated DCS members Michelle Baum, Janice White, and Brooklyn Winchell. During the interview with Ms. Wheeler, I observed the surveillance video dated July 10, 2024, documenting Resident A's falls. Per the surveillance video, at around 6:20am on July 10, 2024, Resident A was sitting in her wheelchair in the hallway by herself when it appeared she bent over in her wheelchair and fell out. This fall did not show Resident A hitting her head. Per the video, Resident A laid on the floor for about five minutes until DCS members Michelle Baum and Brooklyn Winchell were observed walking down the hall towards Resident A when Ms. Baum yelled "oh my god she is on the floor." Per the video, Ms. Winchell was texting on her cell phone and stepped over Resident A while Ms. Baum said to Resident A "did you hit your head?, you have been a pain my ass all night, not sleeping, and trying to get out of your wheelchair." Ms. Baum was observed taking Resident A's vital and while doing so yelled at Resident A three time to "stop moving" with one time swatting at Resident A's arm. Ms. Baum and Ms. Winchell assisted Resident A back into her wheelchair and attached the personal alarm to the back of Resident A's pajama shirt. About 10 minutes later DCS Janice White arrived to her shift, saw Resident A sitting in her wheelchair by the medication room, and said to Resident A, "you cannot go in there" to which Resident A said, "watch me" and attempted to enter the medication room. The video documented Ms. White as she yelled, "I told you, you cannot go in the medication room." Per my observation of the video, Resident A told Ms. White to "shut up" and Ms. White said to Resident A, "no you shut up." Per the video, Ms. White got behind Resident A, grabbed the handles of the wheelchair and forcefully moved Resident A away from the medication room causing Resident A to fall out of her wheelchair landing on her head. Ms. Baum was heard on the surveillance video saying, "now you fucking did it, now you

fucking hit your head." Per the video, Ms. White said to Ms. Baum, "did you see that, did you see that, [Resident A] just threw herself out of her chair." Per the video, Ms. White said, "now what do we do with her?" Per my observation of the video, Ms. White attempted to pick Resident A up from the floor but was then aided from Ms. Baum and Ms. Winchell. Per the surveillance video Resident A's vitals were not taken nor was Resident A checked for additional injuries by direct care staff. Ms. Winchell was observed saying, "wow she has big bump on her head" while laughing.

On July 23, 2024, I interviewed Resident A who had a large bruise above her right eye. Resident A reported she got the bruise because she fell. Resident A reported she does not remember when she fell or how she fell. Resident A reported she does not think staff helped her up. Resident A reported she does not remember if any direct care staff swore at her.

On July 24, 2024, Tom Hilla, Clinton County APS and I interviewed DCS Janice White. Upon interview I explained to Ms. White I had observed the falls through the facility surveillance cameras. Ms. White reported she worked first shift 6:30am-6:30pm on July 10, 2024. Ms. White reported upon arriving to her shift Resident A was sitting in her wheelchair heading towards the medication room. Ms. White reported she told Resident A she could not go into the medication room and stepped between Resident A's wheelchair and the doorway of the medication room. Ms. White reported she grabbed the handle of Resident A's wheelchair, started to move the wheelchair away from the door of the medication room when Resident A threw herself out of the wheelchair. Ms. White reported she did not move the wheelchair with force causing Resident A to fall out of the wheelchair. Ms. White denied yelling or telling Resident A to 'shut up.' Ms. White reported she is not aware of a fall protocol for when residents fall. Ms. White reported no additional care was provided to Resident A. Ms. White stated, "I believe later in the morning Careline Hospice came to evaluate [Resident A].

On July 24, 2024, Tom Hilla, Clinton County APS and I interviewed DCS Michelle Baum. Ms. Baum reported she started her shift at 6:30pm on July 09, 2024, and around 6:20am on July 10, 2024, was Resident A's first fall. Ms. Baum reported DCS Brooklyn Winchell needed assistance in another resident's room while Ms. Baum was assisting Ms. Winchell and when they came out into the hallway they saw Resident A lying on the floor. Ms. Baum reported Resident A has a chair/personal alarm that attaches to Resident A's clothing so if she tries to standup the alarm will sound. Ms. Baum reported the clip was attached to Resident A's shirt, but the magnet was attached to the string, so the alarm did not sound. Ms. Baum reported she asked Resident A if she was hurt or if she hit her head and Resident A replied "no." Ms. Baum reported she took Resident A's vitals, moved her back to her wheelchair, and called the home manager, hospice, and family. Ms. Baum reported she reattached the alarm to Resident A's pajamas after placing Resident A back in her wheelchair. Ms. Baum denied saying, "you are a pain in my ass" to Resident A. Ms. Baum reported she treats the residents like family and if she did say Resident A was a "pain in her ass" it was meant to be in a joking matter, not out of anger. Ms. Baum reported she was doing her documentation when Resident A fell the second time. Ms. Baum denied saying, "you fucking did it this

time, you fucking hit your head this time." Ms. Baum reported she assisted Ms. White and Ms. Winchell with getting Resident A back into her wheelchair.

On July 24, 2024, Tom Hilla, Clinton County APS and I left a message for Brooklyn Winchell requesting a call back and no call back was received.

On July 24, 2024, Tom Hilla, Clinton County APS reported he spoke with Officer Stump from Dewitt Township Police Department who reported their report has been completed and has been sent to the prosecutor for charges.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the evidence provided by the surveillance video at the facility, Resident A was not treated with dignity nor provided protection and safety by direct care staff (DCS) Michelle Baum, Janice White, and Brooklyn Winchell. On July 10, 2024, Resident A fell from her wheelchair on two separate occasions. The first incident involved DCS Michelle Baum finding Resident A on the floor and using vulgar language when talking to Resident A. Then while DCS Baum was taking Resident A's vitals, she yelled at Resident A three times to stop moving and then swatted Resident A's arm. During the second incident, DCS Janice White told Resident A to shut up, then forcefully moved Resident A's wheelchair away from the medication room causing Resident A to fall out of her wheelchair and hit her head. DCS Michelle Baum then yelled obscenities at Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On July 26, 2024, an exit conference was completed via telephone with Administrator Cheri Lynn Weaver due to licensee designee Achal Patel being unavailable. Ms. Weaver was informed of the findings and recommendation. Ms. Weaver acknowledged the wrong doings of the direct care staff members and reported those direct care staff members were terminated immediately after watching the surveillance video.

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, it is recommended that the current status of the license remains unchanged.

Bridget Vermeesch

07/30/2024

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 07/30/2024

_____

Dawn N. Timm Date
Area Manager