GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 2, 2025

Achal Patel
Divine Life Assisted Living of Dewitt 3 Inc.
2045 Birch Bluff Dr
Okemos, MI 48864

RE: License #: AL190418056
Investigation #: 2025A0577034
Divine Life Assisted Living of Dewitt 3

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) 335-5985.

Sincerely,

Bridget Vermeesch

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

I. IDENTIFYING INFORMATION

License #:	AL190418056
Investigation #:	2025A0577034
Complaint Receipt Date:	04/21/2025
Investigation Initiation Date:	04/22/2025
Report Due Date:	06/20/2025
Licensee Name:	Divine Life Assisted Living of Dewitt 3 Inc.
Licensee Address:	2045 Birch Bluff Dr Okemos, MI 48864
Licensee Telephone #:	(517) 898-2431
Administrator:	Cheri Weaver
Licensee Designee:	Achal Patel
Name of Facility:	Divine Life Assisted Living of Dewitt 3
Facility Address:	STE 3 1177 SOLON RD DEWITT, MI 48820
Facility Telephone #:	(517) 484-6980
Original Issuance Date:	06/03/2024
License **Status:**	REGULAR
Effective Date:	12/02/2024
Expiration Date:	12/01/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A fell out of bed due to the facility not using the bedrails.	No
Additional findings.	Yes

III. METHODOLOGY

04/21/2025	Special Investigation Intake 2025A0577034
04/22/2025	Special Investigation Initiated – Telephone call made. Interview with Complainant.
04/22/2025	Inspection Completed On-site- Interview with staff, Resident A, and reviewed resident record.
04/24/2025	Contact - Telephone call made to Cheri Weaver, Administrator.
05/01/2025	Inspection Completed-BCAL Sub. Compliance
05/01/2025	Exit Conference with licensee designee Achel Patel.

ALLEGATION: Resident A fell out of bed due to the facility not using the bedrails.

INVESTIGATION:

On April 21, 2025, a complaint was received with allegations of Resident A falling out of bed due to bed rails not being used. The complaint also referenced concerns that Resident A's medical information was not able to be printed for emergency medical staff. There is no administrative rule requirement for the licensee to print resident medical information to emergency medical staff.

On April 22, 2025, I completed an unannounced onsite investigation and interviewed Resident A who reported she does have a bed rail used as a grab bar. Resident A reported the bar does not move because it is screwed into the box spring. Resident A further noted that the grab bar is not adjustable in height. Resident A reported the grab bar was in place when Resident A fell out of bed. Resident A reported this is the first time she has fallen out of bed. Resident A reported she usually sleeps in the middle of her mattress and does not move very much, but for some reason Resident A was put in bed on the side of her mattress instead of the middle. Resident A reported she did not give much thought to her placement on the mattress until after she fell out. Resident A denied that she fell out of bed due to the bedrails/grab bar not being used appropriately.

During the onsite investigation I observed Resident A's bed to be a full-size bed with a bedrail/grab bar screwed into the box frame of the mattress near the top of the mattress. The bedrail/grab bar is not adjustable in height and cannot be removed unless it is unscrewed from the box springs.

On April 22, 2025, I interviewed Nakisha Walker, Executive Director who reported she was not at the facility when Resident A fell out of her bed. Ms. Walker provided me with a copy of the *AFC Licensing Division-Incident/Accident Report* (IR) completed by direct care staff member Regina Houghtaling on April 19, 2025, at 5AM: In the "Explain What Happened" section of the IR it documented, "I was passing meds and heard [Resident A] yell out. I went to her room and found her on the floor. [Resident A] said she hit her left arm. I made sure [Resident A] did not hit her head, called managers and 911." According to the "Corrective Measure" noted: "Request a hospital bed for [Resident A]." Ms. Walker reported the bed is Resident A's personal bed and the bed rail/grab bar were attached as described above when Resident A admitted to the facility. Ms. Walker reviewed Resident A's physician orders and did not see an order for the bedrail/grab bar.

APPLICABLE RULE	
R 400.15305	**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 information gathered during the investigation, Resident A did fall out of bed on April 19, 2025. Resident A denied that the fall occurred because the bedrails/grab bar were not being used rather Resident A stated she fell out of bed due to rolling out of bed. There was no evidence found to support Resident A was not provided with protection and safety.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

During the onsite investigation on April 22, 2025, I observed a bedrail/grab bar screwed into the box spring of Resident A's bed, but no physician order could be provided by the facility Executive Director Nakisha Walker.

On April 24, 2025, I spoke with Cheri Weaver, Administrator, who provided me with a copy of Resident A's *Assessment Plan for AFC Residents*. Per Resident A's *Assessment Plan for AFC Residents*, under section "Health Care Assessment-Special

Equipment Used" and under section "Self-Care Skill Assessment-Assistive Devices" no documentation was found regarding Resident A's utilizing a bedrail/grab bar.

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee. **(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.**
ANALYSIS:	Resident A has a bedrail/grab bar screwed into her bed but did not have a physician order for the use of bedrail/grab bar, nor does Resident A's *Assessment Plan for AFC Residents* specify the need or agreed upon use of the bedrail/grab bar.
CONCLUSION:	**VIOLATION ESTABLISHED**

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

05/02/2025

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm

05/02/2025

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Dawn N. Timm Date
Area Manager