GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 23, 2025

Achal Patel
Divine Life Assisted Living Center 5 LLC
865 S Cedar St
Mason, MI 48858-2001

RE: License #: AL230404954
Investigation #: 2025A0577041
Divine Life Assisted Living Center 5 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 #:	AL230404954
Investigation #:	2025A0577041
Complaint Receipt Date:	05/23/2025
Investigation Initiation Date:	05/27/2025
Report Due Date:	07/22/2025
Licensee Name:	Divine Life Assisted Living Center 5 LLC
Licensee Address:	100 865 S Cedar St Mason, MI 48858-2001
Licensee Telephone #:	(517) 708-8745
Administrator:	Cheri Weaver
Licensee Designee:	Achal Patel
Name of Facility:	Divine Life Assisted Living Center 5 LLC
Facility Address:	1020 Eastbury Drive Lansing, MI 48917
Facility Telephone #:	(517) 708-8745
Original Issuance Date:	11/20/2020
License Status:	REGULAR
Effective Date:	05/20/2025
Expiration Date:	05/19/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On May 15, 2025, Resident A eloped from the facility and was not supervised by a direct care staff.	Yes

III. METHODOLOGY

05/23/2025	Special Investigation Intake 2025A0577041
05/23/2025	Contact - Document Received- Jana Lipps, AFC Consultant.
05/27/2025	Special Investigation Initiated – Letter- Email to Complainant, requesting information.
06/09/2025	Inspection Completed On-site- Interview with Resident A and reviewed file.
06/10/2025	Contact - Document Sent- Email to Samantha Gardner, HM requesting information.
06/10/2025	Contact - Document Received- Email from Samantha Gardner.
06/12/2025	Contact - Telephone call made- Interview with Guardian A1.
06/16/2025	Inspection Completed-BCAL Sub. Compliance
06/16/2025	Contact - Telephone call made- Interviews with DCS.
06/18/2025	Exit Conference with licensee designee Achel Patel.

ALLEGATION: On May 15, 2025, Resident A eloped from the facility and was not supervised by a direct care staff.

INVESTIGATION:

On May 23, 2025, a complaint was received alleging that Resident A eloped from the facility around dinner time due to the door alarm system not working. The complaint reported Resident A was found by police and taken to the hospital for evaluation. The complaint reported information received from facility direct care staff members Zize Gashi and Cheri Weaver was contradictory to the information received from the U of M Sparrow Hospital.

On May 23, 2025, Jana Lipps, Adult Foster Care Licensing Consultant reported she completed a Renewal Onsite Inspection on May 02, 2025, and during this time the door alarm system was working per her observation.

On May 27, 2025, via email I contacted Complainant and requested an interview. On May 27, 2025, I interviewed Complainant who reported that on May 20, 2025, Complainant received information from Administrator Cheri Weaver that the locking mechanism and door alarm were not functioning properly on May 14, 2025, but the system and mechanism were fixed on the afternoon of May 15, 2025. Complainant reported she was advised by Ms. Weaver that direct care staff were instructed to complete checks on residents every 30 minutes until the door alarm system could be fixed. Complainant reported Ms. Weaver stated Resident A eloped from the facility around 6:30pm on May 15, 2025. Complainant reported Ms. Weaver stated it had been approximately 30 minutes before direct care staff realized Resident A was missing and began looking for Resident A. Complainant reported Ms. Weaver stated direct care staff started checking the entire facility, and before they finished inspecting the rooms, first responders knocked on the door to return Resident A to the facility. Complainant reported Ms. Weaver stated the company arrived to fix the door about the same time as Resident A's return to the facility. Complainant reported they were advised by Ms. Weaver to purchase window and door safety alarms to keep on hand and use if the issue were to reoccur in the future.

On May 27, 2025, via email, Complainant provided me with a copy of the *AFC Licensing Division-Incident/Accident Report* (IR) Complainant received on May 20, 2025. The IR documented the following information: "On May 15, 2025, at 6:30pm reporting while staff helped with others, someone from Building 4 says they got a call about a missing resident and to call 911. Before staff could call 911, the EMT's arrived telling us he was down the street and looked exhausted and that they will be taking him to the hospital." The IR reported corrective measures taken were fixing the lock on the door and that direct care staff will pay closer attention to the door and residents. The IR documented Taquelea Watkins, Adrianna Larkins, Jemima Milien were the direct care staff working when the elopement happened. Complainant also provided me with a copy of Resident A's Admission, Discharge, Transfer (ADT) services from U of M Sparrow Hospital, documenting Resident A was admitted to the Emergency Department on May 15, 2025, at 6:52pm and was discharged on May 16, 2025, at 11:22am, after being kept overnight for observations and fluids.

On June 09, 2025, I completed an unannounced onsite investigation and interviewed Resident A who reported he remembers leaving the facility without a direct care staff due to being upset. Resident A reported he told direct care staff he was leaving but they were not in the room when he left. Resident A reported the door was not locked nor was the alarm working. Resident A reported he cannot remember the specific date this occurred or the length of time he was away from the facility. Resident A reported he was picked up by an ambulance, brought back to the facility and taken to the hospital. Resident A reported stated, "I am not sure how long I was gone for."

On June 09, 2025, I emailed Home Manager Samantha Gardner requesting a copy of Resident A's *Assessment Plan for AFC Residents* which was provided via email on June 10, 2025. Per Resident A's *Assessment Plan for AFC Residents* under section Social/Behavior Assessment: Moves Independently In Community, marked no, with documentation of "Requires maximum assistance in community." Ms. Gardner reported via email that Resident A's elopement took place after she had already left for the day. Ms. Gardner reported direct care staff did notify Ms. Gardner right away when they noticed Resident A was missing. Ms. Gardner reported the door locking mechanism and alarm stopped working on May 14, 2025, and was fixed late afternoon on May 15, 2025.

On June 12, 2025, I interviewed Missy Peterson, Community Liaison, for Guardian A1 who reported their office did not receive a copy of the IR regarding Resident A eloping. Ms. Peterson reported their office was notified on May 15, 2025, of Resident A eloping by U of M-Sparrow Hospital, calling to receive permission to treat Resident A.

On June 16, 2025, I left a message for DCS Adrianna Larkins and Taquelea Watkins requesting a return call with no return call.

On June 16, 2025, I interviewed DCS Jemima Milien who reported she was working the evening of May 15, 2025, and the door alarm was not working when she arrived at work. DCS Milien reported she is not sure when the door alarm was fixed, she did not notice any company at the facility to fix the door alarm system. DCS Milien reported she did not realize Resident A eloped during her shift until another direct care staff notified DCS Milien that Resident A had eloped. DCS Milien reported she did not provide any care to Resident A during her shift on May 15, 2025, and was not aware of completing 30 minutes checks on residents.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Resident A's *Assessment Plan for AFC Residents* under section Social/Behavior Assessment Moves Independently In Community it documented that Resident A, "Requires maximum assistance in community." It has been found, on May 15, 2025, per the IR and interview with Resident A, that Resident A eloped from the facility without the knowledge of direct care staff. It has been determined the licensee did not provide supervision and protection to Resident A as specified in the resident's written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, I recommend continuation of the current status of the license of this AFC adult large group home.

Bridget Vermeesch

06/23/2025

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm

06/23/2025

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Dawn N. Timm Date
Area Manager