GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 6, 2025

Achal Patel
Divine Life Assisted Living Center 1, LLC
2045 Birch Bluff Drive
OKEMOS, MI 48864

RE: License #: AM190404916
Investigation #: 2025A0577038
Divine Life Assisted Living Center 1 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 (517) 335-5985.

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

I. IDENTIFYING INFORMATION

License #:	AM190404916
Investigation #:	2025A0577038
Complaint Receipt Date:	05/13/2025
Investigation Initiation Date:	05/13/2025
Report Due Date:	07/12/2025
Licensee Name:	Divine Life Assisted Living Center 1, LLC
Licensee Address:	607 Turner Street DeWitt, MI 48820
Licensee Telephone #:	(517) 277-0544
Administrator:	Cheri Weaver
Licensee Designee:	Achal Patel
Name of Facility:	Divine Life Assisted Living Center 1 LLC
Facility Address:	607 Turner Street DeWitt, MI 48820
Facility Telephone #:	(517) 277-0544
Original Issuance Date:	11/18/2020
License Status:	REGULAR
Effective Date:	04/18/2024
Expiration Date:	04/17/2026
Capacity:	11
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not administered medications as prescribed due to the medication not being available for direct care staff to administer.	Yes

III. METHODOLOGY

05/13/2025	Special Investigation Intake 2025A0577038
05/13/2025	APS Referral
05/13/2025	Special Investigation Initiated – Telephone call to Tom Hilla, Clinton Co APS.
05/21/2025	Inspection Completed On-site
05/22/2025	Inspection Completed-BCAL Sub. Compliance
05/22/2025	Contact - Document Sent- Email to Courtney Hammill, DON.
05/22/2025	Contact - Document Received- Documents received via email.
05/23/2025	Exit Conference with licensee designee Achel Patel.

ALLEGATION: Resident A was not administered medications as prescribed due to medication not being available for direct care staff to administer.

INVESTIGATION:

On May 13, 2025, a complaint was received alleging that on May 11, 2025, Resident A was transported to the hospital due to hypertension. The complaint reported that Emergency Medical Services (EMS) requested to see Resident A's medication for hypertension but the mediation bottle provided was empty despite having nine refills remaining.

On May 13, 2025, I spoke with Tom Hilla, Clinton County Adult Protective Services (APS) who reported he found evidence of neglect and will be substantiating.

On May 22, 2025, I completed an unannounced onsite investigation and reviewed Resident A's *AFC Licensing Division-Incident/Accident Reports* (IR) dated May 11,

2025, and completed by direct care staff (DCS) Janaya McKinney. The IR documented the following, “I took [Resident A’s] blood pressure, and it was high, I went to grab the PRN and the bottle was empty. I waited five minutes and took it again and it was still registering high. I called the manager, who advised I call on-call nurse, who advised to take [Resident A’s] blood pressure in the other arm, and it was still registering high. On-call nurse advised I send [Resident A] to the hospital. I called for an ambulance and [Resident A] was taken to hospital.”

I also received and reviewed Resident A’s Medication Administration Record (MAR), Resident A’s *Vital Sign Log-Vital BP* (blood pressure) from May 01, 2025, through May 21, 2025, and Resident A’s physician order for blood pressure medication Hydralazine. Per Resident A’s physician order written on June 17, 2024, Resident A was prescribed “to start Hydralazine 10mg tablet; take 1 tablet oral three times a day as needed, check pt's BP three times daily and administer Hydralazine for blood pressure higher than 160/90.” Upon review of Resident A’s *Vital Sign Log- Vital BP*, Resident A’s blood pressure is taken at 10:00am, 2:00pm, and 8:00pm. Per Resident A’s blood pressure log, Resident A’s blood pressure was taken, registering above 160/90 on the following dates and times:

Date	Time	Blood Pressure	Hydralazine Administered
May 01, 2025	10:18am	203/71	Yes
May 06, 2025	9:15pm	175/81	Yes
May 07, 2025	8:49pm	175/80	Yes
May 08, 2025	8:40pm	173/66	Yes
May 13, 2025	8:40pm	176/87	Yes
May 14, 2025	8:52pm	165/70	Yes
May 15, 2025	8:15pm	191/77	No
May 17, 2025	10:06am 9:20pm	199/84 180/80	Medication marked as administered with staff initials on May 17, 2025, but time of administration is unknown per MAR.
May 20, 2025	9:07am 9:06pm	163/75 172/75	Medication was administered on May 20, 2025, with MAR marked at 2X, time and signature of staff who administered is unknown per MAR.

Per Resident A’s MAR, Hydralazine was not administered on May 15, 2025, when blood pressure was taken at 8:15pm and registered 191/77 which was higher than 160/90 per

the physician instructions. Resident A's *Vital Sign Log- Vital BP* documented Resident A's blood pressure was taken on May 17, 2025, at 10:06am, registering at 199/84, and then taken again at 9:20pm, registering a blood pressure of 180/60. However, Resident A's MAR reflected direct care staff member with the initials JH administered the medication but no times were listed. On May 20, 2025, per Resident A's *Vital Sign Log- Vital BP*, Resident A's blood pressure was taken at 9:57am and registered as 163/76 and then taken again at 9:06pm, registering at 172/75 with Resident A's MAR marked with '2X' with no explanation of '2X", no initials of direct care staff, or time of Hydralazine being administered if administered.

During the onsite investigation, I interviewed DCS Jayana McKinney who reported Resident A's blood pressure is prescribed to be taken three times a day and if it is high, DCS McKinney stated, "parameters unknown off hand" Hydralazine is supposed to be administered at that time. DCS McKinney reported on May 11, 2025, Resident A's blood pressure had been running high. DCS McKinney could not recall the exact blood pressure readings but stated these were documented on Resident A's blood pressure log. DCS McKinney reported she went to administer Resident A's Hydralazine but could not because the bottle was empty. DCS McKinney reported she contacted management and then the on-call nurse for specific instructions. DCS McKinney reported Resident A was sent to the hospital due to high blood pressure readings and not being able to administer Resident A's Hydralazine because it was not available in the facility to be administered.

On May 22, 2025, I interviewed Director of Nursing (DON), Kortney Hammill who reported Resident A is prescribed Hydralazine to be administered as needed, PRN. Ms. Hammill stated, "it is my understanding, per a licensing consultant, name unknown, we are not required to have PRN medications in the facility at all times, we are able to order them as needed and have a certain time range for them to be delivered." Consultation was provided to Ms. Hammill that all medications prescribed must be in the facility at all times to be administered immediately when needed. Ms. Hammill reported she received a call from DCS Jayana McKinney on May 11, 2025, reporting Resident A's blood pressure had been taken multiple times and is registering over the physician ordered limits. Ms. Hammill reported she advised DCS McKinney to take Resident A's blood pressure in the other arm and it still had a high reading. Ms. Hammill reported DCS McKinney reported she is not able to administer Resident A's Hydralazine due to the medication not being available. Ms. Hammill reported she advised DCS McKinney to send Resident A to the hospital.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Per Resident A's physician order, written on June 17, 2024, Resident A was prescribed to start Hydralazine 10mg tablet; "Take 1 tablet oral three times a day as needed, check pt's BP three times daily and administer Hydralazine for BP higher than 160/90." Resident A's Hydralazine medication was not administered per the label instructions, specifically on March 11, 2025, causing Resident A to be taken to the hospital due to continued high blood pressure readings that could not be addressed with medication since Resident A's Hydralazine medication was not available in the facility. This same issue occurred on March 15, 2025, when Resident A's blood pressure registered 191/77 and Hydralazine was not in the facility to be administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of mediation by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual mediation log that contains all of the following information:** **(iv)Time to be administered** **(v) The initials of the person who administers the mediations, which shall be entered at the time the medication is given.**
ANALYSIS:	Per Resident A's MAR, Hydralazine is marked with initials of JH on March 17, 2025, as being administered, but Resident A's MAR did not reflect the time this PRN medication was administered. Resident A's MAR also documented a "2X" on March 20, 2025, under Hydralazine, but there were no staff initials, explanation of "2X", or a time the medication was administered. Consequently, Resident A's MAR did not reflect the time nor the initials of the staff who administered Resident A's Hydralazine PRN medication on March 17 and March 20, 2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference completed on May 23, 2025, with Achel Patel, Licensee Designee via email. Mr. Patel responded via email, stating, "I am adding the responsible

team members to this email so they can respond." Mr. Patel reported he has no known knowledge of the Special Investigation and deferred to Administrator Cheri Weaver.

IV. RECOMMENDATION

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

Bridget Vermeesch

06/06/2025

_____

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 06/06/2025

_____

Dawn N. Timm Date
Area Manager