GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 21, 2025

Achal Patel
Divine Nest Assisted Living, LLC
2045 Birch Bluff Dr
Okemos, MI 48864

RE: License #: AL330387563
Investigation #: 2025A0577048
Divine Nest Assisted Living, 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

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 #:	AL330387563
Investigation #:	2025A0577048
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/08/2025
Report Due Date:	09/05/2025
Licensee Name:	Divine Nest Assisted Living, LLC
Licensee Address:	4887 Hull Road Leslie, MI 49251
Licensee Telephone #:	(517) 878-6111
Administrator:	Cheri Weaver
Licensee Designee:	Achal Patel
Name of Facility:	Divine Nest Assisted Living, LLC
Facility Address:	4887 Hull Road Leslie, MI 49251
Facility Telephone #:	(517) 878-6111
Original Issuance Date:	09/18/2018
License Status:	REGULAR
Effective Date:	03/18/2025
Expiration Date:	03/17/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A fell due to direct care staff Nina Yergler not using the Hoyer lift when transferring Resident A.	No
The facility has frequent food shortages and cannot make the meals as planned on the menu.	No
Additional Findings	Yes

III. METHODOLOGY

07/07/2025	Special Investigation Intake 2025A0577048
07/08/2025	Special Investigation Initiated – Telephone call made to Jana Lipps, AFC Consultant.
07/28/2025	Inspection Completed On-site
07/28/2025	Contact - Telephone call made- Interview with Witness 1.
08/08/2025	Contact - Telephone call made- Optimal Home Care and Hospice.
08/12/2025	Contact - Telephone call made- Interview with Witness 2.
08/13/2025	Contact - Telephone call made to Guardian A1.
08/15/2025	Exit Conference with licensee designee Achel Patel.
08/15/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A fell due to direct care staff Nina Yergler not using the Hoyer lift when transferring Resident A.

INVESTIGATION:

On July 07, 2025, a complaint was received alleging that Resident A dislocated her shoulder due to direct care staff (DCS) Nina Yergler dropping Resident A while attempting to manually lift Resident A instead of using the Hoyer lift as required for transferring Resident A.

On July 08, 2025, Janna Lipps, Adult Foster Care Licensing Consultant reported she was not aware of Resident A's falls or injuries. Ms. Lipps reported she was last at the facility in March 2025 to complete the renewal inspection.

On July 28, 2025, I completed an unannounced onsite investigation and interviewed DCS Nina Yergler, whose role is Home Manger (HM), and she reported that Resident A has fallen twice in the last six months, once on May 06, 2025, and again on July 18, 2025. DCS Yergler reported AFC Licensing Division-Incident/Accident Reports (IR) were completed and a copy provided.
The IR's provided documented, in part, the following information:

- IR dated May 06, 2025, at 4:50am. "Persons Involved: DSC Valerie Lundy, Shawne Bannerman, and [Resident A]. What Happened: Valerie Lundy walked by [Resident A's] room to complete a check and [Resident A] was fine. DCS Lundy assisted another resident, came back by [Resident A's] bedroom and [Resident A] was on the floor. [Resident A] smacked her face-nose, shoulder and elbow. [Resident A's] vitals were taken, assisted [Resident A] back into bed." IR documented that Optimal Home Care and Hospice and POA were contacted.
- IR dated July 18,2025 at 4:45pm. "Persons Involved: DCS Nina Yergler, Shea Johnson, Shawne Bannerman, and [Resident A]. What Happened: [Resident A's] chair alarm went off, [Resident A] was found face down on floor, stated she was reaching for something on the floor and fell out of her chair. [Resident A] was lifted with gait belt off of the floor, skin check done, gash on nose and lip bleeding, right hand bruised." The IR documented Optimal Home Care and Hospice was called and Resident A was evaluated.

Ms. Yergler reported the incident that occurred on July 18, 2025, that she heard Resident A's chair alarm going off and went to Resident A's bedroom to see why and found Resident A lying on the floor. Ms. Yergler reported DCS Shawn Bannerman came into the room and assisted Ms. Yergler with the use of a gait belt to transfer Resident A to her bed. Ms. Yergler denied that she assisted Resident A with transferring by herself and denied that she dropped Resident A. Ms. Yergler reported she was not working the night Resident A fell in May 2025. Ms. Yergler reported she is not aware of any other falls Resident A has had other than the two in which IRs were completed.

During the onsite investigation I interviewed DCS Shawn Bannerman who reported she worked both days, on May 06, 2025, and July 18, 2025, when Resident A fell. DCS Bannerman reported neither herself nor her coworker assisted Resident A with a transfer by themselves and dropped Resident A. DCS Bannerman reported Optimal Home Care and Hospice was contacted on both occasions and Resident A was evaluated by their medical team with no concerns noted. DCS Bannerman reported Resident A forgets she cannot walk and attempts to stand up and walk from her bed or her wheelchair and falls. DCS Bannerman reported Resident A is supposed to be transferred with a Hoyer lift or assistance from two direct care staff. DCS Bannerman reported she is unaware of Resident A being transferred independently by DCS Yergler. DCS Bannerman reported DCS Yergler found Resident A on her bedroom floor on July 18, 2025, and called for assistance from other direct care staff to assist Resident A into bed to complete an evaluation.

On July 28, 2025, I interviewed DCS Valerie Lundy who reported she was working on May 06, 2025, and was the direct care staff who found Resident A lying on the floor of

her room. DCS Lundy reported DCS Yergler was not working during that fall. DCS Lundy reported she called for assistance and DCS Shawne Bannerman assisted with evaluating Resident A and getting Resident A back into bed. DCS Lundy reported Optimal Home Care and Hospice was called and Resident A was evaluated with no concerns. DCS Lundy denied that either she or any direct care transferred Resident A by themselves and/or dropped Resident A.

On August 08, 2025, I interviewed Brittany Maples, Clinical Coordinator with Optimal Home Care and Hospice, who reported not being aware that Resident A fell out of bed or if a direct care staff transferred Resident A independently and dropped Resident A causing injury. Ms. Maples reported Resident A was observed by Optimal Home Care and Hospice staff on two occasions, May 06, 2025, and July 18, 2025, due to Resident A sitting in her wheelchair and reaching to pick something up on the floor and falling out of wheelchair. Ms. Maples reported due to Resident A's dementia, Resident A forgets she is not able to walk or not able to judge how far something is out of reach, and falls out of her wheelchair. Ms. Maples reported Resident A has a chair alarm but is often in her room and when the alarm goes off, Resident A is usually out of her chair. Ms. Maples reported Optimal Home Care and Hospice does not have any concerns regarding the care of Resident A.

On August 13, 2025, I interviewed Guardian A1who reported Resident A is having frequent falls due Resident A reaching for items on the floor or out of reach and falling out of her wheelchair. Guardian A1 reported she does not believe DCS Nina Yergler assisted Resident A by herself due to Resident A being non-weight baring.

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 had two falls on May 06 and July 18, 2025, and both falls occurred after Resident A tried to grab something from the floor while sitting in her wheelchair resulting in Resident A falling out of her wheelchair. Based on the information gathered during the investigation, there was no evidence to support the allegation that Resident A fell due to direct care staff Nina Yergler transferred Resident A by herself and did not use the Hoyer Lift as prescribed for transfers.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility has frequent food shortages and cannot make the meals as planned on the menu.

INVESTIGATION:

On July 07, 2025, a complaint was received alleging the facility runs out of food during the weekends and direct care staff must provide food for residents. The complaint reported there were 10 hot dogs to feed 20 residents over the weekend.

On July 08, 2025, I spoke with Jana Lipps, Adult Foster Care Licensing Consultant, who reported these allegations have been brought to her attention. Ms. Lipps reported there are concerns about the facility not having the food as documented on the menus.

During the onsite investigation on July 28, 2025, I observed the lunch meal of chicken nuggets, macaroni and cheese, and french fries. I observed residents being served six chicken nuggets, a large serving of macaroni and cheese and french fries.

On July 28, 2025, I interviewed DCS Nina Yergler who reported she creates menus and does shopping every two weeks. DCS Yergler reported the facility often is not able to make meals on the menus or runs out of food items needed to make a meal due to direct care staff making meals the direct care staff want to make, using the ingredients for other menu items, instead of following the menu created. DCS Yergler reported there is always food in the facility to make something.

On July 28, 2025, I interviewed DCS Valerie Lundy, Shawne Bannerman, and Katie Anderson who all reported there is always food in the facility but often there is not enough of a specific item to serve the 20 residents, so additional items need to be made. DCS Lundy, DCS Bannerman, and DCS Anderson reported there was a day when there were not enough hot dogs to serve one to all residents so other options were provided.

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:	Based on the information gathered during the investigation, there was not enough evidence to find that three regular meals daily were not provided.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite investigation on July 28, 2025, I observed and received copies of the menus for July 27- August 09, 2025. Per the menu, on July 28, 2025, for lunch the residents were supposed to be served chicken salad with breadstick, coffee, juice, and milk but were observed eating chicken nuggets, macaroni and cheese, and french fries. Per my observation some of the chicken nuggets were burned and of poor quality. The menu also documented that for dinner on July 28, 2025, BBQ meatballs, mashed potatoes, green beans, ice cream, juice, coffee, and milk were scheduled to be served but during my investigation there were no meatballs, potatoes, or instant potatoes available to make dinner. The only items I observed in the facility to make dinner were canned green beans and ice cream.

On July 28, 2025, I interviewed DCS Katie Anderson, DCS Valerie Lundy, and DCS Shawne Bannerman who all reported not having the items needed to make documented meals from the menu for lunch and dinner on July 28, 2025. DCS Anderson reported substitutions will be documented for both lunch and dinner for July 25, 2025.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	Based upon my investigation, which consisted of interviews as well as observations made during an unannounced investigation on July 28, 2025, and a review of pertinent documentation relevant to this investigation, the meal served to residents for lunch on July 28, 2025, did not match the meal documented on the menu. The facility also did not have the meatballs or items to make mashed potatoes for the documented dinner and was going to be substituted out for something different. These changes or substitutions to the original menu were not documented.
CONCLUSION:	**VIOLATION ESTABLISHED**

During the Exit Conference completed on August 15, 2025, with Licensee Designee Achel Patel and Administrator Cheri Weaver, consultation was provided regarding quantity of food being served, the nutritious value of the meals being served, the discussion of adding more fruits and vegetables, less canned and processed foods, and following of the menus as written.

IV. RECOMMENDATION

Upon receipt of an acceptable corrections action plan, I recommend the continuation of the current status of the license.

08/21/2025

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

08/21/2025

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Dawn N. Timm Date
Area Manager