GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 22, 2025

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

RE: License #: AL190418056
Investigation #: 2025A0577062
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 #:	2025A0577062
Complaint Receipt Date:	09/16/2025
Investigation Initiation Date:	09/17/2025
Report Due Date:	11/15/2025
Licensee Name:	Divine Life Assisted Living of Dewitt 3 Inc.
LicenseeAddress:	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 AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
	Yes - No
Resident A is not being checked and changed every two hours as required per her assessment plan due to the facility being short staffed.	Yes
Resident A is being yelled and being treated disrespectful by direct care staff.	No
Residents do not have access to direct care staff when they need assistance due to the emergency call system not working.	Yes

III. METHODOLOGY

09/16/2025	Special Investigation Intake-2025A0577062
09/17/2025	Special Investigation Initiated – Telephone, Interview with Resident A.
09/17/2025	Contact - Telephone call made, Interview with Theresa Moore, TCOA.
09/17/2025	Contact - Document Received, Email from Theresa Moore, TCOA.
09/17/2025	Contact - Document Received, Documents Via email from Kortney Hamill, DON.
09/22/2025	APS Referral-Tom Hills, Clinton County APS.
09/24/2025	Contact - Telephone call made, Interview with Relative A1.
10/03/2025	Inspection Completed On-site
10/06/2025	Contact - Telephone call made, Interview with DCS.
10/06/2025	Contact - Telephone call made Left Message with DCS, request a return call with no return call.
10/07/2025	Contact - Document Received, Theresa Moore, SW with TCOA via email send PCP.

10/15/2025	Contact-Document Received, via email from Camie Fisher, Home Manger, Assessment Plans for residents.
10/16/2025	Contact - Telephone call made, Interview with DCS.
10/16/2025	Inspection Completed-BCAL Sub. Compliance
10/16/2025	Exit Conference, Achel Patel, LD.

ALLEGATION: Resident A is not being checked and changed every two hours as required per her assessment plan due to the facility being short staffed.

INVESTIGATION:

On September 16, 2025, a complaint was received alleging that Resident A's adult incontinence brief was not being checked and changed every two hours as required, instead her brief was being checked and changed every four to six hours. The complaint stated that Resident A requires assistance from two direct care staff via a Hoyer lift due to being paraplegic. The complaint stated the facility is short staffed and cannot meet resident needs.

On September 17, 2025, I interviewed Resident A who reported the facility does not have adequate staffing to meet Resident A's needs or the needs of the other residents. Resident A reported she requires two direct care staff assistance when transferring and/or bathing with her Hoyer lift. Resident A reported she is supposed to be checked and changed every two hours and this is not happening, leaving Resident A in soiled briefs for long periods of time. Resident A reported on average she is checked and changed every four hours. Resident A believes the lack of care is due to insufficient staffing and direct care staff not being able to make rounds every two hours. Resident A reported there are two direct care staff scheduled per shift. While being interviewed, Resident A reported her brief was last changed at 5:30am and it was now 9:14am and she was currently sitting in soiled briefs. Resident A stated she called for assistance from direct care staff 15 minutes prior to our interview, around 9:00am but had not yet received any assistance. I advised Resident A to pull the pull cord system while we were talking and during our 30 minute interview no direct care staff came to assist Resident A. During the 30-minute interview, Resident A also yelled "help" on two separate occasions with no response from direct care staff. Resident A reported on September 21, 2025, that around 9:00am she started asking direct care staff members Tyrea Green and Brook Ketcharound to assist Resident A with getting ready for the day but by 2:00pm Resident A was still not ready for the day and was still in bed. Resident A reported this happens often. Resident A reported she is often told by direct care staff that she will have to wait when she is need of assistance because they do not have enough time or staff to assist everyone in a timely manner.

On September 17, 2025, I interviewed Theresa Moore, Social Worker with Tri-County Office on Aging, who reported there are concerns regarding the care Resident A is receiving at the facility. Ms. Moore reported Resident A is not being checked and changed every two hours as required and is usually only checked and changed every five to seven hours. Ms. Moore provided a copy of Resident A's check and change log which documented the following:

- September 12, 2025, Resident A was checked and changed seven times at 9:38, 1:15, 6:30, 10:30, 2:33, unreadable time, and 9:26. AM or PM was not documented.
- September 13, 2025, Resident A was changed six times, at 12:22, 5:53, 9:13, 1:43, 6:20, 9:45. AM and/or PM was not documented.
- September 14, 2025, Resident A was changed seven times, at 12:30, 5:20, 8:20, 11:30, 3:15, 6:30, and 9:40. AM and/or PM was not documented.
- September 15, 2025, Resident A was changed five times, at 1:00, 5:15, 10:40, 2:45, and 1:20. AM and/or PM was not documented.

Ms. Moore reported Resident A continues to bring concerns to Ms. Moore's attention regarding the lack of care being provided. Ms. Moore stated Resident A believes this is due to the facility not having enough direct care staff to meet the needs of the residents. Ms. Moore reported there is a care conference being held soon to address the ongoing concerns.

On September 22, 2025, I interviewed Tom Hills, Clinton County Adult Protective Service Specialist (APS) who reported on September 16, 2025, Mr. Hilla met with Resident A who reported to Mr. Hilla that she was not being checked, changed or turned every two hours as required per her assessment plan. Mr. Hilla reported that Resident A stated that many times when she asks for assistance from a direct care staff she is told she will have to wait.

On September 24, 2025, I interviewed Relative A1 who reported there is paperwork that documents Resident A is supposed to be changed every two hours, which is not happening, rather Resident A is being changed every four hours instead. Relative A1 reported there are times when Resident A will tell direct care staff Resident A wants to be moved from her chair to her bed or vice versa and direct care staff will say 'just a minute' and never return. Relative A1 reported on one occasion, Resident A called Relative A1 and reported she wanted to be moved to her chair, and she needed to be changed. Relative A1 reported he arrived at the facility two hours later and Resident A was still lying in her bed, not moved or changed and Resident A had no way to contact direct care staff other than to yell out with no response. Relative A1 reported there are usually two direct care staff working per shift but this does not appear to be adequate staffing to meet the needs of the residents in a timely manner.

On October 03, 2025, I completed an unannounced onsite investigation and received and reviewed a copy of Resident A's *Assessment Plan for AFC Resident* and under the section titled, 'Self Care Skills Assessment' the document stated that Resident A requires assistance from two direct care staff with toileting, bathing, dressing, personal

hygiene and uses a wheelchair for walking/mobility. Resident A's *Assessment Plan for AFC Resident*, under the section titled 'Health Care Assessment', the document stated that Resident A uses a wheelchair, sit-to- stand, and hospital bed as assistive devices. Resident A's *Assessment Plan for AFC Resident*, under title Physical Limitations, it is marked 'no' with no plan of action. I reviewed and received a copy of the *Resident Register* dated at the time of the complaint which listed 20 residents admitted to the facility but at the time of the onsite investigation there were 16 residents admitted to the facility. There was no documentation that Resident A was required to be checked and/or changed every two hours.

On October 03, 2025, I interviewed direct care staff member Cami Fisher, whose role is as home manager, and she reported the company's expectation for residents who are incontinent are for residents to be checked/changed every two hours if possible and Resident A would meet this requirement. Ms. Fisher reported Resident A has a log in her room for direct care staff to document the check and changes being completed. Ms. Fisher reported Resident A had asked not to be woken up during the night every two hours to be checked and changed rather her preference is for this to be completed every four hours. Ms. Fisher reported on September 18, 2025, a care conference was held with Resident A, Relative A1, and Tri County Office on Aging and at this conference, Resident A agreed to be checked and changed every two hours and agreed to be woken up during the night. I observed the check and change log in Resident A's room from September 18, 2025-October 03, 2025, and check and changes were being completed every two hours around the clock. Ms. Fisher reported they have four residents that are total care and require assistance from two direct care staff with transfers, bathing, dressing, and toileting.

On October 03, 2025, I reinterviewed Resident A who reported there were times when she would tell direct care staff to not wake her up at night for a check and change every two hours. Resident A stated, "they should ask me every night if I want to be woken up or not." Resident A reported that direct care staff are doing better with being more consistent with the check and changes and Resident A stated she did agree to be woken up every two hours during the night for a check and change at her care conference.

On October 03, 2025, I interviewed Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G who reported they have no concerns regarding their care at the facility but all stated there needs to be additional direct care staff scheduled during the daytime hours. Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G reported there are usually at least two direct care staff per shift, one direct care staff to provide hands on care and the second to administer medications. Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G all reported most of the direct care staff who administer medications are helpful, but there are times when some of the direct care staff who administer medications will not provide hands on assistance and will say, "let me get the caregiver for you." Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G all reported the direct care staff are normally quick to assist, but there are times when it takes 20-30 minutes for

assistance. Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G reported they would like to see an additional direct cares staff scheduled during the day when the residents are awake and all require assistance and especially on the weekends when management is not in the facility to assist with care.

On October 06, 2025, I interviewed direct care staff (DCS) Keyonna Brown who reported the facility currently has a total of 16 residents with four residents who require total assistance from two direct care staff with transfers and activities of daily living. DCS Brown reported there are two direct care staff per shift to meet the transfers and activities of daily living needs of the 16 residents. DCS Brown reported the expectation is to check and change those residents who experience incontinence every two hours but this usually happens every three to four hours due to the high acuity of the residents and not having adequate staffing to provide the care required.

On October 06, 2025, I left voicemail message with several direct care staff requesting a return call and no return calls were received.

On October 07, 2025, via email from Theresa Moore, MSW with TCOA I received a copy of Resident A's *Person-Centered Service Plan* for Resident A completed on June 25, 2025, which documents Resident A is able to communicate her needs, will accept help as needed, will use durable medical equipment, and will take medications as prescribed. The *Person-Centered Service Plan* also documented that Resident A will self-report her ability to live in the community, through the performance of daily care task through consistent use of planned interventions and services such as counseling, residential services, primary care physician, and coordinated care services.

On October 15, 2025, I received copies of Resident E, Resident H, and Resident I *Assessment Plans for AFC* Residents via email from Camie Fisher, Home Manager. The Assessment Plans for AFC Residents for Resident E, Resident H, and Resident I documents the three additional residents needing assistance from two direct care staff with toileting, dressing, and mobility/transfers.

On October 16, 2025, I left messages with multiple direct care staff requesting a return call and no return call was received.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	Based on the information gathered during the investigation, it has been found the licensee does not have sufficient direct care staff on duty to meet the personal care needs of the residents. At the time of the complaint per the residents' *Assessment Plan for AFC Residents* and the *Resident Register* there were a total of 20 residents in care with four of those residents requiring assistance from two direct care staff with transfers/mobility, dressing, and toileting. Residents reported it takes direct cares staff on an average of 20-30 minute to provide assistance when asked. I also observed this during the unannounced onsite investigation after Resident A pulled her assistance cord and 30 minutes later no direct care staff came to assist. Resident A also reported that on multiple occasions she asked for assistance to get ready for the day and two hours later this personal care was still not provided.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Per Resident A's *Assessment Plan for AFC Residents* and her *Person-Centered Service Plan* with TCOA there is no documentation requiring Resident A to be checked and changed every two hours. Camie Fisher, Home Manager reported it is the facilities expectation and direct care staff are trained on this expectation to check and change incontinent residents every two hours. It has been determined, per Resident A's *Assessment Plan for AFC Residents* and her *Person-Centered Service Plan* with TCOA, Resident A is being provided personal care as specified in the written plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A is being yelled at and treated disrespectfully by direct care staff.

INVESTIGATION:

The complaint received on September 16, 2025, alleged Resident A is being yelled at and being disrespected by direct care staff.

On September 17, 2025, I interviewed Resident A who reported direct care staff are very disrespectful towards Resident A, often yelling at Resident A when Resident A requests help, telling Resident A she will have to wait, or just yells, “wait”. Resident A reported direct care staff are rude to Resident A. Resident A reported she has not witnessed this treatment towards other residents in care.

On September 17, 2025, I interviewed Theresa Moore, Social Worker with Tri-County Office on Aging, who reported she has not witnessed any direct care staff yelling or being disrespectful towards Resident A. Ms. Moore reported she has not heard these concerns from other Tri-County Office on Aging staff when visiting the facility. Ms. Moore reported this is a concern that is often brought to her attention by Resident A.

On August 22, 2025, I interviewed Tom Hills, Clinton County Adult Protective Service Specialist (APS) who reported when interviewing Resident A on September 16, 2025, Resident A reported to Mr. Hilla one day Relative A1 asked DCS Tyrae Green to assist Resident A with getting ready for the day and was told that Resident A was going to have to wait and proceeded to go outside and to smoke a cigarette. Mr. Hilla reported Resident A reported when the direct care staff returned inside and assisted Resident A with getting her ready for the day, they were mean and nasty to Resident A.

On September 24, 2025, I interviewed Relative A1 who reported they have not witnessed a direct care staff yelling at Resident A. Relative A1 reported Resident A has voiced these concerns, but Relative A1 cannot say this is or is not happening.

During the onsite investigation on October 03, 2025, I interviewed Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G who all denied that direct care staff yell or are rude. Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G reported they have not witnessed direct care staff yelling at other residents or experienced this themselves. Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G stated there are moments when direct care staff have been short when speaking but usually are very respectful to the residents. No direct care staff names were provided

On October 03, 2025, I reinterviewed Resident A who reported the facility has terminated a couple of the direct care staff who are rude and yell, so things have been better.

On October 06, 2025, I interviewed direct care staff Keyonna Brown who reported she does not yell at residents and has not witnessed any direct care staff yelling at

residents. DCS Brown reported she has not witnessed any direct care staff being disrespectful.

APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based on the information gathered during the investigation, there was no evidence found that Resident A or any other resident had been yelled at or disrespected by direct care staff. It has been found the residents are treated with consideration and respect.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Residents do not have access to direct care staff when they need assistance due to the emergency call system not working.

INVESTIGATION:

The complaint received on September 16, 2025, reported the facilities emergency call system was not working and residents had no way to contact the direct care staff if there was an emergency or need while the residents were in their rooms.

On September 17, 2025, I interviewed Resident A who reported the facility does not have a way of calling direct care staff when assistance is needed. Resident A reported the facility does have a pull cord emergency system, but it does not work and has not worked in over a year. Resident A reported that her son provided a blow horn to be used, but that is no longer working either. During our phone interview, I advised Resident A to pull the pull cord of the emergency system while we were talking and during our 30 minute interview no direct care staff came to assist Resident A. During the 30-minute interview, Resident A also yelled “help” on two separate occasions with no response from direct care staff.

On September 17, 2025, I interviewed Theresa Moore, Social Worker with TCOA, who reported about a year ago it was brought to the facilities attention of the pull cord

system not working and nothing has been done about it. Ms. Moore reported either the facility or Relative A1 provided Resident A with a blow horn to use when assistance is needed, but this has since stopped working.

On September 22, 2025, I interviewed Tom Hills, Clinton County APS, who reported on September 16, 2025, Mr. Hilla met with Resident A and while interviewing Resident A, Mr. Hilla pulled the emergency call system cord and no direct care staff came to the room to answer during the time Mr. Hilla was at the facility, approximately for 40 minutes.

On October 03, 2025, during the onsite investigation, I interviewed Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G who all reported the call system has not worked in months, but Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G have not had to use the call system for assistance or an emergency. Resident E reported that if she needs something she will wait until she hears a direct cares staff near the end of the hall and will yell at them for assistance or wait until they come into her room and check on her.

On October 03, 2025, during my onsite investigation I did observe a new emergency call system, a system that is cordless and each resident has their own emergency pendent with a button to call for assistance when needed.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**

ANALYSIS:	Based on the information gathered during the investigation, there were 16 residents in care, including Resident A, Resident E, Resident H and Resident I, who all require two direct care staff to transfer, and because of this limitation have no access to direct care staff when they need assistance or if there was an emergency due to the emergency calling system being nonfunctional. At the time of the complaint, it was determined the facility did not provide any kinds of service or physical accommodations to meet the needs of the residents in care. The licensee has installed a new emergency call system for all residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, I recommend the current status of the license remains unchanged.

Bridget Vermeesch

10/22/2025

_____

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm

10/22/2025

_____

Dawn N. Timm Date
Area Manager