GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 13, 2026

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

RE: License #: AL190418056
Investigation #: 2026A0577020
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 #:	2026A0577020
Complaint Receipt Date:	02/05/2026
Investigation Initiation Date:	02/05/2026
Report Due Date:	04/06/2026
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 AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B was not supervised while taking medications.	No
Resident A was administered Resident C's medications.	Yes

III. METHODOLOGY

02/05/2026	Special Investigation Intake, 2026A0577020
02/05/2026	Special Investigation Initiated – Telephone call made. Interview with Complainant.
02/05/2026	Contact - Telephone call made- Voicemail left at Senior Community Care PACE.
02/13/2026	Inspection Completed On-site
02/17/2026	Contact - Telephone call received- Voicemail from DON with Senior Community Care PACE Program.
02/19/2026	Contact - Telephone call made- Left voicemail for DON, Senior Community PACE Program.
02/19/2026	Contact - Telephone call made- Interviews with DCS.
02/20/2026	Contact - Telephone call made- Bobbi Snider, DCS, attempted interview.
02/23/2026	Contact - Telephone call made, Interviews with DCS.
02/24/2026	Exit Conference with licensee designee Achel Patel and administrator Cheri Weaver.
02/24/2026	Contact - Document Received- Interview with Cheri Weaver, Admin.
03/02/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

- **Resident A was administered Resident C's medications.**
- **Resident B was not supervised while taking medications.**

INVESTIGATION:

On February 05, 2026, a complaint was received reporting that on January 21, 2026, at 8:55pm, the on-call nurse with PACE received a call regarding Resident A receiving another resident's medications as well as their own medications. The complaint reported education was provided to direct care staff to monitor vitals every 15 minutes and if they remain stable to continue to monitor every 30 minutes for the next few hours. The complaint reported education was provided to call 911 if Resident A is not at baseline. The complaint reported that Resident A was later found on the floor falling at 5:19am on January 22, 2026, and Resident A was sent to emergency department for further evaluation.

A second complaint received on February 05, 2026, reported that at 8:20pm on February 03, 2026, Resident B was found by a direct care staff with a cup of medications that were not Resident B's. The complaint reported that direct care staff called the on-call nurse with PACE and reported Resident B took another residents medications before the staff member could take the medications away from Resident B. The complaint reported Resident B was monitored with no changes in baseline. The complaint reported direct care staff (DCS) Camie Fisher stated, "we are still unable to determine what medications [Resident B] took as they cannot determine which resident the medications belonged to."

On February 05, 2026, I interviewed Complainant who could not provide any additional or specific information about these allegations and advised that I contact Senior Community Care PACE. Complainant reported Resident A and Resident B both are participants in the Senior Community Care PACE program. On February 05, 2026, I left a message with Senior Community Care PACE program.

On February 12, 2026, I interviewed DCS Joslyn Hofstetter who reported that she was not working when Resident A was administered the incorrect medication but was made aware of the situation upon shift change on January 22, 2026. DCS Hofstetter reported DCS Sonia Mangum was responsible for passing medications when she popped out Resident C's medications into a cup and asked DCS Analeesia Martin to administer the medications to Resident C. DCS Hofstetter stated DCS Martin misunderstood and thought the medications were for Resident A and thus administered Resident C's medications to Resident A. DCS Hofstetter reported not having any information about a medication error happening with Resident B.

On February 12, 2026, DCS Kim Morgan reported having no knowledge of either Resident A or Resident B being administered the incorrect medications.

On February 13, 2026, I completed an unannounced onsite investigation and received copies of *AFC Licensing Division-Incident/Accident Reports* (IRs). The IR involving

Resident A documented that on January 22, 2026, at 5:20am “Resident receive another residents medications, PACE was contacted and directed staff to monitor blood pressure and continue safety checks. At 5:20am check resident was observed on floor. Resident stated she hit her head, EMS was called and resident was transported to Sparrow.”

The IR involving Resident B documented that on February 02, 2026, at 8:17pm, “Staff entered residents room to give her night medications, and she stated that she had already taken the ones I had sat in her room for her, but I have not been into her room today. I’ve given her all her meds in the common room area where she stayed.” Staff checked Resident B’s vitals, notified management and continued to check vitals. The IR documented at 7:30pm Resident B was administered Bupropion Tab 150mg, Carvedilol, 3.125mg, and Mirtazapine 75mg, with initials FM. During my onsite investigation on February 13, 2026, I reviewed and received a copy of Resident B’s Medication Administration Record (MAR) to verify the medications Bupropion Tab 150mg, Carvedilol, 3.125mg, and Mirtazapine 75mg, administered were Resident B’s prescribed medications.

On February 13, 2026, I interviewed DCS Camie Fisher and Director of Facility Operations Zize Gashi who both reported being aware that direct care staff were not supervising residents while taking their medications. Ms. Fisher and Ms. Gashi reported that all direct care staff who administer resident medications have completed and were deemed competent in medication administration training. Zize Gashi reported it is unclear if Resident B even took mediations prescribed to a different resident on February 02, 2026. Ms. Gashi stated, “[Resident B] reported she had already taken medications and had an empty medication cup in her hand, but no direct care staff observed Resident B taking medications and direct care staff were unsure where the medication cup came from.” Ms. Fisher reported the internal investigation that Resident B had an old medication cup in her bedroom that she was referring to when Resident B told DCS Felicidad Mangum that she had already taken her medications. Ms. Fisher reported that per internal review of the facility video, no one had administered medications to Resident B prior to DCS Felicidad Mangum entering Resident B’s room to administer her medications.

On February 19, 2026, I attempted to interviewed Sonia Mangum and Felicidad Mangum but left a messages requesting a return call.

On February 23, 2026, I interviewed DCS Sonia Magnum who reported she had popped Resident C’s medications and placed them in a medication cup then asked DCS Analeesia Martin to administer Resident C’s medications. DCS Magnum reported that DCS Martin returned to the medication cart and reported she just completed administering Resident A’s medications. DCS Magnum reported she verified with DCS Martin who the medications were administered too and DCS Martin stated, “I thought you said they were [Resident A’s] medications.” DCS Magnum reported she immediately contacted Senior Community Care PACE, who were advised to monitor Resident A’s vitals every 15 minutes for the first hour and then hourly and if there were

any changes in vitals to send Resident A to the hospital. DCS Magnum reported upon checking on Resident A after the medication error occurred, it was discovered that Resident A had fallen out of bed and hit her head, so Resident A was sent to the hospital for evaluation.

On February 23, 2026, I interviewed former DCS Shawn Nelson, whose previous role was assistant home manager, who reported she no longer works for the company. DCS Nelson confirmed that she was the on-call manager on February 02, 2026, when she received a call from DCS Felicidad Mangum who reported concern about a potential medication error with Resident B. DCS Mangum told DCS Nelson that when she went into Resident B's bedroom to pass medications, Resident B had an empty medication cup in her hand and reported to DCS Magnum that she had already taken her medications. DCS Nelson reported DCS Magnum reported to DCS Nelson she had not passed Resident A's medications yet that night shift and was not sure who's medications were in the cup or when they were taken. DCS Nelson reported she advised DCS Mangum to hold Resident B's mediations and monitor vital every 15 minutes for the next hour. DCS Nelson reported she came into the facility immediately to monitor Resident B for reactions to medications. Ms. Nelson reported they could not determine if Resident B just had an empty medication cup in her room that she showed DCS Mangum, if the medications were from a previous shift, if Resident B had even taken any medications or if these medications were from another resident.

On February 24, 2026, I interviewed administrator Cheri Weaver who reported on upon reviewing the cameras on February 02, 2026, there was no evidence found that Resident B was administered another resident's medications. Administrator Weaver stated only DCS Mangum entered Resident B's bedroom to administer medications per the review of the facility cameras. Ms. Weaver reported she reviewed the camera video from the entire day and did not observe any direct care staff taking Resident B mediations or Resident B having a mediation cup in her hands and entering her room with it. Ms. Weaver reported it is believed Resident B had an old medication cup on her table and due to her dementia, Resident B thought it was a recent cup from taking her medications.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(3) Giving, taking, or applying of prescription medications must be supervised by a licensee, administrator, or direct care staff unless otherwise directed by an appropriately licensed health care professional in writing.

ANALYSIS:	Based on the information gathered during the investigation, there was insufficient evidence that Resident B had already been given medications administered by DCS Felicidad Mangum or that Resident B had been administered another resident's medications. It has been found the direct care staff supervise the taking of medications by residents in care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	It has been found on January 21, 2026, Resident A was administered Resident C's medications by DCS Analeesia Martin. Direct care staff did not ensure that Resident C's medications were not used by another resident as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On March 03, 2026, I interviewed DCS Camie Fisher who reported DCS Analeesia Martin had not been trained in resident medication administration. Ms. Fisher provided me with a copy of DCS Martin's training records which documented DCS Martin had not been trained on proper handling and administration of medication**.**

APPLICABLE RULE	
R 400.675	**Resident Medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medications by a resident: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	During the investigation, it has been found on January 21, 2026 that DCS Analeesia Martin administered Resident A medications despite not been properly trained in the handling and administration of medication. This led to Resident A being administered the wrong medications.
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 03/02/2026

Bridget Vermeesch Date
Licensing Consultant

Approved By:

Dawn Timm 03/13/2026

Dawn N. Timm Date
Area Manager