GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 10, 2026

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

RE: License #: AL190418056
Investigation #: 2026A1033016
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:

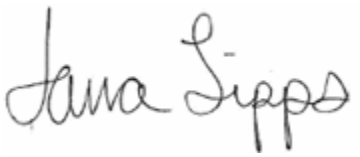
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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,



Jana Lipps, 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
THE RESIDENTS CODED IN THIS INVESTIGATION ARE NOT CODED IN SEQUENTIAL ORDER AS THIS INVESTIGATION REFERENCES SPECIAL INVESTIATION #2025A1033042.

I. IDENTIFYING INFORMATION

License #:	AL190418056
Investigation #:	2026A1033016
Complaint Receipt Date:	02/03/2026
Investigation Initiation Date:	02/05/2026
Report Due Date:	04/04/2026
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 Lynn 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?
The residents' bathrooms are not kept in a sanitary condition.	No
The direct care staff did not seek medical care for Resident K in a timely manner.	Yes

III. METHODOLOGY

02/03/2026	Special Investigation Intake 2026A1033016
02/05/2026	Special Investigation Initiated - On Site
02/05/2026	APS Referral Assigned for investigation to adult services worker, Tom Hilla.
02/05/2026	Contact - Document Received Email correspondence received from direct care staff, Camie Fisher.
03/03/2026	Contact – Telephone call made Interview conducted with Relative A1, via telephone.
03/03/2026	Contact – Document received Email correspondence received from Relative A1.
03/10/2026	Exit Conference Conducted face-to-face with licensee designee, Achal Patel & Administrator, Cheri Lynn Weaver.

ALLEGATION: The residents' bathrooms are not kept in a sanitary condition.

INVESTIGATION:

On 2/3/26 I received an online complaint regarding the Divine Life Assisted Living of Dewitt 3, adult foster care facility (the facility). The complaint alleged that Resident K was recently visited at the facility by family members and taken to the hospital. The allegation states that the family found the resident's bathroom was filthy on this date. The complaint alleged that the raised toilet seat in the bathroom was covered with feces and was in an unsanitary condition.

On 2/5/26 I conducted an unannounced, on-site investigation at the facility with Adult Protective Services, adult services worker, Tom Hilla. I completed a walkthrough of the facility on this date. I observed every resident bathroom in the facility. All resident bathrooms were found to be clean and in sanitary conditions. There was not any feces on the toilet seats or surrounding areas. I observed Resident K's bathroom, which was also clean. Resident K was hospitalized and not at the facility during the time of the unannounced on-site investigation.

During the unannounced on-site investigation on 2/5/26 I interviewed direct care staff/home manager, Camie Fisher. Ms. Fisher reported that the facility employs housekeeping services to clean the facility one time per week. She reported that daily, direct care staff are tasked with tidying up resident rooms and bathrooms. She reported that direct care staff should monitor the cleanliness of the bathrooms and cleaning them if soiled on the days the housekeeping staff are not present at the facility. Ms. Fisher reported that Resident K shared her bathroom with another resident, but the other resident was away from the facility during the dates in question. Ms. Fisher reported that there had been a gastrointestinal virus spreading around the facility and Resident K had presented as ill for several days prior to her hospitalization.

During the unannounced on-site investigation on 2/5/26 I interviewed direct care staff, Candice Pugh, regarding the allegation. Ms. Pugh reported that she was working on the date and time that Resident K's family came to visit her and took her to the hospital. She reported that she assisted with cleaning Resident K's bedroom after she left for the hospital. Ms. Pugh reported that she did not find the bathroom to be in unsanitary conditions on this date. She reported that direct care staff, Brooke-Lynn Ketchum, was assisting her on this date and cleaned the bathroom prior to Ms. Pugh being able to observe the room. Ms. Pugh reported that Ms. Ketchum did not report the bathroom being unsanitary on this date. Ms. Pugh reported that Resident K had been ill for a number of days prior to her hospitalization. She reported she was ill with a gastrointestinal virus.

During the unannounced on-site investigation on 2/5/26 I interviewed direct care staff, Ila Gebott, regarding the allegation. Ms. Gebott reported that the facility employs a housekeeping service who visit about once per week to thoroughly clean the facility. She reported that during her shift she is expected to check on resident bedrooms and bathrooms for cleanliness. Ms. Gebott reported that she has observed Resident K's bathroom with feces on the seat and she cleans this up as soon as she notices the issue. Ms. Gebott reported that she never found the bathroom to be unsanitary and noted it was usually clean. Ms. Gebott reported that Resident K has been ill for a number of days prior to her hospitalization. She reported that Resident K appeared to have a gastrointestinal virus.

During the unannounced on-site investigation on 2/5/26 I interviewed direct care staff, Joslyn Hofstetter, regarding the allegation. Ms. Hofstetter reported that she had not observed Resident K's bathroom to be unsanitary. She reported that Resident K was independent with toileting and required minimal assistance with this task. She reported

that Resident K had been ill with a gastrointestinal virus for multiple days and did experience vomiting and loose stools.

On 2/5/26 I interviewed Ms. Ketchum, via telephone, regarding the allegation. Ms. Ketchum reported that Resident K is independent with toileting. She reported that there was a period where she was ill with a gastrointestinal virus prior to her hospitalization. Ms. Ketchum reported that she was working at the facility the date Resident K was taken to the hospital. She reported that she assisted in cleaning Resident K's bedroom and bathroom after she was taken to the hospital. Ms. Ketchum reported the bathroom was not unsanitary and she did not find any feces on the toilet seat or surrounding areas.

On 3/3/26 I interviewed Relative A1 regarding the allegation. Relative A1 reported that she observed Resident K's restroom to have dried urine on the raised toilet seat. She reported that Resident K shared this bathroom with another resident. Relative A1 denied seeing any feces on the toilet seat.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based upon the interviews conducted and the observations made during the unannounced on-site investigation it can be determined that there is not adequate evidence to determine that the facility is not being kept clean and sanitary. It appears that if the bathroom were found in unsanitary conditions on the date Resident K was sent to the hospital it may have been due to the gastrointestinal symptoms she was experiencing. It cannot be determined whether the bathroom was soiled that morning prior to the resident being taken to the hospital or days prior. Judging by the state of each resident bathroom assessed during the unannounced on-site investigation, it appears that the bathrooms are kept in sanitary conditions. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The direct care staff did not seek medical care for Resident K in a timely manner.

INVESTIGATION:

On 2/3/26 I received an online complaint regarding the facility. The complaint alleged that Resident K was currently hospitalized with diagnosis of urinary tract infection (UTI),

and a yeast infection under both breasts. The complaint reported that Resident K's symptoms were confusion and a rash under both breasts. The complaint reported that Resident K had been quarantined to her bedroom while at the facility due to an RSV outbreak. The complaint reported that direct care staff called Resident K's family to report that she was not doing well and not eating. The complaint alleged that Resident K's shirt was saturated with blood stains due to the progressing yeast infection under her breasts. It further noted that the skin under her breasts is breaking down because of the yeast infection.

On 2/5/26 I conducted an unannounced, on-site investigation at the facility with Mr. Hilla. We interviewed Ms. Fisher regarding the allegation. Ms. Fisher reported that Resident K was sent to the hospital on 2/1/26 by her family. She reported that there was a gastrointestinal virus going around the facility and Resident K had not been feeling well for about two days. She reported she had stayed in her bedroom for at least two days. She reported direct care staff were bringing food to Resident K's bedroom to accommodate her during this time. Ms. Fisher reported that Resident K was still coming out of her room at least a couple times per day to refill her water. She reported that when she would interact with Resident K she was talking and responsive and appeared to be just dealing with a stomach bug. Ms. Fisher reported that Resident K is historically a very private and independent individual. She reported that she performs her own showers with minimal assistance from direct care staff to help her obtain towels and supplies. She reported that Resident K can toilet herself and rarely requires direct care staff assistance with this task. Ms. Fisher reported on 2/1/26 direct care staff called Resident K's family due to Resident K not feeling well. She reported that direct care staff sensed a foul odor in Resident K's bedroom and Resident K's family found Resident K to have a rash under her breasts. Ms. Fisher reported that Resident K's family made the decision to take her to the hospital on 2/1/26.

During the unannounced, on-site investigation on 2/5/26 I interviewed Ms. Pugh regarding the allegation. Ms. Pugh reported that Resident K is very independent and private person. She reported that she was able to perform her own showers and direct care staff would stand by to assist if needed. She reported that Resident K could also toilet herself and would decline direct care staff assistance with this task. Ms. Pugh reported that Resident K became ill with a gastrointestinal virus and was not acting like herself for several days. Ms. Pugh was uncertain about how many days Resident K was not feeling well. She reported that typically Resident K would ask to shower twice per week. Ms. Pugh reported that she could not be certain when Resident K's last shower had been prior to her hospitalization. She reported that She did observe that Resident K stopped coming out to the common area and started staying in her bedroom more, which she felt was odd behavior for Resident K. Ms. Pugh reported that someone told her Resident K had been "quarantined." She reported she could not recall who told her this information. Ms. Pugh reported that Resident K was typically a good eater and enjoyed her meals. She noted that the days leading to Resident K's hospitalization she was eating "hit and miss."

During the unannounced, on-site investigation on 2/5/26 I interviewed Ms. Gebott regarding the allegation. Ms. Gebott reported that Resident K is a very independent person and typically refuses direct care staff assistance with showering and toileting. She reported that Resident K has been capable of performing these tasks independently. Ms. Gebott reported that she had not been working at the facility on the days leading up to Resident K's hospitalization. She reported that she heard Resident K was sick, but she did not have much information to provide. Ms. Gebott reported that the last shower she observed Resident K take was prior to her illness and she could not recall the date.

During the unannounced, on-site investigation on 2/5/26 I interviewed Ms. Hofstetter regarding the allegation. Ms. Hofstetter reported that Resident K is independent with her showers and toileting. She reported that direct care staff will stand by for assistance if needed but this is rarely required. Ms. Hofstetter reported that Resident K had not been feeling well and was experiencing gastrointestinal symptoms of loose stools and upset stomach. She reported that she observed "[Resident K] hadn't left her room in a while." She reported that previously Resident K would come down to the dining room for every meal and this activity stopped. Ms. Hofstetter reported that direct care staff were checking on Resident K in her bedroom about every two hours. She reported that she could not recall the date but she did notice an odor in Resident K's bedroom. She reported that this odor was similar to a combination of feces and vomit. Ms. Hofstetter reported that Resident K stated she had been vomiting. She reported that she made a note about this occurrence in the direct care staff chart notes. Ms. Hofstetter reported that she would offer Resident K, food, water, and her medications, but she was not eating well. Ms. Hofstetter reported that this was not normal behavior for Resident K and she was concerned about her symptoms. She reported she did express this concern to Ms. Fisher but she is uncertain if Resident K's family was made aware of her continued declining health.

On 2/5/26 I interviewed Ms. Ketchum via telephone regarding the allegations. Ms. Ketchum reported that Resident K was normally social and would come out of her bedroom for all meals. She reported that she was an independent person and would shower and toilet herself with zero to minimal assistance. Ms. Ketchum reported that for the past two weeks, prior to Resident K's hospitalization, she would not come out of her bedroom for meals. She reported that the direct care staff started taking her meals to her bedroom. She reported that Resident K would come out of her bedroom to ask for her water to be refilled. She reported that on 2/1/26 Resident K came out and asked for a refill of her water and Ms. Ketchum observed a blood stain on her t-shirt. Ms. Ketchum reported that Resident K would not allow Ms. Ketchum to look at her skin and requested that her daughter be called. Ms. Ketchum reported this information to Ms. Fisher, who advised her to contact Resident K's family. Ms. Ketchum reported that she called Resident K's daughter who came to the facility. Ms. Ketchum reported that Resident K had a yeast infection spreading under her breasts and this is what caused the blood stain on her t-shirt. She reported that it had been at least two weeks since Resident K had showered due to Resident K refusing showers. She reported that this was all uncharacteristic behavior for Resident K to stay isolated in her bedroom, not eat her

meals in the dining room, and to refuse showers. Ms. Ketchum reported that she is unaware whether anyone made contact with Resident K's family prior to 2/1/26 to update them to Resident K's continued health decline. Ms. Ketchum was also unaware whether anyone had contacted Resident K's medical provider to update them to her change in health over the past two weeks. Ms. Ketchum reported that when she entered Resident K's bedroom on 2/1/26 the room smelled very strong. I inquired what type of odor she was describing and Ms. Ketchum replied, "Like something died in her room."

On 2/5/26 I had email correspondence with Ms. Fisher. I inquired "During the course of [Resident K's] illness was her physician or family contacted regarding her change in condition?" Ms. Fisher responded, "[Resident K's] PCP nor family was contacted because we thought this was the stomach issue that was trickling through the facility. Her daughter, [Relative A1] was aware of the recent illness in the facility but at that time [Resident K] had not been sick yet."

During the on-site investigation on 2/5/26 I reviewed the following documentation:

- *Resident Register*. This document notes Resident K admitted to the facility on 6/4/24 and discharged on 2/2/26.
- *Assessment Plan for AFC Residents,* for Resident K, dated 1/8/25. This document is signed by Administrator, Cheri Lynn Weaver, and Relative A1. On page two, under section, *II. Self Care Skill Assessment*, subsections, *B. Toileting, D. Grooming (hair care, teeth, nails, etc), E. Dressing, F. Personal Hygiene*, all indicate Resident K does not require assistance in these areas. Subsection, *C. Bathing*, indicates "yes" Resident K does require assistance, with the narrative, "Stand by assist (after breakfast)".
- *Assessment Plan for AFC Residents,* for Resident K, not dated. Ms. Fisher presented a recently updated assessment plan for Resident K but noted this plan had not been agreed upon with Relative A1 and was not yet signed by Relative A1. The document was signed by licensee designee, Achal Patel, but not dated in any areas. The document highlights similar information from the assessment plan dated 1/8/25 including that Resident K does not require assistance with toileting, grooming, dressing, or personal hygiene. The document continues to note "stand by assist" for bathing.
- *AFC Licensing Division – Incident/Accident Report,* for Resident K, dated 2/1/25. This document was completed by Ms. Ketchum. Under the section, *Explain What Happened/Describe Injury*, it reads, "Resident has not been coming out of her room and didn't look good when I checked on her." Under the section, *Action taken by Staff/Treatment Given*, it reads, "I called her daughter and management to see what I should do and her daughter is taking her to the ER due to her having bleeding under the breast."
- *Medication Administration Record (MAR),* for Resident K, January 2026. On page five and six, under the section, *Exceptions for [Resident K]*, it is noted that the direct care staff were "physically unable to take" Resident K's weight on 1/20/26, 1/21/26, 1/29/26, 1/30/26, 1/31/26. On page six, under the section, *Pass Notes*, it is noted that Resident K could not have her weight checked on 1/21/26, due to "Resident is quarantine DE to sickness".

- *ADL Log* for Resident K for January 2026. Under the section, *DLC ADL Library: Shower Day*, it is recorded that Resident K had a shower on the following dates, 1/1/26, 1/8/26, 1/12/26, 1/22/26, 1/26/26, 1/29/26. It is documented that Resident K refused a shower on 1/5/26 and 1/19/26. Ms. Hofstetter documented showering Resident K on 1/22/26, Ms. Ketchum documented showering Resident K on 1/26/26, and Ms. Gebott documented showering Resident K on 1/29/26. The *ADL Log* documents other activities of daily living, such as face washing, teeth brushing, hair combing, and peri care. These areas are signed as being completed by direct care staff members, noting Resident K is independent with these tasks. There are a few dates with no direct care staff signatures/initials to indicate the task was completed, but the log indicates Resident K is independent in these areas.

On 2/5/26 I reviewed the following documentation provided via email by Ms. Fisher:

- *Charting Notes for [Resident K] Last 90 Days*. This document incapsulated direct care staff charting notes on Resident K from 11/8/25 thru 1/31/26. I observed the following information:
    - From 11/8/25 thru 11/23/25 the documentation notes Resident K eating meals in the dining room, spending time in her bedroom, taking medications, and doing well.
    - On 12/24/25 the note reads, “[Resident K] was feeling sick going to ask her to stay in her room.”
    - From 12/25/25 thru 1/7/26 the documentation notes regular activity for Resident K. Eating meals, taking medications, no indications of illness.
    - On 1/8/26 the notes reads, “Resident took all medications throughout the night. Resident stated she was not feeling good staff took blood pressure and it was 185/83 heart rate was 80. Staff retook it after she took blood pressure pill and it went down to 135/70 heart rate was 69 resident stated she was feeling better.”
    - From 1/9/26 thru 1/17/26 the documentation notes regular activity for Resident K, eating meals, taking medications, no indication of illness.
    - On 1/20/26 the note at 5:04pm reads, “Has been in her room laying down all day. [Resident K] claimed she wasn’t feeling well today.”
    - On 1/21/26 the note at 2:39am reads, “[Resident K] expressed that she was not feeling the best tonight she has a slight cough.”
    - On 1/21/26 at 5:47am the note reads, “Resident has been throwing up and having loose stools she is stating she does not feel well.”
    - The note on 1/24/26 at 2:13pm reads, “Declined all meals used bathroom at noon.”
    - The note on 1/28/26 at 1:53am reads, “Resident has a strong body odor I asked if she did want a shower she told me no maybe we could encourage her to possibly shower it could make her feel a lot better and not depressed.”
    - The note on 1/30/26 at 12:14pm reads, “[Resident K] has been feeling really ill the past few days. Meals are offered everyday and she refuses. She typically comes out of her room during the day and during meals but

recently she hasn't been super present. Been consist on checking in on her."

On 3/3/26 I interviewed Relative A1 via telephone regarding the allegation. Relative A1 reported that she received a telephone call from an unknown direct care staff member the weekend of 2/1/26. She reported that she was informed by this direct care staff member that Resident K had not left her bedroom for two weeks, had not showered in two weeks, and was not eating. She reported that this direct care staff member asked if she wanted Resident K sent to the doctor for evaluation. Relative A1 reported that she would come to the facility to assess Resident K's condition. Relative A1 stated that she arrived at the facility and found Resident K lying on her side in her bed with her back to her. She reported she could immediately see a stain on Resident K's shirt and upon closer examination she found this stain to be blood. She reported that she could not believe the condition of Resident K's clothing and how soiled her shirt was on this date. She reported that Resident K was in a confused and lethargic state of consciousness. Relative A1 reported that she further assessed Resident K and found that she had a large yeast infection under her breasts and the skin was starting to peel. She reported that the blood was coming from the yeast infection. Relative A1 reported that Resident K's bedroom smelled of a foul odor on this date. She reported that the odor was so strong it "would make you gag." Relative A1 reported that she took photographs of the yeast infection as did the direct care staff member working on this date. Relative A1 reported that Resident K was taken to the emergency department and diagnosed with a yeast infection under both breasts, a yeast infection in her peri area, and a urinary tract infection. She reported that Resident K spent about a week at the hospital and then was transferred to a nursing home, where she now currently resides.

Relative A1 reported that prior to this conversation and telephone call she received from the unidentified direct care staff member on 2/1/26, she did not receive any information about her mother's illness or continued decline. Relative A1 reported that she had heard that weeks prior there was a "quarantine" at the facility for an outbreak of norovirus and another quarantine for an outbreak of the flu. She reported that these "quarantines" were not discussed with her by direct care staff members but rather mentioned in conversation when she called the facility to check on her mother. Relative A1 reported that typically, Resident K was able to shower herself and perform her own activities of daily living. She reported that Resident K was incontinent at times. She reported that Resident K was fairly active and enjoyed walking around the facility with her walker and even going to get the mail from the mailbox and distributing it throughout the facility prior to her illness. Relative A1 reported that Resident K was in an unkempt physical state when she arrived to take her to the emergency department. She reported her clothing was soiled, her hair was greasy, and her hair had knots in it from needing to be groomed, in addition to the growing yeast infection under her breasts and in her peri area.

On 3/3/26 I received email correspondence from Relative A1. This correspondence contained images Relative A1 took of Resident K's physical condition upon taking Resident K to the emergency department on 2/1/26. Two images are of the yeast

infection under Resident K's breasts. These images depict a large deeply reddened area of skin with significant irritation. Multiple images were provided of the shirt Resident K was wearing when found in her bedroom at the facility by Relative A1. This shift is a light-colored t-shirt with visible stains from blood and other bodily discharge. The shirt is visibly soiled to the naked eye.

On 3/10/26 I conducted a face-to-face exit conference with licensee designee, Achal Patel, Administrator, Cheri Lynn Weaver, and adult foster care licensing consultant, Bridget Vermeesch. The recommendation for a six-month provisional license was discussed. Mr. Patel reported that he reviewed documentation and discussed with direct care staff members what had occurred with Resident K's care at the facility. He reported that Resident K had previously been assessed as requiring minimal support with ambulating, dressing, showering, and personal hygiene. He reported that direct care staff members indicated that they had offered Resident K opportunities to shower while she was feeling ill and she refused these offers. Mr. Patel reported that Resident K's continued physical decline was addressed with Ms. Fisher by direct care staff members and Ms. Fisher did seek the advice of the facility nurse, Courtney Hamill, regarding Resident K's care needs. Mr. Patel reported that Ms. Hamill advised Ms. Fisher to continue to monitor Resident K and push hydration. Mr. Patel reported that the direct care staff did fail to seek medical attention when they identified that Resident K's illness was not resolving and worsening. He reported that once the direct care staff identified Resident K as having a foul body odor, more could have been done to provide for her care and seek medical attention. He reported that direct care staffing changes are being made at the facility as a corrective measure and further training will be completed with current direct care staff to ensure the understanding of seeking medical attention when a resident's illness continues to progress in a negative direction.

On 8/5/25, Special Investigation #2025A1033042 cited a rule violation of Rule R400.15310, Resident health care. (4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately. The analysis of special investigation #2025A1033042 noted inconsistencies found with resident weight records for eight residents that were not reported to a medical provider or to the facility administration by the direct care staff members recording the weights. The *Corrective Action Plan* (CAP), dated 8/15/25, and completed by Licensee Designee, Achal Patel, noted, effective 8/14/25 training had been completed with facility managers/direct care staff and a new chart had been established to record monthly resident weights to be able to compare between months for administration to review for any fluctuations in resident weights. Noting, significant fluctuations in resident weights will be communicated with the proper health care provider. Adult foster home rules were updated and promulgated on 11/3/2025 and Rule R 400.15310 (4) is equivalent to Rule R 400.689 (3).

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Based upon the interviews conducted and documentation reviewed it can be determined that Resident K experienced a significant change in her health/physical status and the direct care staff did not contact a medical provider or Resident K's family regarding this change for at least twelve days after her initial symptoms were identified on 1/20/26. It was identified, during interviews conducted and via documentation review, that Resident K was previously independent or a standby assist with showering, toileting, dressing, and other grooming activities. The documentation reviewed demonstrates that Resident K began to have a significant change in health status on 1/20/26, which persisted and worsened over the course of the following days. This health condition included loose stools, vomiting, not eating well, isolating in her bedroom, and refusing showers. It was identified that when Resident K is feeling well she enjoys showering at least two times per week, walking through the facility, eating meals in the dining room and so forth. The direct care staff interviewed noted Resident K refusing showers and personal care for a period of almost two weeks. Ms. Fisher identified that neither family nor medical provider were informed of these changes as they felt it was just a virus Resident K was experiencing. On 1/28/26 it was identified that Resident K had a "strong body odor", yet no interventions of calling the family were attempted to inform them of her continued decline. By 2/1/26 Resident K had deteriorated to the point of lethargy, confusion due to an untreated urinary tract infection and open wounds under her breasts from a growing yeast infection. Relative A1 found Resident K in soiled clothing and smelling of a strong odor related to the expanding yeast infection. Due to this delay in notifying a physician or family regarding Resident K's continued declining status a violation has been established.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2025A1033042 Rule 310.4, AND CAP DATED 8/15/25.]**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, a six-month provisional license is being recommended at this time due to the extent of the quality-of-care violation cited.

3/10/26

_____

Jana Lipps — Date
Licensing Consultant

Approved By:

03/10/2026

_____

Dawn N. Timm — Date
Area Manager