GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 19, 2026

Sara Dickendesher
Senior Living Devonshire, LLC
7927 Nemco Way, Ste 200
Brighton, MI 48116

RE: License #:	AL440406519
Investigation #:	2026A1039018
	Devonshire Retirement Village

Dear Sara Dickendesher:

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) 64-7960.

Sincerely,

Martin Gonzales, 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 #:	AL440406519
Investigation #:	2026A1039018
Complaint Receipt Date:	01/20/2026
Investigation Initiation Date:	01/20/2026
Report Due Date:	03/21/2026
Licensee Name:	Senior Living Devonshire, LLC
Licensee Address:	7927 Nemco Way, Ste 200 Brighton, MI 48116
Licensee Telephone #:	(810) 538-2533
Administrator:	Sara Lesnesky
Licensee Designee:	Sara Dickendesher
Name of Facility:	Devonshire Retirement Village
Facility Address:	101 Devonshire Drive Lapeer, MI 48446
Facility Telephone #:	(586) 255-7301
Original Issuance Date:	08/05/2021
License Status:	REGULAR
Effective Date:	02/05/2024
Expiration Date:	02/04/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had missing prescribed medication and narcotic records.	Yes
Devonshire Retirement Village had a broken furnace and Residents were exposed to negative degree temperatures.	No

III. METHODOLOGY

01/20/2026	Special Investigation Intake 2026A1039018
01/20/2026	Special Investigation Initiated - Telephone Called in complaint via telephone to APS.
01/20/2026	APS Referral Called in via telephone by LARA consultant.
01/20/2026	Contact - Document Received Administrator Lesnesky sent documentation of their internal investigation.
01/28/2026	Contact - Document Received received additional complaint in regards to the facility having no heat for multiple days and residents freezing in the home.
01/28/2026	Contact - Document Received Received email from Centralized Intake that the complaint regarding Resident A's medication being stolen was denied.
02/10/2026	Inspection Completed On-site Interviewed Administrator, DCW's and Residents A, B and C.
02/10/2026	Contact - Document Received Administrator Lesnesky sent furnace invoice.
02/10/2026	Contact - Face to Face Completed onsite interview with Building Manager Andrew Buckholder.
03/03/2026	Contact - Telephone call made

	Completed phone interview with POA1.
03/03/2026	Exit Conference Completed with LD and administrator.
03/03/2026	Inspection Completed-BCAL Sub. Compliance
03/09/2026	Contact - Telephone call made Attempted phone call with DCW Tobbie Beebe. No Answer.
03/09/2026	Contact - Telephone call made Attempted phone call with DCW Jennifer Garner. No answer left message.
03/17/2026	Contact - Telephone call made Phone call with Lapeer Police Department Deputy Director Candy Anderson.
03/17/2026	Contact - Telephone call made Attempted phone call with DCW Tobbie Beebe. No answer.
03/17/2026	Contact - Telephone call made Attempted phone call with DCW Jennifer Garner. No answer left message.
03/18/2026	Contact - Telephone call made Attempted phone call with DCW Garner. No answer left message.
03/18/2026	Contact - Telephone call made Attempted phone call with DCW Jennifer Garner. No answer left message.

ALLEGATION:

Resident A had missing prescribed medication and narcotic records.

INVESTIGATION:

On 01/20/2026, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Resident A had missing prescribed medication and narcotic records.

On 01/20/2026, a referral was made to Adult Protective Services regarding this complaint. The Department of Health and Human Services Centralized Intake denied the complaint for investigation.

On 01/20/2026, I interviewed Administrator Sara Lesnesky concerning the allegations. Administrator Lesnesky informed me that they had completed their internal investigation and she would send me the Incident Report (IR) and the results of their investigation and their corrective action steps that were developed to ensure that this type of incident does not happen again. Administrator Lesnesky stated that she had informed the Power of Attorney (POA), Adult Protective Services (APS), Licensing Consultant and Law Enforcement.

On 02/10/2026, I completed an unannounced onsite investigation at Devonshire Retirement Village and spoke to the following people: Administrator Sara Lesnesky, Medical Coordinator Anita Jones, Direct Care Worker Sydney Serrels, Resident A, Resident B and Resident C.

On 02/10/2026, I completed an interview with Administrator Sara Lesnesky concerning the allegations. Administrator Lesnesky stated that she was familiar with the allegations and that they were true. It was discovered that Oxycodone was missing for Resident A. Administrator Lesnesky stated that management completed their internal investigation and they were able to identify two staff members who were involved in the incident. Administrator Lesnesky stated that Direct Care Worker (DCW) Jennifer Garner was a team leader and had no past issues of discipline in her file. Administrator Lesnesky stated that they interviewed DCW Garner and did not find any evidence that she took medication. Administrator Lesnesky stated that they did find that DCW Garner did not follow protocol as far as removing sheets from the log after they were full and putting them in separate file. Administrator Lesnesky stated that the Medical Coordinator or supervision are supposed to do that and she is not approved to remove any sheets from active log and file it away. Administrator Lesnesky stated that DCW Garner was written up and continues to work for the home. Administrator Lesnesky stated that they also identified Direct Care Worker (DCW) Tobbie Beebe as being involved in the incident. Administrator Lesnesky stated that during their interview with DCW Beebe that she became visibly upset at the questions concerning missing medication and quit and walked out of the interview and they have not had contact with her since. Administrator Lesnesky stated that they have instituted new protocols to ensure that this type of incident does not happen again. Administrator Lesnesky stated that the narcotics are double locked and have separate keys for entry. Administrator Lesnesky stated that they have added an additional staff at shift change when medication is reviewed and counted to ensure that there is always a third person to review medication count and ensure that it is accurate. Administrator Lesnesky stated that the Lapeer Police Department was notified but no police report was completed and that they contacted the family and adult protective services. Administrator Lesnesky stated that they have had no issues with medication since they instituted the new protocols for medication review and that Resident A did not miss any of her medication as the pharmacy sent over medication to cover the missing doses.

I reviewed an Incident Report (IR) dated 01/15/2026. The IR is titled Notice of Investigation – Suspected Drug Diversion. On 01/12/2026, the Care Coordinator (CC) Colleen Childers had difficulty ordering narcotic medication from the pharmacy for Resident A. The pharmacy informed CC Childers that it was too early to refill and the resident should have sufficient supply until the next refill date. On 01/13/2026, staff informed Resident A's Power of Attorney (POA). Staff also spoke directly to the resident regarding the issue with her medication. On 01/15/2026, a comprehensive investigation was completed. It was determined that since Resident A's admission on 10/10/2025, they are unable to account for 77 doses of prescribed Oxycodone. In addition, there was 26 missing shift to shift narcotic count sheets and 4 missing Controlled Drug Received Records (proof of use). Review of the documentation indicates that two employees were consistently either coming on shift or leaving shift when the alleged narcotic cards/sheets were removed. As a result of the findings, they implemented multiple interventions effective immediately. A report was filed with local law enforcement. The following parties were notified: Licensing Consultant, Adult Protective Services and Power of Attorney.

On 02/10/2026, I completed an interview with Medical Coordinator (MC) Anita Jones concerning the allegations. MC Jones stated that she was familiar with the allegations and they were true. MC Jones stated that she is the one who tried to re-order Resident A's medication and she received an alert from the pharmacy that it was too early to refill the medication. MC Jones stated that she began to look into the medication to see what the issue was and why Resident A's medication was low. MC Jones stated that she noticed some discrepancies and began an investigation. MC Jones stated that she pulled the records and were able to come up with a number of doses of Oxycodone that were missing. MC Jones stated that she no other resident's medication were missing and that the only missing medication was from Resident A. MC Jones stated that narcotic count sheets and shift reports were missing and they were able to determine who was working during those days and narrow it down to a couple workers. MC Jones stated they interviewed two people, DCW Beebe and DCW Garner, that were identified and one quit during the interview and the other was disciplined for not following protocol and removing shift reports and filing them herself. MC Jones stated that staff are not allowed to remove any reports from the active logs and file them, that is a function that is completed by the Medical Coordinator or supervision. MC Jones stated that the family, supervision, Power of Attorney, Law Enforcement and APS were notified. MC Jones stated that the staff completed narcotic and medication administration training again and new protocols were put in place where additional staff are involved in the medication count to ensure security. MC Jones stated that the narcotics are double locked and stored separately.

MC Jones took me to the medication room and the medication cart and I reviewed three random resident medications and Medication Administration Records (MARs) and there did not appear to be any issues concerning medication. The MARs appeared to be accurate and up to date. The medication was locked properly and secured.

On 02/10/2026, I completed an interview with Direct Care Worker (DCW) Sydney Serrels concerning the allegations. DCW Serrels stated that she was aware of the allegations and that they were true. DCW Serrels stated that she was not involved with the missing medication but she working in the home during the time period that the incident occurred. DCW Serrels stated that she was present when the medication was called in and the pharmacy said that it was too early to refill the medication. DCW Serrels stated that all she knows was that supervision was notified of the missing medication and that they began an investigation immediately. DCW Serrels stated that all staff had to complete narcotic training and medication administration training again. DCW Serrels stated that only certain staff have access to the narcotic medication and that there have not been any other issues concerning medication. DCW Serrels stated that she does not know the results of the investigation but that she knows one person quit and has not been back since.

On 02/10/2026, I completed an interview with Resident A. Resident A was sitting on her bed at the time of our interview. Resident A appeared neat and clean and was able to communicate. Resident A stated that she was aware of the allegations but doesn't too much about it. Resident A stated that her family took care of it. Resident A stated that she did not miss any of her medications and only knew medication was missing because the staff told her and her family. Resident A stated that the staff bring her medication to her in the room because she does not get around very good anymore. Resident A stated that the staff is amazing and she loves it at Devonshire and does not want to leave. Resident A stated that the staff is really good to her and take care of all her needs and has no complaints at all about Devonshire.

On 02/10/2026, I completed interview with Resident B and Resident C. I spoke with each resident in their room. The residents appeared neat and clean and were able to communicate. The residents stated that they were not aware of any missing medication and that they have never had any issues with missing medication and they get their medication daily. The residents stated that the staff bring the medication to their room and administer it to them there. The residents stated that the staff are really good and they have no issues with the care they receive in the home.

On 03/03/2026, I completed an interview with Resident A's Power of Attorney, POA 1. POA 1 stated that he was aware of the allegations and they were true. POA 1 stated that Devonshire staff communicated with him right away concerning the issues and informed him of the steps they took to resolve it. POA 1 stated that they informed him that the staff is no longer working at the facility and that Resident A's medication was filled by the pharmacy to ensure she did not miss her scheduled medication times. POA 1 stated that Devonshire takes great care of Resident A and that they acted quicky to get it taken care of and he has no issues with their care.

On 03/17/2026, I completed a phone interview with Lapeer Police Department Deputy Director (DD) Candy Anderson concerning the allegations. DD Anderson stated that she was not familiar with the allegations but that she would look in their system to see if a report had been completed concerning the incident. DD Anderson stated that she did

see an officer responded to a call but did not see a corresponding police report. DD Anderson stated that she would look into the situation more and have a detective contact me if there was additional information.

I attempted to contact Direct Care Worker (DCW) Tobbie Beebe for an interview concerning the allegations. I attempted to contact DCW Beebe with no success on 03/09/2026, 03/17/2026 and 03/18/2026. I left my contact information for DCW Beebe to call me back.

On 03/18/2026, I completed a phone interview with Direct Care Worker (DCW) Jennifer Garner concerning the allegations. DCW Garner stated that she was familiar with the allegations and they were true. DCW Garner stated that she was interviewed about the missing medication as she made an error in the Medication Administration Record (MARs). DCW Garner stated that she did not have anything to do with the missing medication but she was interviewed and disciplined internally concerning an error in the entry in the MARs. DCW Garner stated that she also filed some paperwork from an active file that should have been filed by supervision and that was also addressed. DCW Garner stated that she has not had past issues with discipline or missing medication. DCW Garner stated that all the staff were spoken to as a group concerning the missing medication and the person they believe is responsible for the missing medication is no longer working at the home.

On 03/03/2026, I completed an exit conference with Licensee Designee (LD) Sara Dickendesher and informed her of the results of my investigation. LD Dickendesher did not have any follow up questions.

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 was alleged that Resident A had missing prescribed medication and narcotic records. I interviewed the Administrator, Medical Coordinator, Direct Care Workers, Power of Attorney for Resident A, Resident A, Resident B and Resident C. The parties are in agreement that the allegations were true. I reviewed the Incident Report which confirmed the allegations and the follow up safety plan to ensure medication safety. I reviewed the medication room and medication cart and they appear properly secured.

	Upon completion of my investigation, it has been determined that there is a preponderance of evidence to conclude that a rule has been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Devonshire Retirement Village had broken furnace and Residents were exposed to negative degree temperatures.

INVESTIGATION:

On 01/28/2026, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that Devonshire Retirement Village had broken furnace and Residents were exposed to negative degree temperatures.

On 01/28/2026, The Department of Health and Human Services Centralized Intake denied the complaint for investigation.

On 02/10/2026, I completed an unannounced onsite investigation at Devonshire Retirement Village and interviewed the following people: Administrator Sara Lesnesky, Medical Coordinator Anita Jones, Building Manager Andrew Burkholder, Direct Care Worker Sydney Serrels, Resident A, Resident B and Resident C.

On 02/10/2026, I completed an interview with Administrator Sara Lesnesky concerning the allegations. Administrator Lesnesky stated that she was aware of the allegations but that they did not have any residents exposed to negative degree temperatures. Administrator Lesnesky stated the home has multiple furnaces and one of them went out on Friday, 01/23/2026, at approximately 5 p.m. Administrator Lesnesky stated that they put in an emergence service request to get it fixed. Administrator Lesnesky stated that Macomb Mechanical came out and inspected the furnace and they told them that the furnace had to be replaced. Administrator Lesnesky stated that the furnace supplied heat to 5 resident rooms and that they had space heaters for each resident room. Administrator Lesnesky stated that Macomb Mechanical replaced the furnace on Monday, 01/26/2026. Administrator Lesnesky stated that the staff checked on the residents rooms multiple times a day to ensure that the space heaters were working properly and maintaining appropriate temperature for the residents. Administrator Lesnesky stated that the rest of the home was not affected by the furnace that went out. Administrator Lesnesky took me to the mechanical room and showed me the two furnaces that heated the home and she also showed me the rooms that were affected when the furnace went out. Administrator Lesnesky was able to provide the invoice from Macomb Mechanical for replacement of the furnace on 01/26/2026. Administrator

Lesnesky stated that they have had no issues with the heating since the furnace was replaced.

On 02/10/2026, I completed an interview with Medical Coordinator (MC) Anita Jones concerning the allegations. MC Jones stated that she was aware of the allegations but they were not true. MC Jones stated that she doesn't know all of the details because she deals mostly with medication but she said that she was aware that a few residents had space heaters because the furnace went out. MC Jones stated that she was working while the furnace was out and the rest of the building had heat. MC Jones stated that staff checked on the residents who had space heaters multiple times a day to make sure they were ok and did not need anything. MC Jones stated that the furnace was out for a few day and was replaced right away and they have had no issues in the home since.

On 02/10/2026, I completed an interview with Direct Care Worker (DCW) Sydney Serrels concerning the allegations. DCW Serrels stated that she was aware of the allegations but that no residents were left in freezing temperatures. DCW Serrels stated that she was working during the time that the furnace was out and only a few resident rooms were affected and the staff put space heaters in their rooms immediately to ensure that they were not cold. DCW Serrels stated that the staff were checking on the residents hourly to make sure that the temperatures in the room were appropriate for the residents. DCW Serrels stated that the rest of the home was not affected and that the furnace was only out for a few days and they haven't had any issues since then.

On 02/10/2026, I completed an interview with Building Manager (BM) Andrew Burkholder concerning the allegations. BM Burkholder stated that he was aware of the allegations because he is in charge of all building maintenance. BM Burkholder stated that no resident had to deal with freezing temperatures inside of the home. BM Burkholder stated that when the furnace went out, it was immediately addressed and he personally took the space heaters to the residents rooms that were affected. BM Burkholder stated that no other parts of the home were affected and he took me to the furnace that had to be replaced and showed me on the floor plan which rooms were affected and what space heaters were used in the resident rooms. BM Burkholder stated that the rooms temperatures were maintained at 72 degrees. BM Burkholder stated that they have no history of issues with their furnaces and they have not had any issues since they have been replaced.

On 02/10/2026, I completed an interview with Resident A concerning the allegations. Resident A was sitting in her bed at the time of the interview. Resident A appeared neat and clean and was able to communicate. Resident A stated that she remember when the furnace when out but it did not affect her room or most other parts of the home. Resident A stated that the only reason she knew the furnace was out because she saw the furnace trucks pull in the driveway and asked a staff member why there were here. Resident A stated that if she didn't see the trucks she would not have known there was anything wrong with furnace at all because her heat was working fine and it wasn't cold

in the dining room or the day room. Resident A stated that it's always nice and warm in the home and she doesn't have any complaints.

On 02/10/2026, I completed an interview with Resident B concerning the allegations. Resident B was sitting in a chair in her room at the time of the interview. Resident B appeared neat and clean and was able to communicate. Resident B stated that she was familiar with the allegations as the heat in her room went out when the furnace went down. Resident B stated that the staff brought in a space heater right way and came in and checked on her all weekend to make sure she was warm and didn't need anything. Resident B stated that she was never in freezing conditions and she was very comfortable. Resident B stated that this is the first time that she is aware of that the home had any problems with the heat.

On 02/10/2026, I completed an interview with Resident C concerning the allegations. Resident C was sitting in a chair in his room at the time of the interview. Resident C appeared neat and clean and was able to communicate. Resident C stated that he was familiar with the allegations because his room didn't have heat for the weekend when the furnace went out. Resident C stated that he was never cold or suffered freezing temperatures and if someone said that they were probably lying. Resident C stated that the staff brought in a big heater for his room and it was on the entire weekend and he was pretty warm. Resident C stated that the staff addressed it right away and that he couldn't really ask for them to do anything else. Resident C stated that those things happen and that he is fine and there haven't been any issues since the furnace was replaced.

On 03/03/2026, I completed an exit conference with Licensee Designee (LD) Sara Dickendesher and informed her of the results of my investigation. LD Dickendesher did not have any follow up questions.

APPLICABLE RULE	
R 400.647	**Safety and maintenance of premises.**
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	It was alleged that Devonshire Retirement Village had broken furnace and Residents were exposed to negative degree temperatures. I interviewed the Administrator, Medical Coordinator, Direct Care Workers, Building Manager, Resident A, Resident B and Resident C. The parties are in agreement that the furnace went out but that no residents suffered from freezing temperatures and that staff addressed the situation immediately and provided

	space heaters to ensure residents had appropriate room temperatures. I reviewed the Macomb Mechanical Invoice to confirm that a new furnace was put in on 01/26/2026. I viewed the resident rooms affected and there were no heating issues at the time of my inspection. Upon completion of my investigation, it has been determined that there is no preponderance of evidence to conclude that a rule was violated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 03/03/2026, I completed an exit conference with Licensee Designee (LD) Sara Dickendesher and informed her of the results of my investigation. LD Dickendesher did not have any follow up questions.

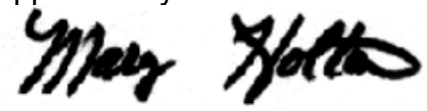
IV. RECOMMENDATION

Upon receipt of approved corrective action plan, I recommend no change to the licensure status.

03/18/2026

Martin Gonzales Licensing Consultant	Date

Approved By:



03/19/2026

Mary E. Holton Area Manager	Date