STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

April 17, 2026

Achal Patel
Vivek Thakore
Divine Life Assisted Living of Dewitt 2 Inc.
2045 Birch Bluff Dr
Okemos, MI 48864

RE: License #: AL190418069
Investigation #: 2026A0466022
Divine Life Assisted Living of Dewitt 2 Inc

Dear Mr. Patel and Mr. Thakore:

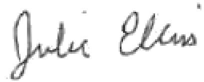
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Julie Elkins, 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 #:	AL190418069
Investigation #:	2026A0466022
Complaint Receipt Date:	02/23/2026
Investigation Initiation Date:	02/24/2026
Report Due Date:	04/24/2026
Licensee Name:	Divine Life Assisted Living of Dewitt 2 Inc
Licensee Address:	2045 Birch Bluff Dr Okemos, MI 48864
Licensee Telephone #:	(517) 898-2431
Administrator:	Cheri Lynn Weaver
Licensee Designee:	Achal Patel and Vivek Thakore
Name of Facility:	Divine Life Assisted Living of Dewitt 2 Inc
Facility Address:	1177 Solon Rd, Ste 2 DeWitt, MI 48820
Facility Telephone #:	(517) 484-6980
Original Issuance Date:	06/03/2024
License Status:	REGULAR
Effective Date:	12/03/2024
Expiration Date:	12/02/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION:

	Violation Established?
Resident A, a full-code resident, was left unmonitored overnight, found unresponsive in the morning, and direct care worker (DCW) failed to perform Cardiopulmonary resuscitation (CPR).	No
Additional Findings	Yes

III. METHODOLOGY

02/23/2026	Special Investigation Intake 2026A0466022.
02/24/2026	APS Referral Does not apply resident is deceased.
02/24/2026	Special Investigation Initiated - On Site.
02/24/2026	Contact - Telephone call made to Kerri Wheeler for employee records.
02/24/2026	Contact- Documents received from Cami Fisher from Resident A's record.
02/25/2026	Contact - Document Received CPR documents for Carolyn Morton.
02/25/2026	Contact - Telephone call made, DCW Tatyana Smith interviewed.
04/10/2026	Contact – Document sent/recevied to/from HR for Divine Life, Kerri Wheeler for employee records for Tatyana Smith.
04/15/2026	Contact – Document sent/received to/from administrator Cheri Lynn Weaver requesting documents.
04/16/2026	Contact – Document sent to administrator Cheri Lynn Weaver requesting documents.
04/17/2026	Exit Conference with Achal Patel.

ALLEGATION: Resident A, a full-code resident, was left unmonitored overnight on 02/15/2026, found unresponsive in the morning, and direct care worker (DCW) failed to perform Cardiopulmonary resuscitation (CPR).

INVESTIGATION:

On 02/23/2026, anonymous Complainant reported that the overnight direct care worker (DCW) on 02/15/2026 did not check on Resident A for 10 hours and then he was found unresponsive in the morning around 6:45am-7am. Complainant reported that cardiopulmonary resuscitation (CPR) was not performed even though Resident A had a full code status. Complainant was anonymous so no additional details could be gathered.

On 02/24/2026, I conducted an unannounced investigation and I interviewed Cami Fisher, facility manager, who reported that DCW Tatyana Smith worked the overnight shift independently on 2/15/2026. Ms. Fisher reported that the facility policy is for all residents to be checked on every two hours. Ms. Fisher reported that DCW Smith told her and emergency medical services (EMS) upon their arrival that after she passed evening medications, Resident A told her not to come back to his room. Ms. Fisher reported that DCW Smith reported that she respected Resident A's wishes and did not check on him throughout the night. Ms. Fisher reported that DCW Carolyn Morton worked the morning of 2/16/2026. Ms. Fisher reported that the director of facility operations, Zize Gashi, has Resident A's resident record currently off site but that the *Adult Foster Care (AFC) Licensing Division Incident/Accident Report* (IR) was completed and the IR was provided for review.

The IR was completed on 2/16/2026 at 6:45am and documented that Resident A, DCW Smith and DCW Morton were involved. In the "Explain What Happened / Describe Injury" section of the report it stated, "*Staff member stated that they went in residents room to check on him and he would not respond. Resident was cold to the touch and stiff. Attempts to wake resident, were unsuccessful*." In the "Action taken by Staff / Treatment Given" section of the report it stated, "*911 called. EMS and police pronounced death.*" There were no signatures on the report however under the "signature of person completing report print name and title, it documented Camie Fischer-administrator." The licensee designee did not sign this document.

I interviewed DCW Morton who reported that she worked the morning shift on 2/16/2026. DCW Morton reported that DCW Smith contacted her by phone at 6:43 am while she was punching in and told her that Resident A was not responding to her. DCW Morton reported she walked into Resident A bedroom but she could not get Resident A to wake up. DCW Morton reported that she shook Resident A and he did not move. DCW Morton reported that Resident A's left arm was stretched out and stiff and the right arm was up to his mouth with his eyes wide open and it appeared that rigor mortis had already set it. DCW Morton reported that Resident A's lips changed color and he was cold to the touch. DCW Morton reported that she could not get a pulse, blood pressure, pulse oxygen level, or any vitals for Resident A. DCW Morton reported that Resident A was full code however she believed that

Resident A had been gone for a while since he was cold and stiff. DCW Morton reported that DCW Smith called 911 and gave her the phone. DCW Morton reported that they could not move Resident A to the floor as the operator had directed and DCW Morton reported that she told the 911 operator that they could not move him to the floor. DCW Morton reported that she was never directed to start CPR or do chest compression by the 911 operator. DCW Morton reported that DCW Smith told her that at 10:45pm on 02/15/2026, Resident A told her to “get the hell out and not to come back.” DCW Morton reported that DCW Smith told her that she did not check on him again until the morning when she found him unresponsive. DCW Morton reported that at times Resident A baseline behavior was angry or frustrated. DCW Morton reported that Resident A had not smoked in days and he had not asked for cigarettes in weeks even though previously he had tobacco seeking behavior.

Later in the day on 02/24/2026, Ms. Fisher sent an email that contained Resident A’s written *Assessment Plan for AFC Residents* that was dated 6/25/2025 and signed by Resident A’s designated representative and licensee designee Achal Patel. It documented that Resident A was 80 years, not able to be in the community unsupervised, and required constant redirection to control aggressive behavior and to assist with getting along with others. It documented Resident A had tobacco seeking behavior and required set up and cueing for eating and personal hygiene. Resident A did not require any toileting assistance and there was nothing documented about required checks or any additional need that he required overnight.

On 2/26/2026, Kerri Wheeler, Director of Human Resources, provided documentation that DCW Morton completed CPR training 02/28/2025 which was valid until 2/28/2027.

I interviewed DCW Smith by phone who reported that she was not sure if Resident A was sick or if he had any change of condition as he acted normally throughout the day while she conducted rounds. DCW Smith reported that she worked third shift on 2/15/2026, from 6:45pm-7am. DCW Smith reported that Resident A ate dinner around 5pm and she interacted with him twice that night. DCW Smith reported that Resident A was wanting/asking for things that he could not have such as coffee throughout the day, snacks and sweets. DCW Smith reported that when she administered evening medications around 8pm, he told her not to come back in the room. DCW Smith reported that she did not check on him every two hours but that she did check on him throughout the night but she could not recall when or how many times. DCW Smith reported she was not sure if he was in rigor mortis when she checked on him. DCW Smith reported that when she went into his room around 6:45am, she tried to get his vitals when he was not responding. DCW Smith reported that she called DCW Morton for help as she was not sure what to do as Resident A was full code but that he was showing no signs of life. DCW Smith reported that she recalled being in a CPR class a while ago, probably a “couple years ago.”

On 4/13/2026, an email was received from Ms. Wheeler who reported that DCW Smith was employed from 01/02/2024–07/13/2024 and was rehired from 03/20/2025–02/27/2026. I reviewed DCW Smith's CPR certification which documented a completion date of 3/19/2024 and valid until 3/2026.

On 04/15/2026, administrator Cheri Lynn Weaver confirmed that Resident A was a full code. Administrator Weaver reported that she and nurse Kortney Hamill conducted an interview on the day of Resident A's death, Resident A appeared to be sleeping in his room and facing the wall during his normal hours of rest. Administrator Weaver reported that when staff later found Resident A deceased, there were obvious signs of irreversible death.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Resident A's written *Assessment Plan for AFC Residents* did not document a do-not resuscitate order and administrator Weaver reported that Resident A was a full code. Both direct care workers with Resident A on the morning of 02/16/2026 reported that the 911 operator did not direct for CPR to be performed as Resident A was not able to be safely moved from the bed to the floor or flat surface as requested. Resident A's written *Assessment Plan for AFC Residents* documented that Resident A did not require any toileting assistance nor was there any documentation of required supervision checks of Resident A throughout the nighttime hours, therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 02/24/2026 at the time of the unannounced investigation Resident A's record was not at the facility or available for review. Ms. Fisher reported that she had to obtain Resident A's record and email the documents that I requested later as Zize Gashi, director of facility operations, had the file off site.

APPLICABLE RULE	
R 400.691	**Resident records.**
	(3) Resident records must be kept on file in the facility for 2 years after the date of resident discharge unless a shorter retention is specified elsewhere in these rules.
ANALYSIS:	At the time of the unannounced investigation Resident A's resident record was not available for review therefore a violation has been established as all records are required to be kept at the facility for 2 years after the date of discharge, including death.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.

04/17/2026

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Julie Elkins Date
Licensing Consultant

Approved By:

04/17/2026

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Dawn N. Timm Date
Area Manager