



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 16, 2026

Prabhjot Singh
Park Place OPCO LLC
PO BOX 1568
Portage, MI 49081

RE: License #: AL390418617
Investigation #: 2026A1024031
Park Place Senior Living A

Dear Mr. Singh:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On June 4, 2026, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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 (616) 356-0183.

Sincerely,

A handwritten signature in cursive script that reads "Ondrea Johnson".

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

License #:	AL390418617
Investigation #:	2026A1024031
Complaint Receipt Date:	04/24/2026
Investigation Initiation Date:	04/27/2026
Report Due Date:	06/23/2026
Licensee Name:	Park Place OPCO LLC
Licensee Address:	4218 S Westnedge Ave Kalamazoo, MI 49008
Licensee Telephone #:	(269) 329-8187
Administrator:	Prabhjot Singh
Licensee Designee:	Prabhjot Singh
Name of Facility:	Park Place Senior Living A
Facility Address:	4214 S Westnedge Ave Kalamazoo, MI 49008
Facility Telephone #:	(269) 329-8187
Original Issuance Date:	05/28/2025
License Status:	REGULAR
Effective Date:	11/28/2025
Expiration Date:	11/27/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff members did not seek medical attention for Resident A in a timely manner.	Yes

III. METHODOLOGY

04/24/2026	Special Investigation Intake 2026A1024031
04/27/2026	Special Investigation Initiated – Telephone direct care staff member Gloria Kabaseke
04/28/2026	APS Referral not warranted
04/28/2026	Inspection Completed On-site with administrator/licensee designee Prabhjot Singh and Tabitha Watts
05/26/2026	Contact - Telephone call made with direct care staff member Atso Agouze
05/26/2026	Contact - Telephone call made with Relative A1
05/26/2026	Contact - Telephone call made with supports coordinator Kim Whittaker from Milestone Medicaid Waiver Program
05/26/2026	Inspection Completed-BCAL Sub. Compliance
05/26/2026	Exit Conference with licensee designee Prabhjot Singh
05/26/2026	Corrective Action Plan Requested and Due on 6/4/2026
06/04/2026	Corrective Action Plan Received
06/04/2026	Corrective Action Plan Approved

ALLEGATION: Direct care staff members did not seek medical attention for Resident A in a timely manner.

INVESTIGATION:

On 4/27/2026, I received this complaint through the LARA-BCHS online complaint system. This complaint alleged there are concerns that staff members did not seek medical attention for Resident A in a timely manner.

On 4/27/2026, I conducted an interview with direct care staff member Gloria Kabaseke who stated that on 4/22/2026 she was working with Resident A and noticed a difference in Resident A's behavior during lunchtime when she did not eat her food and requested to go back to her bedroom to lie down. Gloria Kabaseke stated about 30 minutes after this, she went back to Resident A's bedroom and observed Resident A severely shaking as if something was wrong. Gloria Kabaseke stated Resident A's face color also started to change to a "pale, ashy-like appearance." Gloria Kabaseke stated she became very concerned however she did not know what to do because she had never experienced anything of this nature with a resident and believed that she was not trained to handle these types of situations. Gloria Kabaseke stated that Resident A then asked her to call Relative A1 at which time she contacted Relative A1 and asked Relative A1 what she wanted staff members to do since Resident A did not seem well. Gloria Kabaseke stated that Relative A1 then requested staff to contact 911 to seek medical attention. Gloria Kabaseke stated she instructed direct care staff member Atso Agouze, the other staff who was working at the time, to call 911. Gloria Kabaseke stated that Atso Agouze then left the area assumingly to call 911 and Gloria Kabaseke stayed with Resident A to monitor her while help was on the way. Gloria Kabaseke stated that about 30 minutes later, Relative A1 arrived at the facility but EMS had still not arrived. Gloria Kabaseke stated Relative A1 contacted 911 and learned from the 911 dispatch representative that no staff members had ever called 911 even though Atso Agouze indicated to her that he did. Gloria Kabaseke stated that EMS eventually transported Resident A to the hospital and Relative A1 expressed that she was very upset that 911 was not called sooner. Gloria Kabaseke stated that she has not seen Resident A since this incident and believes Resident A was relocated to another facility.

On 4/28/2026, I conducted an onsite investigation at the facility with administrator/licensee designee Prabhjot Singh and direct care staff member Tabitha Watts who is in training to be the administrator. Prabhjot Singh stated that he had no knowledge of this allegation and to his knowledge both Gloria Kabaseke and Atso Agouze are trained to handle medical situations which include immediately contacting 911 when adverse changes appear to occur with a resident. Prabhjot Singh stated that they have a standard procedure for medical emergencies in place that falls in the order of contacting 911 first, then contacting the on-call supervisor, followed by contacting any documented relatives or designated representatives. Prabhjot Singh stated that he does not believe staff members handled this incident properly since they did not immediately contact 911 when Resident A appeared to be unwell.

Tabitha Watts stated that she was not made aware of this incident until she was contacted by Resident A's designated representative from Milestone, Kim Whittaker. Tabitha Watts stated Kim Whittaker reported that staff members failed to contact 911 in a timely manner when Resident A became ill at which time Relative A1 had to seek medical attention instead of staff members. Tabitha Watts stated shortly after she spoke with Kim Whittaker, she then received and reviewed the incident report regarding this incident written by staff member Atso Agouze.

While at the facility, I reviewed a training log for direct care staff member Gloria Kabaseke which documented that by 02/11/26 she has been trained in all required trainings per AFC administrative rules. I also reviewed a training log for Atso Agouze which documented that he has been trained in all required training per administrative rules by 10/10/2025.

I also reviewed the *AFC Licensing Division Incident/Accident Report* dated 4/22/2026 which documented that a few hours after Resident A returned from the hospital with her daughter, Resident A only took two bites of her dinner and requested to her return to her bedroom. This report stated Resident A then reported that she did not feel well and was observed to severely shake therefore staff member Astou Agouze called Relative A1 who instructed him to call 911. Resident A was then taken back to her room where she reported to Astou Agouze that she was in pain and requested to lie down. This report stated that 911, Milestone and facility supervisor were contacted while they waited for EMS to arrive.

On 5/26/2026, I conducted an interview with direct care staff member Atso Agouze who stated that on 4/22/2026 he was working with staff member Gloria Kabaseke when Resident A notified them that she did not feel well and appeared to be distressed as evidence by her shaking. Atso Agouze stated Resident A asked them to contact Relative A1 who instructed them to call 911 after we informed her of Resident A's symptoms. Astou Agouze stated while Gloria Kabaseke stayed with Resident A in her bedroom, he contacted 911 from his personal cell phone however he had a bad connection with the 911 operator who repeatedly expressed that they could not hear him on the call. Atso Agouze stated that due to the bad connection, he hung up the phone and did not call 911 back to ensure medical attention was on the way. Atso Agouze stated that "everything was happening so fast" and by the time he attempted to call 911 again, Relative A1 had arrived at the facility and placed the 911 call herself. Atso Agouze stated that he has not seen Resident A since this incident, therefore he believes Resident A relocated to another facility.

On 5/26/2026, I conducted an interview with Relative A1 who stated on 4/22/2026 she received a phone call from staff members who stated that Resident A was not feeling well. Relative A1 stated the staff members asked for guidance on what she wanted them to do. Relative A1 stated she instructed staff to immediately call 911 since they were concerned that Resident A was not acting like normal. Relative A1 stated when she eventually arrived at the facility, EMS had not yet arrived so she contacted 911 and learned that no one had ever called 911 to get Resident A medical attention. Relative

A1 stated that she is very concerned that staff members contacted her instead of immediately contacting 911 when they noticed Resident A showing signs of being severely ill. Relative A1 further stated Resident A was diagnosed with Sepsis and she immediately relocated Resident A to another facility due to the staff members' incompetence.

On 5/26/2026, I conducted an interview with Resident A's supports coordinator Kim Whittaker who stated that Resident A participates in the Milestone Medicaid Waiver Program which provides funding for most of the care and services provided to Resident A by the facility. Kim Whittaker stated that she was contacted by Relative A1 to notify her that Relative A1 had to obtain medical attention for Resident A because staff members failed to contact 911 when Resident A showed signs of being severely ill. Kim Whittaker stated that she then contacted facility staff member Tabitha Watts to inform her of the incident. Kim Whittaker stated Tabitha Watts was not aware that this incident took place. Kim Whittaker stated after this incident, Relative A1 immediately relocated Resident A to another facility.

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:	<p>Based on my investigation, which included interviews with direct care staff training Gloria Kabaseke, Atso Agouze, Tabitha Watts, Relative A1, Milestone supports coordinator Kim Whittaker, licensee designee Prabhjot Singh and review of the facility's <i>AFC Licensing Division Incident/Accident Report</i> there is evidence to support that staff members did not seek medical attention for Resident A in a timely manner.</p> <p>According to Relative A1, she had to seek medical attention for Resident A because staff members failed to contact 911 after noticing Resident A was severely ill. Relative A1 stated staff members called her first to seek direction rather than calling 911 immediately. Further upon her arrival at the facility, approximately 30 minutes later, Relative A1 realized 911 had not been called and so she made the call to 911 at that time. Relative A1 stated Resident A waited at least an additional 30 minutes for emergency medical attention due to staff members' lack of action.</p> <p>Prabhjot Singh stated that both Gloria Kalabseke and Atso Agouze are trained to handle medical situations which includes immediately contacting 911 when residents experience adverse changes in their health. Consequently, Prabhjot Singh agreed that staff members did not handle this incident appropriately nor did they follow the standard medical procedures for the facility.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

According to the facility's *AFC Licensing Division Incident/Accident Report* dated 4/22/2026 written by Atso Agouze, Milestone, Resident A's responsible agency, was notified of this incident on 4/22/2026 at 7:52pm.

Kim Whittaker stated that Milestone, who is Resident A's designated representative, was not made aware of Resident A going to hospital by any staff member however staff members disclosed misinformation on the facility's incident report that Milestone was notified. Kim Whittaker stated that she was notified of this incident by Relative A1 multiple days after this incident.

APPLICABLE RULE	
R 400.693	Incident notification, incident records.
	<p>(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following:</p> <p>(b) Unexpected and preventable inpatient hospital admission.</p>
ANALYSIS:	<p>According to the facility's <i>AFC Licensing Division Incident/Accident Report</i> dated 4/22/2026 written by Atso Agouze, Milestone was notified of this incident on 4/22/2026 at 7:52pm. However, according to Kim Whittaker Milestone was not made aware of Resident A going to hospital by any staff member rather she believes staff members disclosed misinformation on the facility's incident report that Milestone was notified.</p>
CONCLUSION:	VIOLATION ESTABLISHED

On 5/26/2026, I conducted an exit conference with licensee designee Prabhjot Singh and informed him of my findings. I allowed him an opportunity to ask questions and make comments. On 6/4/2026, I received and approved an acceptable corrective action plan.

IV. RECOMMENDATION

An acceptable corrective action plan was approved; therefore, I recommend the current license status remain unchanged.



Ondrea Johnson
Licensing Consultant

6/11/2026
Date

Approved By:



06/16/2026

Dawn N. Timm
Area Manager

Date