GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2026

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

RE: License #: AL190418056
Investigation #: 2026A0622039
Divine Life Assisted Living of Dewitt 3

Dear Mr. Patel:

Attached is the Amended Special Investigation Report for the above referenced facility. Amended changes are located on page 13, as it now states violation established. Due to the violations identified in the report, a written corrective action plan is required and continuation of the provisional license is recommended. 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,

Amanda Blasius, 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 #:	2026A0622039
Complaint Receipt Date:	04/17/2026
Investigation Initiation Date:	04/17/2026
Report Due Date:	06/16/2026
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:	Achal Patel
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:	1ST PROVISIONAL
Effective Date:	05/27/2026
Expiration Date:	11/26/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A uses a wheelchair and was recovering from a fractured femur. Resident A remained in bed for days after hospital discharge due to direct care staff not knowing how to use the Hoyer lift. This was despite Resident A requesting assistance numerous times to get out of bed.	Yes

**Please note the allegation that Resident A was injured after one direct care staff member transferred Resident A from the toilet despite Resident A requiring two direct care staff to assist with transfers is being investigated under SIR#2026A1033040. This allegation will not be investigated in this special investigation report.*

III. METHODOLOGY

04/17/2026	Special Investigation Intake 2026A0622039
04/17/2026	Special Investigation Initiated – Documentation received from complainant.
04/17/2026	APS Referral- not required as a denied APS was sent to BCHS for investigation.
04/21/2026	Contact - Document Received from the complainant.
05/06/2026	Inspection Completed On-site
05/26/2026	Contact - Telephone call made to direct care workers, Aliana Phillis, Joslyn Hofstetter, Brookelynn Ketcheum and Bre-anna Johnson.
05/27/2026	Contact - Document Received from direct care worker, Zize Gashi.
06/02/2026	Inspection Completed-BCAL Sub. Compliance
06/17/2026	Exit conference with licensee designee Achal Patel.

ALLEGATION: Resident A uses a wheelchair and was recovering from a fractured femur. Resident A remained in bed for days after hospital discharge due to direct care staff not knowing how to use the Hoyer lift. This was despite Resident A requesting assistance to get up.

INVESTIGATION:
On 4/17/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, an adult protective services complaint was denied and sent over to LARA for investigation. The complaint stated that Resident A was discharged from the hospital on 04/13/2026, had a fractured femur and must utilize a Hoyer lift for transfers. According to the complaint, as of 4/16/2026, Resident A had not been out of bed since being discharged from the hospital on 04/13/2026 despite requesting multiple times to be helped out of bed. The complaint stated that staff informed Resident A that she couldn't get out of bed because she has stiches and staples. According to the complaint, when two female staff attempted to get Resident A out of bed, they did not know how to use the Hoyer lift and other staff members had to assist them, as well as obtain a sling that was the correct size for Resident A. On 04/16/2026, when Complainant observed staff get Resident A out of bed, Resident A did not complain of pain.

On 04/17/2026, I received documentation from Complainant regarding Resident A and confirmed the allegations via phone with Complainant. Complainant reported that when she talked with Resident A in person on 4/17/2026, Resident A was requesting to get out of bed, so Complainant asked staff to get Resident A out of bed. Complainant stated that she observed two direct care staff, names unknown, who were unable to use the Hoyer lift with Resident A. Complainant stated these two direct care staff requested assistance from a third staff member. Complainant explained that the sling size was not correct for Resident A and needed to be changed. Complainant reported that she stepped outside of the room while the direct care staff members transferred Resident A out of bed and during this process never heard Resident A yell or scream during the transfer for any reason. Complainant stated that she then talked with direct care staff member Zize Gashi, whose role is home manager, about Resident A not being allowed out of bed from 04/13/2026 through 04/16/2026 due to Resident A experiencing severe pain. Complainant informed Zize Gashi that it was Resident A's right to get out of bed and there was no physician's order stating she needed to stay in bed.

On 04/17/2026, I viewed an *AFC Licensing Division Incident/Accident Report (IR)*. This IR documented that on 04/04/26 Resident A slipped out of her shower chair resulting in a fall. At the time of this fall, Resident A denied any pain and did not want to be seen or evaluated by EMTs. Resident A also did not want to be sent to the hospital for evaluation. An additional *AFC Licensing Division Incident/Accident Report* was received and dated 4/7/26. The 4/7/26 IR documented that Resident A was seen evaluated at the facility and mobile x-ray was completed. The x-ray

showed a fractured femur so Resident A was sent to the hospital for further treatment.

On 04/17/2026, I received a *Discharge Summary* from Sparrow Health Hospital dated 4/13/26 at 4:20pm which stated that Resident A was diagnosed with "a displaced intertrochanteric fracture of left femur, initial encounter." Discharge instructions stated the following:

- "If you have any new or worsening symptoms before your appointment (fever, trouble breathing, chest pain, confusion, or any symptoms that worry you), call your doctor or seek immediate medical attention.
- Weight bearing as tolerated on left lower extremity. Use of assistive device(s) as instructed / appropriate for ambulation and activities of daily living. Activity as tolerated following fall precautions.
- Total Hip Replacement protocol with therapy, without need to follow hip precautions. Keep dressing clean, dry and intact.
- May shower starting post op day #3 if dressing is tightly sealed with no leakage. Following removal of Mepilex, you may continue to shower provided the wound is sealed / dry (no drainage). NO SOAKING OR SCRUBBING WOUND.
- Ice packs to site several times a day; more often as needed, to help reduce pain and swelling. Please make sure there is something between your skin and the ice pack (for instance a pillowcase or hand towel work well), never place the ice pack directly on the skin.
- Patient is being transferred back to Divine Living in Dewitt at 2:45p via MMR Ambulance. A manual Hoyer lift has been delivered for patient's use."

Medications at the time of discharge for pain

- aspirin (ASPIRIN EC) 81MG EC tablet, Take 1 tablet (81 mg total) by mouth 2 times daily. Start date 4/13/26.
- Hydrocodone-acetaminophen 5-325 MG per tablet. Take 1 tablet by mouth every 12 hours as needed for inadequate pain relief. Start date 3/19/26.
- Acetaminophen (TYLENOL)325 MG tablet. Take two tablets by mouth two times a day. Start date 12/04/2025
- Amitriptyline (ELAVIL) 25MG tablet, take 1 tablet by mouth nightly for chronic pain. Start date 12/4/2025.

On 04/21/2026, I received additional documentation from Complainant. The document was labeled *Active Cares for [Resident A]*. Per my review of this document, a new care need was added as of 4/13/26 documenting Resident A's need for transferring assistance. The instructions stated the following: "provide assistance with all transfers; requires 2 person transfers with Hoyer lift for all transfers."

On 05/06/2026, I completed an unannounced onsite investigation to Divine Life Assisted Living of Dewitt 3. During the unannounced onsite investigation, I interviewed direct care workers and Resident A and viewed documentation.

On 05/06/2026, I interviewed direct care worker (DCW), Zize Gashi in person. She identified her role as the home manager. She reported that Resident A was not assisted out of bed from 04/13/2026 to 04/16/2026 because, despite making multiple requests, Resident A ultimately refused to get out of bed due to pain. She reported that on 4/16/26, Resident A agreed to get up using the Hoyer lift. DCW Gashi reported that Resident A was checked on every day after the fall on 04/04/26 but Resident A refused to go to the hospital until a mobile x-ray confirmed her fractured femur. Once this was confirmed, Resident A agreed to go to the hospital for treatment. DCW Gashi stated that three residents have Hoyer lifts, therefore all direct care staff should know how to use the Hoyer lift.

On 05/06/2026, I interviewed Resident A in person. She reported that she wanted out of bed to smoke but was in a lot of pain. Resident A stated that she did not feel the staff were neglecting her, but the pain was unbearable. Resident A stated that when staff attempted to prepare to transfer her she was in a lot of pain. Resident A stated that she then asked them to stop.

On 05/06/2026, I interviewed DCW Felica Hinton in person. She reported that she worked when Resident A returned from the hospital between 4/13 and 4/16. DCW Hinton stated that Resident A wanted to get up out of bed, but each time they tried to move her Resident A screamed and yelled in pain. DCW Hinton stated that Resident A usually smokes about four times a day and was struggling to stay in bed due to her desire to smoke. DCW Hinton stated that when Resident A was unable to get out of bed, she ate all three meals in bed and was toileted in bed as well.

On 05/06/2026, I interviewed DCW Ila Gobott in person. She reported that she works day shift and worked when Resident A returned from the hospital between 4/13-4/16. DCW Gobott stated that Resident A was in a lot of pain and home manager/DCW Zize Gashi advised staff to keep Resident A in bed due to her pain level. DCW Gobott stated that there were no doctor orders requiring Resident A to remain in bed. DCW Gobott reported that Resident A asked to get up and smoke often but was also screamed in pain every time DCWs attempted to transfer Resident A. DCW Gobott stated Resident A also experienced severe pain during toileting as well. DCW Gobott confirmed that she is aware of how to use a Hoyer lift.

On 05/06/2026, I interviewed DCW Carolyn Morton in person. DCW Morton stated that she mainly works first shift and that she was told by manager Zize Gashi to let Resident A stay in bed until her pain improves. DCW Morton stated that she observed Resident A screaming in pain from her leg.

On 05/06/2026, I interviewed DCW Caylynn Mitchell who had been the wellness coordinator for about a month. She reported that Resident A was asking to get up

many times a day but was also scared of the Hoyer lift and was yelling in pain while changing Resident A in bed and also when preparing to transfer Resident A. DCW Mitchell reported that Resident A had a PRN for pain.

On 05/06/2026, I received Resident A's medication administration record for the month of April. According to her medication administration record, Resident A received the following pain medications from 4/13/26-4/16/26.

- 4/13/26; 8pm- Acetaminophen (TYLENOL)325 MG tablet and Hydrocodone-acetaminophen 5-325 MG per tablet.
- 4/14/26;8am- Acetaminophen (TYLENOL)325 MG tablet, Aspirin low dose 81 mg
  2pm- Hydrocodone-acetaminophen 5-325 MG per tablet.
  8pm- Acetaminophen (TYLENOL)325 MG tablet, Aspirin low dose 81 mg
- 4/15/26; 8am- Acetaminophen (TYLENOL)325 MG tablet, Aspirin low dose 81 mg
  9am- Hydrocodone-acetaminophen 5-325 MG per tablet.
  8pm- Acetaminophen (TYLENOL)325 MG tablet, Aspirin low dose 81 mg
- 4/16/26; 8am- Acetaminophen (TYLENOL)325 MG tablet, Aspirin low dose 81 mg
  8:37am- Hydrocodone-acetaminophen 5-325 MG per tablet.
  8pm- Acetaminophen (TYLENOL)325 MG tablet, Aspirin low dose 81 mg

When reviewing Resident A's medication administration record, the physician order for Hydrocodone-acetaminophen 5-325 MG per tablet stated that it could be administered every 12 hours as needed for pain. Based on the Resident A's medication administration record, Resident A received it once per day on 4/13/26, 4/14/26, 4/15/26 and 4/16/26 despite multiple reports of continued severe pain.

On 05/06/2026, I received observation notes for Resident A. On 04/13/2026 at 5:30pm the following note was documented: "[Resident A] returned today from the hospital. She is now a Hoyer transfer. The hospital sent a referral to Sparrow home care for nursing, PT and OT. [Resident A] had surgery on her left leg this dressing will need to stay dry until nursing can evaluate. Staff has been informed that she will need bed baths on shower days until nursing can see her."

On 04/14/2026 at 10:15am, the following note was documented: "resident has been asking to get up constantly, but we have been told not to since she is in so much pain after being hospitalized. She did not eat breakfast because she was upset, but I will continue to encourage her throughout the day."

On 04/14/2026 at 6pm the following note was documented: "Resident has been quiet most of the day because she can't get out of bed and have a cigarette. She is still in pain. She finally did eat some dinner, she was refusing breakfast and lunch today."

On 04/15/26, no observation note was documented.

On 04/16/2026 at 2:30am, the following note was documented: “Resident received all night medications. Resident was quiet and slept throughout the whole night. She did yell a little when getting checked and changed every two hours. She stated it was hurting her really bad when she gets moved around. When 3rd shifters arrived she was requesting to get out of bed and to get a cigarette. Staff told her she had to stay in bed or she was going to be yelling due to being in a lot of pain. Resident received a fresh cup of ice water, no concerns at this time.”

On 04/17/2026 at 6:30am, the following note was documented: “Patient complained of pain all night within left leg. States the area feels as if it’s burning. Patient did request if Norco can be changed to every six hours, proper staff was informed and notified.”

Based upon review of Resident A’s medication administration record, the following medication was changed on 4/17/2026, Hydrocodone-acetaminophen 5-325 MG per tablet, take one tablet by mouth every six hours as needed for pain.

On 05/26/2026, I interviewed DCW Aliana Phillis via phone. She reported that she worked on 4/13/26 from 7am-7pm. DCW Phillis stated that she was informed by management if Resident A is screaming when trying to get her out of bed to not get her up. DCW Phillis stated that Resident A asked to get up often because she likes to smoke. DCW Phillis explained that Resident A was screaming in pain and told them to stop trying to get her out of bed but then would want to get up again. DCW Phillis reported suddenly an administrator called and stated if Resident A wants to get out of bed, it’s her right even if she is in pain. DCW Phillis reported that Resident A then started getting out of bed while in pain.

On 05/26/2026, I interviewed DCW Joslyn Hofstetter via phone. She reported that she worked on 4/13/26 and staff were instructed by their boss, DCW Zize Gashi that Resident A needed to stay in bed if she was in a lot of pain. DCW Hofstetter stated Resident A was yelling with pain.

On 05/26/2026, I interviewed DCW Brookelynn Ketcheum via phone. She reported that she worked on 4/14/26 and 04/15/2026 from 7am-7pm. She stated that Resident A would scream in pain every time DCWs tried to roll her, therefore they did not think they should get her up. DCW Ketcheum stated that a doctor was called to increase the number of times Resident A received pain medication each day.

On 05/26/2026, I interviewed DCW Bre-anna Johnson via phone. She stated that she worked on 04/13 and 04/14. She explained that Resident A did not want to get out of bed because she was in too much pain. DCW Johnson stated that Resident A was getting her PRN medication, but lives for her cigarettes. Therefore, she pushes her call button every two minutes.

On 05/27/2026, I requested all documentation regarding contact with Resident A’s doctor’s regarding her pain or care from 4/14/26-4/16/26. I received paperwork from

direct care worker Zize Gashi regarding communication with the pharmacy, which was dated 4/23/26. The medication change came from a visit she had with University of Michigan Health Sparrow Orthopedic Trauma. When asking specially for any contacts regarding her pain level between 4/14/26-4/16/26, I received the following statement: “She had PRN hydrocodone during that time that it was utilized for pain.”

It was confirmed through a job description that staff sign at hire that direct care workers core duties include assisting with transferring residents with assistive devices such as gait belt, walker, wheelchair, etc.

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).

On 03/10/2026, Special investigation #2026A1033016 cited a repeat rule violation of 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. The analysis of special investigation #2026A1033016 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. The *Corrective Action Plan* (CAP), was received 3/25/26, and completed by Licensee Designee, Achal Patel, noted, effective 04/15/2025, new training regarding what constitutes a call to the physician has been created by their clinical team. The training will be conducted upon hire, and posted throughout the facility for quick reference in an emergency situation.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(b) Exercise individual constitutional rights including right to vote, right to practice religion of choice, freedom of movement, and freedom of association.**
ANALYSIS:	Based upon interviews with all direct care workers, all stated being directed by DCW Zize Gashi not to transfer Resident A out of bed due to the severe pain Resident A was experiencing while attempting to be transferred. Although there was no physician's order or discharge instructions stating that Resident A had to stay in bed, Resident A reported telling direct care staff to stop mid-transfer due to the severe pain she was experiencing. Consequently, direct care staff members followed Resident A's instructions to stop the transfer process and also used their best judgment to stop transferring her due to the severe level of pain and desire not to cause further injury. It's concluded that there is not a 51% preponderance of the evidence, at this time, to support allegation that direct care staff were ignoring Resident A requests to get out of bed, did not know how to use the Hoyer lift, or forced Resident A to remain in bed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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 interviews conducted with multiple direct care workers, all reported that Resident A was experiencing severe pain following her return from the hospital. All direct care workers reported that due to Resident A's pain level she was not transferred out of bed, despite Resident A's constant requests and subsequent refusals due to severe pain experienced during transfer attempts. Based upon documentation received, no attempts were made to contact Resident A's doctor or an additional health care professional to receive guidance and direction regarding Resident A experiencing an intense level of pain from 4/14/26-4/16/26. The decision was made by AFC management to have Resident A stay in bed instead of calling Resident A's physician or taking Resident A back to the hospital for further evaluation. Direct care workers also did not seek immediate care or direction from Resident A's physician regarding the dosage instructions for the pain medication until 04/17/2026 after Resident A asked a direct care worker if they could call her doctor and request that the Hydrocodone medication be changed to every six hours. Instead direct care workers only continued to report and document how much pain Resident A was in, but no effort was made from 4/16/26-04/17/26 to call a health care professional to obtain additional pain medication to assist in supporting Resident A's comfort level to be assisted out of her bed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR#2025A1033042 Rule 310.4, AND CAP DATED 8/15/25. SIR#2026A1033016 Rule 689. 3, AND CAP RECEIVED 3/25/26.]**

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medications must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Upon review of Resident A's medication administration record, it was found that direct care workers were not administrating Resident A's Hydrocodone-acetaminophen 5-325 MG per tablet twice a day as needed for pain despite all direct care workers statements that Resident A was in pain and could not be assisted out of bed due to pain. Per the label instructions for Resident A's Hydrocodone-acetaminophen 5-325 MG medications, this medication could be given twice per day for pain yet was not given twice per day despite Resident A voicing experiencing continued severe pain throughout a 24 hour time period. Lastly, I also found that no additional efforts were made to call Resident A's doctor to discuss her pain level and to request additional pain medication or medical recommendations to support Resident A's mobility until 04/17/2026 four days after her return from the hospital. Consequently, this medication was not given as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

On March 10, 2026, Special Investigation Report #2026A1033016 recommended a six month provisional license due to quality of care violations cited in the report. On May 27, 2026, a provisional license was issued. At this time, I recommend continuation of the provisional license status.

06/11/2026

Amanda Blasius Date
Licensing Consultant

Approved By:

06/15/2026

Dawn N. Timm Date
Area Manager