GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 6, 2026

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

RE: License #: AL190418056
Investigation #: 2026A1033040
Divine Life Assisted Living of Dewitt 3

Dear Mr. Patel:

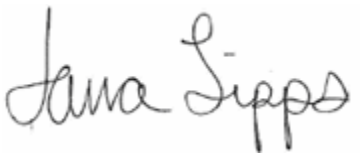
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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,



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

I. IDENTIFYING INFORMATION

License #:	AL190418056
Investigation #:	2026A1033040
Complaint Receipt Date:	05/21/2026
Investigation Initiation Date:	05/21/2026
Report Due Date:	07/20/2026
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:	1ST PROVISIONAL
Effective Date:	05/27/2026
Expiration Date:	11/26/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

	TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has experienced two falls with injury at the facility due to negligence of direct care staff.	Yes
Direct care staff are administering Resident A's medications in an unsafe manner.	No

III. METHODOLOGY

05/21/2026	Special Investigation Intake 2026A1033040
05/21/2026	Special Investigation Initiated - Letter Letter to APS, Tom Hilla, from licensing consultant, Bridget Vermeesch.
05/21/2026	APS Referral Assigned to APS, Adult Services Worker, Tom Hilla.
05/26/2026	Contact - Document Sent Email correspondence sent to APS, Tom Hilla.
05/29/2026	Inspection Completed On-site Interviews conducted with Resident A and Director of Facility Operations, Zize Gashi. Review of Resident A's resident record initiated.
06/02/2026	Contact - Telephone call made Interview conducted with Adult Foster Care Licensing Consultant, Amanda Blasius, via telephone.
06/03/2026	Contact - Telephone call made Attempt to interview Sparrow Home Care, Occupational Therapist, Alicia Feldpausch, via telephone. Left message, awaiting response.
06/03/2026	Contact - Telephone call received Interview conducted with Sparrow Home Care, Occupational Therapist, Alicia Feldpausch.
06/04/2026	Contact – Telephone call made Interview conducted with direct care staff, Brooke-Lynn Ketchum, via telephone.

06/04/2026	Contact – Telephone call made Interview conducted with Citizen 1, via telephone.
06/04/2026	Contact – Document Sent Email correspondence with Tri County Office On Aging, Theresa Moore.
06/05/2026	Contact – Document Received Email correspondence received from Ms. Gashi.
06/08/2026	Contact – Document Received Email correspondence received from Ms. Gashi.
06/23/2026	Contact – Telephone call made Attempts to interview direct care staff, Derriah Ford & Felicia Hinton. Voicemail and text messages left requesting a returned call. Awaiting response.
06/23/2026	Contact – Telephone call made Interview conducted with Administrator, Cheri Lynn Weaver, and facility nurse, Kortney Hamill, via telephone.
07/06/2026	Exit Conference Attempted to call licensee designee, Achal Patel. No voicemail available to leave a message. Conducted interview with Administrator, Cheri Lynn Weaver, via telephone and conducted exit conference.

ALLEGATION: Resident A has experienced two falls with injury at the facility due to negligence of direct care staff.

INVESTIGATION:

On 5/21/26 I received an online complaint regarding the Divine Life Assisted Living of Dewitt 3, adult foster care facility (the facility). The complaint alleged that direct care staff have been negligent with Resident A's care as she requires a two-person assist with transfers and this level of care was not provided, resulting in injury. The complaint alleged that Resident A experienced an initial fall and fractured her left femur and later, on 5/15/26, experienced a second fall, fracturing her knee cap. The complaint was not specific about the date of the first fall, or which leg was impacted by the fractured knee cap.

On 5/20/26, Adult Foster Care Licensing Consultant, Bridget Vermeesch, received email correspondence from Adult Protective Services (APS), Adult Services Worker, Tom

Hilla, regarding the allegations. Mr. Hilla provided Ms. Vermeesch with his investigative contacts thus far in his APS investigation into Resident A's care at the facility. Ms. Vermeesch shared this email with this licensing consultant on 5/22/26. Mr. Hilla's investigative contacts noted the following:

- 5/20/26: Mr. Hilla interviewed Liz (last name unknown) at Guardian A1's office regarding the allegations. Guardian A1 reported that the facility was the only one willing to accept Resident A as Resident A requires a two-person assistance with her care needs. Guardian A1 reported that she is aware of the allegations at this time.
- 5/20/26: Mr. Hilla interviewed Kortney Hamill, Registered Nurse, for the facility. Ms. Hamill denied that Resident A experienced falls without two direct care staff members present. She reported that there were two direct care staff members present during both sustained falls where she fractured her femur and when she fractured her knee cap. Ms. Hamill reported to Mr. Hilla that the physician orders did not indicate the use of a Hoyer lift for Resident A and she was working on getting this changed.
- 5/20/26: Mr. Hilla received email correspondence from Guardian A1. This correspondence provided contact telephone numbers for Resident A's Community Mental Health worker, Tri County Office on Aging case manager, and mental health therapist.
- 5/20/26: Mr. Hilla interviewed Resident A at the facility in her room. Resident A confirmed that she experienced two falls resulting in injury at the facility. She confirmed that in the first fall she fractured her femur and the second fall she fractured her knee cap. Resident A reported to Mr. Hilla that there were two direct care staff present when she fell.

On 5/29/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Resident A regarding the allegations on this date. Resident A was sitting in her wheelchair, in the dining room, when I arrived. She had a cast on her left leg. Resident A reported that she has only resided at the facility for a couple of months. She reported that when she was first admitted to the facility, she did not require the assistance of two direct care staff members for transfers and she could stand and bear some weight on her legs. She reported that she experienced her first fall while showering. She reported that one direct care staff member was assisting her in the shower and she slipped and fell onto the shower floor. She reported that initially she did not realize she had broken her leg but later was sent to the hospital and realized she had fractured her femur. Resident A reported that the second fall she experienced was in the bathroom. She reported that a direct care staff member was trying to assist her with getting on and off the toilet as she needed to have a bowel movement and did not want to have an accident. She reported that this direct care staff member had her stand up and she was holding herself up with the grab bar in the bathroom when she fell onto her knee. She reported that there was just one direct care staff assisting her with this transfer. She reported that this was painful, and she realized right away that something was wrong. Resident A reported that she suffered a fracture of her kneecap because of this fall.

During the on-site investigation on 5/29/26 I interviewed Director of Facility Operations/direct care staff, Zize Gashi, regarding the allegation. Ms. Gashi reported that Resident A was admitted to the facility on 3/5/26. She reported that when Resident A was admitted she was able to bear some weight on her legs. Ms. Gashi reported that Resident A was not two direct care staff assistance with transfer and personal care when she first admitted to the facility. She reported that on 4/4/26 direct care staff, Christina Shasteen, was giving Resident A a shower when Resident A slipped off the shower chair and landed on the floor of the shower. Ms. Gashi reported that Ms. Shasteen had asked Resident A to stand up in the shower so she could wash her peri area. She reported that when Resident A went to sit back down that she did not sit fully on the shower chair and slid off the front of the chair. Ms. Gashi reported that Resident A denied the need to be sent to the hospital and just wanted to return to her bedroom after her shower. She reported that direct care staff, Ila Gebott and Briona Roberts, assisted Ms. Shasteen in picking Resident A up off the floor on this date. Ms. Gashi reported that Resident A returned to her bedroom and the next day would not get out of bed. She reported that two days after the fall, Resident A began complaining of pain and identified that she has been in pain the past two days since the fall occurred. Ms. Gashi reported that she contacted Resident A's physician, Dr. Madireddy, who ordered a mobile x-ray to be taken at the facility. Ms. Gashi reported that the x-ray identified a fractured femur and Resident A was sent to the hospital to have surgery to repair this injury. Ms. Gashi reported that Resident A was away from the facility from 4/7/26-4/13/26 due to this injury.

Ms. Gashi reported that when Resident A returned to the facility from her femur surgery, she was then identified as needing two direct care staff to assist with mobility and transfers due to her potential for fall risk and the new cast on her leg. Ms. Gashi reported that physical therapy and occupational therapy were started at the facility for Resident A, after her femur surgery. Ms. Gashi reported that the two-person direct care staff assistance was enacted for Resident A on 4/13/26 due to the addition of the requirement for a Hoyer lift transfer after her initial femur fracture. She reported on 5/15/26 direct care staff, Victoria Dominique and Sonia Mangum, were working together at the facility. She reported that Resident A indicated she had to use the restroom and wanted assistance getting to the restroom. Ms. Gashi reported that Ms. Dominique reported that she requested assistance from Ms. Mangum to transfer Resident A to the toilet and Ms. Mangum told Ms. Dominique that she did not need assistance with transferring Resident A and could do so independently. Ms. Gashi reported that she was not at the facility at the time of this occurrence, but it was reported to her by Ms. Dominique. She reported that Ms. Dominque stated that she attempted to transfer Resident A from her wheelchair to the toilet on her own. She reported that Ms. Dominique stated she was trying to pivot transfer Resident A from the toilet back to her wheelchair when she fell on the floor and fractured her kneecap.

Ms. Gashi reported that the facility has since taken proactive measures to address the miscommunication regarding the transfer needs for Resident A. She reported that they are currently in the process of completing training for all direct care staff on safe usage of a Hoyer lift. She reported that one training took place on 5/21/26 and a second

training was scheduled for 6/2/26. I inquired where in the resident record the facility documents the requirement for a two-person assist with mobility/transfers. Ms. Gashi reported that this is documented under “daily tasks” in the electronic medical record. Ms. Gashi demonstrated how to find this information while I was present.

During the on-site investigation on 5/29/26 I reviewed the following documents:

- *Assessment Plan for AFC Residents*, for Resident A, dated 5/27/26. On page two, under the section, *I. Social/Behavioral Assessment Plan of Action*, subsection, *P. Requires Routine Overnight Supervision Checks*, the document is marked, “Yes”, with the narrative, “Every Two Hours check and Change”. Under section, *II. Social/Behavioral Assself [sic] Care Skill Assessment Plan of Action*, subsection, *B. Toileting*, the document is marked, “Yes”, with the narrative, “2 People Assist”. Under subsection, *C. Bathing*, the document is marked, “Yes”, with the narrative, “Two People Assist”. On page four, under the section, *Health Care Assessment Plan of Action*, subsection, *D. Special Equipment Used (Wheelchair, Walker, Cane, etc.)*, the document is marked, “Yes”, with the narrative, “Wheelchair, Hoyer”. This document is signed by Guardian A1 and Administrator, Cheri Lynn Weaver.
- *Health Care Appraisal,* for Resident A, dated 11/14/25. Under section, *11. Mental/Physical Status and Limitations*, it reads, “cognitive impairment”. Under section, *15. Physical Exam*, subsection, Explanation of *Abnormalities/Treatment Ordered*, it reads, “Weakness Lt. side, hemiplegia secondary CVA”. CVA is the acronym for Cerebrovascular Accident, otherwise known as a stroke. Hemiplegia is defined as, a form of paralysis that affects only one side of the body, usually caused by brain or spinal cord damage.
- *Active Cares for [Resident A], Service Plan Task.* This document highlights the care ordered for Resident A and the date ordered. I observed the following information on this document:
    - Under the heading*, Assistive Device,* it reads, “Wheelchair Hospital bed Left arm sling Left arm brace (bedtime)”. This is dated 3/6/26.
    - Under the heading*, Bathing Assistance,* it reads, “Instructions: Provide assistance with bathing/showering (dressing/undressing, washing body/hair, drying, getting safely in and out of shower/tub, etc). Requires staff assistance with bathing/showering needs.” This task is dated 3/27/26.
    - Under the section, *Hoyer Transfer*, it reads, “Instructions: 2 person transfer assist with Hoyer lift for all transfers.” This task is dated 5/20/26.
    - Under the section, *Transferring Assistance*, it reads, “Instructions: Provide assistance with all transfers. Status: Requires 2 person transfers with Hoyer lift [sic] for all transfers.” This task is dated 4/13/26.
- *Observations for [Resident A].* This document provides documentation of daily chart notes entered by direct care staff members pertaining to Resident A’s daily care needs. I made the following observations when reading this document:
    - On 4/7/26 Ms. Shasteen documented, “4/4/26 Resident had a witnessed fall in the shower. I stood her up to wash her bottom and when she went to sit down, she slide [sic] out of the shower chair, I checked for injuries. She has a purple-blue bruise and small cut on her left pinky finger. I asked if

she wanted to go to the hospital she refused said she wanted her pain meds and to get dressed to watch TV. [Ms. Gebott] and [Ms. Roberts] also asked if she wanted to go into be seen. Called her doctor and guardian was not able to get through."
    - On 5/15/26 Ms. Dominique documented, "[Resident A] fell when going to the bathroom".
- *AFC Licensing Division-Incident/Accident Report*, for Resident A, dated 4/4/26. This document was completed by Ms. Shasteen. Under the section, *Explain What Happened/Describe Injury (if any)*, it reads, "Resident slipped out of the shower chair." Under section, *Action Taken By Staff/Treatment Given*, it reads, "Resident denied of any pain and did not want to be seen or evaluated by EMT or she did not wanted [sic] to be sent out to the hospital."
- *AFC Licensing Division-Incident/Accident Report*, for Resident A, dated 4/7/26. Under the section, *Explain What Happened/Describe Injury (if any)*, it reads, "After x-ray was done in the facility that doctor has ordered it showed fractured femur." Under section, *Action Taken By Staff/Treatment Given*, it reads, "Resident was sent to the hospital for further treatment."
- *Incident Report,* for Resident A, dated 5/15/26. Under the section, *Briefly Describe What Occurred*, it reads, "[Resident A] was using the bathroom and as she was going to get back in her wheelchair with assistance she fell and bent her ankle all the way backwards." Under the section, *Resident Statement*, it reads, "Was saying she was in pain and wanted emt called after getting her up she was asking for a cigarette and saying she was fine." This document identifies that Resident A was taken to Sparrow Hospital for further evaluation. The document also notes that Resident A did not sustain injuries.
- Ms. Gashi provided me a handwritten statement from Ms. Dominique regarding the fall Resident A experienced on 5/15/26. This statement was signed and dated by Ms. Dominique on 5/20/26 at 10pm. This statement reads, "I was walking past the med room when [Ms. Mangum] stopped me and asked me if I could go put [Resident A] on the toilet. I then asked [Ms. Mangum] "Isn't [Resident A] a Hoyer lift." Her response was "yes, but people have put her on the toilet" so she asked me to do it. [Resident A] mentioned she hadn't had a bowel movement in 3 to 4 days and that she "Really really had to go poop badly" and didn't want to go in her brief. As [Ms. Mangum] continued to do meds I took [Resident A] to the bathroom and assisted her to the toilet. When [Resident A] was being assisted she had ahold [sic] of the bar as I held her left side to safely make it to the toilet safely for a BM. She then grabbed the bar when she finished for me to wipe her. I then pulled her pants up as she was wiped up and ready. Once helping her turn to be facing her wheelchair to sit she sat down too fast and fell to the floor. I tried to assist her up by myself one time while yelling for help. [Alaina Phillis, direct care staff] came to help me eventually so did [Ms. Mangum] when [Ms. Mangum] came she asked "Why [Resident A's] guard belt wasn't on and that is how you get her up." [Ms. Mangum] and [Ms. Phillis] then were getting [Resident A] up and in the process [Resident A] was yelling "call 911 I need to be sent out." After they got her up [Resident A] wanted a cigarette, [Ms. Phillis] then called [Ms. Gashi] and asked what should be done. Once the call was over [Ms. Phillis]

called for paramedics while I did the incident report, I didn't fully know how to do it so [Ms. Mangum] helped me with it, but then [Resident A] was taken to the hospital by EMT's."

On 6/2/26 I interviewed Adult Foster Care Licensing Consultant, Amanda Blasius, regarding the allegation. Ms. Blasius reported that she is currently working on a separate complaint investigation at the facility regarding Resident A's care. She reported that she had interviewed direct care staff and held communication with Resident A's Tri County Office on Aging case manager, Theresa Moore, regarding Resident A's falls at the facility. Ms. Blasius reported the following:

- Ms. Blasius shared email correspondence she held with Ms. Moore regarding Resident A's care at the facility. This correspondence took place between 4/20/26 – 5/27/26. On 5/20/26 Ms. Moore informed Ms. Blasius that Resident A experienced a fall on 5/15/26 and fractured her tibia, resulting in Resident A now having a cast from her ankle to her thigh. Ms. Moore and Ms. Blasius also shared an exchange regarding Resident A requiring the use of a bedside commode as she was ordered to be a Hoyer lift transfer and the Hoyer lift was not able to be used in the bathroom at the facility. Ms. Moore reported that she was never informed that Resident A required the use of a bedside commode and she would assist in obtaining such an item if the facility had first tried to get it ordered through insurance and this failed.
- Ms. Blasius provided the *Assessment Plan for AFC Residents* document for Resident A that was in effect the date of Resident A's second fall on 5/15/26. This document is dated, 3/24/26. This document is signed by Guardian A1 and Ms. Weaver. This document does not indicate the requirement for a two-person assist for Resident A's transfers, but is marked "yes" for requiring assistance in the following areas, "Toileting, Bathing, Grooming, Dressing, Personal Hygiene, Walking/Mobility". The document also notes the need for assistive devices but does not indicate which assistive devices are required for Resident A.
- Ms. Blasius reported she interviewed Ms. Dominique via telephone on 5/21/26. Ms. Blasius provided the following written transcript of her interview with Ms. Dominique, "On 05/21/26, I interviewed direct care worker Victoria Dominique via phone. She reported that on 5/15/26 she was working an overnight shift with Sonia Mangum and it was her third or fourth shift on overnights. DCW Dominique reported that she was walking past the medication room when DCW Mangum asked her to assist Resident A with getting on the toilet. DCW Dominique reported that she questioned DCW Mangum, with "isn't [Resident A] a Hoyer lift?" DCW Dominique also explained that Resident A was behind her in the hallway and reported that she really needed to go. DCW Dominique explained that DCW Mangum stated I'm busy, just take her in there and help her on the toilet. DCW Dominique reported that she helped Resident A onto the toilet and she used the bathroom. She explained that Resident A held herself on the bar, while she cleaned her up and pulled up her brief. DCW Dominique explained that she turned and took a step back, but then attempted to sit down in her wheelchair before it was ready. DCW Dominique stated that she was able to put her foot underneath Resident A to attempt to break her fall. Once Resident A fell, DCW

Dominique reported that she started yelling for help and another staff member Aliana Phillis came into help her. DCW Mangum also came into the room and asked why she didn't have a gait belt on her. DCW Dominique reported that they were able to get Resident A into her wheelchair and called the ambulance as Resident A was requesting to go to the hospital. They also notified their manager. DCW Dominque reported that on 5/15/26 was the first night she worked with DCW Sonia Mangum and on her previous shifts she has not observed any other staff put Resident A onto the toilet. DCW Dominique stated that Resident A does not have a commode and she usually has her brief changed in bed."

- Ms. Blasius reported she interviewed Ms. Phillis via telephone on 5/21/26. Ms. Blasius provided the following written transcript of her interview with Ms. Phillis, "On 05/21/2026, I interviewed direct care worker, Aliana Phillis via phone. She reported that she had just came onto her shift when Resident A fell and she heard someone yelling for help. DCW Phillis reported that Resident A was transferred to the toilet when she was supposed to be a Hoyer lift. DCW Phillis stated that another staff member told DCW Victoria Dominique to put Resident A on the toilet. DCW Phillis stated that it's her understanding that Resident A did not want to lay in bed and use the bathroom in a brief and she does not have a commode either, therefore Resident A asked to use the toilet. DCW Phillis stated that they cannot use the Hoyer lift within the bathroom."
- Ms. Blasius provided the Sparrow Hospital *Discharge Summary* for Resident A dated 4/13/26 for my review. I made the following observations in this document:
    - This document notes Resident A's diagnosis as "Closed displaced intertrochanteric fracture of left femur".
    - On page two, under the section, *Reason for Visit*, it states, "Fall on Saturday in shower at her AFC home, Divine Living Center of Dewitt. Pt. was not seen for this fall. AFC performed X ray today that confirmed a left femur fracture."
    - This document notes Resident A as a "High Fall Risk".
    - On page 25 the document reads, "The following has been arranged for patient to discharge home; Pt is being transferred back to [the facility] in Dewitt at 2:45p via MMR Ambulance. A manual Hoyer lift has been delivered for pts use. [Guardian A1] has been notified leaving a message at 1:10p. [Ms. Hamill] at [the facility] has also been notified at 1:00pm. SHHC will be following pt with PT/OT/nurse and aid."
    - On page 26, under the section, *Ortho Instructions*, the document states, "Weight bearing as tolerated on left lower extremity. Use of assistive device(s) as instructed/appropriate for ambulation and activities of daily living."
    - On page 49, under section, *HPI*, paragraph one states, "[Resident A] is a 61y.o. female with a past medical history of hypertension, hyperlipidemia, COPD, left sided hemiplegia s/p CVA on aspirin, polyneuropathy, chronic pain, MDD, GAD, GERD, among others who presented 4/7/2026 s/p fall from standing. Reportedly, patient was in the shower when she was asked to stand up and then asked to sit back down when she slipped and fell

onto her left side. Patient is a 2-person pivot with wheelchair at baseline and currently resides at an assisted living facility." Paragraph five reads, "PT/OT recommending Hoyer lift at assisted living facility. Patient is medically stable for discharge. Plan to discharge back to [the facility]. Discharge pending prior auth and delivery of Hoyer lift to assisted living facility."

- This document suggests that a probable cancerous neoplasm was found on Resident A's femur during this hospitalization and noted Resident A will be referred to oncology for follow up. On page 54, under the section, *MSK*, paragraph two reads, "Pathological fractures secondary to decreased bone mineralization. Mild trauma in isolation would typically not have caused fracture in mature-healthy bone."

On 6/3/26 I interviewed Sparrow Home Care, Occupational Therapist, Alicia Feldpausch, regarding the allegation. Ms. Feldpausch reported that Sparrow Home Care began working with Resident A post discharge from her hospital stay after her first fall on 4/4/26. She reported that Resident A was admitted to home care services on 4/17/26 and Ms. Feldpausch began providing occupational therapy services to Resident A on 4/20/26. Ms. Feldpausch reported that Resident A has a history of a stroke which caused left sided weakness. She reported that prior to her falls at the facility she could pivot transfer with assistance of direct care staff members. She reported that this pivot transfer would be Resident A standing and bearing weight on her legs while the direct care staff would assist her in pivoting to her wheelchair or to the toilet. She reported that post discharge from the hospital on 4/13/26 it was known that Resident A required a two-person assist with transfers due to the fact that she was now required to be transferred via Hoyer lift. She reported that Resident A experienced a second fall at the facility on 5/15/26 due to one direct care staff member trying to pivot transfer her, without the assist of the Hoyer lift. Ms. Feldpausch reported that this fall appeared to be caused due to direct care staff "negligence" in not following her plan of care.

On 6/4/26 I interviewed direct care staff, Brooke-Lynn Ketchum, via telephone. Ms. Ketchum reported that she provides care to Resident A. She reported that Resident A is currently a two-person assist with transfers because she requires a Hoyer lift transfer. Ms. Ketchum reported that Resident A was not always a two-person assist and this directive changed after Resident A was ordered a Hoyer lift.

On 6/4/26 I interviewed Citizen 1, via telephone, regarding the allegations. Citizen 1 reported that she is a former direct care staff member. She reported that she no longer works at the facility. She reported that she had provided care for Resident A and that she was aware of Resident A's fall on 4/4/26. She reported that she was not present for this fall. Citizen 1 reported that she was informed that Resident A fell on this date during a shower. She reported that Ms. Shasteen was showering Resident A, independently and had her stand up, when Resident A slipped and fell on her left side fracturing her femur. Citizen 1 reported that Resident A was always supposed to be a two-person assist at the facility due to her history of stroke and left sided weakness. She reported that Ms. Shasteen should not have been showering Resident A alone.

On 6/4/26 I had email correspondence with Ms. Moore regarding the allegation. Ms. Moore provided a copy of the *Discharge Summary* from Sparrow Hospital for Resident A's hospitalization related to the fall she experienced at the facility on 5/15/26. I reviewed this document and observed the following information:

- On page one under the section, *Instructions*, subsection, *Ortho Instructions*, it reads, "No weight bearing left lower extremity".
- On page two under the section, *Reason for Visit*, it reads, "Fall". Under the section, *Diagnoses*, it reads, "Fall, initial encounter. Closed fracture of proximal end of left tibia, unspecified fracture morphology, initial encounter."

On 6/4/26 I sent email correspondence to licensee designee, Achal Patel, Administrator, Cheri Lynn Weaver, and Ms. Gashi, regarding the investigation. I requested to review Resident A's hospital discharge summary from her second fall and her current *Health Care Appraisal*. Ms. Gashi responded to this email on 6/5/26 and provided the requested documents. I observed that the *Health Care Appraisal* provided had a date of 4/3/26 and contained the correct license number for the facility.

On 6/23/26 I interviewed Administrator, Cheri Lynn Weaver, and facility nurse, Kortney Hamill, via telephone. Ms. Weaver and Ms. Hamill were on conference call with this consultant. They both expressed that they were not aware that Ms. Dominique transferred Resident A independently on 5/15/26. They both identified that Ms. Dominique's written statement had not been shared with them prior to this interview. Ms. Weaver reported that she was told that there were two direct care staff members present when Resident A fell at the facility on 5/15/26. She reported that prior to this fall Resident A's physical therapist had been to the facility and had spoken with direct care staff members about working with Resident A to become a pivot transfer again and to no longer require a two person assist. Ms. Weaver reported that she wonders if this is where the confusion arose from regarding whether Ms. Dominique could transfer Resident A alone. Ms. Weaver reported that Resident A was not a pivot transfer and was still considered a two-person transfer with a Hoyer when she fell on 5/15/26.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

ANALYSIS:	Based upon interviews conducted and documentation reviewed it can be determined that the direct care staff did not keep Resident A protected and safe while providing for her care at the facility. It has been identified that there was not a written order indicating Resident A required a two-person assist with mobility/transfers prior to her fall on 4/4/26, however it was identified in the hospital discharge summary on 4/13/26 that Resident A would now require a two-person assist with transfers as she was now required to be transferred via Hoyer lift due to the fracture she sustained to her left femur. The directive for a two-person assist was known to the direct care staff and documented on the *Active Cares for [Resident A], Service Plan Task* document, with the date of 4/13/26. This document further stating Resident A required a two-person direct care staff assistance with a Hoyer lift for "all" transfers. Ms. Dominique identified in her written statement that she did attempt to pivot transfer Resident A from the toilet to her wheelchair, independently, without the use of the Hoyer lift because Ms. Mangum instructed her to complete this task. Ultimately, Resident A fell during this transfer, further injuring her left leg by fracturing her kneecap. Due to these facts a violation has been established, as Ms. Dominique knew Resident A required a two-person assist using a Hoyer lift with all transfers and attempted to transfer Resident A on her own, resulting in further injuries to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Direct care staff are administering Resident A's medications in an unsafe manner.

INVESTIGATION:

On 5/21/26 I received an online complaint regarding the facility. The complaint alleged that direct care staff members are not administering Resident A's medications correctly as they are allowing her to remain lying back in her bed while she swallows her pills. The complaint alleged that this action could lead to Resident A aspirating her medications and water, possibly causing pneumonia or other health related conditions.

On 5/29/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Resident A regarding the allegation. Resident A reported that the direct care staff administer her medications in a safe manner. She reported that she is sitting upright when she takes her medications. Resident A reported no knowledge of being in a lying position when her medications were administered. Resident A had no complaints about how her medications are being administered at this time.

During the unannounced on-site investigation on 5/29/26 I interviewed Ms. Gashi regarding the allegation. Ms. Gashi reported that the direct care staff members are trained to ensure that all residents are seated in an upright position prior to having their medications administered. Ms. Gashi reported that direct care staff are aware of aspiration risks, and she has not observed any direct care staff administering medications to residents in a lying position. Ms. Gashi reported that there have been some issues with Resident A just telling direct care staff to put the pills in her mouth when she is lying down in her bed. Ms. Gashi reported that the direct care staff have been instructed to sit Resident A up in her bed for medication administration, which is not difficult since she has a hospital bed.

On 6/3/26 I interviewed Ms. Feldpausch regarding the allegation. Ms. Feldpausch reported that she made a visit to Resident A on 5/20/26 to discharge her from occupational therapy services. She reported that during this discharge visit, a direct care staff member (name she could not recall) entered Resident A's room and administered Resident A's medications while she was lying, almost flat in her bed. Ms. Feldpausch reported that Resident A's hospital bed might have been inclined at a 30% incline, but she was concerned that at the angle Resident A was lying she could have aspirated on the medications she took on this date. Ms. Feldpausch reported that she did not intervene or say anything about this observation to the direct care staff member on this date.

On 6/4/26 I interviewed direct care staff, Brooke-Lynn Ketchum, via telephone regarding the allegation. Ms. Ketchum reported that she currently works first shift at the facility. She reported that she does administer medications. Ms. Ketchum reported that she does not administer medications to residents who are lying down and if she encounters a resident who was lying down, she will assist them in sitting up to take their medications. Ms. Ketchum reported that she has administered medications to Resident A and has never had Resident A decline to sit up to take her medications.

On 6/4/26 I interviewed Citizen 1, via telephone, regarding the allegations. Citizen 1 reported that she did not administer medications when she was employed at the facility. Citizen 1 reported that she did observe direct care staff member, Derriah Ford, administer Resident B's medications while he was lying flat in his bed. Citizen 1 reported that Resident B receives his medications through his feeding tube and should be elevated in his bed to prevent aspiration. She reported that she spoke with Ms. Ford about sitting Resident A up in his bed for medication administration and she ignored the education Citizen 1 was attempting to provide. Citizen 1 reported that this was the only instance she observed a direct care staff administering medications to someone who was lying down in bed.

On 6/4/26 I sent email correspondence to licensee designee, Achal Patel, Administrator, Cheri Lynn Weaver, and Ms. Gashi. I requested to review the *Medication Administration Records* (MARs) for Resident A and Resident B for the month of May 2026. Ms. Gashi responded on 6/5/26 and provided the requested documentation. I observed the following information:

- Resident A's MAR for May 2026 identified that during the time when Ms. Feldpausch was conducting her discharge visit with Resident A on 5/20/26, direct care staff, Felicia Hinton, is noted on the MAR as the person who administered Resident A's medications on this date.
- Resident B's MAR for May 2026 identified that Resident B receives all oral medications via his peg tube.

On 6/8/26 Ms. Gashi sent the following documentation for my review, via email:

- Derriah Ford training record. This record documented that Ms. Ford completed medication administration training and peg tube training on 4/2/26. These trainings were signed off by Ms. Gashi.
- Felicia Hinton training record. This record documented that Ms. Hinton completed medication administration training and peg tube training on 3/1/26. These trainings were signed off by Ms. Gashi.

On 6/23/26 I interviewed Ms. Weaver and Ms. Hamill via telephone regarding the allegation. Ms. Hamill reported that the direct care staff are trained to always make sure the head of a resident's bed is at least at a 30-degree angle when administering tube feedings and medications via tube feedings. She reported that the direct care staff are trained to ensure residents are sitting upright to take medications by mouth. Ms. Hamill and Ms. Weaver reported that the medication administration training presented to direct care staff is extensive and they will send further information regarding these trainings.

On 6/23/26 I attempted to interview Derriah Ford and Felicia Hinton via telephone. I left messages and did not receive returned calls from either individual.

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

ANALYSIS:	Based on the interviews conducted and documentation reviewed there is not adequate evidence to suggest that direct care staff members are routinely administering resident medications while they are lying down in their beds. Ms. Feldpausch did report observing Ms. Hinton administer Resident A's medications while she was lying at a 30 degree angle but also noted she did not take the time to educate Ms. Hinton as to the concerns she had regarding this practice. Both Ms. Hinton and Ms. Ford have completed extensive medication administration training which was signed as completed by Ms. Gashi. Ms. Hamill reported that she ensures direct care staff are aware of head positioning as a component of the medication administration training. Based on the information gathered, consultation has been provided on refreshing Ms. Ford and Ms. Hinton on head positioning when administering medications. A violation has not been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

Exit conference conducted with Administrator, Cheri Lynn Weaver, on 7/6/26. Discussed recommendation to continue the current six-month provisional license. Ms. Weaver reported understanding of the findings in this investigation.

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.

7/1/26

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Jana Lipps Date
Licensing Consultant

Approved By:

07/06/2026

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Dawn N. Timm Date
Area Manager