GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 23, 2026

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

RE: License #: AL190418056
Investigation #: 2026A0466043
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,

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 #:	AL190418056
Investigation #:	2026A0466043
Complaint Receipt Date:	05/29/2026
Investigation Initiation Date:	05/29/2026
Report Due Date:	07/28/2026
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:

	Violation Established?
High numbers of emergency calls and resident falls over multiple years raise serious concerns about chronic understaffing, inadequate training, and poor resident care at the facility.	Yes

III. METHODOLOGY

05/29/2026	Special Investigation Intake 2026A0466043.
05/29/2026	Special Investigation Initiated - Face to Face with assigned licensing consultant Bridget Vermeesch.
06/02/2026	Contact - Document Sent to DeWitt Fire Department.
06/02/2026	Contact - Document Received from Fire Chief Dave DeKorte.
06/10/2026	Contact - Face to Face meeting with Fire Chief Dave DeKorte, Jessica Jones and Dawn Timm.
06/10/2026	Inspection Completed On-site with Fire Chief Dave DeKorte and Dawn Timm.
06/17/2026	Contact - Telephone call made to Courtney Hamill, RN.
06/17/2026	APS Referral.
06/18/2026	Contact - Telephone call made to Tom Hilla, APS.
7/07/2026	Contact - Telephone call from Tom Hilla, APS.
07/14/2026	Contact- Document sent to/from administrator Cheri Lynn Weaver and facility director Zize Gashi.
07/16/2026	Contact - Document sent to/from DeWitt Fire Department.
07/16/2026	Contact- Document sent to administrator Cheri Lynn Weaver and facility director Zize Gashi.
07/20/2026	Contact- Telephone call made to DCW Brookelynn Ketchum, message left.
07/20/2026	Contact – Telephone call received from Fire Chief Dave DeKorte.

07/20/2026	Contact- Document sent to/from administrator Cheri Lynn Weaver and facility director Zize Gashi.
07/20/2026	Contact – Telephone call made to DCW Allyana Eastman interviewed
07/20/2026	Contact – Telephone call made to DCW Gina Trevino, message left.
7/21/2026	Exit conference with licensee designee Achal Patel.

ALLEGATION: High numbers of emergency calls and resident falls over multiple years raise serious concerns about chronic understaffing, inadequate training, and poor resident care at the facility.

INVESTIGATION:
On 05/29/2026, Complainant reported that DeWitt Township Fire Department has responded to Divine Life Assisted Living of Dewitt 3, 129 times for medical issues so far this year. Complainant reported that so far in 2026 DeWitt Township Fire responded to 55 calls for falls including lift assistance. Complainant reported that calls specific to Resident A required DeWitt Township Fire Department to respond 22 times this year due to falls from her wheelchair and lift assistance back to her wheelchair. Complainant reported that in 2025 DeWitt Township Fire responded to call from the facility 192 times with 73 falls. Complainant reported that in 2024 DeWitt Township Fire responded to 122 calls from the facility with 52 falls. Complainant reported being concerned that due to the increased number of calls to Dewitt Township Fire Department, there were not enough staff to provide care to residents, direct care staff are not adequately trained especially to assist with lifting residents after falls, and direct care staff do not provide adequate care to residents.

On 06/10/2026, a face-to-face meeting was held with Fire Chief Dave DeKorte, Jessica Jones, Administrative Assistant DeWitt Township Fire Department, Dawn Timm, Area Manager and this consultant. Fire Chief DeKorte reported that DeWitt Township Fire Department is called to respond to fire and medical problems at this facility more than any other licensed AFC facility within its jurisdiction. Fire Chief DeKorte reported that medical calls include falls, lift assists, medical emergencies, seizures, psychiatric patients, etc. Fire Chief DeKorte reported that medical runs to the facility have increased 54% from 2024 to 2025.

Fire Chief DeKorte reported that since January 1, 2026- June 3, 2026, the DeWitt Township Fire Department has been called to this facility 72 times. Fire Chief DeKorte reported that for Resident A alone, DeWitt Township Fire Department has been called to this facility 25 times: 22 times for falls, twice for psychiatric reasons including a behavioral issue and suicide attempt, one incident of choking, and one

hemorrhage due to fall (included in fall count noted above). Fire Chief DeKorte reported that for the 25 runs, 14 resulted in hospital transfers and 11 hospital refusals for Resident A.

Fire Chief DeKorte reported the number of falls per year has risen as well. Fire Chief DeKorte reported that this trend is expected to continue. Fire Chief DeKorte reported that facility staff may not be adequately trained to meet resident needs which could account for the dramatic rise in calls. Fire Chief DeKorte reported that direct care workers (DCWs) at the facility are not evaluating residents' conditions after a fall as it is easier for them to call 911 and let the fire department and ambulance do the evaluation. Fire Chief DeKorte reported that dates and direct care worker names were not always available when evaluating if one direct care staff worker is calling 911 more frequently than others. Fire Chief DeKorte the following calls demonstrated that direct care staff were not adequately trained to care for residents:

- Fire Chief DeKorte reported DeWitt Township Fire Department arrived to assist with a resident who was having a medical emergency, but direct care workers had left this resident alone and were eating a meal upon EMS arrival. The DCW also directed fire fighter/EMS to the wrong resident bedroom. (date not known)
- Fire Chief DeKorte reported on another call for lift assistance a resident was covered in feces after experiencing a bowel accident and no effort was made prior to their arrival to clean this resident. (date not known)
- Fire Chief DeKorte reported the direct care worker on duty did not know how to use the Hoyer, and the worker on duty reported that the Hoyer is resident specific. (date not known)
- Fire Chief DeKorte reported on 1/17/2026, Resident A was sitting on the ground. Lifted Resident A up to standing position and back into bed. Transport declined by Resident A.
- Fire Chief DeKorte reported on 1/26/2026, Resident A was already sitting in bed when they arrived and Resident A said she was fine, declined transport.
- Fire Chief DeKorte reported on 3/23/2026, Resident A was sitting in her wheelchair with no complaints. Guardian A1 contacted before arrival and stated that she did not think it was necessary to have her be transported to the hospital. Courtney was the staff with her.
- Fire Chief DeKorte reported on 3/29/2026, Resident A sitting upright in chair with no visible injuries. Resident A declined transport.
- Fire Chief DeKorte reported on 4/12/2026, Resident A on floor, Resident A reported no new injures and declined transport. Brooklyn, last name not given, was the DCW on duty.
- Fire Chief DeKorte reported on 5/6/2026, called for sick person, refusal transport by Resident A.
- Fire Chief DeKorte reported on 5/15/2026, Resident A was sitting on the floor, not hurt and Resident A refused transport.
- Fire Chief DeKorte reported on 5/16/2026 upon arrival Resident A was in bed under no apparent distress. Staff reported that she was at baseline behavior. Staff reported that Resident A had been walking around the building

belligerent with no pants on and she was not cooperating with staff therefore she wanted her transported to the hospital for evaluation. Fire Chief DeKorte reported Resident A cooperated with responders by putting clothes on and sitting on the cot.

- Fire Chief DeKorte reported that lift assistance was provided on 5/16/2026 to Resident A because the DCW (name unknown) is “tired of picking up residents.”
- Fire Chief DeKorte reported on 5/17/2026, Resident A was found seated upright on the ground. Resident A had been choking on a burrito and the Heimlich maneuver was successful and dislodged the foreign body. Abrasion sustained to Resident A’s right temple. DeWitt Township Rescue 59 assisted Resident A back into her wheelchair and all vitals were within normal limits. Guardian A1 did not wish for Resident A to be transported to the hospital.
- Fire Chief DeKorte reported that lift assistance was provided on 5/22/2026 to Resident A, found patient sitting on the floor, EMS performed assessment and Resident A declined transport.
- Fire Chief DeKorte reported on 5/23/2026, Resident A is the same resident that was run on first thing this morning and is run on numerous times during any given week. Resident A assessed by EMT and refused transport.
- Fire Chief DeKorte reported on 06/01/2026, met in parking lot by staff who reported that Resident A has been acting out all day being aggressive towards staff and other residents. While acting out, Resident A fell out of her wheelchair. Resident A transported to hospital. Felisha, last name not given, on duty.

On 06/10/2026, an unannounced investigation was conducted at the facility with Fire Chief DeKorte and area manager Timm. Fire Chief DeKorte reported that his department responded to a call regarding Resident A falling on 06/09/2026. Resident A was observed to have a bump on her head and scraped knees from the fall.

Area manager Timm and I interviewed direct care worker whose role is Community Manager Zize Gashi who reported that Resident A was given a 30-day discharge notice a week ago. Ms. Gashi reported that Resident A was admitted in August 2025, is diagnosed with Huntington’s Disease and based on her current behaviors the facility can no longer meet her needs. Ms. Gashi reported that Resident A fell on 06/09/2026 around 4:30pm and she reported that Resident A has a band aid and a “goose egg bump” on her head and scratched knees and elbows. Ms. Gashi reported that the bump on her head occurred during the weekend of 06/06/2026. Ms. Gashi reported that she was in the common area near the front of the facility when Resident A fell forward out of her wheelchair. Ms. Gashi denied that a lap belt would help Resident A stay in her wheelchair as she likes to stand up and if this occurred with the belt attached, Resident A could injure herself further. Ms. Gashi reported that Resident A transfers herself but is a “very wobbly walker.” Ms. Gashi reported that Resident A does not receive an Occupation Therapy (OT) or Physical Therapy (PT) services. Ms. Gashi reported that Resident A is provided services through Tri

County Office on Aging. Ms. Gashi reported that Resident A moves too much to be safely transferred via a Hoyer lift.

Ms. Gashi reported that currently there were 11 residents admitted to the facility. At the time of the onsite investigation, two direct care workers were providing direct care to residents along with another direct care worker administering medications, one housekeeper, and separate kitchen staff to prepare meals. Ms. Gashi stated she is an additionally trained direct care worker to assist as needed. Ms. Gashi reported direct care workers do not call for emergency medical services every time a resident experiences a fall. Ms. Gashi reported that if a resident hits their head, they call emergency medical services. Ms. Gashi reported that if a resident does not hit their head and the resident feels ok, they check their vitals and help them up with a gait belt. Ms. Gashi reported that if the resident is in pain, they call emergency medical services.

I reviewed Resident A's record which contained a written *Assessment Plan for Adult Foster Care (AFC) Residents (assessment plan)* dated 8/1/2025 and signed by licensee designee Achal Patel and Guardian A1 but not signed by Resident A's Tri County Office on Aging case manager. The assessment plan documented that Resident A requires one direct care worker to assist with toileting, bathing, grooming, dressing and personal hygiene. In the "walking/mobility" section of the report it stated, "wheelchair." In the "assistive devices" section of the report it stated, "wheelchair, hospital bed." There were no additional supervision measures added to the assessment plan.

I reviewed *After Visit Summaries* for Resident A from the University of Michigan Health- Sparrow Lansing Emergency Room for the following dates:

- 06/01/2026, reason for visit, "fussy", diagnosis, "dementia with aggressive behavior (HCC)." Follow up with Srinivasa Madireddy, MD.
- 5/31/2026, evaluated for a fall. Follow up with Srinivasa Madireddy, MD.
- 5/27/2026, head injury in adults. Schedule an appointment with Srinivasa Madireddy, MD as soon as possible for a visit.
- 5/24/2026, "Contusion and muscle and joint pain." Schedule an appointment with Srinivasa Madireddy, MDs soon as possible for a visit.

I reviewed Resident A's medication administration record (MAR) for May 2026. Resident A is not prescribed any PRN medication for behavior. Resident A is prescribed 12 PRN medication, "acetamin tab 325 and 500, albuterol, benzonatate, bisacodyl, diclofenac gel, geri tussin, ondansetron, prochloper, simethicone, sore throat loz 15-3.6 mg" and all was administered as prescribed.

I reviewed a *30-day notice of Discharge/Termination of Residency* that was dated 5/26/2026 and signed by administrator Cheri Weaver. The notice stated:

> *"This letter serves as formal written notice that Divine Living Centers of Dewitt will be terminating the residency agreement for [Resident A]*

effective thirty (30) days from the date of this notice, with a discharge date of 06/26/2026.

This decision has been made after careful assessment of the resident's current condition and care needs. Due to a significant increase in medical needs, recurrent falls resulting in injuries, and behavioral concerns that cannot be safely managed within the scope of services provided by our assisted living community, we are no longer able to meet the resident's health and safety needs appropriately.

Specific concerns include, but are not limited to:

Increased medical and personal care needs requiring a higher level of care

Multiple falls with injury and ongoing safety risks

Behavioral concerns affecting the safety and well-being of the resident, other residents, and/or staff

Care needs that exceed the staffing, licensure, and service capabilities of this assisted living facility

Our team has evaluated possible interventions and accommodations; however, it has been determined that transition to a setting capable of providing a higher level of supervision and medical care is necessary for the resident's safety and well-being.

We will work cooperatively with the resident, family/responsible party, physician, and any involved agencies to assist with discharge planning and transition arrangements during this 30-day period."

I reviewed EMS and Fire Runs from DeWitt Township dated January 1, 2026, through June 3, 2026, which confirmed information provided by Fire Chief DeKorte.

On 6/17/2026, Courtney Hamill, RN reported that they are at a loss as to how best to meet Resident A's needs. RN Hamill reported that Guardian A1 is willing to take Resident A home and care for her, but she is currently homeless. RN Hamill reported that staff are trained to call for EMS when a resident falls if the fall is unwitnessed to ensure their safety. RN Hamil reported that Resident A would not benefit from a seatbelt and that this assistive device has been discussed with the physician and ruled out as an option. RN Hamill reported that they believe that they have secured a placement for Resident A but that the bed would not be available until August 1, 2026.

On 07/07/2026, APS Hilla reported that Resident A will be moving out on August 1, 2026.

On 07/14/2026, administrator Cheri Lynn Weaver provided documentation that Resident A was seen by Srinivasa Madireddy, MD on 5/27/2026 and on 6/3/2026. On 06/03/2026, in the “Plan” section of the report it stated:

“The patient's specialized pharmacological care plan will be maintained as currently ordered to support ongoing neurodegenerative and psychotropic stability. Her anti-hyperkinetic maintenance baseline continues on Austedo (deutetrabenazine) 9 mg twice daily to target her progressive motor chorea. Her scheduled psychotropic profile-including Risperdal 4 mg twice daily, Clonazepam 1 mg three times daily, Diazepam 5 mg every 12 hours, and Depakote Sprinkles-remains active without any immediate modifications to manage her severe underlying anxiety, chronic delusions, and neurodegenerative muscle spasticity. Nursing staff will monitor her clinical parameters closely, maintaining careful tracking for extrapyramidal complications, severe sedation, orthostatic blood pressure variances, or signs of worsening depression associated with the vesicular monoamine transporter 2 (VMAT2) inhibitor protocol.

Regarding environmental safety and physical assistance, her mobility and nursing instructions remain strictly enforced. She must remain strictly ambulatory via a wheelchair for spatial navigation, and facility caregiving staff will attempt to provide total, comprehensive, hands-on physical assistance for all activities of daily living (ADLs), bathroom transitions, and positional transfers to prevent further traumatic balance failures. In light of her acute care resistance, staff are instructed to utilize advanced behavioral de-escalation techniques, avoiding forced mechanical restraints or safety belts that trigger combative thrashing and heighten her risk of overturning the wheelchair. Extensive counseling regarding on-site fall prevention interventions will continue, noting that her poor cognition, advanced neurodegenerative pathology, and lack of safety awareness significantly contribute to her ongoing mechanical risk. Staff will continue to perform detailed skin checks across her boney prominences and resolving contusions.

In accordance with the explicit mandates and updated care preferences finalized with the patient's family and director of administration (DOA), facility staff are instructed to immediately transfer the patient to the acute care emergency room for a full medical and traumatic workup following every single subsequent mechanical fall event. The family remains fully cognizant that her progressive propulsive falls are functionally unavoidable due to her central nervous system degeneration, and they recognize that regional alternative care institutions have formally refused her admission. They choose to continue her current localized, conservative care plan within this nursing environment and express that they remain very happy with the services provided at Divine Assisted Living. We will continue to pursue every clinical opportunity to maximize her physical safety and support her quality of life. Staff are instructed to contact physician services immediately for any non-fall clinical changes, extrapyramidal developments, questions, or acute concerns.”

On 07/16/2026, Ms. Gashi provided the facility *Fall Policy* which stated:
"In case of a witnessed or unwitnessed fall follow the steps: (If unresponsive follow Resident Emergency plan) If responsive after fall than follow the steps as mentioned below:

1. *Ask the resident if they hit their head during the process of falling down. (Whenever the resident admits or if witnessed by staff/others hitting head hard during fall and/or any visible head injury/trauma, confusion following fall etc. call 911 right away for residents who are NOT on hospice services irrespective of DR status or call hospice first if resident on hospice services and follow instructions provided) If in case of any doubt whether 911 should be called or not please call resident DR for advice right away and follow instructions.*
2. *If no head injury but in an emergency, situation including but not limited to major/obvious injury/trauma, resident moaning in pain etc. following the fall, call 911 right away for residents who are NOT on hospice services irrespective of DR status. Give a copy of the facesheet & MAR to EMS or to the family (if the family is transporting). For Hospice residents, please call Hospice first and follow the instructions provided.*
3. *If no obvious injury: Check for any visible injuries by scanning open areas, gently touching covered body parts. Avoid excessive movement of any extremities/ the resident. Ask for pain, take a full set of vitals, complete skin assessment form, Call the Doctor's office and inform the incident and follow instructions/ Hospice if resident on hospice services and follow instructions provided.*
4. *Call & inform Administrator/Manager/ Health and Wellness Manager.*
5. *Inform Resident family/Guardian/representative.*
6. *Fill out the incident report."*

On 07/16/2026, Fire Chief DeKorte reported that Since June 3rd, DeWitt Township Fire has been called to Building Three 25 times which included 19 times specifically for Resident A. The calls for Resident A included 17 calls for falls, one Hemorrhage/Laceration as a result of a fall and one sick person. Resident A refused transport twice and EMS transported her to the hospital 17 times. The six other calls were for three seizures, two falls and one sick person for other residents.

On 07/17/2026, administrator Weaver reported that training, equipment policies and resident transfers are a standard part of the staff's core job description. Administrator Weaver reported that training for Hoyer lifts is integrated into the 36-hours of hands-on-floor training that all staff members receive upon hire. Administrator Weaver reported that the facility utilizes official American Red Cross training curriculum to certify staff in cardiopulmonary resuscitation (CPR) and first aid, ensuring each staff member is fully prepared to evaluate injuries and respond to emergencies. Administrator Weaver provided a copy of the resident care giver job description and copies of the specific training materials provided to staff during in-service training sessions which I reviewed. In the "Core Duties" of the job description and some of the pertinent ones are listed below:

- “Assist with bladder or bowel requirements, which may include helping the resident to and from the bathroom, assisting with incontinent care, or assisting the client with bedpan routines.
- Assist with turning, positioning, and getting clients into and out of bed.
- Assist with transferring residents with assistive devices such as gait belt, walker, wheelchair, etc.
- Assists residents with comfort and anxiety relief.
- Meets needs of residents with special conditions, i.e. mental illness, developmental disabilities, and behavior disorder.
- Respond to call system promptly and arrange for emergency services as needed.”

On 7/20/2026, Fire Chief DeKorte called and reported that since January 1, 2026, the facility has contacted EMS 49 times for Resident A. Fire Chief DeKorte reported that they received a call on 7/18/2026 at 12:48 am and when they arrived at the facility staff was not present upon entry, Fire Chief DeKorte reported EMT Powers led DeWitt Township Police Department (DTPD) to the patients room due to familiarity with the patient and found her sitting on the floor next to her wheelchair by herself, appearing to be calm/acting at her baseline. Fire Chief DeKorte reported Resident A stated that she was not hurt/injured. Fire Chief DeKorte reported Resident A stated that she has Huntington's disease that results in frequent falls along with borderline personality disorder (BPD) and she had fallen out of her chair. Fire Chief DeKorte reported that staff then approached us and stated that they called to have Resident A transported for a psychiatric evaluation and wanted the police to talk to Resident A in hopes to help with her behavior. Fire Chief DeKorte reported Resident A stated that she did not want to be transported to the hospital and since there was a not a need, Resident A was not transported. Fire Chief DeKorte reported that the DTPD and the DeWitt Township Fire Department (DTFD) it is not the role of these emergency personnel to talk with residents about their behavior rather this is the responsibility of direct care workers who should be adequately trained to meet this need.

Fire Chief DeKorte reported that they were called a second time on 7/18/2026 at 2:11pm. Fire Chief DeKorte reported that DeWitt Township Fire and Eaton area EMS were dispatched to find Resident A sitting in hallway after a fall out of her wheelchair. Fire Chief DeKorte reported that the fire department is very familiar with Resident A as we run on her multiple times a week. Fire Chief DeKorte reported that fire fighters assisted in getting Resident A up off floor and onto the cot. Fire Chief DeKorte reported that no transport to the ER was required.

Ms. Gashi provided in Incident Report (IR) dated 7/18/2026 at 2:19am. It stated “resident repeatedly threw herself to floor, she was assaulting staff as well as calling names. Unwitnessed fall.” In the “treatment provided” section of the IR it stated, “EMT were called and said she was OK and refused to take her.” This was created by DCW Allyana Eastman.

I interviewed DCW Allyana Eastman who reported that she works third shift and that there are always two DCWs on duty during third shift. DCW Eastman reported that she has contacted EMS when Resident A has slipped out of her wheelchair, bed or when she has thrown herself on the floor multiple times for an extended period of time as the DCWs on duty cannot keep picking her up as “it’s a lot on them.” DCW Eastman reported that on 7/18/2026, her coworker DCW Gina Trevino was working with Resident A and DCW Trevino reported that Resident A had been combative all night by throwing herself out of bed, kicking and hitting her. DCW Eastman reported that Resident A picks and chooses who she is mean, aggressive and angry toward. DCW Eastman reported that EMS came out about 2am. DCW Eastman reported that when they called for EMS they did not ask for the police but the police came out with the EMTs. DCW Eastman reported that Resident A had been taken to the hospital during the day and had already returned when she became physically aggressive towards staff. DCW Eastman reported that Resident A typically calms down after EMS comes out. DCW Eastman reported that she called dispatch for lift assistance for help to get Resident A off the floor. DCW Eastman reported that she and DCW Trevino had already helped Resident A several times and they just could not lift her up anymore as this had been going on for a couple of hours. DCW Eastman reported that when Resident A does not have an assigned one to one caregiver, but when they have dedicated one DCW to her during the day, Resident A’s behavior is manageable. DCW Eastman reported that on one occasion a DCW watched movies with Resident A and was there to get her water when she needed it and Resident A had a great day. DCW Eastman reported that there is a group chat the includes nurse Courtney Hamill, administrator Weaver and community director Gashi where the suggestion was made to assign Resident A one to one supervision however administration never followed up on that suggestion. DCW Eastman reported that Resident A requires more care than the facility can provide which is why EMS intervention is needed. DCW Eastman reported that she is trained to administer medications and she is not aware of any PRNs that can be administered to Resident A if she is having a behavior. DCW Eastman reported that EMS is out regularly to intervene with Resident A for lift assistance. DCW Eastman reported that some days Resident A does not have any behavioral issues. DCW Eastman reported that Resident A does well after Realtive A1 visits because she is happy. DCW Eastman reported DCWS are busy during third shift and don’t have time to dedicate one DCW directly to Resident A to give her the attention she needs so she does not have inappropriate behaviors. DCW Eastman reported that they additionally, all DCWs have been taking Resident A to the bathroom to help curb her falls.

On 7/21/2026, an exit conference was conducted with licensee designee Achal Patel, who acknowledged and understood the violations established. Mr. Patel asked that it be documented that the facility recognizes it cannot meet Resident A’s needs; however, efforts to locate an appropriate next placement have been unsuccessful. He stated that stakeholders have been more inclined to point out perceived errors than to assist in identifying a placement capable of meeting Resident A’s needs.

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(4) Direct care staff shall possess all of the following qualifications before working independently: **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	Based on my review of EMT and Dewitt Township fire runs from January 1, 2026 to present, it is clear that direct care workers are not fully capable of managing Resident A's behaviors and have inappropriately utilized 911 assistance, including lift assistance, when this should have been completed by direct care staff. Per my review of training records and regular direct care worker duties, providing transfer and/or lift assistance and managing challenging behaviors is part of the expected work to be completed by direct care workers. Given the sheer volume of calls for Resident A alone since January 1, 2026, 49 times, direct care staff members are not equipped to manage her high, intense level of physical and mental health care. This is also evident in the statements made by the licensee designee Achal Patel and facility RN Courtney Hammill who stated respectively not being able to meet Resident A's needs and being at a loss as to how to best meet her needs. Fire Chief DeKorte recalled a recent specific incident on 7/18/2026 at 12:48 am and again at 2:11pm, when EMS was contacted regarding Resident A and neither incident required transport to the emergency room. Fire Chief DeKorte reported that at the first call, staff stated that they wanted the police to talk to Resident A to help with her behavior which is not their role. The second time on 7/18/2026, Fire Chief DeKorte reported that fire fighters assisted in getting Resident A up off floor and onto her bed which can also be completed by direct care staff. DCW Eastman confirmed that she has contacted EMS when Resident A has slipped out of her wheelchair, bed or after Resident A has thrown herself on the floor multiple times for an extended period of time as the DCWs on duty can keep picking her up as "it's a lot on them" even though this is responsibility of the licensee and direct care staff to meet this need not EMS. Statements like this are consistent with other DCW statements and behaviors as noted by EMS such as not being present by the resident after calling 911 for assistance, not cleaning a resident covered in feces before calling 911 for lift assistance, sending EMS to the wrong resident room after calling in a medical emergency, and not knowing how to use a Hoyer lift. Consequently, direct care workers are not capable of appropriately handling emergency situations and overutilize 911 for assistance.
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, contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the provisional license status.

07/21/2026

_____

Julie Elkins — Date
Licensing Consultant

Approved By:

07/22/2026

_____

Dawn N. Timm — Date
Area Manager