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 Center 5 LLC
100
865 S Cedar St
Mason, MI 48858-2001

RE: License #: AL230404954
Investigation #: 2026A1033042
Divine Life Assisted Living Center 5 LLC

Dear Mr. Patel:

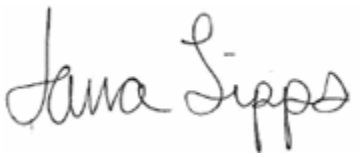
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL230404954
Investigation #:	2026A1033042
Complaint Receipt Date:	06/09/2026
Investigation Initiation Date:	06/12/2026
Report Due Date:	08/08/2026
Licensee Name:	Divine Life Assisted Living Center 5 LLC
Licensee Address:	100 865 S Cedar St Mason, MI 48858-2001
Licensee Telephone #:	(517) 708-8745
Administrator:	Cheri Lynn Weaver
Licensee Designee:	Achal Patel
Name of Facility:	Divine Life Assisted Living Center 5 LLC
Facility Address:	1020 Eastbury Drive Lansing, MI 48917
Facility Telephone #:	(517) 708-8745
Original Issuance Date:	11/20/2020
License **Status:**	REGULAR
Effective Date:	05/20/2025
Expiration Date:	05/19/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS

	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has a history of elopements and a lack of safety awareness. He did not receive appropriate supervision from direct care staff and eloped from the facility on multiple occasions. His last elopement on 6/8/26 he was not identified as missing for multiple hours and was located about eight miles away from the facility.	Yes
Resident B was assaulted by Resident C due to improper direct care staff supervision of the residents.	No

III. METHODOLOGY

06/09/2026	Special Investigation Intake 2026A1033042
06/12/2026	Special Investigation Initiated - On Site- Interviews conducted with direct care staff/facility manager, Samantha Gardner, Community Operations Manager, Brittnay Kyles, and Resident A. Review of Resident A's resident record initiated.
06/12/2026	APS Referral- Assigned to APS, adult services worker, Heather Townsend.
06/12/2026	Contact - Document Sent- Email correspondence sent to APS, Heather Townsend.
06/16/2026	Contact - Telephone call received- Interview conducted with APS, Heather Townsend, via telephone.
06/16/2026	Contact - Document Sent- FOIA request emailed to Eaton County Sheriff's office.
06/16/2026	Contact - Document Sent- FOIA request sent to Lansing Police Department.
06/17/2026	Contact - Document Received- FOIA responses received from Eaton County Sheriff and Lansing Police Department.
06/24/2026	Contact - Document Received- Special Investigation Intake #211213 received via email on 6/24/26. Allegation of lack of supervision provided to residents resulting in Resident B being hit by an unknown resident. This allegation was added to current SIR #2026A1033042.

06/24/2026	Contact - Telephone call made- Interview conducted with Tri County Office on Aging, support coordinator, Janel Bellinger, via telephone.
06/24/2026	Contact - Telephone call made- Attempt to interview Tri County Office on Aging, support coordinator, Jackie Fedewa. Voicemail message left, awaiting response.
06/24/2026	Contact - Telephone call made- Attempt to interview Citizen 1, via telephone. Left message, awaiting response.
06/24/2026	Contact - Telephone call made- Attempt to interview direct care staff, Antariyanah Williams. Voicemail message left, awaiting response.
06/24/2026	Contact - Telephone call received- Interview conducted with Citizen 1.
06/24/2026	Contact - Telephone call received- Interview conducted with direct care staff, Antariyanah Williams.
06/25/2026	Contact - Telephone call received- Interview conducted with Tri County Office on Aging, Support Coordinator, Jackie Fedewa.
06/30/2026	Contact - Face to Face- On-site visit completed related to additional allegations received 6/24/26. Interview conducted with direct care staff/home manager, Samantha Gardner. Review of Resident B and Resident C records initiated.
07/07/2026	Inspection Completed-BCAL Sub. Compliance
07/21/2026	Contact – Telephone call made- Interview conducted with Administrator, Cheri Weaver, via telephone.
07/23/2026	Exit Conference Conducted via telephone with Administrator, Cheri Weaver, and via email with licensee designee, Achal Patel.

ALLEGATION: Resident A has a history of elopements and a lack of safety awareness. He did not receive appropriate supervision from direct care staff and eloped from the facility on multiple occasions. His last elopement on 6/8/26 he was not identified as missing for multiple hours and was located about eight miles away from the facility.

INVESTIGATION:

On 6/9/26 I received an online complaint regarding the Divine Life Assisted Living Center 5, adult foster care facility (the facility). The complaint alleged that Resident A has a history of elopements and resides at the facility due to it being a locked and secure setting. The complaint reports that on 6/8/26 Resident A climbed the six-foot privacy fence in the courtyard of the facility and direct care staff did not know he was missing until several hours after he eloped. The complaint further alleged that Resident A was found at least eight miles away from the facility. The complaint stated that this was not the first elopement for Resident A from this facility.

On 6/12/26 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/home manager, Samantha Gardner, regarding the allegation. Ms. Gardner reported that Resident A was admitted to the facility on 5/29/26. She reported that she was told he had a history of elopements and required a secured setting. She reported that previously Resident A resided with a family member, Citizen 1, but he kept eloping from their apartment and was caught wandering out into traffic. Ms. Gardner reported that the referral for Resident A was received from the Tri County Office on Aging (TCOA). Ms. Gardner reported that Resident A was brought to this facility for care because this facility has locked doors and a gated courtyard. She reported that since admission Resident A has eloped from this facility on about six occasions. She reported she cannot be certain who assessed Resident A to determine he would be a good fit at the facility. Ms. Gardner reported that some of the times Resident A eloped he just followed people out the front door when the lock was disengaged and they did not have sufficient staff to send someone after him to bring him back into the facility. She reported that there has been an instance where Resident A held down the door handle for 15 seconds and was able to bypass the delayed egress door as the lock releases after 15 seconds. She reported that on the occasion he was able to hold down the door handle and deactivate the lock, direct care staff had been providing personal care to a resident who required two-person direct care staff assistance. She reported that there were only two direct care staff on duty on this occasion. Ms. Gardner reported that there is no real pattern for when Resident A attempts to elope that the direct care staff have been able to determine. She reported that the facility is always staffed with two direct care staff, but there are times when there are three direct care staff available. She reported that the facility is usually staffed with three direct care staff on weekdays in the mornings.

Ms. Gardner reported that on 6/8/26 Resident A eloped from the back courtyard area during third shift. She reported the direct care staff members working on this shift were

Citizen 2 and Antariyanah Williams. She reported her understanding of the recall of this shift was that the two direct care staff members last saw Resident A around 1am on 6/8/26. She reported that shift change occurred at 6am and the two relief direct care staff, Amanda Wright and Adrianna Larkins, began conducting morning rounds which is when it was realized that Resident A was missing. Ms. Gardner reported that Ms. Wright identified that Resident A was missing and direct care staff immediately began implementing their elopement protocol. She reported that this includes searching the facility, the facility grounds, calling the police, contacting family/guardian, and Ms. Wright called Ms. Gardner. She reported that after Resident A was reported missing, he was found at his old apartment. She reported the Lansing Police Department found Resident A at this location. The address provided for his location was 510 N. Cedar St. Lansing, MI. Ms. Gardner reported that Resident A was found outside this apartment complex and was taken into police custody. She reported Community Operations Manager, LPN, Brittnay Kyles, drove to the address and observed Resident A in police custody. Resident A was then transported to University of Michigan Sparrow Health hospital for a medical evaluation. Once cleared by the hospital staff, Resident A was discharged back to the facility. Ms. Gardner reported that to the best of their understanding they think Resident A used a small table in the courtyard to climb over the privacy fence and elope from the facility.

Ms. Gardner reported that the expectation is for direct care staff to conduct two-hour rounds to ensure all residents' care needs are met and to have eyes on all residents every two hours. She reported that when Resident A was admitted to the facility on 5/29/26 she entered these two-hour checks on his care plan, but for some reason the care plan did not save correctly in the computer system, and these two-hour checks did not show up on the care plan. Ms. Gardner reported that all direct care staff know that two-hour checks are required for each resident but further explained that the evening of 6/8/26 these checks were not recorded on Resident A's care plan as this was not a saved task on the care plan due to the computer error. Ms. Gardner further reported that nothing saved on Resident A's initial care plan and the direct care staff did not inform her of Resident A having no care plan items to follow until she discovered this on 6/8/26. When asked if this was expected for every resident to have a care plan to follow and an expectation that direct care staff would have informed her if the care plan was not available she reported that this should have been reported to her by any direct care staff who realized there was not a completed care plan in the system. She reported that Resident A's first complete care plan is dated 6/8/26 due to this error. Ms. Gardner reported that she has made attempts to interview Citizen 2 and Ms. Williams regarding Resident A's elopement. She reported that Citizen 2 stated she last checked on Resident A at 1am on 6/8/26. She reported that Ms. Williams had not yet returned her telephone call. When asked about surveillance cameras at the facility and whether there was footage of Resident A leaving the premises, Ms. Gardner reported that the surveillance cameras are not working correctly. She reported that the Wi-Fi system at the facility is not strong enough to power these cameras and this has been an ongoing problem for about 1.5 years. She reported that she has discussed this with licensee designee, Achal Patel, and brought this up on multiple occasions with other management team members who oversee the facility. She reported that co-licensee

designee, Vivek Thakore, has sent an information technology (IT) specialist out to check on the Wi-Fi system in the past but nothing has really changed regarding this issue. Ms. Gardner reported that since the elopement on 6/8/26 the facility has added alarms to the courtyard door and Resident A's bedroom door. She reported direct care staff will now be able to hear when Resident A opens his bedroom door and when the courtyard door is being opened. Ms. Gardner was asked why it took six elopement attempts before any proactive measures were taken to assist in preventing Resident A's elopements. She reported that the previous elopement attempts were made during daytime hours when there are more direct care staff available to supervise him and if he eloped, they usually saw it happening right away and reported to police immediately.

During the on-site investigation on 6/12/26 I attempted to interview Resident A. Resident A was sitting in the courtyard during this interview. Resident A was combative, easily agitated, and uncooperative with the interview. Resident A reported in multiple ways that he does not want to reside at the facility and he wants to leave. When asked if he had climbed the privacy fence in the courtyard, he reported having no recollection of this event. Resident A's memory recall appeared to be limited to 30 second intervals. He has very poor short-term memory and became easily agitated as he would ask the same question multiple times in a row as he did not recall the answers provided.

During the unannounced on-site investigation on 6/12/26 I reviewed the following documents:

- *Resident Register*. This document identified Resident A was admitted to the facility on 5/29/26.
- *Assessment Plan for AFC Residents*, document for Resident A, dated 5/30/26. This document is signed by Administrator, Cheri Lynn Weaver, and Citizen 1. On page one, under section, *I. Social/Behavioral Assessment Plan of Action*, subsection, *A. Moves Independently in Community*, the document is marked, "No", with the narrative, "Requires supervision and guidance." Subsection, *D. Alert to Surroundings*, is marked, "No", with the narrative, "Requires redirection and cueing." Subsection, *P. Requires Routine Supervision Checks*, the document is marked, "Yes", with the narrative, "Every two hour checks will be provided by staff."
- *Health Care Appraisal*, for Resident A, dated 5/28/26. Under section, *16. Other Health-Related Information or Concerns*, is the written narrative, "Difficulty in home with redirecting, risk for elopement poor judgement related to dementia. Irritable and angry at times, but no physical aggression."
- *Durable Power of Attorney for Health Care,* for Resident A. This document identifies Citizen 3 and Citizen 1 as the patient advocates appointed for Resident A.
- *AFC Licensing Division – Incident/Accident Report,* for Resident A, dated 5/29/26, and completed by direct care staff, Adrianna Larkins. Under the section, *Explain What Happened/Describe Injury*, it reads, "Resident wanted to leave the facility even after being redirected multiple times he eventually went out the front door telling staff everything we told him was bullshit and kept walking." Under section, *Action Taken by Staff/Treatment Given*, it reads, Staff called police and

both contacts on file, no answer from either contact. Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Once he was found resident wanted to go to Sparrow so he was sent out."

- *AFC Licensing Division – Incident/Accident Report,* for Resident A, dated 5/30/26, and completed by direct care staff, Amanda Wright. Under the section, *Explain What Happened/Describe Injury*, it reads, "Resident keep pacing saying he wanted to leave I told him he just had to stay awhile longer. I went to help another resident and he exited the front door." Under section, *Action Taken by Staff/Treatment Given*, it reads, "Staff called police and contacted people on file." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Resident was sent to Sparrow."
- *AFC Licensing Division – Incident/Accident Report,* for Resident A, dated 6/5/26, and completed by direct care staff, Samantha Gardner. Under the section, *Explain What Happened/Describe Injury*, it reads, "Resident eloped from facility by jumping the fence while staff was providing cares to other residents." Under section, *Action Taken by Staff/Treatment Given*, it reads, "Staff called 911, DPOA and DON. Resident was sent to McLaren hospital." Under the section, *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, it reads, "Follow hospital instructions."
- Direct care staff schedule from 5/28/26-6/8/26. I observed the following on this document:
    - 5/28/26: There were at least three direct care staff on duty between 8am – 4pm. The rest of the shifts were covered by two direct care staff.
    - 5/29/26: At least three direct care staff on duty between 8am – 5pm. The rest of the shifts were covered by two direct care staff.
    - 5/30/26: two direct care staff scheduled for all shifts.
    - 6/1/26: Three direct care staff scheduled between 5pm – 9pm. The rest of the shifts were covered by two direct care staff.
    - 6/2/26: At least three direct care staff between the hours of 7am – 4pm. The rest of the shifts were covered by two direct care staff.
    - 6/3/26: At least three direct care staff between the hours of 8am – 6pm. The rest of the shifts were covered by two direct care staff.
    - 6/4/26: At least three direct care staff between the hours of 8am – 4pm. The rest of the shifts were covered by two direct care staff.
    - 6/5/26: At least three direct care staff between the hours of 8am – 4pm. The rest of the shifts were covered by two direct care staff.
    - 6/6/26: Two direct care staff scheduled for all shifts.
    - 6/7/26. Only one direct care staff scheduled from 6am to 2pm on this date. Third shift identifies Citizen 2 and Ms. Williams scheduled to work 10pm to 6am on 6/8/26.
    - 6/8/26: At least three direct care staff scheduled between the hours of 8am to 4pm and 5pm to 9pm. Two direct care staff scheduled the remaining hours.
- Active Cares, care plan for Resident A. The following tasks were observed on this document:

- Check Door Alarms: Patio and Bedroom. Check that the door alarm to the patio and on Resident's bedroom door are on and active. This is dated 6/8/26.
- Hourly Checks. This is dated 6/8/26.

On 6/16/26 I submitted Freedom of Information Act (FOIA) requests to the Eaton County Sheriff's Office and the Lansing Police Department regarding police reports involving Resident A. I received the following documents:

- *Incident/Investigation Report*, Eaton County Sheriff's Department, for Resident A, dated 5/29/26. In section, *Crime Incident*, it reads, "Missing Person". Under the section, *Narrative*, it reads, "On 05/29/26, at approximately 1912 hours, I was dispatched to 1020 Eastbury Drive (New Life Assisted Living) in reference to a missing person complaint called in by an employee, later identified as ADRIANNA NICOLE LARKINS. Call notes indicated [Resident A], had walked away from the referenced location. It was further reported [Resident A] was last seen wearing blue scrubs, a Michigan State University hat, and a Michigan State University jacket. Once arriving on scene, I was advised there had been a fifteen minute time delay between [Resident A] eloping from the care facility and myself arriving. Shortly after, I was provided with a video showing what [Resident A] was last seen wearing. During that video, I observed he was last seen wearing orange scrubs, a Michigan State University hat, and a Michigan State University jacket. After being provided with this information, I was advised [Ms. Larkins] had attempted to contact family but was unsuccessful. I was further informed [Resident A] was experiencing early onset dementia and hallucinating. Shortly after, I asked DEP. LANE to come to the scene to utilize her drone to assist in locating [Resident A]. Prior to traveling around the area, I provided [Ms. Larkins] with the missing persons form where she provided me with information and signed her name on the sheet. The sheet was later sent to dispatch for [Resident A] to be entered into LEIN as a missing person. Further Information: While checking the local area, I traveled eastbound on W. Saginaw Highway, and I observed [Resident A] walking eastbound near Fast Eddie`s Car Wash, near the intersection of W. Saginaw Highway and S. Creyts Road. Due to this observation, I made contact with [Resident A] and took him into protective custody. When speaking with [Resident A], I believed he did not know he was currently being placed into assisted living for his mental health condition. Shortly after, I transported [Resident A] back to the assisted living facility where he was turned over to Delta Fire for an evaluation."
- *Incident/Investigation Report*, Eaton County Sheriff's Department, for Resident A, dated 6/5/26. In section, *Crime Incident*, it reads, "Missing". Under the section, *Narrative*, it reads, "On 6/5/26, at approximately 0715 hours, I was dispatched to 1020 Eastbury Drive room 112 for a missing person. Dispatch advised a resident had left the property approximately 10 minutes ago. He was identified as [Resident A], 2/25/60. The male was last seen wearing a green Spartan jacket and blue jeans, and he had an unknown direction of travel. Upon arrival on scene, I checked the surrounding area to the east of the assisted care facility and could not locate [Resident A]. I went inside and contacted the nurse on duty,

ADRIANNA LARKINS. She advised approximately 20 minutes ago [Resident A] pushed a chair against the south fence and jumped it, exiting the property. [Resident A] has a history of doing this and has been found multiple times by deputies. [Ms. Larkins] said last time he was found trying to get cigarettes at Fast Eddies. She said [Resident A] is court ordered to be there due to his predementia. Other than that, [Resident A] has no health issues and is still able to get around. I checked his room, room 112, to double check that he is not inside, and I confirmed he was not. Other deputies checked the surrounding areas, but we were unable to locate him. A missing person form was turned into Dispatch, and a BOL was sent to Ingham County, due to notes from other deputies saying he likes to walk eastbound back to Lansing, since [Resident A] used to live on the east side of Lansing. Later during the shift dispatch advised me [Resident A] had been located at Walgreens located at Saginaw Hwy and Waverly. The New Life Assisted Living advised they would meet PD at Walgreens to hand over the PRT paperwork they had completed. At Walgreens I escorted [Resident A] to the back of my patrol car so he could wait in the A/C. New Life staff told me they wanted [Resident A] transported by EMS. EMS was called and when they arrived on scene they transported [Resident A] to McLaren hospital."

- *Incident/Investigation Report*, Eaton County Sheriff's Department, for Resident A, dated 6/8/26. In section, *Crime Incident*, it reads, "Missing Person". Under the section, *Narrative*, it reads, "On June 8th, 2026, at approximately 0623 hours, I was dispatched to Divine Life Assisted Living, located at 1020 Eastbury Drive in Delta Township for a missing person. Dispatch advised a resident left. He is [Resident A], 66-year-old white male, last seen wearing a grey shirt and blue jeans. He jumped the back fence around 15 mins ago, possibly. Dispatch advised he has alcohol induced dementia. They just did shift change, and he was not in his room. The staff does not know where he is, and the caller would be on the floor working with other residents. I arrived to the area and drove through the neighborhoods and nearby establishments looking for the male, who was identified as [Resident A]. He has been known to run away from this facility previous times in the past. I was not able to locate him. I spoke to a couple walking along the trail near Eastbury Drive. They advised they did not see anyone on the trail and were coming from Creyts Road. Other deputies checked the surrounding areas and areas in a wider scope because it is known he makes it pretty far when he leaves the facility. I then contacted the complainant/caller, who is a nurse at the facility, identified as AMANDA JEAN WRIGHT. She advised she did her rounds when she came in for her shift at 0600 hours this morning and noticed [Resident A] was missing. She advised the last person to see him was an employee they refer to a "REE-REE," identified as ANTARIYANAH JZANEAN WILLIAMS. She advised her and another employee work the night shift that night. That employee is identified as LAUREN ELIZABETH HANNA. I spoke with ANTARIYANAH over the phone. She advised she last saw [Resident A] around 0200 hours when she did a check on him, and he was sleeping. She advised their last check was at 0600 hours, but she last saw him at 0200 hours. [Ms. Wright] advised me checks are supposed to be done every two hours, and night

shift advised they thought they heard something loud this morning and assumed it was [Resident A] leaving, but they did not see [Resident A] leave. [Ms. Wright] advised me [Resident A] is known to leave out the back door and jump the fence. The front door and the east and west side doors all have alarms, but the back door does not have an alarm. There is an enclosed gate with no door opening to lead out to the backyard, but [Ms. Wright] advised me there was a footprint. I went out and observed the outdoor area that the residents use. I observed a plastic table near the east fence. There was a footprint on the table and a partial footprint on part of the fence located on the east side. [Ms. Wright] advised they saw him previously jump the fence. [Ms. Wright] advised me she is not sure if he goes in the woods; he is usually down the sidewalk when he leaves the facility. She advised he has gone to Walgreen`s and Fast Eddies and is usually outside of establishments. [Ms. Wright] said she stayed in the facility because the last time she followed one of the residents who left she advised they are not allowed to do that because they needed two staffing minimal on floor at all times. She advised me brief changes are logged but not the two-hour checks. They still have to go to every room if their brief is not changed. There are no logs for when the door alarms go off. I checked Walgreen`s and Fast Eddies and did not locate [Resident A]. SGT. STUDLEY had K9 ROSCOE run a track, but he picked up nothing other than normal areas for foot traffic. CAPT. BLOCK also had a drone up in the area to look for [Resident A]. I was advised [Resident A's] power of attorney is his sister-in-law, identified as [Citizen1]. I spoke with [Citizen1] over the phone and let her know what was going on. She confirmed the address the facility had on file for [Resident A] of 6129 Beechfield Drive apartment 113 Lansing, Michigan 48911 has not been his address for years. She confirmed the 510 North Cedar Street apartment 308 Lansing, Michigan 48912 address on his driver`s license used to be his previous license where they resided together. She advised he still resides there, and he was not there at that time. She advised he is a veteran, can ride the bus free, and has veteran buddies in the area of the Beechfield address, so maybe he headed that way. I had Dispatch request for units to check that address. [Citizen 1] informed me [Resident A] is a veteran and he can take the bus for free. His sister also has power of attorney over him, [Citizen 3], but she resides in Florida per [Citizen 1]. I was not able to get a further description of any of the employees of what he was wearing, but [Resident A] is known to wear blue jeans, a grey shirt, and a green MSU hat. When speaking to [Citizen 1], she advised me she already contacted the AG`s office because he is a flight risk. She also advised he has a full beard and has not shaved. When I spoke to [Ms. Wright], she also advised me he had no phone for us to ping. I had Dispatch check the hospitals, and he was not at Sparrow ER or McLaren. I checked with the Fairfield Inn and their cameras between 0200 and 0600 hours and did not see him walking down Delta Commerce Rd. [Ms. Wright] advised me there are no working cameras in the facility. She advised me he had an apartment key that he refused to give to staff, possibly for his apartment on his driver`s license, and was last staying with [Citizen 1], who is his POA. I had LEIN enter him in as missing endangered, system ID number 50921635. I spoke to the owner, who was identified as VIVEK THAKORE. He advised me there are

digital logs, but he will make sure they are logging every two hours when they are checking on the patients. He also advised me none are the cameras are working because of wi-fi issues they have been having. He told me he has been working with the AG's office to get [Resident A] relocated because this facility is not fit for him given how many times he has escaped the facility. I had been in contact with [Citizen 1] throughout the duration of the day. She left me a voicemail advising she believed [Resident A] was at the apartment trying to ring the door to get in. I spoke with her on the phone, and she advised she did not know if it was for sure him, but it was for her apartment, unit 308, and she believed it was him. I had dispatch ask LPD to be en route to that address. I was then advised LPD contacted [Resident A] and asked for them to hold onto him in protective custody so I could transport him to Sparrow per [Citizen 1's] wishes when speaking to her. I arrived at 510 Cedar address and contacted [Resident A]. He was clearly confused and said he was just trying to go home. He does not remember living at a living facility and said he walked all the way here; he did not take a bus. He said he left around midnight but does not remember much. I then had to take him to the hospital. [Resident A] was frustrated with going to the hospital; he just wanted to make his own decisions and did not understand why he could not just be free. I advised [Citizen 1] he would be taken to Sparrow. Initially, she was not going to head out, but then I advised her she had to because it was of her request even though she contacted the AG's office JACKIE FEDEWA and his social worker, ERIN SCOTT. I contacted both and left both a voicemail. I then transported [Resident A] to Sparrow main, located at 1215 East Michigan Avenue Lansing, Michigan 48912. While I was there, I received a phone call from the AG's office, JACKIE FEDEWA. I spoke with her. She was aware of what was going on and would also be contacting APS. She advised they were having trouble with finding somewhere for [Resident A] to go because of his personality and different stage of dementia, but they were working on it. She advised they did not know if there were any beds he would qualify for or would fit his needs. I explained to her my concerns of him going back to the facilities [sic] since he is a flight risk and explained how far he walked. I provided the nurse at Sparrow [Citizen 1's] contact information. I advised them she would be on her way and also let JACKIE know that as well, and they would be handling it from there. I also contacted Adult Protective Services. They did not give me an intake number but advised I would receive a letter in the mail on the status of my complaint."

**Please note that the AG referred to in police reports should be Tri-County Office on Aging (TCOA) as that is Jackie Fedewa's employer.*

On 6/16/26 I interviewed Adult Protective Services (APS), adult services worker, Heather Townsend, via telephone, regarding the allegations. Ms. Townsend reported that she received a complaint related to a lack of supervision for Resident A at the facility. She reported that during her investigation she has been informed that Resident A has eloped multiple times from this facility, since his admission, and direct care staff and/or management did not make any changes to his plan of care until this last elopement on 6/8/26. She reported that her understanding is that there are now alarms

on his bedroom door and the courtyard door to alert direct care staff to when Resident A is moving about the facility. She reported that she would soon be closing her case as these safety measures have been instituted.

On 6/24/26 I interviewed Citizen 2 via telephone, regarding the allegation. Citizen 2 reported that they previously were employed at the facility. She reported that she had worked with Resident A and he had eloped from the facility on several occasions. Citizen 2 reported that Resident A was first admitted to the facility as a respite patient over a long holiday weekend. She reported that on the day he admitted Ms. Gardner had unlocked the courtyard fence to allow the lawn care company access to mow the courtyard. Citizen 2 reported that Ms. Gardner did not relock the gate after the lawn care company mowed and Resident A was able to elope from the facility on this date through the unlocked gate. She reported that on 6/8/26 Resident A eloped from the courtyard again by moving a table in front of the privacy fence and climbing over the fence. She reported she did not witness him climb the fence on 6/8/26. She reported that it was discovered he was missing from the facility at 6am that morning when the direct care staff were making rounds in resident bedrooms and noticed he was gone. Citizen 2 reported that she had worked that evening and last saw Resident A at 5:30am. Citizen 2 then later in her interview indicated that she last saw Resident A around 10pm or 11pm and reported him missing around this time. Her recall of the evening was contradictory in nature. She reported that this was Resident A's second elopement on this date and that earlier in the day he eloped and was found by the police near Firehouse Subs. She reported that the police were called and he was eventually found several miles from the facility on 06/08/26. Citizen 2 reported that Resident A eloped on a daily basis. She reported that there were at least 7 to 10 times, since his admission that he eloped. She reported direct care staff had "no help" to keep Resident A inside the building. She reported that the surveillance cameras do not work and have not worked for at least a year. She further reported that there are no lights outside and the direct care staff cannot see around the facility at night. Citizen 2 reported that Ms. Gardner did want Resident A to receive a mental health review because he was eloping so frequently, but he was sent back to the facility because he has dementia and it was determined it was not a mental illness that required inpatient therapy to address his elopements. She reported direct care staff were told that the answer to his elopements is to have better supervision. Citizen 2 reported that the facility is usually only staffed with two direct care staff members and this is not adequate to provide for Resident A's supervision needs. Citizen 2 reported that she feels the facility is not adequately staffed and that they accept resident respite admissions, often on weekends, and do not have adequate information about the residents they are receiving and very little management support to provide for the care needs of these respite residents. She reported that when there are only two direct care staff on duty for third shift and they have residents who require a two person assist with personal care/transfers, it makes it difficult to provide adequate supervision when there is a resident who is an active elopement risk.

On 6/24/26 I interviewed direct care staff, Antariyanah Williams, via telephone regarding the allegation. Ms. Williams reported that she did work the evening of 6/8/26 when Resident A last eloped from the facility. Ms. Williams reported that she worked with

Citizen 2 on 6/8/26 and she last had eyes on Resident A around 4:30am. She did not report where she last saw him in the facility. She reported that around 6am the direct care staff were conducting rounds on all residents and found that Resident A was missing from the facility. She reported that the police were called once it was discovered Resident A was missing. She reported that since this event alarms have been installed on Resident A's bedroom door and the back patio door leading to the courtyard. She reported that direct care staff did find a chair near the gate that it appeared Resident A had stepped on to get himself over the gate. She reported that there was a shoe print on the chair. Ms. Williams reported that there are usually just two direct care staff members on duty when she works her shift from 10pm to 6am. She reported that currently there are no residents who require a two person assist with personal care, transfers, or mobility since one of the residents who required this level of care recently died. She reported that this resident was still alive on 6/8/26. Ms. Williams reported that the facility does have surveillance cameras, but she is not certain that these cameras are operational.

On 6/25/26 I interviewed TCOA, Support Coordinator Jackie Fedewa, via telephone, regarding the allegations. Ms. Fedewa reported that she is the supports coordinator assigned to Resident A. She reported that she has been working with Resident A for the past six months. She reported that Resident A has an alcoholic induced dementia which causes him to experience behaviors such as elopements. She reported that previously he was living with Citizen 1 and this became unsafe because he was eloping from their apartment and putting himself in harms way by walking out into traffic. She reported that a respite stay was tried at the facility to see how Resident A might adjust to the facility setting. She reported that it was decided to admit Resident A to the facility. She reported that her understanding is on 6/8/26, while Citizen 2 and Ms. Williams, were providing care to another resident, Resident A eloped from the facility, by climbing the privacy fence in the back courtyard. Ms. Fedewa reported that Resident A walked multiple miles away from the facility to his former apartment and was eventually found by the police. She reported that he was found unharmed and transported to the hospital for evaluation. She reported that she "begged" the hospital for a psychiatric consult for Resident A and this was denied due to his "dementia process." Ms. Fedewa reported that Resident A was returned to the facility, and alarms were added to his bedroom door and the back patio door that leads to the courtyard. Ms. Fedewa reported that starting sometime the week of 6/15/26 TCOA increased the amount of reimbursement they were providing for Resident A's care to increase staffing at the facility to provide for Resident A's care. She reported that there should now be three direct care staff scheduled per shift. Ms. Fedewa reported that when she was working on admitting Resident A to the facility, Ms. Gardner is the only contact she had regarding this process. She reported that the direct care staff reported to her that they had last seen Resident A in the middle of the night on 6/8/26. She reported that she did not ask what time that occurred. She reported that Resident A was found to be missing at breakfast time, and the police were called and did find him. She reported that now his medications have been adjusted and he is much less combative and presents as cooperative with direct care staff. She reported that medications added to his plan of care were Ativan, Depakote, and Zyprexa.

On 6/30/26 I conducted a follow-up, on-site investigation at the facility. I interviewed Ms. Gardner on this date. Ms. Gardner reported that Resident A is doing much better and there have not been any elopement attempts since 6/8/26. She reported that since the last elopement Resident A was evaluated by his physician and ordered medications to assist with his agitation and combative behaviors. She reported that these medications are not sedating Resident A and he is still interacting with direct care staff and participating in activities but is much less aggressive and the exit seeking has decreased dramatically.

On 7/21/26 I interviewed Administrator, Cheri Weaver, regarding the allegation. Ms. Weaver reported that Resident A was admitted to the facility on 5/29/26. She reported that Resident A had a history of elopement and required a secure setting. She reported that the facility seemed like an appropriate place because it was a locked unit. Ms. Weaver reported that Resident A began eloping from the facility the day he was admitted. She reported direct care staff were told to conduct regular checks on Resident A and he was scheduled for hourly checks. She reported that Resident A's physician, Dr. Srivivasa Madireddy, was actively working with Resident A on making medication changes to decrease his potential for elopement and decrease his agitation and anxiety. She reported that Dr. Madireddy added Lorazepam to Resident A's medications on 5/30/26, after his first elopement. She reported that Dr. Madireddy changed the Lorazepam dosage on 6/2/26 and 6/3/26 in efforts to decrease agitation for Resident A. Ms. Weaver reported that Dr. Madireddy prescribed nicotine gum for Resident A on 6/3/26, as it was determined that the primary motivation for Resident A's elopements was his cigarette dependency. Ms. Weaver reported that Resident A refused the nicotine gum until 6/9/26 when he began to use this product regularly. Ms. Weaver reported that Dr. Madireddy also added Olanzapine to Resident A's medications on 6/5/26 to address his mental health. Olanzapine is prescribed as an antipsychotic medication. Ms. Weaver reported that door alarms on the patio door and Resident A's bedroom door were added as of 6/8/26 after his last elopement from the facility when he was found several miles away from the facility. Ms. Weaver reported that there has been issues with the security cameras at the facility not working and this is currently being addressed. She reported that the Wi-Fi system has been going in and out of service and when the Wi-Fi is down and reboots they must reconnect every camera to the Wi-Fi again. She reported that as of today the facility is being equipped with a new Wi-Fi system through a different internet provider to address this issue.

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 the interviews conducted and documentation reviewed it can be determined that the direct care staff did not keep Resident A protected and safe at the facility specifically on 6/8/26 and multiple times between 5/29/26 and 6/8/26. It has been identified that Resident A was admitted to the facility on 5/29/26 with a known history of elopement. The only safety mechanism in place at the time of admission was the fact that the front door and side entry/exit doors were equipped with alarms. On day one of Resident A's admission he began exit seeking and was successfully able to exit the facility on multiple occasions. Ms. Weaver did note that Dr. Madireddy was working on adjusting Resident A's medications in efforts to reduce his agitation and anxiety in efforts to control his exit seeking. The Eaton County Sheriff's Office had records of three incidents of elopement from the facility where they were involved in returning Resident A to the facility. It was disclosed that it was not until the last episode of elopement on 6/8/26 that a door alarm was placed on the back patio door and Resident A's bedroom door. The two direct care staff working on 6/8/26, during the shift when Resident A eloped, had differing stories related to when they last checked on Resident A and how many hours it had been since the last time they had eyes on him at the facility. His disappearance was not identified until the next shift direct care staff came on duty and began conducting their daily rounds on all residents. Resident A was gone for multiple hours as he was able to climb the fence in the courtyard and walk multiple miles to his old apartment building. Since Resident A was a known elopement risk, immediately began exit-seeking upon admission to the facility, experienced multiple elopements resulting in law enforcement needing to locate him, and was not responding to changes in medications made by Dr. Madireddy, additional features such as the door alarms should have been instituted prior to 6/8/26, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B was assaulted by Resident C due to improper direct care staff supervision of the residents.

INVESTIGATION:

On 6/24/26 I received an online complaint regarding the facility. The complaint alleged that Resident B was assaulted by Resident C due to a lack of supervision provided by direct care staff. There was no Complainant to interview regarding the allegation. The complaint noted that Resident C hit Resident B and did not show any signs of injury

from the altercation. The complaint further reported that the direct care staff are now trying to keep the two residents apart.

On 6/24/26 I interviewed Janel Bellinger, Support Coordinator with Tri County Office On Aging (TCOA). Ms. Bellinger reported that she provides services to Resident B. She reported that Resident B has resided at the facility since December 2024. She reported that she received an email from Ms. Gardner on 6/17/26, informing her that Resident B had been yelling at another resident and the resident assaulted Resident B by hitting him. Ms. Bellinger reported that to her knowledge there was not an injury sustained by Resident B. She reported that she and Guardian B1 have a meeting set up at the facility on 6/30/26 to discuss the incident and review Resident B's care plan. Ms. Bellinger invited this licensing consultant to the care plan meeting on 6/30/26. Ms. Bellinger reported that the facility has been a good placement for Resident B. She reported that Resident B has some mental health challenges and a history of elopement. She reported that since this facility has locked entry and exit doors that this has been a good fit for Resident B. Ms. Bellinger reported that to date, the facility has provided adequate supervision for Resident B and she has not had any cause for concern. She reported that Resident B has a tendency toward verbal aggression, but not physical aggression.

On 6/30/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Gardner regarding the allegation. Ms. Gardner reported that on 6/16/26 Resident B was watching television in the common area, and Resident C had been pacing in the area. She reported that she was not present at the facility but she was on the telephone with direct care staff members on duty due to a computer issue they were experiencing. Ms. Gardner reported that direct care staff, Isis Blakenburg & Taquela Watkins, were working at the time of the incident. Ms. Gardner reported that she could hear commotion at the facility while she was on the telephone. She reported that Resident C becomes upset with loud noises and direct care staff on duty feel the volume of the television upset Resident C. She reported that Resident B began yelling at Resident C and then Resident C hit Resident B. Ms. Garnder reported that since the incident Resident C has met with his primary care physician to discuss his behaviors and his medications were changed to assist with his anxiety and agitation. Ms. Gardner reported that neither Resident B nor Resident C had experienced physical aggression toward one another before this incident. She reported that direct care staff are now monitoring their interactions more closely in effort to de-escalate any potential issues.

During my on-site investigation at the facility, I participated in the care plan meeting for Resident B. Those present for this meeting were Ms. Gardner, Ms. Bellinger, Guardian B2, and Older Adult Services worker with Clinton-Eaton-Ingham Community Mental Health Authority (CEI-CMH), Nichole Busch. All participants are active participants in Resident B's care planning needs. All participants agreed that Resident B has been kept safe at the facility and this was a unique incident that occurred with Resident C. All participants agreed that the facility is the best setting for Resident B at this time and they do not believe Resident B is currently in danger at the facility. Discussions were had about increasing social stimulation for Resident B by incorporating some outings for him.

During the on-site investigation at the facility on 6/30/26 I reviewed the following documentation:

- *AFC Licensing Division – Incident/Accident Report*, for Resident B, dated 6/16/26, completed by Ms. Blakenburg. Under the section, *Explain What Happened/Describe Injury*, it reads, “Staff was on the phone with management and heard both of the residents hitting each other.” Under the section, *Action Taken by Staff/Treatment Given*, it reads, “Separated the residents and gave them PRN’s, called legal guardian.”
- *AFC Licensing Division – Incident/Accident Report*, for Resident C, dated 6/16/26, completed by Ms. Blakenburg. Under the section, *Explain What Happened/Describe Injury*, it reads, “Staff was on the phone with management and heard both of the residents hitting each other.” Under the section, *Action Taken by Staff/Treatment Given*, it reads, “Separated the residents and gave them PRN’s, called legal guardian.”
- *Assessment Plan for AFC Residents*, for Resident B, dated 10/27/25. This document is signed by licensee designee, Achal Patel, and Guardian B1. Under the section, *I. Social/Behavioral Assessment*, subsections, *I. Controls Aggressive Behavior* and *K. Gets Along With Others*, the document is marked, “Yes”, in both subsections.
- *Assessment Plan for AFC Residents*, for Resident C, dated 4/3/26. This document is signed by licensee designee, Achal Patel, and Citizen 1. Under the section, *I. Social/Behavioral Assessment*, subsections, *I. Controls Aggressive Behavior* and *K. Gets Along With Others*, the document is marked, “Yes”, in both subsections.

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 the interviews conducted and documentation reviewed, there is not adequate evidence to suggest that the direct care staff members did not provide appropriate supervision for Resident B and Resident C on 6/16/26. Neither Resident B nor Resident C's assessment plans indicated that they had the potential for aggressive behaviors or that they could not get along with others. Resident B's care team, comprised of his guardian, TCOA Supports Coordinator, and CEI-CMH case manager, all agreed that they had no reason to suspect that Resident B was not being afforded adequate supervision and support from the direct care staff. This appears to be an isolated incident between the two residents, and no injury was sustained by either resident. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the current status of the license recommended at this time.

7/21/26

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Jana Lipps Date
Licensing Consultant

Approved By:

07/22/2026

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Dawn N. Timm Date
Area Manager