GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2026

Achal Patel
DIVINE LIFE ASSISTED LIVING OF DEWITT 2
2045 Birch Bluff Dr
Okemos, MI 48864

RE: License #: AL190418069
Investigation #: 2026A0466056
Divine Life Assisted Living of Dewitt 2

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 #:	AL190418069
Investigation #:	2026A0466056
Complaint Receipt Date:	06/18/2026
Investigation Initiation Date:	06/18/2026
Report Due Date:	08/17/2026
Licensee Name:	DIVINE LIFE ASSISTED LIVING OF DEWITT 2
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 2
Facility Address:	1177 SOLON RD DEWITT, MI 48820
Facility Telephone #:	(517) 484-6980
Original Issuance Date:	06/03/2024
License Status:	REGULAR
Effective Date:	12/03/2024
Expiration Date:	12/02/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

	TRAUMATICALLY BRAIN INJURED

II. ALLEGATION:

	Violation Established?
Resident A has bruises on her body therefore there is concern of abuse.	No
Additional Findings	Yes

III. METHODOLOGY

06/18/2026	Special Investigation Intake 2026A0466056.
06/18/2026	APS Referral-APS Tom Hilla assigned.
06/18/2026	Special Investigation Initiated – Telephone call to APS Tom Hilla.
06/30/2026	Inspection Completed On-site Resident A's record not available for review- staff could not access.
06/30/2026	Contact - Telephone call received from administrator Cheri Lynn Weaver called about the documents that were needed.
07/28/2026	Inspection Completed On-site, second time.
07/28/2026	Contact – Email sent to administrator Cheri Lynn Weaver about the documents that were needed.
07/29/2026	Contact – Email recevied from administrator Cheri Lynn Weaver documents sent.
7/29/2026	Contact- telephone call made to DCW Carolyn Morton, interviewed.
07/30/2026	Exit Conference with licensee designee Achal Patel.

ALLEGATION: Resident A has bruises on her body therefore there is concern of abuse.

INVESTIGATION:
Complainant reported on 6/18/2026 that Resident A went to the emergency room (ER) for a medication adjustment and blood work completed. Complainant reported that Resident A has bruises in her pelvic region. Complainant reported that the bruise is purple and yellow and is above the genital area in Resident A's pubic hair. Complainant reported that the bruise may be bigger than 4 centimeters and round in shape. Complainant reported that Resident A has been discussing sex a lot but has

not disclosed any sexual abuse by anyone including a direct care staff or resident. Complainant reported that Resident A had completed computed tomography (CT) to ensure that she did not fall causing a bleed. Complainant reported that there was blood noted in Resident A's vaginal cavity on CT, but Resident A declined a speculum exam. Complainant reported that Resident A also has bruises on her forearm that are brown. Complainant stated these bruises differ from the bruise in the genital area. Complainant reported that due to this, there is a concern that Resident A may be being sexually or physically abused.

Complainant reported that Resident A is 74 years old and diagnosed with vascular dementia, limited mobility, and cannot perform her activities of daily living (ADLs) without direct care staff assistance. Complainant also reported that Resident A uses a walker, takes medication described as blood thinners and has a history of stroke and blood clotting. Complainant also described Resident A as a modest person who does not like to shower or be showered at the facility where she resides.

On 6/18/2026, Adult Protective Services (APS) worker Tom Hilla reported that he will be petitioning the court to appoint a legal guardian for Resident A, as she was determined to be no longer capable of making her own medical decisions. He stated that although concerns were raised regarding possible sexual abuse, the facility employs no male direct care staff members and the emergency department (ER) found no evidence of abuse. There was also no history of challenges with other residents. APS Hilla also reported that Resident A will not return to the facility following her hospital discharge. The APS investigation was completed with no substantiation of abuse.

On 6/30/2026, I conducted an unannounced investigation however I was not able to access Resident A's record for review as direct care staff Zeza Gashi and Kaylynn Mitchell were not at the facility and they are the only ones with access to resident records. Resident A was not able to be interviewed as she had already been discharged from the facility.

On 06/30/2026, administrator Cheri Weaver contacted me after learning that I had visited the facility and was unable to review Resident A's record as requested. Administrator Weaver reported that APS Hilla completed an investigation regarding concerns of possible sexual abuse involving Resident A. She stated that the facility does not employ any male staff and that there have been no concerns suggesting a male resident may have sexually abused Resident A. She further reported that there have been no resident behavioral disturbances at the facility. Administrator Weaver explained that Resident A has bruising due to prescribed blood thinners, which are frequently adjusted by her physician. As a result, Resident A bruises easily and develops new bruises often.

On 07/07/2026, administrator Weaver emailed the documents requested on 6/30/2026. I reviewed Resident A's *Assessment Plan for AFC Residents*

(assessment plan), dated 5/26/2026. The plan indicates that Resident A is not alert to her surroundings due to confusion, controls her sexual behavior, gets along with others, and requires assistance with bathing, dressing, and personal hygiene. It also noted that Resident A uses a walker for ambulation. This assessment plan did not document that Resident A required any additional supervision.

I reviewed Resident A's Medication Administration Records (MAR) for May and June 2026. The records show that Resident A is prescribed blood-thinning medications, which carry an increased risk of bruising even with minor trauma. The blood thinners prescribed to Resident A are:

- Clopidogrel tab 75MGTake 1 Tablet by Mouth Daily, started on 5/26/2026.
- Warfarin sodium 6mg Take one tablet by mouth daily started on 6/6/2026.

On 07/29/2026, administrator Weaver clarified that Resident A lived at the facility from 5/26/2026, through 6/14/2026, for a total of 18 days. Resident A was sent to the hospital on 6/14/2026 and did not return. I reviewed an *AFC Licensing Division Incident Report* dated 6/14/2026, at 7:19 a.m., which documented that Resident A had blood in her urine and stool and was sent to the hospital per the facility nurse's direction. Resident A's record did not contain a *Health Care Appraisal*, as her provider, Harmony Cares, was scheduled to complete it within the 30-day requirement; however, she was discharged before this could occur.

I interviewed direct care worker (DCW) Carolyn Morton who reported that Resident A was admitted to the facility following a hospital stay and arrived with existing bruises. DCW Morton stated that Resident A did not exhibit hypersexual behaviors and never spoke about sexual topics. She confirmed that no male direct care staff work at the facility. DCW Morton reported that Resident A never disclosed any abuse or mistreatment by any DCW or resident. She described Resident A as often confused and required redirection to her room or the dining area. Resident A did not display behavioral challenges, did not require special supervision, and wore adult incontinence briefs but was able to toilet herself.

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:	Complainant reported concerns that Resident A had bruising suggesting possible abuse. DCW Morton stated that Resident A was admitted with pre-existing bruises and never reported any abuse or mistreatment from any direct care worker or resident. DCW Morton, Administrator Weaver, and APS Hill all confirmed that no male direct care staff work in the facility and there is no evidence indicating that Resident A was abused. Resident A's *Assessment Plan for AFC Residents* indicates that she is not fully alert to her surroundings due to confusion, controls her sexual behavior, and gets along with others. It also notes that she uses a walker for ambulation and does not require additional supervision. Based on this information, there is insufficient evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
During the unannounced onsite investigation on 6/30/2026, I was not able to access Resident A's record for review. I was informed that only DCWs Zeza Gashi and Kaylynn Mitchell are the only ones with access to resident records and they were not at the facility on 06/30/2026.

APPLICABLE RULE	
R 400.691	**Resident records.**
	(3) Resident records must be kept on file in the facility for 2 years after the date of resident discharge unless a shorter retention is specified elsewhere in these rules.
ANALYSIS:	Resident A's record was not available for review on 06/30/2026. I was informed that only two direct care workers have access to resident records and neither was at the facility on 06/30/2026.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 07/07/2026, administrator Weaver emailed Resident A's *Assessment Plan for AFC Residents*, dated 5/26/2026, which she had signed in the licensee section of the document in lieu of the licensee's signature as required.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	Resident A's *Assessment Plan for AFC Residents* was completed on 5/26/2026 and not signed by the licensee designee as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION:

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.

07/30/2026

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Julie Elkins Date
Licensing Consultant

Approved By:

07/30/2026

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Dawn N. Timm Date
Area Manager