GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 17, 2026

Prabhjot Singh
Park Place OPCO LLC
PO BOX 1568
Portage, MI 49081

RE: License #: AL390418617
Investigation #: 2026A0581034
Park Place Senior Living A

Dear Prabhjot Singh:

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,

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL390418617
Investigation #:	2026A0581034
Complaint Receipt Date:	06/23/2026
Investigation Initiation Date:	06/23/2026
Report Due Date:	08/22/2026
Licensee Name:	Park Place OPCO LLC
Licensee Address:	4218 S Westnedge Ave Kalamazoo, MI 49008
Licensee Telephone #:	(269) 329-8187
Administrator:	Prabhjot Singh
Licensee Designee:	Prabhjot Singh
Name of Facility:	Park Place Senior Living A
Facility Address:	4214 S Westnedge Ave Kalamazoo, MI 49008
Facility Telephone #:	(269) 329-8187
Original Issuance Date:	05/28/2025
License Status:	REGULAR
Effective Date:	11/28/2025
Expiration Date:	11/27/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION

	Violation Established?
On 06/14/2026, the facility was left unattended by direct care staff.	Yes
Additional findings.	Yes

III. METHODOLOGY

06/23/2026	Special Investigation Intake - 2026A0581034
06/23/2026	Special Investigation Initiated - On Site - Interviewed staff.
06/25/2026	APS Referral - APS referral not made due to not allegations of abuse/neglect.
06/25/2026	Contact - Telephone call made - Interview with multiple direct care staff including, Shelley Simmons, Tristan Sigsbee, Isreal McCurtis, Ariana Sykes, and Alexander Brooks.
06/30/2026	Contact - Face to Face - Conducted a follow up inspection. Interviewed staff and attempted to interview residents.
08/05/2026	Contact - Document Sent - Email to Tabatha Watts.
08/06/2026	Contact - Document Received - Received fax from facility.
08/07/2026	Inspection Completed-BCAL Sub. Compliance
08/07/2026	Contact – Document Received – Email from Tabatha Watts.
08/10/2026	Contact – Document Received – Email from Tabatha Watts.
08/12/2026	Exit conference with the licensee designee, Prabhjot Singh.

ALLEGATION: On 06/14/2026, the facility was left unattended by direct care staff.

INVESTIGATION: On 06/23/2026, while investigating allegations at a neighboring licensed AFC facility, I obtained information that direct care staff, Alexander Brooks and Isreal McCurtis, who were assigned to work at Park Place Senior Living A, left the facility on 06/14/2026 to assist staff at the neighboring licensed AFC facility. Based on this information, I initiated an investigation to determine whether Park Place Senior Living A was left unattended and without the minimum required direct care staff.

On 06/23/2026, I interviewed Tabatha Watts, who identified herself as the facility's Administrator. She stated that at approximately 7 pm on 06/14/2026, a resident at the neighboring licensed AFC facility fell. She stated Alexander Brooks and Isreal McCurtis, who were working in Park Place Senior Living A, went over to this facility and assisted staff with lifting and transferring the resident back into bed.

On 06/25/2026, I interviewed direct care staff from both facilities, including Tristan Sigsbee, Shelley Alexander Brooks, and Isreal McCurtis. Their statements were consistent that Alexander Brooks and Isreal McCurtis were the staff assigned to Park Place Senior Living A and both left the facility sometime between approximately 7 pm and 7:30 pm to assist staff at a neighboring licensed AFC facility with lifting and transferring the resident. Staff statements differed regarding the length of time Alexander Brooks and Isreal McCurtis were away from Park Place Senior Living A with Tristan Sigsbee and Isreal McCurtis estimating approximately 20-25 minutes while Alexander Brooks estimating approximately 2-3 minutes. Shelley Simmons was unable to estimate the length of time because she was leaving the neighboring licensed AFC facility when Alexander Brooks and Isreal McCurtis arrived to the facility.

On 07/02/2026, I interviewed direct care staff, Ariana Sykes whose statement was consistent with the other staff regarding Alexander Brooks and Isreal McCurtis leaving Park Place Senior Living A to provide assistance at the neighboring licensed AFC facility; however, she estimated they were gone for approximately 10 minutes from the facility.

On 06/30/2026, I conducted a follow-up onsite inspection and interviewed direct care staff, Alexis Sanchez and Glenda George. Neither staff had direct knowledge of the 06/14/2026 incident; however, both staff described previous occasions when staff left Park Place Senior Living A to assist with resident care at neighboring facilities. They stated that during those occasions, at least one staff remained at Park Place Senior Living A.

I interviewed Resident A and Resident B; however, neither resident was able to provide information relevant to the allegation. Both stated observing staff in the

facility but stated they would not necessarily observe staff while in their bedrooms at night.

I attempted to review video footage from Park Place Senior Living A and the neighboring licensed AFC facility; however, licensee designee, Prabhjot Singh, determined video footage was only retained for 13 days due to the number of cameras and available hard drive capacity. Consequently, footage from 06/14/2026 was unavailable for review. I informed Prabhjot Singh and Tabatha Watts of my concern regarding staff leaving the facility to provide assistance at another facility, which resulted in residents being left without direct care staff supervision.

On 08/06/2026, I reviewed the facility's census record confirming there were 17 residents residing in the facility on 06/14/2026. I reviewed each resident's available Health Care Appraisal (HCA) and assessment plan, except Resident Q's HCA due to one not being available for review, and determined that Resident C, D, F, G, H, L, and M had diagnoses of either dementia, Alzheimer's, memory issues, and/or cognitive impairment. Resident E's assessment plan documented that a two person direct care staff assistance was required for toileting, transferring and repositioning.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.**

ANALYSIS:	Based on my investigation, which included interviews with direct care staff, Tristan Sigsbee, Shelley Simmons, Ariana Sykes, Alexander Brooks, and Isreal McCurtis, and a review of the facility's resident census and pertinent AFC documentation, there is sufficient evidence to establish the facility did not maintain the minimum required staffing ratio on 06/14/2026. The facility had 17 residents during waking hours, requiring a minimum of two direct care staff. Staff interviews corroborated that Alexander Brooks and Isreal McCurtis, who were both assigned to Park Place Senior Living A, left the facility to assist with resident care at a neighboring facility. Consequently, Park Place Senior Living A was without the minimum two direct care staff required during that time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGAITON: As part of my investigation, I requested to review the Health Care Appraisals for all 17 residents; however, an HCA was not available for review for Resident Q. Tabatha Watts documented Resident Q was admitted to the facility on 04/03/2026 and she was unable to locate Resident Q's HCA.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(10) A resident or resident's designated representative shall provide a written health care appraisal or a medical discharge summary by an appropriate health care professional that is completed within the 90-day period before admission. A written health care appraisal must be completed at least annually thereafter. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be completed no later than 30 days after admission.
ANALYSIS:	Resident Q was admitted to the facility on 04/03/2026; however, as of 08/12/2026, the licensee was unable to provide a Health Care Appraisal for Resident Q, as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/12/2026, I conducted my exit conference with licensee designee, Prabhjot Singh. I allowed him an opportunity to ask questions or provide comments relating to the findings. He acknowledged my findings and indicated Resident Q's missing HCA was an oversight but would address it to prevent a reoccurrence.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

08/12/2026

Cathy Cushman — Date
Licensing Consultant

Approved By:

08/17/2026

Dawn N. Timm — Date
Area Manager