



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 16, 2026

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

RE: License #: AL390418621
Investigation #: 2026A0581044
Park Place Senior Living B

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,

A handwritten signature in black ink that reads "Cathy Cushman". The script is cursive and fluid, with the first name "Cathy" and last name "Cushman" clearly legible.

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 #:	AL390418621
Investigation #:	2026A0581044
Complaint Receipt Date:	07/27/2026
Investigation Initiation Date:	07/27/2026
Report Due Date:	09/25/2026
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 B
Facility Address:	4218 S Westnedge Ave Kalamazoo, MI 49008
Facility Telephone #:	(269) 329-8187
Original Issuance Date:	12/20/2024
License Status:	REGULAR
Effective Date:	06/20/2025
Expiration Date:	06/19/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATIONS

	Violation Established?
On or around 06/02/2026, direct care staff did not assist Resident D with his toileting needs.	No
Resident D did not receive his prescribed antibiotic for a urinary tract infection.	Yes
Additional findings.	Yes

*** To maintain the coding consistency of residents across multiple special investigations, the residents in this special investigation report are not identified in sequential order.

III. METHODOLOGY

07/27/2026	Special Investigation Intake - 2026A0581044
07/27/2026	Special Investigation Initiated – Telephone - Interview with APS specialist, Mara Asher
07/27/2026	APS Referral - APS referral not necessary. APS received allegations and are investigating.
07/27/2026	Contact - Document Sent - Email correspondence with VA case manager, Amber Lowery.
08/05/2026	Contact - Document Sent - Email to Tabatha Watts, Administrator
08/07/2026	Contact - Document Received - Resident D's documentation.
08/07/2026	Contact - Telephone call made - Left voicemail with Carewell case manager, Lori Wilfong
08/11/2026	Inspection Completed On-site - Interviewed staff and Resident D
08/11/2026	Contact - Telephone call made - Interview with Lori Wilfong.
09/11/2026	Inspection Completed-BCAL Sub. Compliance
09/14/2026	Contact – Document Sent – Email correspondence with Amber Lowery.
09/15/2026	Exit conference with licensee designee, Prabhjot Singh. I left a message.

09/16/2026	Contact – Telephone call made – Interview with Prabhjot Singh.
------------	--

ALLEGATION: On or around 06/02/2026, direct care staff did not assist Resident D with his toileting needs.

INVESTIGATION: On 07/27/2026, I received this complaint through the Bureau of Community Health Systems (BCHS) online complaint system. The complaint alleged on or around 06/02/2026, Resident D remained in the dining room for approximately 11 hours without direct care staff approaching him regarding his toileting needs. The complaint further alleged that Resident D experienced significant urinary retention, resulting in an emergency room (ER) department visit and subsequent placement of an indwelling catheter.

On 07/27/2026, I interviewed Adult Protective Services specialist, Mara Asher. She stated she had been involved with Resident D for approximately two months but did not have direct knowledge of the allegations. Mara Asher stated Resident D currently had an indwelling catheter and prior to placement of the indwelling catheter, Resident D utilized a self-catheter.

On 07/27/2026, I received email correspondence from Amber Lowery, Resident D's Veterans Administration (VA) case manager. Amber Lowery documented that direct care staff, Hayley Shook, reported to VA registered nurse (RN) that she worked at the facility until 11 pm on 06/02/2026 and Resident D remained in the dining room throughout the day. According to Amber Lowery, the VA RN informed Hayley Shook that staff should have recognized that Resident D was not leaving the dining room to use his self-catheter.

Amber Lowery documented that this reportedly occurred the day before Resident D was taken to the ER, where approximately 1.6 liters of urine was documented in his bladder. Amber Lowery acknowledged that the information regarding Resident D remaining in the dining room was not based on her direct knowledge and that Hayley Shook could not verify that Resident D remained there for the entire day and she was in and out of the facility for her shift.

On 08/11/2026, I conducted an unannounced inspection at the facility and interviewed Administrator, Tabatha Watts. Tabatha Watts stated Resident D independently utilized a self-catheter prior to receiving an indwelling catheter in early June 2026. She stated the indwelling catheter was placed due to concerns regarding sanitation and recurrent urinary tract infections (UTIs). Tabatha Watts stated staff were not responsible for reminding Resident D to self-catheterize because he completed the task independently and did not require reminders or assistance from staff with toileting needs.

I attempted to interview Resident D; however, he had difficulty identifying the current date and month and providing specific information regarding past events. Resident D stated he currently had an indwelling catheter due to experiencing frequent infections while self-catheterizing. He stated staff currently assist him with emptying the catheter bag when it becomes full.

Resident D stated that prior to receiving the indwelling catheter, he independently used a self-catheter and did not require staff assistance or reminders. He stated he recalled self-catheterizing approximately eight times per day and stated he had subsequently been told this was too frequent. He was unable to recall an incident where he remained in the dining room and did not self-catheterize for 11 hours.

I interviewed Resident E, who stated she had observed staff assisting Resident D with emptying his indwelling catheter bag. Resident E stated she was not aware of any occasion when Resident D required assistance with his catheter and staff refused or failed to assist him. She did not have information regarding Resident D self-catheterizing.

I interviewed direct care staff, Stephanie Shook, whose statement was consistent with Tabatha Watts' statement. Stephanie Shook stated she was not aware of an incident in which Resident D remained in the living room or dining room for an entire day without self-catheterizing.

I interviewed direct care staff and Resident Care Manager (RCM), Hayley Shook, whose statement was consistent with Stephanie Shook's and Tabatha Watts' statements. She stated she recalled an occasion when Resident D spent much of the day in the dining room; however, she was unable to recall the specific date. Hayley Shook stated she was coming and going from the facility that day and could not confirm that Resident D remained in the dining room continuously or if he did not leave the area to self-catheterize. She stated Resident D commonly spent extended periods of time in the facility's common areas and could have left to self-catheterize without her observing him doing so.

On 08/11/2026, I interviewed Carewell case manager, Lori Wilfong. Lori Wilfong stated she's been involved with Resident D's case management since approximately 02/10/2026 and met with him twice, most recently on 05/05/2026 for his 90 day assessment. Lori Wilfong stated Resident D's May 2026 Brief Interview for Mental Status (BIMS) results indicated his cognition was intact, with little to no memory impairment. Lori Wilfong stated that during her visits to the facility, she generally observed Resident D sitting in the living room. According to her, there had been concern that Resident D was self-catheterizing too frequently, rather than not self-catheterizing enough, and that he was experiencing recurrent UTIs.

I reviewed Resident D's assessment identified as his "6 Month Assessment", dated 12/02/2025. The assessment did not identify Resident D as utilizing either a self-catheter or an indwelling catheter. Regarding toileting, the assessment contained

conflicting information. It identified Resident D as independent with toileting and requiring no staff assistance, while also identifying that staff assistance was required in the form of monitoring or cueing. The assessment further identified Resident D had incontinence with intermittent episodes of incontinence.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on my investigation, on or around 06/02/2026, Resident D was self-catheterizing. Resident D acknowledged that he knew how to self-catheterize and did not require staff assistance or reminders to do so. Although it was alleged Resident D remained in the dining room for approximately 11 hours without self-catheterizing or receiving staff reminders, the investigation did not establish that Resident D required staff prompting or assistance to self-catheterize at that time.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: (a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.
R 400.601	Definitions. (1) As used in these rules: (e) "Assessment plan" means a written plan that is prepared in cooperation with a responsible agency or individual that identifies the specific care and on-going support, services, and activities appropriate for a resident's

	physical and behavioral needs and well-being and the methods of providing the care and services, considering the preferences and competency of the resident.
ANALYSIS:	Based on my investigation, which included interviews with the Administrator, Tabatha Watts, multiple direct care staff, Resident D's VA and Carewell case managers, Amber Lowery, and Lori Wilfong, respectively, and review of Resident D's assessment plan, dated 12/02/2025, there is sufficient evidence to conclude Resident D's assessment plan did not accurately identify his care and support needs related to catheter use. The assessment plan did not identify that Resident D utilized a self-catheter or specify any associated care or support needs related to self-catheterizing. Additionally, the assessment plan was not updated to reflect Resident D's subsequent use of an indwelling catheter or the care and assistance associated with its use.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident D did not receive his prescribed antibiotic for a urinary tract infection.

INVESTIGATION: The complaint alleged that on or around 06/04/2026, Resident D was prescribed an antibiotic for a UTI following an ER visit. The complaint alleged direct care staff, Hayley Shook, received the paper prescription, but did not forward it to the VA or a local pharmacy to be filled.

The complaint further alleged that on or around 06/17/2026, Resident D's VA case manager, Amber Lowery, contacted Hayley Shook and learned Resident D had not received the prescribed antibiotic. According to the complaint, Hayley Shook questioned why the VA had not sent the medication and was informed the prescription needed to be faxed to the VA before it could be filled. The complaint alleged the VA subsequently filled the medication and overnighted it to the facility.

The complaint alleged that while Resident D was without the prescribed antibiotic, he experienced confusion, repeatedly removed his catheter, and had additional ER visits.

Amber Lowery documented the VA provider wrote a prescription for Cephalexin after reviewing records from Beacon Health System's ER. Amber Lowery documented the VA had not received the paper prescription from the licensee, Hayley Shook, or the ER. According to Amber Lowery's documentation, Hayley Shook reported faxing the prescription to the VA; however, Amber Lowery documented there was no evidence the VA received any fax.

Tabatha Watts stated Resident D receives his medications through the VA. She stated if he returned from the hospital with a prescription, the RCM was expected to fax the prescription to the VA immediately. Tabatha Watts stated it was her understanding that RCM, Hayley Shook, faxed Resident D's antibiotic prescription immediately, but the VA took an extended period of time to send the medication to the facility.

Stephanie Shook stated Resident D experienced recurrent UTIs and had been prescribed antibiotics to treat the infections. She stated it was her understanding that the hospital would send prescriptions to the VA and the VA would then provide the medication to the facility. She was unsure of the facility's process if Resident D returned from the hospital with a paper prescription.

Hayley Shook stated Resident D experienced multiple UTIs and had several ER visits related to them. She recalled Resident D being prescribed an antibiotic following an ER visit, but did not recall a prescription from the ER visit in early June 2026. Hayley Shook recalled speaking with the VA multiple times in late June regarding an antibiotic prescribed to Resident D on or around 06/22/2026. She identified the medication as Fosfomycin 500 mg and stated she recalled faxing that prescription to the VA.

Hayley Shook stated that if a resident returned to the facility with a paper prescription, she would leave the prescription for Tabatha Watts, who would scan the document into the licensee's electronic record system.

During a follow up interview, Tabatha Watts confirmed that upon receipt of a resident's written order or prescription, the RCM was responsible for faxing it to the VA. Tabatha Watts was unable to confirm if Resident D's prescription was sent to the VA.

I reviewed Resident D's Beacon Health System discharge Instructions, dated 06/04/2026, which documented Resident D was evaluated in the ER for a UTI and prescribed Cephalexin 500 mg capsule, one capsule by mouth three times daily. The discharge documentation identified the prescription as a "Printed Prescription."

I also reviewed the facility's June 2026 Observation Notes for Resident D. On 06/04/2026 at 1:45 pm, Hayley Shook documented Resident D was more confused than normal and that she contacted the VA regarding testing for a UTI. On 06/05/2026 at 9:30 am, Hayley Shook documented Resident D had been sent to the ER on 06/04/2026 at the direction of the VA nurse and tested positive for a UTI.

I reviewed Resident D's June 2026 Medication Administration Record (MAR). The MAR documented Resident D began Cephalexin 500 mg, one capsule by mouth

four times daily for seven days, on 06/22/2026 and completed the medication on 06/28/2026.

During the inspection, Hayley Shook accessed the facility's electronic medication system, where I reviewed an order for Cephalexin 500 mg, dated 06/17/2026. The order was for 28 capsules with instructions to take one capsule by mouth four times daily for seven days and listed an expiration date of 06/24/2026.

On 09/14/2026, Amber Lowery provided a follow up email clarifying information she previously provided. Amber Lowery stated she contacted Hayley Shook on 06/17/2026 regarding an unrelated matter, at which time Hayley Shook asked about the antibiotic prescribed during Resident D's 06/04/2026 ER visit. Amber Lowery stated she subsequently contacted the VA pharmacist and provider who reviewed the ER discharge documentation and placed an order for the antibiotic on 6/17/2026.

Amber Lowery further documented that VA nursing notes indicated Hayley Shook reported she did not realize the printed prescription needed to be forwarded to a pharmacy to be filled because she believed the medication would arrive by mail.

According to SIR # 2026A0581024, dated 04/16/2026, the facility was in violation of Adult Foster Care administrative Rule 400.675(1) when it was established a resident's medication was not available to be administered in December 2025. Additionally, during an unannounced inspection on 03/25/2026, multiple PRN medications for the same resident were not available in the facility.

The facility's approved Corrective Action Plan (CAP), dated 05/03/2026, documented a cart audit would be completed to ensure the facility's medications were in stock and discontinue or hold orders for medications no longer needed would be obtained. The CAP documented the "med tech" and supervisor in charge would ensure there is no missing medications by reviewing refill orders remaining on file. The CAP documented this process would ensure the physician had enough time to send refill orders to the pharmacy. The CAP further documented that if a power of attorney did not want the facility to administer specific medications, then the power of attorney would request a discontinue or a hold order from the resident's physician.

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

ANALYSIS:	Based on my investigation, Resident D was evaluated in the ER on 06/04/2026 for a UTI and was provided a printed prescription for Cephalexin 500 mg. The prescription was not processed following Resident D's discharge, and Resident D did not begin receiving Cephalexin until 06/22/2026, which was 18 days after it was initially prescribed.
CONCLUSION:	REPEAT VIOLATION ESTABLISHED [SEE SIR 2026A0581024, DATED 04/16/2026, CAP DATED 05/03/2026]

On 09/16/2026, I conducted the exit conference with licensee designee, Prabhjot Singh. He disagreed with the finding regarding Resident D's prescribed antibiotic not being available for administration as prescribed. He stated the hospital should not have sent a prescription with Resident D. I informed Prabhjot Singh that regardless of how the prescription was transmitted by the hospital, the licensee was responsible for ensuring Resident D's prescribed medication was obtained, available, and administered as ordered. I explained that the investigation established that Resident A did not receive his physician ordered medication as prescribed as the prescription was not provided to Resident A until 18 days after it was ordered.

IV. RECOMMENDATION

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

Cathy Cushman

09/16/2026

Cathy Cushman
Licensing Consultant

Date

Approved By:

Dawn Timm

09/16/2026

Dawn N. Timm
Area Manager

Date