GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 4, 2023

Saramani Jayaraman
Sylva Villas, L.L.C.
680 Larkspur Pl
St. Joseph, MI 49085

RE: License #: AM110383672
Investigation #: 2024A0579004
Sylva Villas 2

Dear Ms. Jayaraman:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (616) 356-0183.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM110383672
Investigation #:	2024A0579004
Complaint Receipt Date:	10/10/2023
Investigation Initiation Date:	10/10/2023
Report Due Date:	12/09/2023
Licensee Name:	Sylva Villas, L.L.C.
Licensee Address:	680 Larkspur Pl, St. Joseph, MI 49085
Licensee Telephone #:	(269) 281-0428
Administrator:	Mohan Jayaraman
Licensee Designee:	Saramani Jayaraman
Name of Facility:	Sylva Villas 2
Facility Address:	8934 George Avenue, Berrien Springs, MI 49103
Facility Telephone #:	(269) 473-1729
Original Issuance Date:	12/08/2016
License Status:	REGULAR
Effective Date:	06/06/2023
Expiration Date:	06/05/2025
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED/ MENTALLY ILL/ DEVELOPMENTALLY DISABLED/ AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not receiving their medications as prescribed.	Yes
Resident C does not have access to a winter coat.	No
Resident C does not have an acceptable mattress.	No
Additional Findings	Yes

III. METHODOLOGY

10/10/2023	Special Investigation Intake 2024A0579004
10/10/2023	Special Investigation Initiated - Letter Complainant
10/18/2023	Contact- Document Received Tasha Stewart, Office of Recipient Rights (ORR)
10/25/2023	Contact- Document Received Anne Simpson, ORR
10/26/2023	Contact- Face to Face Resident A, Resident C, Resident D, Resident E, Lonjezo Makulumiza (Direct Care Worker), and Joyce Mbomea (Direct Care Worker).
10/26/2023	Contact- Document Sent Saramani Jayaraman, Licensee Designee Mohan Jayaraman, Administrator
10/30/2023	Contact- Document Sent Saramani Jayaraman, Licensee Designee Mohan Jayaraman, Administrator
11/15/2023	Contact- Document Received Sylvan Jayaraman, Relative of Saramani and Mohan Jayaraman
11/22/2023	Contact- Document Sent Anne Simpson, ORR Tasha Stewart, ORR

11/22/2023	Contact -Document Sent Saramani Jayaraman, Licensee Designee Mohan Jayaraman, Administrator
10/30/2023	Exit Conference Unsuccessful

ALLEGATION:

Residents are not receiving their medications as prescribed.

INVESTIGATION:

On 10/10/23, I entered this referral into the Bureau Information Tracking System after being made aware that on 10/5/23, Riverwood case manager Mikayla Davis was at the home and the direct care worker (DCW) working asked Ms. Davis how to give Resident A his medication. Ms. Davis reviewed Resident A's medication administration record (MAR) and found that Resident A was receiving a medication that was discontinued in July 2023. He was also out of his Trazodone and Depakote prescriptions.

On 10/10/23, I exchanged emails with the complainant confirming receipt of the allegations.

On 10/18/23, I received an email from Office of Recipient Rights (ORR) worker, Tasha Stewart, who reported ORR was also investigating these allegations. Ms. Stewart stated she received additional information Ms. Davis learned from Resident B on 10/16/23, Resident B reported he was without medication on 10/15/23. Ms. Davis contacted Genoa Pharmacy who reported they have not delivered Resident B's medication since August 2023. Ms. Davis talked to a DCW on 10/16/23, who reported they are calling Walgreen's Pharmacy for refills because Resident B is out of medication. I confirmed with Ms. Stewart that I would address these allegations in this investigation.

On 10/26/23, I completed an unannounced on-site investigation. Resident A, Resident C, Resident D, DCW Lonjezo Makulumiza, and DCWJoyce Mbomea were interviewed. Resident B was reported to be at a day program and not available for interviewing.

Resident A presented with delusions, warning me I would die of contamination as law enforcement and the Federal Bureau of Investigation workers had when they came to the home, if I entered the home. He spent much of my nearly three hours in the home screaming and yelling his delusions. He reported he does not take

medication because he does not have any health needs and he fears that medications would poison him.

Resident C denied knowledge of whether he takes medication.

Resident D reported he receives his medication daily and believes he receives it correctly.

I interviewed Ms. Mbomea who reported she could not answer my questions regarding resident medications as she does not know how to pass medications. She reported she has gone to Kalamazoo for in-person medication training through Community Mental Health (CMH) twice, but she was turned away both times. She stated she was told CMH would contact her when she could attend the next medication training, but they have not contacted her. She stated she has worked at this home for seven to eight months. She stated she does not work alone and always works with someone who is trained to pass medication.

Ms. Makulumiza reported she completed an in-person medication training and can pass medications. She presented her certification of medication training. She stated at times, due to delays in shipments, residents will go days without medication. She stated Resident C is missing medication, but it will be delivered today. She stated when the medication is present in the home, it is given correctly. She stated the MAR was filled out correctly.

I reviewed the October MARs for all residents of the home, which were in a medication binder, and found the following:

The MAR for Resident A was not initialed demonstrating his evening Trazadone PRN was passed, although it appeared it was given regularly. There were loose pills in his plastic medication box.

Resident B's MAR for October was not available in the binder and Ms. Makulumiza could not locate it. I reviewed Resident B's MAR for September and found all medications, aside from Ferrous Sulfate, available in the home. Loose pills were found in Resident B's medication box.

Resident C was missing his Docusate, Depakote, and Seroquel. Like Resident A and B, loose pills were found in his plastic medication box.

Resident D had loose pills in his medication box.

Resident E had loose pills in his medication box.

Resident F had Metformin pills that were not listed on his MAR and had loose pills in his medication box.

Resident G was missing his prescription Fluoride which Ms. Makulumiza reported he does not use, and he had expired Ibuprofen in his medication box.

Resident H had a bottle of Spiriva in his medication box which was not listed on his MAR.

Resident I did not have his Flonase and had bags of old medication that Ms. Makulumiza reported he arrived with but does not use. I advised Ms. Makulumiza that medications Resident A was not using, including the bags of older medications and the Nicotine patches that were not signed for on the MAR, should be discussed with his physician and, if directed to, disposed of properly. Ms. Makulumiza reported Resident I does wear his Nicotine patch and is wearing it today and wore it 10/20/23 and 10/24/23 when she worked as well. There were no staff initials indicating Resident I had been administered his Nicotine patch at any time in October.

On 11/22/23, I exchanged emails with Ms. Simpson who reported Resident A does, at times, present with different behaviors and delusions, and that is typical behavior for him. She provided Resident A's medical case notes dating back to 10/7/22 which noted he is diagnosed with schizoaffective disorder and received a monthly Invega injection throughout the reporting period, while his psychiatrist also tried modifying other psychiatric medications he takes.

Resident A's behavioral case notes noted on 9/20/23, Resident A reported being medication compliant. He rambled thoughts he had written in a notebook at times during the case manager meeting. On 9/25/23, Resident A refused to consent to his Behavioral Treatment Plan and presented with delusions and chaotic, unintelligible speech and poor hygiene. On 10/5/23, it was noted Resident A was not medication compliant, due to no fault of his own, because he had been receiving medication that was discontinued in July 2023 and had not been receiving two of his current prescriptions. Resident A presented as difficult to engage with and would begin screaming and going on tangents. On 10/30/23, Resident A refused to meet with his caseworker.

Ms. Simpson reported, and it was confirmed through case notes, that efforts are being made to move Resident A into a different placement to better assist with his behaviors and medication management, due to him being court ordered for treatment and needing to make progress with his behaviors and treatment plan.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:

	Medications.
ANALYSIS:	I attempted to investigate the concerns of case manager Davis and ORR worker Stewart but was unsuccessful due to the lack of record keeping and staff and resident competence. Resident B did not have available for administration his prescription Ferrous Sulfate while having a physician order for it. Resident C did not have available for administration his prescription Docusate, Depakote, and Seroquel while having physician orders for them. Resident G did not have available for administration his prescription Fluoride while having a physician order for it. Resident I did not have available for administration his prescription Flonase while having a physician order for it. Based on the observations made, there is sufficient evidence that the instructions and recommendations of a resident's health care professionals were not followed regarding securing and administering medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Resident's A, B, C, D, E, and F's medication boxes containing the resident's packages of labeled medications each had loose unidentifiable medications laying on the bottom of the boxes.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Resident A's prescription Trazodone package was missing tablets indicated he was regularly administered the medication. However, his MAR lacked initials of the staff person that administered the medication. Staff had a supply of and administered Resident F's Metformin medication. However, his MAR did not list the medication. Resident I was wearing an administered prescription Nicotine patch. Review of his MAR revealed staff had not initialed the administration of the patch. Ms. Makulumiza reported he was administered patches on 10/20, 10/24, and 10/26 but the MAR was not initialed to evidence this having been done. Based on the observations made, there is sufficient evidence that direct care staff responsible for resident medications did not always maintain an accurate and updated medication log and

	ensure initials of the person who administered the medication at the time it was given.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(ii) Medication logs.**
ANALYSIS:	Resident B, while receiving medications as a resident of the home during the month of October, did not have a MAR for that month.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A does not have access to a winter coat.

INVESTIGATION:

On 10/25/23, I received an email from ORR worker Anne Simpson. The email stated she was investigating an allegation that Resident C does not have access to his winter coat because it is locked in the basement of the home.

On 10/26/23, I spoke with Resident C who denied knowing if he had a winter coat or where it would be if he had one.

Ms. Makulumiza reported Resident C will often lose items in the community. Ms. Makulumiza stated she believes that this past spring, Resident A likely left in the morning when it was cool outside and when it warmed up, he removed his jacket and left it somewhere in the community. She stated all Resident C's belongings are in his room; none are stored elsewhere.

Ms. Mbomea confirmed resident belongings are kept in their rooms and nowhere else.

On 11/22/23, I exchanged emails with Ms. Simpson who reported during her investigation, two coats belonging to Resident A were found in the basement of the home. They were washed and placed in Resident A's room for him to use.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(j) The right of reasonable access to and use of his or her personal clothing and belongings.**
ANALYSIS:	Resident C denied knowledge of whether he had a winter coat or where it would be. Ms. Makulumiza and Ms. Mbomea reported residents' belongings are kept in their rooms. Ms. Simpson reported during her investigation two of Resident C's coats were found in the basement of the home and returned to him. There is insufficient evidence to support that Resident C is not given reasonable access to and use of his personal clothing since the coats were located and returned to Resident C.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident C does not have an acceptable mattress.

INVESTIGATION:

I interviewed Resident C who denied any concerns regarding his mattress.

I observed Resident C's mattress and found it appeared clean, in good condition, supportive, well protected, and not less than four inches thick.

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a waterbed is not prohibited by this rule.
ANALYSIS:	Resident C's mattress was consistent with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

I observed blinds and blankets on a sliding glass bedroom window that were covered with pink and black colored mold or mildew.

Resident D requested I observe his bedroom door which was damaged. Resident D stated he had requested the door be repaired but it has not been.

I observed a hole in the door, which appeared it had been kicked causing the damage.

Resident D requested I observed his bedroom window screen which he reported he had asked to be repaired but had not been. I found Resident D's window screen to be damaged with an approximately one-inch hole that Resident D had wedged paper into.

I observed there to be a strong odor of urine in Resident C's room. It was unknown where the odor came from as his sheets appeared dry and his mattress was enclosed in a waterproof cover which did not appear damaged.

I observed the walls in the hallways to have dirt on them in area where residents may have wiped their hands.

APPLICABLE RULE	
R 400.14403	**Maintenance of premise.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	I observed mold/mildew on the blinds and blankets covering a bedroom window. Resident D's door and window screen were damaged. Resident C's room had a strong odor of urine. The walls of the hallways were unclean.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Resident A, Resident C, and Resident D stated they do not like the food served in the home, that it does not taste good, and they eat a lot of the same foods.

The menu read residents were to have tuna fish sandwiches for lunch. I observed plates prepared by Ms. Mbomea which she stated were beef barbeque. I inquired why the prepared food did not match the menu and Ms. Mbomea reported the beef barbeque was available in the home. I inquired if she wrote down this change to the menu anywhere, such a substitution log, and she reported she had not.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	I observed beef barbeque prepared for residents for lunch when the menu reported lunch was to have been tuna fish sandwiches. Ms. Mbomea reported beef barbeque was available, but she had not logged the change to the menu.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I observed a fire extinguisher on the main level of the home that had a needle that was in the red area, indicating it was not adequately charged.

APPLICABLE RULE	
R 400.14506	**Fire extinguishers; location, examination, and maintenance.**
	(2) Fire extinguishers shall be examined and maintained as recommended by the manufacturer.
ANALYSIS:	A fire extinguisher on the main level of the home was not replaced once it became incorrectly charged.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 10/26/23, I sent an email requesting a time to meet with administrator, Mohan Jayaraman, or licensee designee, Saramani Jayaraman, to discuss the findings of this report. Mohan Jayaraman responded that he was out of the country and that I should communicate the findings with Sylvan Jayaraman.

On 10/30/23, I exchanged emails with Mohan Jayaraman and Saramani Jayaraman that read Sylvan Jayaraman was not appointed licensee designee nor administrator and therefore by state law I could not discuss the findings with him. Mohan Jayaraman responded that Saramani Jayaraman was also outside the country through the month of November, and therefore Sylvan Jayaraman was responsible for their businesses and communication should be done with him.

On 11/15/23, I received an email from Sylvan Jayaraman that read, Saramani Jayaraman had attempted to call me on 11/13/23 and would like to arrange a time for her to speak to me. He reported she will be available to meet the week of 11/27/23. Sylvan Jayaraman claimed he had been in touch with staff and working to remedy the issues I had identified on the day of the inspection.

On 11/22/23, I exchanged emails with Mohan Jayaraman who provided airplane tickets confirming he left for India on 9/27/23 and Saramani Jayaraman left for India on 10/29/23. Saramani Jayaraman returned from India on 11/22/23. Mohan Jayaraman is set to return from India on 12/4/23.

APPLICABLE RULE	
MCL 400.713	**; criminal history and records check;**

	(19) An applicant, if an individual, or an owner, partner, or director of the applicant who has regular direct access to residents or who has on-site facility operational responsibilities shall give written consent at the time of original license application and a licensee designee shall give written consent at the time of appointment for the department of state police to conduct both of the following: **(a) criminal history check.** **(b) A criminal records check through the Federal Bureau of Investigation.**
ANALYSIS:	The home's licensee designee and administrator informally appointed Sylvan Jayaraman to handle the affairs of the licensed adult foster care facility during the time they were outside the country. Sylvan Jayaraman has not had a background check clearance consistent with the appointment of his position and during the absence of the licensee designee and administrator that provides him the authority to act on behalf of the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

I attempted to provide an exit conference with the administrator and licensee designee during this investigation. However, both were out of the country and unavailable to act on behalf of the home.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license be modified to a provisional license.

Cassandra Duursma 11/20/23

Cassandra Duursma Date
Licensing Consultant

Approved By:

Russell Misiak 11/22/23

Russell B. Misiak Date
Area Manager