GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 29, 2025

Yogarajah Saverus
Serenity Shore Assisted Living Facility, LLC
3955 Rose Drive
Berrien Springs, MI 49103

RE: License #: AL110366288
Investigation #: 2025A0790032
Serenity Shore Assisted Living Facility

Dear Mr. Saverus:

Attached is the Special Investigation Report for the above-referenced facility. Due to the violation 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
gillr@michigan.gov
(517)980-1433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110366288
Investigation #:	2025A0790032
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/08/2025
Report Due Date:	09/05/2025
Licensee Name:	Serenity Shore Assisted Living Facility, LLC
Licensee Address:	3955 Rose Drive Berrien Springs, MI 49103
Licensee Telephone #:	(269) 927-7097
Administrator:	Yogarajah Saverus
Licensee Designee:	Yogarajah Saverus
Name of Facility:	Serenity Shore Assisted Living Facility
Facility Address:	1883 W. Glenlord Road Stevensville, MI 49127
Facility Telephone #:	(269) 408-8547
Original Issuance Date:	10/27/2014
License Status:	REGULAR
Effective Date:	04/27/2025
Expiration Date:	04/26/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff members are neglecting Resident A.	No
Resident A has personal belongings that are missing.	No
Additional Findings	Yes

III. METHODOLOGY

07/07/2025	Special Investigation Intake 2025A0790032
07/08/2025	APS Referral is not necessary because Adult Protective Services is investigating the allegations.
07/08/2025	Special Investigation Initiated - Telephone I interviewed Adult Protective Services (APS) worker John Wheeler.
07/14/2025	Inspection Completed On-site I interviewed direct care staff member Margoriet Trisnanizsih.
07/28/2025	Contact – Telephone call made to interview registered nurse (RN) Kyria Bodley. I left a voicemail message requesting a return call.
07/29/2025	Contact – Telephone call made I interviewed RN Kyria Bodley.
07/29/2025	Contact – Document Received Mr. Wheeler emailed medical documentation for Resident A.
07/29/2025	Inspection Completed-BCAL Sub. Compliance
07/29/2025	Corrective Action Plan Requested and Due on 08/14/2025
07/30/2025	Exit Conference with licensee designee Yogarajah Stanley Saverus.

ALLEGATION:

Direct care staff members are neglecting Resident A.

INVESTIGATION:

On 7/8/25, I reviewed a Michigan Department of Licensing and Regulatory Affairs – Bureau of Community and Health Systems Online Complaint Form dated 7/7/25. The complaint indicated that Resident A was brought to Corewell Hospital located in St Joseph, Michigan with severe bed sores over a large percent of his body. The worst being on his left leg under the knee, foot, and backside. Also, he has malnutrition levels down to 1.6, normal is above 3.0. Resident A had to have surgery on the left leg to remove dead skin and tissue.

The complaint indicated it was reported on 7/7/25 that Resident A will have his left leg amputated on 7/9/25. The complaint indicates pictures and Dr. Schultes' report, and diagnoses are available upon request. The complaint indicated Dr. Schultes' surgery prognosis will be available upon request.

On 7/8/25, I reviewed a second Michigan Department of Licensing and Regulatory Affairs – Bureau of Community and Health Systems Online Complainant Form dated 7/7/25. The complaint indicated Resident A resides at Serenity Shore Assisted Living Facility. Resident A was in a car accident when he was 17 years old. Resident A suffers from short-term memory issues and history of a stroke.

The complaint indicated Resident A has lost over one hundred pounds since April 2025. Direct care staff members (DCSMs) stated that Resident A had a sore on the top of his mouth so he could not eat for a time, but there is no sore there currently.

The complaint indicated on 6/29/25, Resident A's legs were wrapped in bandages because of his sores. The sores are so deep they have bacteria in them. The sores are holes in Resident A's legs and buttocks.

DCSMs are not getting Resident A out of bed. It is believed they are not feeding Resident A and he cannot feed himself. There are concerns with the significant amount of weight Resident A has lost in a short amount of time.

Resident A is currently hospitalized at Corewell Health Lakeland Hospital. The sores are so deep he will most likely be hospitalized for quite a while. Resident A may need surgery to clean the sores out and additional medical treatment.

On 7/8/25, I interviewed Adult Protective Services (APS) worker John Wheeler via phone. Mr. Wheeler stated Resident A had Lakeland Home Calls and Lakeland House Calls visiting him regularly. He said a case manager / visiting nurse from Lakeland Home Calls provided wound care. Mr. Wheeler said he is unaware how often the visiting nurse cared for Resident A.

Mr. Wheeler stated a visiting physician from Lakeland House Calls visits Resident A every three months. Mr. Wheeler is unaware of the names of the case manager /

visiting nurse and/or the visiting physician currently. He said he does know the visiting nurse's first name is Kyria.

Mr. Wheeler stated he interviewed Resident A in the hospital. He said Resident A appeared competent, communicative, and mobile. Mr. Wheeler stated Resident A indicated DCSMs brought him his meals three times a day and he could get food brought to him whenever he wanted it. Mr. Wheeler stated Resident A indicated he has not been hungry recently and does not feel like eating when the food is brought to him. Mr. Wheeler said Resident A appeared to be capable of feeding himself.

Mr. Wheeler said Resident A was septic and suffering from malnutrition when he arrived at the hospital.

Mr. Wheeler stated licensee designee Yogarajah (Stanley) Saverus indicated on or about 6/27/25, Resident A was examined by the visiting physician. The visiting physician ordered that Resident A go to a wound clinic. The first appointment for Resident A to go to the wound clinic was scheduled for 7/2/25. Mr. Saverus indicated that he was not able to transport Resident A to that first wound clinic visit because it was too soon to get an extra DCSM to transport him. Mr. Saverus said he contacted Area Agency on Aging, and they instructed Mr. Saverus to arrange for Resident A to be transported to the emergency room.

Mr. Wheeler stated the case manager from Area Agency on Aging name unknown indicated Resident A's wounds were always wrapped up when they visited.

The case manager said they did not notice any evidence of physical neglect when visiting Resident A. Mr. Wheeler said he is currently uncertain who is responsible for not providing adequate care to Resident A if anyone. He said he is unsure how Resident A's physical condition specifically his wounds became so compromised so quickly.

Mr. Wheeler stated Resident A did not disclose any instances of neglect on the part of DCSMs occurring while at the facility.

On 7/14/25, I conducted an unannounced onsite investigation. I interviewed DCSM Margoriet Trisnanizsih. Ms. Trisnanizsih indicated Resident A was admitted and remains in the hospital.

Ms. Trisnanizsih stated registered nurse Kyria Bodley from Lakeland Home Calls was visiting Resident A twice weekly and providing wound care before Resident A's hospitalization. She said Resident A's wounds had progressively got worse before his hospitalization and Ms. Bodley and DCSMs could not figure out why. Ms. Bodley was concerned Resident A had a blood infection and had requested an antibiotic. She said Ms. Bodley visited Resident A every Monday and Thursday.

Ms. Trisnanizsih stated Resident A was scheduled to go to the wound clinic on 7/2/25. She said Resident A did not go on 7/2/25 to the wound clinic because Mr. Saverus was not able to get an additional DCSM to transport Resident A because it was too soon and he was not given enough time to arrange it.

Ms. Trisnanizsih stated Resident A could walk at one time, but he became very unsteady. She said Resident A would attempt to walk and fall. Ms. Trisnanizsih stated Resident A was never injured when falling. She stated Resident A became wheelchair bound. Ms. Trisnanizsih said they would assist Resident A with getting him in his wheelchair. She stated Resident A would attempt to pick things up off the floor when in his wheelchair and would slide out.

Ms. Trisnanizsih said DCSMs would always bring Resident A his meals and snacks to eat. She stated DCSMs never failed to bring Resident A food to eat, and Resident A was able to feed himself. Ms. Trisnanizsih stated they would assist with getting Resident A in his recliner before he was going to eat so he would not fall. Ms. Trisnanizsih said Resident A had a history of stroke, was a picky eater, and there was very little he would eat.

Ms. Trisnanizsih explained back in 4/25, DCSMs discovered a blister on the bottom of Resident A's right foot. She said she immediately contacted the Area Agency on Aging and Lakeland Home Calls informing them of the blister. She said Lakeland Home Calls responded by sending a home care nurse to the facility to examine and evaluate the blister. Ms. Trisnanizsih said Ms. Bodley began visiting and providing wound care twice a week immediately after that. She said Ms. Bodley would clean and dress Resident A's wound(s) and taught Ms. Trisnanizsih and other DCSMs how to clean and dress his wound on the days she did not visit. She said the wound eventually healed but it reappeared, and then other wounds began to appear. The second wound appeared on his left foot between his big two and index toe.

Ms. Trisnanizsih said Resident A began getting more and more sores on his body. She said Ms. Bodley and the DCSMs were stressed out. She stated Ms. Bodley ordered an antibiotic to treat the sores. Ms. Trisnanizsih stated she and Ms. Bodley thought Resident A must have some type of infection in his blood causing the sores to multiply so quickly.

Ms. Trisnanizsih stated DCSMs would give Resident A either a shower or bed bath daily. She said they would clean and dress the sores twice daily and using compression socks.

Ms. Trisnanizsih said she would immediately call Ms. Bodley and provide an update when a new sore was discovered on Resident A. She stated she and other DCSMs were keeping close track of the sores.

Ms. Trisnanizsih stated they were giving Resident A extra protein daily in the form of Ensure Enlive advanced nutritional shakes.

Ms. Trisnanizsih stated Resident A had developed sores on the front and behind the knee, on his left ankle, and the top and bottom of his feet. She said Ms. Brodley took photos of the sores on 6/27/25. Ms. Trisnanizsih provided me with photos of the sores.

On 7/14/25, I reviewed Resident A's *Resident Records.* I specifically reviewed Resident A's *Resident Weight Record.* I found that Resident A's weight had not been recorded since 2/25. I did not notice that Resident A experienced any rapid weight loss prior to 2/25.

I reviewed Resident A's Monthly Log Reports for 5/25 and 6/25 provided by Area Agency on Aging. I found that all Resident A's activities of daily living (ADLs) and personal needs were checked as completed every day during these two months.

I reviewed Resident A's most recent *Health Care Appraisal.* I found that Resident A suffered a traumatic brain Injury (TBI) hemorrhage, has cognitive deficits, dysphasia, tobacco use, urinary tract issues, and chronic constipation. He also was experiencing weakness in his extremities and left arm contracture.

I reviewed Resident A's *Resident Care Agreement* and found that his basic fee included board and lodging, personal care, supervision, and protection.

I reviewed Resident A's *Assessment Plan for AFC Residents* and found that Resident A was wheelchair bound, required constant assistance, and assistance with all ADLs when the plan was written.

I reviewed Resident A's Daily Progress Notes from 4/25 through 6/25. I found ample evidence that Ms. Bodley was visiting and providing Resident A with wound care at least twice a week. I found DCSMs would chart whenever Resident A was restless, not feeling well, had issues with his sores, a new sore was discovered, was administered his antibiotic, etc. DCSMs appeared to keep copious notes regarding Resident A's physical and medical condition.

On 7/15/25, I reviewed a third Michigan Department of Licensing and Regulatory Affairs – Bureau of Community and Health Systems Online Complaint Form dated 7/10/25. The complaint indicated Resident A has severe bed sores over at least 75% of his body the worst sores are on the left leg under the knee and left top of his foot.

The complaint indicated Resident A was taken to Corewell Hospital on June 29, 2025, only after a visit by a family member on 06/27/25, and subsequent visits by Relative A1 on 6/27/25 and 6/28/25. The complaint indicated it was noticed that Resident A had his legs bandaged all the way to the knees on both legs. Relative A1 spoke to licensee designee Stanley Saverus and was told Resident A was

scheduled to go to the wound clinic on 7/2/25. Relative A1 did not see how bad the wounds were until Resident A was admitted to the hospital.

The complaint indicated Dr. Bell performed surgery on the wound located on Resident A's left leg. The wound ended up being so bad and so dead that Dr. Bell took tendons and muscle out that were no longer healthy. Dr. Bell may have removed up to sixty percent of the "under part" of Resident A's left leg. The complaint indicated relatives were brought into consultation with Dr. Bell on 7/7/25 and were told medical professionals were going to have to amputate Resident A's left leg on 7/9/25. Resident A's left leg was amputated on 7/9/25 after Dr. Bell consulted with Resident A, and Resident A agreed to the surgery. Resident A also appeared to be malnourished when he was admitted to the hospital and may have lost his eyeglasses and dentures while living at the facility.

On 7/24/25, I interviewed APS worker John Wheeler for a second time. Mr. Wheeler indicated he interviewed registered nurse Kyria Bodley from Lakeland Home Calls. Ms. Bodley informed him that she had been visiting Resident A twice weekly since the end of 4/25 and providing wound care. Mr. Wheeler stated that Ms. Bodley informed him that no matter what she and DCSMs did for Resident A, his wounds progressively became worse to the point she requested a prescription for antibiotics. Mr. Wheeler said Ms. Bodley indicated she cared for Resident A up until his hospitalization.

Mr. Wheeler said before Resident A's hospitalization he was unable to get out of bed because one of his legs had atrophied.

Mr. Wheeler said he did not find any evidence of Resident A losing a large amount of weight, as much as one hundred pounds, in a short period of time. He stated he found that Resident A lost approximately ten pounds over a period of two to three years.

On 7/28/25, I contacted registered nurse Kyria Bodley via phone. I left a voicemail message requesting a return call.

On 7/29/25, I interviewed Ms. Bodley via phone. Ms. Bodley stated she did not witness any evidence of physical abuse or neglect on the part of DCSMs while providing wound care for Resident A. She said on the contrary, DCSMs helped her provide wound care for Resident A and did a good and thorough job doing so. Ms. Bodley emphasized never witnessing any evidence of neglect while providing wound care to Resident A.

On 7/30/25, I reviewed Resident A's medical documentation. I reviewed a Physical Examination dated 6/30/25 and printed on 7/2/25. The examination describes Resident A as a frail elderly man with significant contractures. The examination described Resident A's skin as having multiple wounds and notably a posterior left knee wound with discharge. The examination was conducted by Dr. Jordan R. Sall.

I reviewed ED Provider Notes dated 6/30/25 and prepared by Resident of Emergency Medicine Dr. Kortney Z. Smith. The provider notes describe Resident A's diagnoses at time of assessment as wound infection and sepsis, due to unspecified organism, and unspecified whether acute organ dysfunction present (HCC).

The provider notes describe Resident A as an elderly male who presents to the emergency department via emergency medical services (EMS) from his care facility. The patient does have a cognitive delay in it is difficult to attain history. It is reported by EMS that patient has chronic wounds that are evaluated by wound care, however due to transportation issues he was unable to be evaluated. Resident A became febrile (fever) and was brought to the emergency department for evaluation. Bilateral lower extremities with many wounds. On initial evaluation, Resident A does have decubitus ulcers which appears to cause pain when evaluated. Additionally, Resident A does appear to have some lower abdominal tenderness, Infectious workup with labs were ordered. Ceftriaxone and vancomycin ordered for antibiotic coverage. Computed tomography scan (CT) on abdomen and pelvis was obtained.

Labs significant for significant leukocytosis of 27k. Additionally, hemoglobin (Hgb) has decreased form patient's baseline within the last three months. Otherwise, no acute electrolyte abnormality, no acute kidney injury (AKI), non-elevated lactic, CT abdomen and pelvis resulted with inflammatory fat stranding within the soft tissues of the left hip and buttock. No CT evidence of osteomyelitis. Additionally, ovoid low-density lesion within the left illacus muscle seen and reported as concerning for abscess.

The provider notes indict the doctor reached out to interventional radiology who reviewed imaging and agreed to evaluate patient for possible drainage during patient's admission. The provider notes indicated under comments regarding Resident A's skin that Resident A has multiple significant wounds including decubitus ulcers on bilateral lower extremities. Other wounds scattered over the abdomen and upper extremities. The progress notes provided photos of the wounds described above. I reviewed Wound Clinic Consult Notes dated 7/1/25 prepared by Dr. Gary Witucki, DO. The notes described Resident A's physical and medical symptoms similarly as previously documented medical documentation. The notes indicate Resident A has a history of traumatic brain injury (TBI) from motor vehicle accident, hyperlipidemia, depression was evaluated in the emergency room on 6/30/25 for multiple chronic wounds. The notes reiterated emergency room (ER) wound care has been unable to evaluate Resident A due to transportation issues. Resident A was seen by Shelley Thibeault NP on 5/9/25 and was found to have an ulcer on his right foot. At that time according to DCSMs, they felt the ulcer may have occurred due to, at night when Resident A is in bed, he is frequently rubbing and moving legs in bed. DCSMs suspect that is how the wound to foot occurred. In the emergency room Resident A was found to have an elevated white blood count of 27,

glucose 170, BUN 24, and Lactic acid was normal. CT scan of the abdomen and pelvis with IV contrast was performed and demonstrated the following:

- Inflammatory fat stranding within the soft tissue of the left him and buttock. No definite soft tissue ulcer identified and no evidence of osteomyelitis.
- Ovoid low-density lesion within the left iliacus muscle. Consider abscess.
- Multiple bladder stones.
- Constipation
- Benign-appearing soft tissue mass within the right inguinal region, suggestive of enlarged inguinal node.

The provider notes indicate Resident A's diagnoses are severe sepsis, infected skin Wound, inflammatory straightening left hip/buttock with lesion around left iliacus, cognitive impairment dur to TBI, lower extremity contractures, dysphagia, hemiparesis, urinary incontinence, restless leg syndrome, major depressive disorder (MDD), hyperglycemia, normal specific anemia. Resident A was described as ill Appearing. He is not diaphoretic.

I reviewed an Assessment and Plan prepared by Dr. Jordan R. Sall, DO dated 6/30/25. The assessment and plan contained simple diagnoses, testing, and treatment options.

There were no concerns of physical abuse, physical, or medical neglect mentioned in any of the medical documents I reviewed.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with Mr. Wheeler, Ms. Trisnanizsih, and Ms. Bodley there was no evidence found indicating DCSMs neglected Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with Mr. Wheeler, Ms. Trisnanizsih, and Ms. Bodley there was no evidence found indicating DCSMs neglected Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A has personal belongings that are missing.

INVESTIGATION:

The second complaint indicated DCSMs lost Resident A's dentures and do not know where they are. DCSMs lost Resident A's glasses. Resident A does not go anywhere so it is unknown how his belongings have been lost.

Mr. Wheeler stated he has not delved to deeply into Resident A's alleged missing dentures and glasses. He said Resident A's case manager name unknown from Area Agency on Aging indicated Resident A does not like to wear his dentures and his glasses and may have put them up somewhere. The case manager indicated Resident A never used his dentures or wore his glasses, and that they were most likely just misplaced.

Ms. Trisnanizsih stated she was not aware of Resident A losing his dentures and glasses. She said no personal belongings have been reported missing for Resident A.

On 7/30/25, Mr. Saverus said they found Resident A's glasses and part of his dentures. He said he talked to Resident A's family about Resident A's unwillingness to keep his dentures in his mouth because he says they hurt him. Mr. Saverus said Resident A was taking his dentures out all over the facility. He said Resident A's case manager from Area Agency on Aging is aware and can schedule an appointment to get Resident A replacement dentures.

APPLICABLE RULE	
R 400.15315	**Handling of resident funds and valuables.**

	(4) A listing of all valuables that are accepted by the licensee for safekeeping shall be maintained. The listing of valuables shall include a written description of the items, the date received by the licensee, and the date returned to the resident or his or her designated representative. The listing of valuables shall be signed at the time of receipt by the licensee and the resident or his or her designated representative. Upon return of the valuables to the resident or his or her designated representative, the listing shall be signed by the resident or his or her designated representative and the licensee.
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with Mr. Wheeler, Ms. Trisnanizsih, and Ms. Bodley there was a lack of evidence found indicating that Resident A has personal belongings that are missing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 7/14/25, I reviewed Resident A's *Resident Weight Record* and found DCSMs had not recorded Resident A's weight since 2/25. Ms. Trisnanizsih apologized for not writing down Resident A's weights since 2/25. Ms. Trisnanizsih said she had simply forgotten to do so.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.

ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interview with Ms. Trisnanizsih there was sufficient evidence found indicating DCSMs did not record Resident A's weight monthly.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/30/25, I conducted an exit conference with licensee designee (LD) Yogarajah Saverus. Mr. Saverus was informed of the outcome of this special investigation and did not dispute the findings. Mr. Saverus was asked to provide an acceptable Corrective Action Plan (CAP) within the required timeframe and agreed to do so.

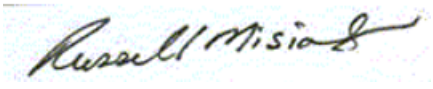
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

7/30/25

Rodney Gill Date
Licensing Consultant

Approved By:



8/6/25

Russell B. Misiak Date

Area Manager