GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2026

Shelly Burza
3676 Lange Rd.
Sebewaing, MI 48759

RE: License #: AL790260639
Investigation #: 2026A0572032
Vadavilla AFC Home

Dear Shelly Burza:

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) 643-7960.

Sincerely,

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL790260639
Investigation #:	2026A0572032
Complaint Receipt Date:	04/13/2026
Investigation Initiation Date:	04/14/2026
Report Due Date:	06/12/2026
Licensee Name:	Shelly Burza
Licensee Address:	3676 Lange Rd. Sebewaing, MI 48759
Licensee Telephone #:	(989) 551-8693
Administrator:	Shelly Burza
Licensee Designee:	N/A
Name of Facility:	Vadavilla AFC Home
Facility Address:	5750 Sheridan Rd Unionville, MI 48767
Facility Telephone #:	(989) 674-2258
Original Issuance Date:	01/12/2005
License Status:	REGULAR
Effective Date:	08/08/2025
Expiration Date:	08/07/2027
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is an 81-year-old with Alzheimer's that suffered multiple falls resulting in a skull fracture and brain bleed, with concerns that staff failed to follow proper notification and care protocols.	Yes
Additional Findings	No

III. METHODOLOGY

04/13/2026	Special Investigation Intake 2026A0572032
04/13/2026	APS Referral APS made referral.
04/14/2026	Special Investigation Initiated – Letter
04/14/2026	Contact - Document Received APS, Gerald Edwards.
04/30/2026	Inspection Completed On-site Staff, Danielle Braba.
06/08/2026	Contact - Telephone call made Staff, Barbara Gainforth.
06/10/2026	Contact - Telephone call made Staff, LeeAnn Stine.
06/10/2026	Contact - Telephone call made Former Staff, Veronica Baldwin.
06/10/2026	Contact - Telephone call made Julie Pero.
06/10/2026	Contact - Telephone call made Hospice Nurse, Maria Pyne.
06/11/2026	Contact - Telephone call made Staff, Veronica Baldwin.

06/11/2026	Contact – Document Received Resident A's Assessment Plan.
06/11/2026	Contact - Telephone call made Resident A's Family Member #1.
06/11/2026	Exit Conference Licensee, Shelly Burza

ALLEGATION:
Resident A is an 81-year-old with Alzheimer's that suffered multiple falls resulting in a skull fracture and brain bleed, with concerns that staff failed to follow proper notification and care protocols.

INVESTIGATION:
On 04/13/2026, the local licensing office received a complaint for investigation. Adult Protective Services (APS) made a referral to licensing.

On 04/14/2026, contact was made with APS Investigator, Gerald Edwards. APS did not substantiate on their case.

On 04/30/2026, I made an unannounced onsite at Vadavilla AFC Home, located in Tuscola County Michigan. Interviewed was Staff, Danielle Braba.

On 04/30/2026, I reviewed the staff schedule for 04/08/2026 and 04/09/2026, which is when Resident A went to the hospital, where she passed on 04/11/2026. LeeAnn Stine and Danielle Braba are the first shift staff (7am – 3pm). The staff on second shift (3pm – 11pm) are Julie Pero and Barbara Gainsforth. The worker on third shift (11pm – 7am) was Veronica Baldwin, and they had an extra "sleep" staff at the time name Danae Gray, who was scheduled to assist in case of an emergency.

On 04/30/2026, I interviewed Staff, Danielle Braba, regarding the allegation. Staff Braba informed me that Resident A went to the hospital on 04/09/2026 and passed away on 04/11/2026. Staff Braba stated that Resident A fell the night before on 04/08/2026 on third shift and believed Resident A may have fallen multiple times. But from what they could gather, Resident A was slowly putting herself to the floor and laying down. Resident A had been doing this for a few weeks. Third shift informed that Resident A was alert and talking, so they didn't think anything of it. When Staff Braba arrived at work, third shift staff, Veronica Baldwin said she got Resident A up to go to the bathroom around 4:30am and then brought her back to the living room so she could keep an eye on Resident A. Staff Baldwin had Resident A sitting on rocking chair, but Resident A wanted to lie on the floor. Veronica Baldwin assisted Resident A onto the floor and put a blanket over Resident A. Based on most recent behaviors, even if she had put Resident A to bed, Resident A would

have gotten out and laid back on the floor. When Danielle Braba and LeeAnn Stine arrived for first shift on 04/09/2026, they got Resident A off the floor, sat Resident A up in wheelchair and checked Resident A's vitals. Resident A was very hot and sweaty, so they used a cold towel to wipe Resident A's face and forehead. They noticed a bump on Resident a's head that was a little black & blue. As they were touching it, Resident A did not exhibit any pain. The 3rd shift worker no longer works for the company.

On 04/30/2026, I received several incident reports which indicate that Resident A kept being found on the floor multiple times. Each time staff would lay Resident A in bed or in Resident A's chair, when they check back on Resident A, Resident A would be back on the floor.

- According to an incident report, on 04/08/2026, during first shift at 12:58pm, Resident A was using a chair to slowly let herself down to the ground. Once on the ground, she gently pulled the chair on top of her chest.
- During second shift, an incident report was written on 04/08/2026 at 4pm and they noticed Resident A sitting in the sitting near the shower room and appeared to be agitated as she was throwing her shoe at another resident who was sitting in a wheelchair. Resident A walked into her bedroom to sit on her recliner, but when the staff returned, she was back sitting on the floor. Staff then got her up and put her to bed for rest, but Resident A was back sitting on the floor when they checked on her. Resident A appeared to be fine, with no signs of discomfort. Resident A came to the dinner table to eat. Resident A did not have any trouble eating with assistance. Resident A remained at the table, drinking her water while sitting in her wheelchair. Staff continued with regular after dinner activities and found Resident A sitting on the floor again. Staff administered Resident A's insulin and checked her blood pressure and gave administer her nightly medications. Staff changed her into her night gown and got her into bed. About 10-20 minutes later, Resident A was on her hands and knees, crawling on the floor. They put her in bed again and began working on paperwork. Staff heard a noise and found Resident A sitting on a bench in the Chapel. Resident walked out of the Chapel and sat at the table with staff and drank some Cranberry Juice. 3rd shift arrived and walked Resident A to the chair in the living room because Resident A did not want to go to bed. A timeline of events was given, and it indicates that at 5:50pm, Staff, Julie Pero, noticed a huge bruise on the left side of Resident A's forehead.
- During third shift, an incident report was written for 04/08/2026, which indicates that when staff, Veronica Baldwin arrived at work at 11:00pm, Resident A was awoke. She tried to get Resident A to go to chair, but Resident A went and laid on living room floor on her own. Staff felt safer with Resident A lying there as she could keep a better eye on Resident A. She allowed her to continue to sleep on the floor of the living room to prevent anymore falls or injuries from falling. Relayed information to first shift staff.

- During first shift on 04/09/2026, staff were informed by third shift staff that Resident A had several falls and that there was a bump and bruise on Resident A's forehead. Resident A was lying on the living room floor and covered in a blanket. Staff, LeeAnn Stein and Danielle Brabo got Resident A into her wheelchair and LeeAnn Stine washed her face with a cool water, wiping her mouth, forehead and neck. She called Licensee, Shelly Burza; who instructed her to call hospice nurse. The Hospice Nurse did a Face Time so that she could see Resident A, then instructed staff to call 911 so that she could be sent out.

On 06/08/2026, I contacted Staff, Barbara Gainforth, regarding the allegation. Staff Gainforth informed that she worked second shift on 04/08/2026 and stated that Resident A was doing a lot of laying and crawling on the floor, which was not Resident A's normal behavior. During the course of Staff Gainforth's shift, she had found Resident A a couple times sitting or laying on the floor. It did not appear to staff that Resident A had fallen. Resident A is non-verbal but did not present with any discomfort and she never noticed Resident A grimacing. Barbara Gainforth indicated that it is hard to tell because Resident A had dementia. It just appeared that Resident A was tired and chose to sit anywhere. Before she left for the day, she gave Resident A some Cranberry Juice and a snack. Resident A was sitting at the table where staff could keep an eye on her.

On 06/10/2026, I contacted LeeAnn Stine regarding the allegation. LeeAnn Stine was working first shift (7am - 3pm) on 04/08/2026 and did not notice any marks or bruises. When Staff Stine came to work the next day on 04/09/2026 at 7am, she was told that Resident A fell multiple times throughout the night. Resident A did not appear to be looking too good. Resident A was hot, but her vitals were normal. Staff put Resident A in wheelchair after getting her off living room floor. Resident A kept slumping over in wheelchair. They took Resident A to bedroom and called the licensee Designee, Shelly Burza, who instructed them to contact hospice nurse. Staff did not feel comfortable putting Resident A in bed, so they made a pallet for Resident A on the floor. They contacted the hospice nurse, and she instructed them to call 911 so that Resident A could be sent out.

On 06/10/2026, I contacted Hospice Nurse, Maria Pines regarding the allegation. Nurse Pines informed me that she received a call from Staff LeeAnn Stine on 04/09/2026 at approximately 7:15am. Staff Stine indicated that Resident A may have fallen multiple times on third shift. Nurse Pines conducted a video chat so she can observe Resident A and then decided to instruct staff to call 911 so Resident A can be sent out. Nurse Pines informed me that Resident A had an extensive health history to go along with her dementia and was not sure if her passing came as a result of a fall. I asked her if Nurse Pines could read the discharge summary for me to see what the diagnosis was. Nurse Pines informed me that it was Cranium Hemorrhaging.

On 06/10/2026, I contacted My Michigan of Saginaw Records Department for the Discharge Summary and Death Certificate, to verify cause of death. As of now, I have not received anything.

On 06/10/2026, I contacted Staff, Julie Pero regarding the allegation. Julie Pero informed me that she had never witnessed Resident A fall, but Resident A had been lying on the floor a lot, ever since a previous hospital visit. Staff Pero indicated that they had a previous resident who used to lay or sit on the floor all the time and just believed that Resident A was mimicking what she saw another resident doing. Julie Pero informed me that she works second shift and when she came to work on 04/08/2026 at 3pm, she noticed a bruise on Resident A's forehead that was green in color. Staff Pero assumed that this was caused on third shift. Staff Pero does not recall having a conversation with first shift staff about the bruise. Medical care was not sought after noticing the bruise.

On 06/11/2026, I received a return phone call from former staff, Veronica Baldwin regarding the allegation. Staff Baldwin informed me that she works from 11pm to 7am. When she arrived at work 04/08/2026, she kept Resident A on the living room floor the entire night because that's where Resident A wanted to sleep. Resident A only got up to use the bathroom and came back and laid back on the floor. The goose egg that Resident A had on her head had to have occurred during second shift because first shift would have noticed it before second shift. If Resident A would have fallen on her shift, she would have awoken the "sleeper" staff, Danae Gray for assistance, but there was no need because the night was very easy as she just had to clean, do rounds and maybe some laundry.

On 06/11/2026, I reviewed Resident A's Assessment Plan. Resident A is 81 years old and receiving hospice care. She is able to walk without her walker, but at times may need to use her walker. There's no indication in the Assessment Plan that Resident A likes to sleep on the floor. Resident A does not need assistance with walking but receives assistance for personal hygiene care.

On 06/11/2026, I contacted Resident A's Family Member #1 regarding the allegation. She informed me that initially, she had no concerns, but she began to have concerns with regards to the timeliness of getting her seen by medical personnel. Family #1 says she received a phone call with regards to a possible stroke as the left side of Resident A's face was drooping on 03/27/2026 and her blood pressure was very low. When she reviewed those records, it showed that her blood pressure was 94/69 on 03/26/2026, 75/61 at 8:30am on 03/27/2026 and later that day at 2:00pm her blood pressure was 108/72. Staff did not call for an ambulance until 4pm on 03/27/2026 and she thought they would have done it the day before. She also had concerns from hearing that Resident A had possibly fallen out of her chair at the dining room table and no one was aware of the fall. Family Member #1 expressed that no one ever mentioned to her about Resident A having several falls or possibly just mimicking what another resident used to do, which is sit or lay on the ground. Resident A being found sitting, laying or crawling on the ground

is highly unusual behavior. Resident A was able to walk, but had a walker if she needed it, but she did not like to use a walker, so they never made her use it. Resident A was not a fall risk and could walk up and down the hallways just fine.

On 06/11/2026, I received a copy of the death certificate which indicates that Resident A passed on 04/11/2026 of Craniocerebral Injuries and Blunt Head Trauma, which was ruled an accident. Other significant conditions were Dementia, Arteriosclerotic and Hypertensive Cardiovascular Disease.

On 06/11/2026, conducted an exit conference with Licensee, Shelly Burza. She informed that Resident A was in Hospice Care, so when they are on hospice, they do not call the ambulance unless otherwise directed by Hospice. Licensee Burza indicated that Resident A had been putting herself on the floor for the last several weeks as she was copying a previous resident. Resident A started this a month or so before she passed away at the hospital. Licensee Burza was informed of the results of this special investigation.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Based on my interviews with staff, hospice nurse, Resident A's Family Member #1, and review of Resident A's file, there is enough to establish a violation of licensing rules. Resident A had been presenting with unusual behaviors and was found to be on the floor several times. Staff were unsure if Resident A had fallen, however, Resident A was found to have had a noticeable bump and bruise on her head. There was a sudden adverse change in behavior and Resident A was not sent to seek medical attention immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that no changes be made to the licensing status of this large adult foster care group home, pending the receipt of an acceptable corrective action plan (capacity 13-15).

06/12/2026

Anthony Humphrey Date
Licensing Consultant

Approved By:

06/12/2026

Mary E. Holton Date
Area Manager