GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 8, 2025

Massey, Sanjiv
330 E. Washington
Berrien Springs, MI 49103

RE: License #: AM750257580
Investigation #: 2025A1030050
R & R Adult Foster Care

Dear Mr. Massey:

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 (616) 356-0100.

Sincerely,



Nile Khabeiry, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM750257580
Investigation #:	2025A1030050
Complaint Receipt Date:	09/26/2025
Investigation Initiation Date:	09/26/2025
Report Due Date:	11/25/2025
Licensee Name:	Massey, Sanjiv
LicenseeAddress:	330 E. Washington Berrien Springs, MI 49103
Licensee Telephone #:	(269) 473-6191
Administrator:	Massey, Sanjiv
Licensee Designee:	Massey, Sanjiv
Name of Facility:	R & R Adult Foster Care
Facility Address:	500 E. Chicago Rd. Sturgis, MI 49091
Facility Telephone #:	(269) 651-5141
Original Issuance Date:	07/29/2004
License Status:	REGULAR
Effective Date:	02/22/2025
Expiration Date:	02/21/2027
Capacity:	10
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided with protection and safety.	No
Resident A was not provided transportation to physical therapy appointments.	Yes
Additional Findings	No

III. METHODOLOGY

09/26/2025	Special Investigation Intake 2025A1030050
09/26/2025	APS Referral Received and reviewed APS referral
09/26/2025	Special Investigation Initiated - On Site Interview with Resident A
09/26/2025	Contact - Face to Face Interview with Kelly Massey
09/30/2025	Contact - Telephone call made Interview with Kelsey Dules
10/01/2025	Contact - Telephone call made Interview with Brandy Tead
10/07/2025	Exit Conference Exit conference by phone

ALLEGATION:

Resident A was not provided with protection and safety.

INVESTIGATION:

On 9/26/26, I interviewed Resident A at the facility. Resident A reported she has lived at the facility for 35 years. Resident A confirmed that there was an incident between her and Resident B that occurred several months ago but was unsure the exact date. Resident A reported Resident B was upset about something and was yelling and she told him to "shut up" and in response he picked up an object and hit her on the leg. Resident A reported the staff intervened and nothing else happened. Resident A reported this is the first time something like this ever happened and feels safe at the facility.

On 9/26/25, I interviewed Kelly Massey at the facility. Ms. Massey reported there was a physical conflict between Resident A and Resident B about five months ago and indicated Resident B has cognitive and emotional impairments and although he is 74 years is very immature. Ms. Massey reported nothing like this has ever happened before and intervened when the incident occurred.

On 10/1/25, I interviewed Resident B's case manager, Brandy Tead by phone. Ms. Tead reported she has been Resident B's case manager for two years and was aware of the incident between him and Resident A. Ms. Tead confirmed that this is the first time something like this has happened but did acknowledge that Resident B does have behavioral problems from time to time but has never known him to assault other people.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged Resident A was not provided with protection and safety. Based on interviews this violation will not be established. According to all interviews conducted there was an incident between Resident A and Resident B resulting in Resident A being hit with an object that caused a bruise. This appears to be an isolated incident and the facility staff responded appropriately to the situation.

CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not provided transportation to physical therapy appointments.

INVESTIGATION:

Resident A reported she is currently receiving physical therapy and the two staff members provide transportation to and from the appointments. Resident A reported the facility did not take her to her physical therapy appointment on 9/18/25 because they forgot about the appointment however is unaware of the appointment missed on 9/4/25. Resident A reported there were two times that the staff members were late picking her up from her appointment.

Ms. Massey acknowledged that Resident A missed her physical therapy appointments on 9/4 and 9/18 but indicated Resident A refused to go on 9/4 and she forgot about the appointment on 9/18 and would not refuse to provide transportation for any of the residents. Ms. Massey also acknowledged they had been late to pick Resident A up from her physical therapy appointments on two occasions and indicated one of their residents fell and they were attending to that resident. Ms. Massy reported that they were late to pick Resident A up for the appointment on 9/18 and accepted responsibility for the oversight.

On 9/30/25, I interviewed Kelsey Dules who works at the Strugis Hospital Physical Therapy Center. Ms. Dules reported she is concerned about Resident A missing her physical therapy appointments. Ms. Dules referred to her notes and indicated that on 9/4/25 Resident A was a no show, and the office called the facility and spoke to Kelly Massey who indicated she thought the appointment was scheduled for 4:00pm. Ms. Dules reported that Ms. Massey did not mention anything about Resident A refusing to go to the appointment. Ms. Dules reported Resident A was a no show on 9/18 and they called the facility and left a message. Ms. Dules reported Resident A was also a no show on 9/24 for her re-assessment and Ms. Massey was called and informed them that she was unaware of the appointment today. Ms. Dules reported that Ms. Massey was informed that the office discharged Resident A from the practice due to three no-shows and Ms. Massey did not appear to be concerned and did not ask to reschedule the re-assessment appointment.

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: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	It was alleged that Resident A was not provided transportation to physical therapy appointments. Based on interviews this violation will be established. According to medical documentation Resident A missed three physical therapy appointments due to the facility not providing transportation and was late on two occasions which seems to indicate a lack of organization.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/7/25, I shared the findings of my investigation with the licensee by phone. Mr. Massey acknowledged the findings and agreed to submit a corrective action plan.

IV. RECOMMENDATION

Based on the submission of an acceptable corrective action plan, I recommend no change in the current license status.

Nile Khabeiry, LMSW

10/9/25

Nile Khabeiry Date
Licensing Consultant

Approved By:

Russell Misiak

10/9/25

Russell B. Misiak Date
Area Manager