GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 22, 2021

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

RE: License #: AM110369574
Investigation #: 2021A0578046
Ammu's

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.

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) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM110369574
Investigation #:	2021A0578046
Complaint Receipt Date:	07/30/2021
Investigation Initiation Date:	07/30/2021
Report Due Date:	09/28/2021
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:	Ammu's
Facility Address:	124 Elm Street Niles, MI 49120
Facility Telephone #:	(269) 876-7212
Original Issuance Date:	04/20/2015
License Status:	REGULAR
Effective Date:	10/20/2019
Expiration Date:	10/19/2021
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Residents are abused and yelled at by staff.	No
Water was withheld from one resident because they wet the bed	No
Residents are made to stay in their room.	No
Residents are not taken to see a doctor.	No
The rooms are dirty and covered with dust and dirt.	No
The toilets the residents share are filled with feces.	No
The inside of the tubs are covered with an inch of scum	No
Residents are not helped to bathe and are often dirty	No
Residents are not allowed to receive or visit family members.	No
Additional Finding:	Yes

III. METHODOLOGY

07/30/2021	Special Investigation Intake 2021A0578046
07/30/2021	Special Investigation Initiated - Telephone -With NP Kim Nelson.
07/30/2021	APS Referral Completed.
08/04/2021	Special Investigation Completed On-site -Interview with direct care staff Love Soko, Interview with Resident A and Resident B.
08/04/2021	Contact-Telephone -Interview with administrator Mohan Jayaraman.
09/15/2021	Contact-Telephone -Interview with Relative A1.
09/17/2021	Exit Conference -Message left for the licensee, Ms. Saramani Jayaraman.

ALLEGATION:

- **The residents are abused and yelled at by staff.**
- **Water was withheld from one resident because they wet the bed.**

- **Residents are made to stay in their room.**

INVESTIGATION:

On 07/30/2021, I received this anonymous complaint through the BCHS on-line complaint system. Anonymous Complainant reported that residents are verbally abused and made to stay in their rooms with access to water restricted. No additional information was provided.

On 07/30/2021, I interviewed Kim Nelson NP, regarding the allegations. Ms. Nelson reported being familiar with this facility for the last 13 years and clarified that she had been doing house calls to this facility for the last nine years. Ms. Nelson reported that she had never personally witnessed any of the staff at this facility being verbally disrespectful to any of the residents. Ms. Nelson reported that she had purposely been in this facility at varying times during the day and never observed the reported allegations. Ms. Nelson denied having any concerns for this facility

Equipped with personal protective equipment, on 08/04/2021, I completed an unannounced investigation on-site at this facility and interviewed Resident A regarding the allegations. Resident A reported living at this facility for over 25 years. Resident A denied ever being yelled at by any staff member and denied ever observing any other resident being yelled at by staff.

Resident A denied ever being restricted from drinking water and denied ever observing any other resident being restricted from drinking water. Resident A explained that any resident can obtain water in this facility at any time. Resident A denied ever being confined to his room by staff and added that he leaves the facility on weekends to work for his father. Resident A was observed watching television in the living room of the facility. Resident A denied having any additional concerns.

While at the facility, I interviewed Resident B regarding the allegations. Resident B reported living at this facility for almost a year. Resident B denied ever being yelled at by any staff member and denied ever observing any other resident being yelled at by staff. Resident B denied ever being restricted from drinking water and denied ever observing any other resident being restricted from drinking water. Resident B clarified that he obtains his water from the kitchen but added that he stays out of the kitchen when staff are cooking meals. Resident B denied ever being confined to his room by staff and denied knowledge of any other resident confined to their room.

While at the facility I interviewed staff member Love Soko regarding the allegations. Ms. Soko reported working at this facility for over two months. Ms. Soko denied ever yelling at any residents or observing any other staff member yelling at residents. Ms. Soko reported that one Resident speaks with a friend on the phone and will sometimes get irritated and yell if he cannot hear the person on the phone speak.

Ms. Soko denied that any resident is ever restricted from having water. Ms. Soko explained that every resident obtains their own drinking water from the kitchen. Ms. Soko denied that any resident has ever been restricted or confined to their room. I noted during this unannounced investigation on-site that several residents were observed watching television in the living room while other residents were observed outdoors and congregated on a patio.

On 08/04/2021, I interviewed Mr. Mohan Jayaraman, administrator for this facility regarding the allegations. Mr. Jayaraman denied that residents are ever yelled at or confined to their rooms or have their access to water restricted.

On 09/15/2021, I interviewed Relative A1 regarding the allegations. Relative A1 reported that she is routinely in this facility to visit Resident A. Relative A1 denied ever observing staff members being verbally abusive towards residents and clarified that some residents can be loud and yell, but this may be because of the individual diagnosis of each resident. Relative A1 denied ever witnessing or being informed by Resident A that water was being restricted from residents or that residents were being confined to their rooms.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	During interviews, Resident A and Resident B denied ever being yelled at by staff, or observing any other resident being yelled at by staff. During an interview, direct care staff Love Soko denied ever yelling at residents or observing any other staff member yelling at residents. In an interview, Relative A1 denied ever observing any staff member being verbally aggressive towards any resident and denied that Resident A had ever reported to her that staff were yelling at residents. As such there is no evidence that residents are being yelled at or mistreated or exposed to any serious risk of emotional harm.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.**
ANALYSIS:	During interviews, Resident A and Resident B denied ever being confined to their rooms or having their access to water restricted. Resident A and Resident B denied ever observing any other resident confined to their rooms or having their access to water restricted. During an interview, direct care staff Love Soko denied ever confining a resident to their room or restricting a resident's access to water or observing any other staff member confining a resident to their room or restricting their access to water. In an interview, Relative A1 denied ever witnessing or being informed by Resident A that water was being restricted from residents or that residents were being confined to their rooms. As such there is no evidence that residents have been confined to their rooms or had their access to water withheld.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not taken to see a doctor.

INVESTIGATION:

On 07/30/2021, Complainant alleged that Residents are not taken to see a doctor. Complainant added that instead, a visiting nurse comes to this facility and "over medicates" and "misdiagnoses residents".

On 07/30/2021, I interviewed Kim Nelson NP, regarding the allegations. Ms. Nelson acknowledged visiting this facility on a routine basis but clarified that most of the residents at this facility are provided psychological services by Riverwood Center. Ms. Nelson clarified that it would be out of her scope of practice to diagnose

residents and she does not prescribe medications for residents that are provided services by Riverwood Center. Ms. Nelson denied having any concerns for the access to medical care provided by this facility and clarified that it is in close proximity to Lakeland Hospital.

Ms. Nelson recalled one resident who had kidney issues and used a suprapubic catheter and required frequent visits. Ms. Nelson reported this resident was intensely schizophrenic and repeatedly pulled out their catheter insisting the catheter was dirty. Ms. Nelson recalled this resident contracted Covid-19 and passed away earlier in the year. Ms. Nelson clarified that every resident and staff at this facility contracted Covid-19, resulting in several deaths. Ms. Nelson denied having any concerns for this facility.

On 08/04/2021, I interviewed Resident A regarding the allegations. Resident A denied ever not being provided medical treatment or being refused transportation to a hospital if necessary. Resident A reported having several medical conditions and clarified that he would not be living here if this were true. Resident A denied any knowledge of any resident that was denied medical treatment or transportation to a hospital.

On 08/04/2021, I interviewed Resident B regarding the allegations. Resident B denied ever not being provided medical treatment or being refused transportation to a hospital if necessary. Resident B reported being sick in the past and staff were very attentive and watched him closely and called his guardian to make her aware that he was not feeling well. Resident B denied any knowledge of any resident that was denied medical treatment or transportation to a hospital.

On 08/04/2021, I interviewed staff member Love Soko regarding the allegations. Ms. Soko reported that residents are provided with appointments with their primary physician and if necessary, provided transportation to Lakeland Hospital.

On 08/04/2021, I reviewed the details of the allegations with Mohan Jayaraman, administrator for this facility. Mr. Jayaraman acknowledged this facility is routinely visited by Ms. Kim Nelson NP, and clarified that if a resident needed medical attention, staff could either transport or call for emergency services as Lakeland Hospital is only a few blocks away.

On 09/15/2021, Relative A1 reported that if Resident A needed to see a physician staff would take Resident A to the nearest hospital which is only two minutes away. Relative A1 suggested that Resident A was the source of the allegations, as Resident A was unhappy with how an outing was not conducted on time and made a comment about getting the facility closed. Relative A1 denied having any concerns for the level of care provided at this facility.

APPLICABLE RULE	
R 400.14310	**Resident health care**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	During interviews, Resident A and Resident B denied ever not being provided with medical treatment or being refused transportation to a hospital if necessary and were unaware of any resident that was not provided with medical treatment or transported to a hospital if necessary. During interviews, direct care staff Lobe Soko and administrator Mohan Jayaraman reported that if a resident needed medical attention, staff could either transport or call for emergency services at a nearby hospital. In an interview, Ms. Kim Nelson, NP, acknowledged making frequent visit to this facility to provide ongoing medical care. As such there is no evidence that residents are not provided access to needed medical care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **The rooms are dirty and covered with dust and dirt.**
- **The toilets the residents share are filled with feces.**
- **The inside of the tubs are covered with an inch of scum.**

INVESTIGATION:

On 07/30/2021, Complainant alleged that resident bedrooms are dirty and covered in dust and dirt. Complainant alleged that toilets are filled with feces and the bathtubs are covered with an inch of scum. No additional details or information was provided.

On 08/04/2021, Resident A reported that he keeps his own bedroom and bathroom clean and obtains cleaning supplies directly from staff. I observed Resident A's bedroom and bathroom to be neat and clean with no visible signs of dust or dirt.

On 08/04/2021, Resident B reported that he does all his own cleaning including his bedroom and bathroom. Resident B clarified that cleaning supplies are locked in the facility but are provided by staff. I observed Resident B's bedroom and bathroom to be neat and clean with no visible signs of dust or dirt.

While at the facility, I inspected resident bedrooms and found them to be neat and clean with no visible signs of dirt or dust. I inspected private resident bathrooms and communal resident bathrooms and observed urine or feces inside several toilet bowls and these toilets did not appear to be flushed after resident use. I inspected the functionality of these toilets and found them to be fully functional. I observed the inside of several bathtubs and found them to be nonremarkable.

On 08/04/2021, Ms. Soko reported that residents clean their own rooms but acknowledged that staff may provide assistance and clean the common areas. Ms. Soko reported there are usually two staff working but one staff was currently attending a two-hour training that could not be rescheduled. When asked about the toilets that had urine and feces present, Ms. Soko clarified that she had spent most of the morning preparing breakfast and passing medications and did not have an opportunity to clean yet. Ms. Soko reported that she has never had to work by herself in the past but clarified that with another worker, one of them could go through the facility to make sure it was clean.

On 08/04/2021, I reviewed the details of the allegations with Mohan Jayaraman, administrator for this facility. Mr. Jayaraman acknowledged that one staff was working at this facility while the other scheduled staff was at training. Mr. Jayaraman reported that he was originally going to come into the facility to work for the staff member that was at training but since recovering from Covid-19, Mr. Jayaraman reported that he still had lingering symptoms and did not feel well and therefore did not come into the facility to provide assistance. Mr. Jayaraman reported there are usually two staff working during the day and one staff at night. Mr. Jayaraman reported that overnight staff do general cleaning while the day staff will clean the bathrooms as needed. Mr. Jayaraman reported the one staff were probably unaware that toilets had not been flushed after resident use.

On 08/04/2021, Ms. Kim Nelson, NP, reported that she had purposely been in this facility at varying times during the day and never observed the bathrooms or bedrooms or kitchen to be dirty.

On 09/15/2021, I interviewed Relative A1 regarding the allegations. Relative A1 denied ever observing the facility to be unclean and stated this facility “looks very nice”.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises**.
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.

ANALYSIS:	During the unannounced investigation on-site, Resident A and Resident B acknowledged cleaning their own bedrooms and bathrooms and obtaining necessary cleaning supplies from staff. I observed the resident bedrooms and bathrooms to be relatively clean but with feces and urine present in some of the toilet bowls due to residents not flushing after use. In an interview, direct care staff Love Soko reported that she was the only staff working and that usually another worker would spend time cleaning while she completed other duties. During an interview, administrator Mohan Jayaraman acknowledged that one staff was at training and would ordinarily complete cleaning tasks. In an interview, Ms. Kim Nelson NP, denied ever observing the bathrooms or bedrooms or kitchen to be dirty and reported visiting this facility at various times during the day. In an interview, Relative A1 denied ever observing this facility to be unclean. As such there is not enough evidence this facility does not present with a comfortable, clean, and orderly appearance.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Residents are not helped to bathe and are often dirty.**

INVESTIGATION:

On 07/30/2021, Complainant alleged that residents are not helped to bathe and are often dirty. No additional details were provided.

On 08/04/2021, Resident A reported that he can shower whenever he likes and has never been refused the opportunity to shower. Resident A clarified that he showers at least three times a week. Resident A denied being aware of any resident that was unable to shower or not provided assistance to shower if necessary. I observed Resident A to be neat and clean with no visible signs of poor hygiene.

On 08/04/2021, Resident B reported that he can shower as often as he wants and has showered as much as three times a day. Resident B denied being aware of any resident that was not allowed to shower or not provided assistance to shower if necessary. I observed Resident B to be neat and clean with no visible signs of poor hygiene.

On 08/04/2021, Ms. Soko reported that every resident showers at least two to three times a week. Ms. Soko denied that any resident is kept from showering or bathing and denied that any resident would not be provided with assistance if necessary.

Ms. Soko clarified that every current resident is capable of showering or bathing independently.

On 09/15/2021, Relative A1 reported that Resident A does not require any assistance with bathing but knows that Resident A is provided with the opportunity to shower at this facility several times a week.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	During interviews, Resident A and Resident B reported being able to shower several times a week and denied knowledge of any resident that was unable to shower or not provided with assistance to shower if necessary. During the unannounced investigation on-site, I observed Resident A and Resident B to be neat and clean with no visible evidence of poor hygiene. In an interview, direct care staff Love Soko denied that any resident is kept from showering or bathing and denied that a resident would not be provided with assistance with bathing or showering if necessary. Ms. Soko clarified that all current residents are capable of showering or bathing independently. During an interview, Relative A1 reported that Resident A does not require any assistance with bathing but confirmed that Resident A is provided with the opportunity to shower at this facility several times a week. As such there is no evidence that residents are not afforded the opportunity or instructions when necessary for bathing and personal hygiene**.**
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not allowed to receive or visit family members.

INVESTIGATION:

On 07/30/2021, Complainant alleged that residents are not allowed to receive or visit with family members if they are on “punishment”. Complainant was identified as anonymous, and no additional details were provided.

On 08/04/2021, Resident A reported routinely having visitors to the facility, including visits with his mother and father on the weekends. Resident A denied ever not being allowed visitors before or after the Covid-19 restrictions related to visitors. Resident A denied knowledge of any other resident that was denied visitors.

On 08/04/2021, Resident B reported that he is allowed to have visitors whenever he likes and clarified that visitors must be approved by his mother who is his guardian. Resident B denied knowledge of any resident that was not allowed visitors.

On 08/04/2021, direct care staff Love Soko denied that any resident would have any restrictions related to visitors and reported that family members often visit the facility at varying times during the day. Ms. Soko denied that any resident was ever put on "punishment" and clarified that each resident has rights.

On 09/15/2021, Relative A1 reported that she can visit Resident A whenever she wants at whatever time of day and has done so with no concerns. Relative A1 denied ever being refused the opportunity to visit with Resident A.

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: **(k) The right to have contact with relatives and friends and receive visitors in the home at a reasonable time. Exceptions shall be covered in the resident's assessment plan. Special consideration shall be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**

ANALYSIS:	During interviews, Resident A and Resident B reported routinely receiving visitors in this facility and denied knowledge of any resident that was not allowed visitors. In an interview, direct care staff Love Soko denied that any resident is restricted from having visitors and reported that visitors are received at this facility several times a day. During an interview, Relative A1 reported that she can visit Resident A whenever she wants at whatever times of day and has done so with no concerns. As such there is no evidence that residents are not being provided with the right to receive visitors at this facility at a reasonable time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

On 08/04/2021, while inspecting the facility, I observed carpet in the basement level of the facility occasionally occupied by residents to be heavily stained with what appeared to be coffee or soda. The threshold of this room was missing, and the carpet was worn and torn and exposed the subfloor.

On 08/04/2021, Mr. Jayaraman acknowledged the basement carpet was stained and the subflooring was exposed and reported the flooring was scheduled to be replaced at the end of the month. Mr. Jayaram reported this project was to have occurred earlier in the year but was delayed by Covid-19 and lack of access to products and service people availability.

APPLICABLE RULE	
R 400.14403	**Maintenance of premises**.
	(5) Floors, walls, and ceilings shall be finished so as to be easily cleanable and shall be kept clean and in good repair.
ANALYSIS:	During the unannounced investigation on-site, I found the carpets in a basement level occasionally occupied by residents with several heavy stains and tears near a threshold entrance that exposed the subfloor. During an interview, administrator Mohan Jayaraman acknowledged that carpets were heavily stained and the subflooring exposed and indicated these carpets were scheduled to be replaced later in the month after being delayed due to Covid-19.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

09/17/2021

Eli DeLeon Date
Licensing Consultant

Approved By:

09/22/2021

Dawn N. Timm Date
Area Manager