GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 9, 2023

Yogarajah Saverus
Long Acres Adult Foster Care, LLC
3955 Rose Drive
Berrien Springs, MI 49103

RE: License #: AM110400478
Investigation #: 2023A1031008
Long Acres Adult Foster Care

Dear Mr. Saverus:

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) 356-0183.

Sincerely,

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
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 #:	AM110400478
Investigation #:	2023A1031008
Complaint Receipt Date:	01/19/2023
Investigation Initiation Date:	01/23/2023
Report Due Date:	03/20/2023
Licensee Name:	Long Acres Adult Foster Care, LLC
Licensee Address:	3955 Rose Drive Berrien Springs, MI 49103
Licensee Telephone #:	(269) 277-0970
Administrator:	Yogarajah Saverus
Licensee Designee:	Yogarajah Saverus
Name of Facility:	Long Acres Adult Foster Care
Facility Address:	11793 N. Redbud Trail Buchanan, MI 49107
Facility Telephone #:	(269) 473-2156
Original Issuance Date:	07/13/2021
License Status:	REGULAR
Effective Date:	01/13/2022
Expiration Date:	01/12/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	AGED

II. ALLEGATION(S)

	Violation Established?
A male staff would not let Resident A out of her chair. Resident A has bruises on her wrist caused by a male staff.	No
Additional Findings	Yes

III. METHODOLOGY

01/19/2023	Special Investigation Intake 2023A1031008
01/19/2023	APS Referral received.
01/23/2023	Special Investigation Initiated - Telephone interview completed with Adult Protective Services Specialist John Wheeler.
01/24/2023	Contact - Telephone interview completed with PACE worker Sherry Simpson.
01/31/2023	Contact - Face to Face interview completed with Nurse Jill Chaffin and Resident A.
01/31/2023	Inspection Completed On-site
01/31/2023	Contact - Face to Face interviews completed with DCW Any Tokan, DCW Ellen Senduk, Resident B, Resident C, Resident D and E.
01/31/2023	Contact - Telephone interview completed with Individual #1.
02/03/2023	Contact - Telephone interview completed with licensee Yogarajah Saverus.
02/06/2023	Voicemail left with Resident A's guardian.
02/09/2023	Exit Conference held with licensee Yogarajah Saverus.

ALLEGATION:

A male staff would not let Resident A out of her chair.

Resident A has bruises on her wrist caused by a male staff.

INVESTIGATION:

On 1/23/23, I interviewed adult protective services (APS) worker John Wheeler via telephone. Mr. Wheeler reported Resident A was at Long Acres AFC for respite for a brief period. Mr. Wheeler reported he spoke with Resident A's PACE worker Sherry Simpson and she reported seeing bruises on Resident A's wrist and hand. Mr. Wheeler reported Ms. Simpson stated Resident A identified a male staff at the home that caused the bruises. Mr. Wheeler reported he spoke to direct care worker (DCW) Any Tokan at the home and Ms. Tokan reported there is no male staff employed at the home. Mr. Wheeler reported he was informed there is a previous resident Individual #1 that visits the home. Mr. Wheeler reported he interviewed Resident A at the home, and she showed him the bruises on her hand and wrist. Mr. Wheeler reported Resident A stated a "black man did it" and he kept telling her to sit down in the chair. Mr. Wheeler reported Resident A did not report any additional details. Mr. Wheeler reported Resident A appeared to have difficulty remembering things as she was not able to identify the month or year when asked. Mr. Wheeler reported Resident A has been diagnosed with dementia and a cognitive impairment.

On 1/24/23, I interviewed PACE worker Sherry Simpson via telephone. Ms. Simpson reported Resident A was at Long Acres AFC for respite care. Ms. Simpson reported Resident A was previously received psychiatric treatment at the hospital and transitioned to respite care. Ms. Simpson reported she went to Long Acres AFC to see how Resident A was doing. Ms. Simpson reported she noticed a bruise on Resident A's left wrist and left hand. Ms. Simpson reported Resident A stated a "black man" did it when asked about the bruises on her arm. Ms. Simpson reported Resident A did not provide any further details. Ms. Simpson reported she observed Resident A to be sitting in an electric reclining chair that was not plugged in. Ms. Simpson reported Resident A had difficulty getting out of the chair and she provided assistance. Ms. Simpson reported she did not have any information regarding staff not letting Resident A out of her chair.

On 1/31/23, I interviewed Nurse Jill Chaffin at Westwood of Bridgman Nursing home. Ms. Chaffin reported she did not observe any marks or bruises when Resident A was admitted into the facility. Ms. Chaffin reported Resident A has not made any reports of abuse or neglect since being in the facility.

On 1/31/23, I interviewed Resident A at Westwood of Bridgman Nursing Home. Resident A reported she did not remember being at Long Acres AFC home. Resident A reported she does not remember anyone hurting her. Resident A

reported being treated well at the nursing home. There were not any marks or bruises observed on Resident A.

On 1/31/23, I interviewed DCW Any Tokan at Long Acres AFC home. Ms. Tokan reported she only worked in the home one and half shifts when Resident A was there for respite. Ms. Tokan reported she did not notice any marks or bruises when she observed Resident A. Ms. Tokan reported she did not observe any staff or residents harm Resident A. Ms. Tokan reported she did not see anyone tell Resident A that she was not able to get out of her chair. Ms. Tokan reported there are no male staff employed at the home. Ms. Tokan reported there Individual #1 visits the home on occasion. Ms. Tokan reported Individual #1 visits the home and does not provide any direct assistance for residents. Ms. Tokan reported she does not know who would have caused any marks or bruises on Resident A.

On 1/31/23, I interviewed DCW Ellen Senduk at Long Acres AFC home. Ms. Senduk reported she was not aware that Resident A had any marks or bruises on her. Ms. Senduk reported she did not observe any other staff or residents harm Resident A. Ms. Senduk reported there are no male staff that work at the home. Ms. Senduk reported Individual #1 visits the home. Ms. Senduk reported Individual #1 does not assist the residents. Ms. Senduk reported she had no knowledge of anyone telling Resident A she could not get out of her chair.

On 1/31/23, I interviewed Resident B in the home. Resident B reported she did not observe anyone harm Resident A.

On 1/31/23, I interviewed Resident C in the home. Resident C reported she did not observe anyone harm Resident A.

On 1/31/23, I interviewed Resident D in the home. Resident D did not engage in the interview process.

On 1/31/23, I interviewed Resident E in the home. Resident E reported she did not observe anyone harm Resident A.

On 1/31/23, I interviewed Individual #1 via telephone. Individual #1 reported he used to reside at Long Acres AFC. Individual #1 reported he has dementia and could not remember when he moved out of the home. Individual #1 reported staff treat all the residents well and they are very nice to the people that live there. Individual #1 reported he observed staff treat Resident A nicely when he visited. Individual #1 denied having any physical contact with Resident A. Individual #1 reported he does not know why Resident A would have had any bruises on her.

On 2/03/23, I interviewed licensee Yogarajah Sevarus via telephone. Mr. Sevarus reported there are no male staff employed at the home. Mr. Sevarus Individual #1 visits the home. Mr. Sevarus reported Individual #1 does not have any physical

contact with any of the residents. Mr. Sevarus reported he did not have any knowledge of how she obtained the bruises.

On 2/06/23, I left a voicemail with Resident A's guardian.

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:	There is not sufficient evidence to support a staff in the home caused the bruises observed on Resident A's wrist and hand. Resident A was not able to identify how she obtained the bruises. There were no witnesses that observed anyone cause harm to Resident A while at Long Acres AFC. There were no reports or observations made of Resident A being told she could not get out of her chair. Resident A was observed by the PACE worker to have difficulty getting out of a reclining chair independently and requiring assistance.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

A previous resident visits the home and performs duties of direct care staff.

INVESTIGATION:

Mr. Wheeler reported he was informed Individual #1 visits the home. Mr. Wheeler reported he was informed that Individual #1 comes to the home to visit but is not a resident. Mr. Wheeler did not observe Individual #1 at the home when he completed an onsite inspection.

Ms. Simpson reported when she visited the home Individual #1 was there. Ms. Simpson reported Individual #1 "acted as staff" and thought he was a staff member. Ms. Simpson reported Individual #1 was wearing scrubs. Ms. Simpson Individual #1 was folding laundry, sitting with the residents, and directing the residents around.

Resident A reported she could not remember being at Long Acres AFC home and was not able to identify anyone associated with the home.

Ms. Tokan reported Individual #1 moved out of the home sometime last year. Ms. Tokan reported Individual #1 will visit the home on occasion. Ms. Tokan reported Individual #1 does not assist with any household duties or provide any direct care for the residents.

Ms. Senduk reported Individual #1 no longer lives in the home. Ms. Senduk reported Individual #1 visits the home at times to spend time with the residents. Ms. Senduk reported Individual #1 does not assist with any household duties or provide any direct care for the residents.

Resident B reported Individual #1 is a very nice man and he visits frequently. Resident B reported she has observed Individual #1 cleaning the house, vacuuming, taking out the trash, and shoveling snow. Resident B reported Individual #1 is very helpful when he comes to the home. Resident B reported Individual #1 was at the house earlier in the day and put on television shows for them to watch. Resident B reported Individual #1 will assist Resident C with sitting down in her chair and sometimes helping her out of her chair.

Resident C reported Individual #1 comes to the home to visit. Resident C reported Individual #1 is nice to her and does some things around the house. Resident C reported she did not want to share what he does around the home to help. Resident C became disengaged when asked if Individual #1 provides any assistance to her.

Resident D was not able to engage in the interview process.

Resident E reported Individual #1 visits the home “all the time”. Resident E reported Individual #1 helps around the house a lot. Resident E reported Individual #1 will make her bed for her and change the sheets. Resident E reported Individual #1 will also clean the house, take the trash out, and shovel the snow outside. Resident E reported Individual #1 is very helpful and does what she asks him to do. Resident E reported she has observed Individual #1 assisting Resident C with getting in and out of her chair.

Mr. Sevarus reported Individual #1 was discharged from the home three to four months ago. Mr. Sevarus reported Individual #1 only visits the home and does not perform any duties related to the home or residents. Mr. Sevarus reported he has informed staff and they are aware that Individual #1 is there to visit and not perform any duties in the home or assist with residents.

APPLICABLE RULE	
R 400.14201	**Direct care staff, licensee,**
	(10) All members of the household, employees, and those volunteers who are under the direction of the licensee shall be suitable to assure the welfare of residents.
ANALYSIS:	As a result of interviews held with staff and residents, it has been determined that Individual #1 performs direct care worker duties when visiting the home. Individual #1 is a previous resident of Long Acres AFC and is not an approved direct care staff or volunteer. Individual #1 has not been assessed to be suitable to assure the welfare of the residents or the home Individual #1 has been observed to provide physical assistance to residents and complete household chores such as cleaning, taking out the trash, changing linens, and snow removal.
CONCLUSION:	**VIOLATION ESTABLISHED**

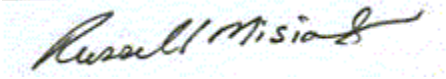
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

2/6/23

Kristy Duda Date
Licensing Consultant

Approved By:



2/9/23

Russell B. Misiak Date
Area Manager