GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 2, 2023

Shelly Burza
3676 Lange Rd.
Sebewaing, MI 48759

RE: License #: AL790260639
Investigation #: 2023A0572026
Vadavilla AFC Home

Dear Ms. 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 #:	2023A0572026
Complaint Receipt Date:	03/07/2023
Investigation Initiation Date:	03/10/2023
Report Due Date:	05/06/2023
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:	08/08/2021
Expiration Date:	08/07/2023
Capacity:	15
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was observed with bruises on her left knee and had an open wound on the inside of her right leg near her ankle.	No
Staff Danea Hartman held Resident A down and hit her. She was yelling and being rough with Resident A.	Yes

III. METHODOLOGY

03/07/2023	Special Investigation Intake 2023A0572026
03/07/2023	APS Referral APS made referral.
03/10/2023	Special Investigation Initiated - On Site
03/10/2023	Contact – Face to Face Staff, Dawn Rivard, Staff, Lauran Russell, and Resident A and 7 other residents.
05/01/2023	Exit Conference Exit Conference, Shelly Burza.
05/01/2023	Contact - Telephone call made Ex-Staff, Danae Hartman.
05/01/2023	Contact - Telephone call made Resident A's Family Member #2
05/02/2023	Contact - Telephone call made Resident A's Family Member #1
05/02/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:
Resident A was observed with bruises on her left knee and had an open wound on the inside of her right leg near her ankle.

INVESTIGATION:
On 03/07/2023, the local licensing office received a complaint for investigation. Adult Protective Services (APS) made the referral to licensing.

On 03/10/2023, I made an unannounced onsite to Vadavilla AFC Home, located in Tuscola County Michigan. Interviewed were Staff, Dawn Rivard; Staff, Lauran Russell and Resident A. Seven other residents were also observed in the home.

On 03/10/2023, I interviewed Staff, Dawn Rivard regarding the allegation. Ms. Rivard informed that she does not know about Resident A having bruises, but indicated that if she had to guess, it could be from Resident A putting her feet behind the foot peg of the chair because she usually sits like that. She has notice some swelling in her legs, so they are keeping her feet elevated.

On 03/10/2023, I interviewed Staff, Lauran Russell regarding the allegation. Ms. Russell was not aware of any bruising of the ankle but did see a cut, so she decided to keep it bandaged so it does not reopen. Ms. Russell has noticed some swelling and it has been going up and down. The physician says that it could be due to one of her medications.

On 03/10/2023, I spoke with Resident A regarding how she likes the home, with the understanding that she may not be able to remember past events due to her diagnosis. Resident A informed that she likes her home, and the staff does a lot of good things in the home as they are very nice, and the food is pretty good too. In my observation of Resident A's foot, it appeared to be swollen and dark in color. Resident A stated, "I don't have any trouble with my feet, thank goodness." Resident A does not have any immediate issues or concerns.

On 05/01/2023, I spoke with Licensee, Shelly Burza regarding the allegation. Ms. Burza informed that Resident A has swollen legs and some discoloration, but that is the way her legs were when she moved into the home. Resident A does not walk because of a compression fracture. Resident A's Family Member #1 transported Resident A to doctor's appointment for her pacemaker. She believes the pacemaker may have had something to do with some of the swelling and discoloration. The heart doctor recommended that they keep her feet elevated on a stool and it has helped.

On 05/01/2023, I spoke with former staff, Danae Hartman regarding the allegation. She informed that she does not know about Resident A having any cuts or bruising but recalls Resident A's Family Member #1 wanting them to keep Resident A's foot elevated as her feet tends to get discolored and swollen.

On 05/01/2023, I spoke with Resident A's Family Member #2 regarding the allegation. Family Member #2 informed that he does not know about the bruising because he is in another State and is not able to see her, but informed that at 90 years of age, she bruises and cuts very easily. Resident A used to reside with him, and she would barely bump her leg and it would look like she was getting abused. He cannot say whether or not staff is abusing Resident A but knows that she does bruise and cut very easily because of her age.

On 05/01/2023, I reviewed Resident A's Healthcare Appraisal. It indicates that Resident A had a compression fracture in 2019, permanent atrial fibrillation, has a pacemaker, hypertension, aortic stenosis and generalized-weakness.

On 05/01/2023, I reviewed the medical log, and it indicates that Resident A was transported to the doctor's office for an appointment on 03/02/2023 for new batteries for her pacemaker.

On 05/02/2023, I spoke with Resident A's Family Member #1 regarding the allegation. Family Member #1 informed that this she noticed the cuts and bruising towards the beginning of March 2023 after transporting Resident A to her doctor's appointment for her pacemaker. The batteries had to be changed in the pacemaker and that may have had something to do with the swelling and discoloration in her legs. The doctor wants them to keep her legs elevated and she believes that the staff are doing that.

APPLICABLE RULE	
R 400.15308	**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 my investigation, I interviewed staff, Resident A, family members and observed other residents in the home. Staff was not aware of any cuts or bruising but informed that she does have swollen feet that gets discolored. Family Member #1 took Resident A to an appointment as the pacemaker was not working properly and according to Family Member #1, it may have been the cause of swelling and discoloration of her feet. There is not enough evidence to support a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
Staff Danea Hartman held Resident A down and hit her. She was yelling and being rough with Resident A.

INVESTIGATION:
On 03/10/2023, I interviewed Staff, Dawn Rivard regarding the allegation. Ms. Rivard informed that Ms. Danae Hartman was terminated the day of the incident. She did not work with Ms. Hartman very often but had not heard anything previously about Ms. Hartman being physically or verbally abusive towards any residents.

On 03/10/2023, I interviewed Staff, Lauran Russell regarding the allegation. Ms. Russell heard about the incident between Resident A and former staff, Ms. Hartman. The incident came to a surprise to her because she was never overly pushy or aggressive. She informed that Ms. Hartman was terminated that day or the very next morning.

On 03/10/2023, I observed Resident A, sitting in the living room area. She was smiling and her well-being and supervision appeared to be adequate. I observed 7 other residents in various areas of the home. They all appeared to be well taken care of with proper care and supervision.

On 05/01/2023, I spoke with Licensee, Shelly Burza regarding the allegation. She informed that she was contacted by Resident A's Family Member #1 and informed what had happened. From her understanding, Ms. Hartman was trying to change Resident A, but Resident A was upset and was flailing her arms. Resident A was yelling, and Ms. Hartman was yelling back and grabbed her arm in the process. Family Member #1 walked in on them and asked Ms. Hartman to leave the room. Resident A had just returned from her appointment and could have still been sedated, plus she has dementia, which could have made changing her at that moment even more difficult. Ms. Hartman was let go immediately.

On 05/01/2023, I spoke with former staff, Danae Hartman regarding the allegation. Ms. Hartman informed that she was trying to change Resident A, but Resident A was being difficult and took a swing at her. Ms. Hartman informed that she grabbed Resident A's arms and gently laid them down so that she wouldn't get hit in the face. Family Member #1 walked in the room as her and Resident A were arguing with each other.

On 05/01/2023, I spoke with Resident A's Family Member #2 regarding the allegation. Family Member #2 heard about the incident but does not know much of the details. He says that all he knows is that Family Member #1 walked in on a staff member yelling at Resident A and the staff member was terminated afterwards.

On 05/02/2023, I spoke with Resident A's Family Member #1 regarding the allegation. Family Member #1 informed that she walked in on Ms. Hartman

screaming at Resident A. Ms. Hartman had her hands on Resident A's arms, but she is uncertain if she was being physical with Resident A. Ms. Hartman was terminated from employment.

APPLICABLE RULE	
R 400.15308	**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: **(f) Subject a resident to any of the following:** **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.**
ANALYSIS:	During my investigation, I interviewed staff, former staff and the family of Resident A. Ms. Hartman informed that Resident A's Family Member #1, walked in on her arguing with Resident A. Family Member #1 overheard some yelling as soon as she walked in the home and saw the staff yelling at Resident A. Ms. Hartman was terminated due to yelling at Resident A. There is enough evidence to establish a violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/01/2023, an Exit Conference was held with Licensee, Shelly Burza regarding the results of the special investigation. She was informed that a citation would be issued and a corrective action plan would need to be submitted within 15 days of receipt of this report.

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 1-15).

05/02/2023

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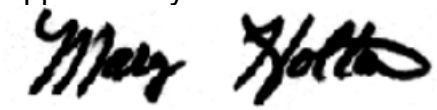
Anthony Humphrey Date
Licensing Consultant

Approved By:



05/02/2023

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Mary E. Holton Date
Area Manager