GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 24, 2022

Jorge Garcia
Aion Silverbell LLC
7007 Metro Pkwy
#7081
Sterling Heights, MI 48311

RE: License #: AS630407930
Investigation #: 2022A0991034
Silverbell Manor

Dear Mr. Garcia:

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 (248) 975-5053.

Sincerely,

Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630407930
Investigation #:	2022A0991034
Complaint Receipt Date:	07/08/2022
Investigation Initiation Date:	07/11/2022
Report Due Date:	09/06/2022
Licensee Name:	Aion Silverbell LLC
Licensee Address:	11681 Whitehall Dr. Sterling Heights, MI 48313
Licensee Telephone #:	(248) 342-9015
Licensee Designee:	Jorge Garcia
Name of Facility:	Silverbell Manor
Facility Address:	1241 E. Sliverbell Road Lake Orion, MI 48360
Facility Telephone #:	(248) 977-1618
Original Issuance Date:	10/08/2021
License Status:	REGULAR
Effective Date:	04/08/2022
Expiration Date:	04/07/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
• Resident A was lying on the floor covered in urine for hours and staff did not help her get up. • Resident B and Resident C had bruising on their faces.	No
Resident B was in a wheelchair and was strapped down.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/08/2022	Special Investigation Intake 2022A0991034
07/08/2022	APS Referral Received from Adult Protective Services (APS)
07/11/2022	Special Investigation Initiated - Telephone Call to Adult Protective Services (APS) worker, Tiffany Pitts
07/12/2022	Inspection Completed On-site Unannounced onsite inspection- interviewed home manager, staff, and residents
07/12/2022	Contact - Document Received Assessment plan, hospital discharge paperwork
07/15/2022	Contact - Document Received Prescriptions for assistive devices
07/20/2022	Contact - Telephone call made Left message for staff Jacqueline Futura
07/20/2022	Contact - Telephone call made Left message for staff, Jasmine Jones
08/23/2022	Contact - Telephone call made Interviewed staff, Jasmine Jones
08/23/2022	Contact - Telephone call made Left message for APS worker, Tiffany Pitts

08/23/2022	Contact - Telephone call made Left message for staff, Jacqueline Futura
08/24/2022	Contact - Telephone call made To Resident A's power of attorney
08/24/2022	Exit Conference Held via telephone with licensee designee, Jorge Garcia

ALLEGATION:

- **Resident A was lying on the floor covered in urine for hours and staff did not help her get up.**
- **Resident B and Resident C had bruising on their faces**.

INVESTIGATION:

On 07/08/22, I received a complaint from Adult Protective Services (APS) alleging that on 6/18/22, Resident A was lying on the floor in her urine. Resident A had been on the floor for hours and no one helped her get up. Resident A was transported to the hospital. Resident B and Resident C were observed to have bruising on their faces. The complaint also alleged that Resident B was in a wheelchair and was strapped down. I initiated my investigation on 07/08/22 by contacting the assigned APS worker, Tiffany Pitts.

On 07/12/22, I conducted an unannounced onsite inspection at Silverbell Manor. I interviewed the home manager, Angel White. Ms. White stated that she has worked in the home for 18 years, but a new company took over about a year ago. Ms. White stated that Resident A “puts herself on the ground” frequently. She does not fall, but she will crawl around on the floor. Resident A is able to get up on her own. Recently, a new staff person, Jasmine Jones, was working and found Resident A on the floor. She called emergency medical services (EMS), because she did not know that Resident A could get up on her own. EMS came to the home, but they did not transport Resident A to the hospital. Resident A was not lying on the ground in her urine. Resident A is fairly independent and does not receive assistance from staff for toileting. Resident A is very vocal and would let staff know if she was on the ground and needed assistance. Ms. White stated that Resident A was recently hospitalized due to having suicidal thoughts and tendencies. She was taken to the hospital for an evaluation due to her behaviors.

Ms. White was not aware of a time when Resident B or Resident C had bruising on their faces. She stated that the residents are very well taken care of by staff. She did not have any concerns about anyone being physically aggressive or neglectful towards the residents.

On 07/12/22, I interviewed direct care worker, Jackie Green. Ms. Green stated that she has worked in the home for six months. She was not aware of a time when Resident A fell and was lying on the floor for hours in her urine. She stated that Resident A is always on the floor, but it is not due to falling. Resident A is visually impaired. She will get on the floor to look for things and is always crawling around. She is able to get up on her own. She stated that she was working when Resident A went to the hospital because she was having suicidal thoughts. Ms. Green stated that she had to help Resident A up from the floor several times the night prior to Resident A going to the hospital. Ms. White gets a chair and Resident A uses the chair to lift herself up. Ms. Green stated that she did not have any concerns about Resident A's care.

Ms. Green did not recall a time when there were bruises on Resident B or Resident C's faces. She stated that if she observed bruises or had any concerns, she would report it.

On 07/12/22, I interviewed Resident A. Resident A stated that she has not fallen in a long time. She did not recall ever being on the ground in her urine. She stated that she can always get up on her own when she is on the ground. She can go to the bathroom on her own and does not need assistance from staff. She stated that there was a time when she was lying on the ground for hours, but it was not when she was living at Silverbell Manor. It happened when she was in the hospital or another place. She stated that EMS came when she was living with her daughter, but she did not remember EMS coming to Silverbell Manor. Sometimes it takes staff a long time to come assist her, because they are helping other residents.

On 07/12/22, I interviewed Resident B. Resident B stated that staff in the home are very nice. She stated that they are a family and staff take very good care of the residents. She did not remember ever having a bruise on her face. She stated that nobody ever hurt her. I did not observe any marks or bruises on Resident B.

On 07/12/22, I observed Resident C sitting in the living room. Resident C was unable to answer any questions due to limited cognitive abilities. I did not observe any marks or bruises on Resident C.

On 08/23/22, I interviewed direct care worker, Jasmine Jones. Ms. Jones stated that she has worked in the home for approximately two months. She typically works the midnight shift. Ms. Jones was not aware of a time when Resident A was lying on the floor in her urine for hours. Ms. Jones stated that she contacted EMS on or around 06/30/22 because Resident A fell. Ms. Jones was doing rounds at 11:00pm and heard Resident A fall. When she went into Resident A's room, Resident A was on the floor by the bedside table. The table and lamp had been knocked over. Resident A did not have on a brief or any undergarments. They were sitting next to her. Ms. Jones stated that Resident A is mostly independent with her activities of daily living (ADLs). She dresses herself and uses the bathroom on her own. Ms. Jones stated that Resident A might have fallen while she was trying to put on her undergarments. She was not wet or soiled. Ms. Jones did not want to move Resident A, so she called EMS. When the

paramedics arrived, Resident A was responsive. The paramedics checked Resident A for injuries, and they were able to get her up off the floor. EMS also contacted Resident A's guardian who did not wish to have Resident A sent to the hospital. Ms. Jones stated that Resident A was hospitalized a couple of weeks prior to this incident for an evaluation due to mental health issues. She stated that she was not aware of Resident A ever being neglected or left on the floor for hours. Resident A is very vocal and will yell or hit her walker on the ground in order to get the attention of staff.

Ms. Jones was not aware of Resident B or Resident C having any bruising on their faces. She stated that Resident B picks at her skin, so she occasionally has scrapes on her skin. She did not have any concerns about staff being physically abusive or neglectful.

On 08/24/22, I interviewed Resident A's power of attorney (POA) via telephone. Resident A's POA stated that she had not been visiting with Resident A for a while, because Resident A was upset with her about being placed in a facility. Resident A's POA stated that Resident A is mentally unstable, and it is not unusual for her to be on the floor. Resident A is blind and deaf. She often keeps things on the floor and will crawl around looking for them. She is always crawling around on the floor. She can usually get back up on her own. Resident A's POA stated that Resident A went to the hospital on 06/18/22, because she was mentally unstable, and she was on the floor. The hospital diagnosed Resident A with a urinary tract infection, which in the past has affected Resident A's mental functioning. Resident A's POA stated that she did not know if Resident A was covered in urine when she went to the hospital. Resident A is mostly independent. She requires assistance with showering, but she can use the bathroom on her own. Resident A's POA stated that Resident A's biggest complaint is that she will ask for things and if staff do not respond to her immediately, she will get upset. Resident A's POA stated that she did not believe staff in the home were being abusive.

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:	Based on the information gathered through my investigation, there is insufficient information to conclude that the personal needs of the residents, including protection and safety, were not attended to at all times. There was no information to support that Resident A was on the ground for hours in her urine and staff did not help her. Resident A denied that this happened. Staff and Resident A's power of attorney stated that Resident A

	puts herself on the ground and can get up on her own. They did not have any knowledge of Resident A being on the ground for hours. Resident B stated that staff take good care of her and never hurt her. I did not observe any marks or bruises on Resident B or Resident C. The staff who were interviewed did not have any concerns about anyone being aggressive or neglectful towards Resident B or Resident C.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident B was in a wheelchair and was strapped down.

INVESTIGATION:

On 07/12/22, I conducted an unannounced onsite inspection at Silverbell Manor. I observed Resident B and Resident C sitting in their wheelchairs in the living room area. Resident B and Resident C both had gait belts that were tied around their waists and their wheelchairs. The gait belts were secured in the back of the wheelchair, so Resident B and Resident C could not remove the gait belts and could not move from the chairs.

On 07/12/22, I interviewed the home manager, Angel White. Ms. White stated that they had orders from the primary care physician, Dr. Winters, for gait belts to be used on the wheelchairs due to Resident B and Resident C being fall risks. Ms. White acknowledged that the proper use of a gait belt is to assist residents with ambulating. She thought they could use the gait belts around the wheelchairs due to having an order from the doctor.

I reviewed a copy of Resident B's assessment plan dated 12/08/21. It did not specify the use of any special equipment or assistive devices, including a wheelchair or gait belt. I reviewed a copy of Resident C's assessment plan, which specified the use of a wheelchair. It did not specify the use of a safety belt or gait belt.

I reviewed a copy of a prescription for Resident B from Dr. Winters dated 02/11/22 for a "safety belt in wheelchair to prevent falling." I reviewed a copy of a prescription for Resident C from Dr. Winters dated 01/06/22 which indicates that "safety belts should be used to prevent falling."

APPLICABLE RULE	
R 400.14306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident B's assessment plan did not specify the use of a wheelchair or safety belt. Resident C's assessment plan did not specify the use of a safety belt.
CONCLUSION:	**VIOLATION 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: (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident B and Resident C were restrained with a gait belt during my onsite inspection on 07/12/22. I observed Resident B and Resident C secured to their wheelchairs with gait belts tied around their waists and fastened behind the chairs, preventing them from getting out of the chairs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation, the home manager, Angel White, stated that Resident A went to the hospital in June due to being mentally unstable and having suicidal thoughts.

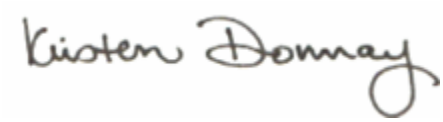
Resident A's power of attorney (POA) stated that Resident A went to the hospital on 06/18/22 due to being mentally unstable and was diagnosed with a urinary tract infect. I reviewed a copy of the hospital discharge paperwork from Ascension Providence Rochester Hospital. The discharge paperwork notes that Resident A was discharged on 06/21/22 with a diagnosis of Alzheimer's disease and a bladder infection. The home manager stated that staff did not complete an incident report when Resident A was hospitalized. I reviewed the facility's licensing file, which did not contain any incident reports regarding Resident A's hospitalization.

On 08/24/22, I conducted an exit conference via telephone with the licensee designee, Jorge Garcia. Mr. Garcia stated that Resident A does put herself on the floor often. He was not aware of Resident B or Resident C having bruises on their faces. He stated that they sometimes have bruises on their arms due to being aged and having thin skin. I provided technical assistance to Mr. Garcia regarding the use of gait belts as a restraint. Mr. Garcia stated that he would add all assistive devices to the assessment plans and had already addressed the issue with incident reports. He stated that he would submit a corrective action plan to address the violations identified during the investigation.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (b) Any accident or illness that requires hospitalization.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not complete an incident report following Resident A's hospitalization on 06/18/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

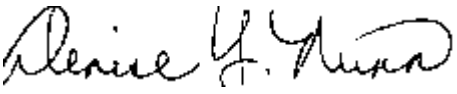
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



08/24/2022

Kristen Donnay Date
Licensing Consultant

Approved By:



08/24/2022

Denise Y. Nunn Date
Area Manager