GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 17, 2022

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

RE: License #: AS630407930
Investigation #: 2023A0602001
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,

Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630407930
Investigation #:	2023A0602001
Complaint Receipt Date:	09/28/2022
Investigation Initiation Date:	09/29/2022
Report Due Date:	11/27/2022
Licensee Name:	Aion Silverbell LLC
Licensee Address:	11681 Whitehall Dr. Sterling Heights, MI 48313
Licensee Telephone #:	(248) 342-9015
Administrator:	Jorge Garcia
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 ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
On 9/2/22 a home visit was completed, and adult protective services (APS) observed Resident B in the living room with a gait belt restraining her to a wheelchair.	Yes

III. METHODOLOGY

09/28/2022	Special Investigation Intake 2023A0602001
09/28/2022	APS Referral Adult Protective Services (APS) referral received.
09/29/2022	Special Investigation Initiated - Telephone Call made to assigned APS worker, Tiffany Pitts
10/06/2022	Inspection Completed On-site Interviewed the Executive Director, William Gross, and residents.
11/02/2022	Contact – Telephone call made Message left for Ms. Pitts.
11/02/2022	Contact – Telephone call made Message left for staff member, Ms. Marshall.
11/02/2022	Contact – Telephone call made Spoke with staff member Crystal Gross.
11/02/2022	Contact – Telephone call made Spoke with staff member Jaleigha Addison.
11/07/2022	Contact – Telephone call made. Spoke with APS worker, Ms. Pitts
11/07/2022	Contact – Document received Received picture of gait belt strapped to Resident A's wheelchair.
11/15/2022	Contact – Telephone call made Message left for staff member, Ms. Marshall

11/15/2022	Exit Conference Message left for the licensee designee, Jorge Garcia requesting a return call.
11/16/2022	Contact – Telephone call received Received a call from the licensee designee, Jorge Garcia.

ALLEGATION:

On 9/2/22, a home visit was completed, and adult protective services (APS) observed Resident B in the living room with a gait belt restraining her to a wheelchair.

INVESTIGATION:

On 9/28/2022, a complaint was received and assigned for investigation alleging that on 9/2/22 a home visit was completed, and adult protective services (APS) observed Resident B in the living room with a gait belt restraining her to a wheelchair. APS informed staff member, Ms. Marshall that per licensing consultant Kristen Donnay, gait belts are not to be used for securing residents.

On 10/06/2022, I conducted an unannounced on-site investigation at which time I interviewed the Executive Director, William Gross, staff member, Jackie Green, Resident A, Resident B, Resident C and Resident D. Mr. Gross stated there was an investigation conducted regarding gait belts being used to strap residents in their wheelchairs last month. A corrective action plan was submitted, and staff are no longer using gait belts to strap residents in their wheelchairs. Mr. Gross went on to state that he thought it was acceptable if a prescription was written by a physician deeming it necessary to use a gait belt.

Ms. Green stated the only resident that she uses a gait belt on is Resident D and it is only used to assist him in and out of his wheelchair. Ms. Green said she had no knowledge of staff members restraining any resident in a wheelchair with a gait belt.

Resident A was sitting at the dining room table with a walker beside her. She stated she does not use a wheelchair and did not know if Resident B was restrained in a wheelchair or not.

I attempted to interview Resident B and Resident C but was unable to obtain any information due to their limited cognitive ability. I did observe Resident B sitting in a wheelchair without the use of a gait belt. Resident C was sitting at the dining room table without a wheelchair or gait belt.

I observed Resident D in his bedroom sitting in a wheelchair with a gait belt around his waist. Resident D was not restrained to the wheelchair. Resident D stated he was not being restrained to his wheelchair.

On 11/02/2022, I interviewed staff member Crystal Gross by telephone. Ms. Gross stated she is a back-up employee and only works when someone does not show up for their shift. She stated that the last time she worked in the facility was about two months ago. Ms. Gross said she has never witnessed any staff member restrain Resident B in her wheelchair with the use of a gait belt.

On 11/02/2022, I interviewed staff member Jaleigha Addison by telephone. Ms. Addison stated she has worked in the home since May 2022 and has never seen staff restrain Resident B in her wheelchair with the use of a gait belt. Resident D has a gait belt, but it is only used to assist with getting him up from his wheelchair.

On 11/02/2022, I spoke with the assigned APS worker Tiffany Pitts by telephone. Ms. Pitts stated there was an investigation (#2022A0991034) conducted back in the summer of this year regarding Resident B being restrained in her wheelchair with the use of a gait belt. Ms. Pitts said it was her understanding that gait belts cannot be used to restrain residents. On 9/02/2022, Ms. Pitts made another visit to facility and observed Resident B again restrained in her wheelchair with the use of a gait belt. The gait belt was fastened behind the wheelchair preventing Resident B from unfastening it.

On 11/02/2022 I reviewed special investigation report #2022A0991034 dated 8/24/2022. The report documents that Resident B was observed in a wheelchair restrained with a gait belt. The licensee designee, Jorge Garcia was provided consultation by the investigating licensing consultant, Ms. Donnay regarding the proper use of gait belts. A corrective action plan was received on 9/07/2022 and indicated that gait belts were removed from the wheelchairs as of 9/01/2022.

On 11/07/2022 I received and reviewed (from Ms. Pitts) a picture of Resident B restrained in her wheelchair with the use of a gait belt that was fastened behind the chair.

On 11/16/2022 I conducted an exit conference with the licensee designee, Jorge Garcia and informed him of the investigative findings and recommendation documented in this report. Mr. Garcia stated these allegations were already investigated and he submitted a corrective action plan to Ms. Donnay. I explained that staff continued to use a gait belt to restrain Resident B in her wheelchair after Ms. Donnay had conducted the exit conference with him and provided consultation to him regarding the use of gait belts. Mr. Garcia went on to state that this occurred during the time he was preparing the corrective action plan and scheduling an in-service with staff to address the issue. I reminded Mr. Garcia that according to the corrective action plan he submitted to Ms. Donnay, gait belts were removed from resident wheelchairs on 9/01/2022. Mr. Garcia agreed to submit a corrective action plan upon receipt of this report.

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 obtained during the investigation, there is sufficient information to determine that on 9/02/2022, Resident B was restrained to a wheelchair with a gait belt tied around her waist and fastened behind the wheelchair, preventing her from getting out of the chair. I received and reviewed a picture of Resident B restrained in her wheelchair on 11/07/2022.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SIR #2022A0991034 dated 8/24/2022, CAP dated 9/07/2022**

IV. RECOMMENDATION

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

Cindy Berry 11/17/2022

Cindy Berry Date
Licensing Consultant

Approved By:

Denise Y. Nunn 11/17/2022

Denise Y. Nunn Date
Area Manager