STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 14, 2023

John Altea
A&A Of Michigan, LLC
13187 Churchill Dr
Sterling Heights, MI 48313

RE: License #: AS630400389
Investigation #: 2023A0465020
A&A Of Bloomfield Hills

Dear Mr. Altea:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-308-6012
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630400389
Investigation #:	2023A0465020
Complaint Receipt Date:	04/06/2023
Investigation Initiation Date:	04/10/2023
Report Due Date:	06/05/2023
Licensee Name:	A&A Of Michigan, LLC
Licensee Address:	13187 Churchill Dr Sterling Heights, MI 48313
Licensee Telephone #:	(586) 214-0684
Administrator:	John Altea
Licensee Designee:	John Altea
Name of Facility:	A&A Of Bloomfield Hills
Facility Address:	4318 Squirrel Rd Bloomfield Hills, MI 48304
Facility Telephone #:	(586) 214-0684
Original Issuance Date:	08/27/2020
License Status:	REGULAR
Effective Date:	02/27/2023
Expiration Date:	02/26/2025
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL; AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

Allegation	Violation Established?
During the month of February 2023, direct care staff, Olivia Torres, slept while on duty.	No
Licensee designee/administrator, John Altea, agreed to provide two-person assistance, as stipulated in Resident A's assessment plan, and did not adhere to this agreement.	Yes
On 3/9/2023, at approximately 8:20am, Resident A began having trouble breathing. Direct care staff, Adrian Najos and Olivia Torres, were directed by Mr. Altea to administer an unprescribed oxygen mask to Resident A and to not call 911 until he arrived at the facility, resulting in Resident A not receiving medical care from EMS until 9:10am. Direct care staff did not seek medical care for Resident A's pressure wounds.	Yes
Direct care staff incorrectly administered to Resident A, Amlodipine 5mg when she was prescribed 2.5mg.	No
Direct care staff did not adhere to Resident A's prescribed special diet.	No
The facility served expired food to Resident A.	No

III. METHODOLOGY

Date	Activity
04/06/2023	Special Investigation Intake 2023A0465020
04/07/2023	APS Referral Adult Protective Services (APS) referral assigned to APS Worker, Carmen Clark, for investigation
04/10/2023	Special Investigation Initiated - Letter Email exchange with APS Worker, Carmen Clark
04/21/2023	Inspection Completed On-site I conducted an onsite investigation. I conducted a walkthrough of the facility, reviewed resident files and interviewed direct care staff, Adrian Najos and Sheila Delontido, and spoke to licensee designee, John Altea via telephone

04/27/2023	Contact - Document Received Documents received via email
05/09/2023	Contact - Document Sent Email exchange with APS Worker, Carmen Clark
05/18/2023	Contact – Telephone call made I spoke to Guardian B1 via telephone
05/22/2023	Contact - Telephone call made I spoke to direct care staff, Estrella Brown via telephone
05/22/2023	Contact - Telephone call made I spoke to direct care staff, Faye Beltran, via telephone
05/22/2023	Contact - Document Received Documents received via email
05/23/2023	Contact - Telephone call made I spoke to Guardian A1 via telephone
05/23/2023	Exit Conference I conducted an exit conference with licensee designee/ administrator, John Altea via telephone
06/14/2023	Exit Conference I conducted a follow-up exit conference with Mr. Altea to discuss the recommendation of a provisional license

ALLEGATION:

During the month of February 2023, direct care staff, Olivia Torres, slept while on duty.

INVESTIGATION:

On 4/6/2023, a complaint was received, alleging that during the month of February 2023, direct care staff, Olivia Torres, slept while on duty. The complaint stated that, on an unknown date, direct care staff, Olivia Torres, told Guardian A1 that she sleeps during 3rd shift and sets an alarm on her phone every two hours throughout the night to wake up and check on residents.

On 4/10/2023 and 5/9/2023, I spoke to Adult Protective Services Worker, Carmen Clark, via email exchange. Ms. Clark confirmed that the information contained in the complaint

is accurate. Ms. Clark stated that she is currently in the process of completing her investigation and has not made a determination as of yet.

On 4/21/2023, I conducted an onsite investigation. At the time of the onsite investigation, there were two residents residing in the home, both of which have medical diagnosis of Dementia and/or non-verbal and were unable to be interviewed. I conducted a walkthrough of the facility, reviewed resident files, and interviewed direct care staff, Adrian Najos and Sheila Delontido, and spoke to licensee designee, John Altea via telephone.

At the time of my onsite investigation, I was informed by Mr. Altea that direct care staff, Olivia Torres and Ewaldz Casa, are out of the country and it is unknown if and when they will return to the United States. Therefore, I was unable to interview them for the purposes of this investigation.

I interviewed direct care staff, Adrian Najos, who stated that he has worked at the facility for one year. Mr. Najos stated, "We are not allowed to sleep when we are working, it doesn't matter what shift we are working. I have never slept while at work. And I don't know of any other staff sleeping while at work. Ms. Torres is out of the country, and I don't know when she comes back but I never seen her sleep while on duty and never heard of her doing anything like that. In the month of February 2023, Ms. Torres and I were rotating 12-hour shifts, and so we had a large break in between shifts to rest and sleep." Mr. Najos denied knowledge of this complaint being true.

I interviewed direct care staff, Sheila Delontido, who stated that she began working at the facility in April 2023. Ms. Delontido stated, "I am a new staff, but I have been trained and told that we are not allowed to sleep at any time while we are working. We have to make sure we are able to care for residents at all times. I have not seen any staff sleep while working."

I interviewed licensee designee/administrator, John Altea, via telephone while onsite at the facility. Mr. Altea stated, "Staff are not allowed to sleep at any time while working. I have never had any concerns that Ms. Torres was sleeping while on duty. Ms. Torres and Mr. Najos work 12 hour shifts and alternate between 8am-8pm and 8pm and 8am shifts. They have 12 hour breaks in between each of their shifts and have weekends off with plenty of time to sleep and rest." Mr. Altea denied knowledge of this complaint being true.

On 5/18/2023, I spoke to Guardian B1, who stated he does not have knowledge specific to this complaint, but does not have any concerns related to the care being provided to Resident B.

On 5/22/2023, I spoke to direct care staff, Estrella Brown via telephone. Ms. Brown stated that she has worked at the facility for two months. Ms. Brown stated, "I primarily work nights (3rd shift) and we are not allowed to sleep while on duty. I have never slept while at work and I am not aware of any other staff doing this."

On 5/22/2023, I spoke to direct care staff, Faye Beltran, via telephone. Ms. Beltran stated that she has worked at the facility for two years. Ms. Beltran stated, "We are not allowed to sleep at night. I work nights and I have never slept while working. I don't know of any other staff sleeping at night either."

On 5/23/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, "During the month of February 2023, I was at the facility, visiting Resident A. I was having a conversation with Ms. Torres, and she made the comment that she sleeps when the residents sleep. I asked her what she meant by that, and she said told me that she sleeps at night and sets her alarm to go off every two hours, so she can get up and check on the residents." Guardian A1 stated that she believes that Ms. Torres was sleeping while on duty during the month of February 2023.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	According to Guardian A1, during the month of February 2023, Ms. Torres told her that she was sleeping while working 3rd shift at the facility. According to Mr. Najos, Ms. Brown, Ms. Beltran, and Ms. Delontido, they have never slept while on duty and are not aware of any other staff sleeping while at work. Mr. Najos, Ms. Brown, Ms. Beltran, and Ms. Delontido denied knowledge of this complaint being true. According to Mr. Altea, staff are not allowed to sleep while working. Mr. Altea denied knowledge of this complaint being true. Due to Ms. Torres being out of the country with an unknown return date, I was unable to interview her for this investigation. Based on the information above, there is not sufficient information to confirm this allegation is true.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Licensee designee/administrator, John Altea, agreed to provide two-person personal care assistance, as stipulated in Resident A's assessment plan, and did not adhere to this agreement.

INVESTIGATION:

On 4/6/2023, a complaint was received, alleging licensee designee/administrator, John Altea, agreed to provide two-person assistance for personal care, as stipulated in Resident A's assessment plan, and did not adhere to this agreement.

On 4/21/2023, at the time of my onsite investigation, Resident A was no longer residing in the facility and there are no residents currently residing in the home that require two-person assistance. I reviewed resident files and interviewed direct care staff, Adrian Najos and Sheila Delontido.

I reviewed Resident A's *Face Sheet,* which indicated that she resided at the facility from 2/13/2023 – 3/9/2023, and has a legal guardian, Guardian A1. The *Health Care Appraisal* listed Resident A's medical diagnosis as Dementia. *The Assessment Plan for AFC Residents*, dated 2/13/2023 and reviewed/updated on 3/4/2023, indicated that Resident A was a two-person assist when in the community, required two-person assistance for toileting, bathing, dressing, personal hygiene, and transfers, and used a wheelchair for mobility assistance.

I reviewed the *Staff Schedule* for the time frame that Resident A was residing in the facility, 2/13/2023 – 3/9/2023. The staff schedule documents that only one staff was on duty for each shift. I did not locate any documentation to confirm that the facility had two staff on duty during the time that Resident A was residing at the facility.

On 5/23/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, "Before I moved Resident A into the facility, I spoke to Mr. Altea, and he agreed to have two staff on duty to meet Resident A's personal care needs. We signed an assessment plan document, where Mr. Altea agreed to provide two-person staffing for personal care needs and transfers. Shortly after Resident A moved into the facility, when I would go visit, I realized that they only had one staff on duty. I confronted Mr. Altea and he said that he was not going to provide two staff because he couldn't afford it. I was very upset. He broke the agreement that we made. Resident A moved out of the home on 3/9/2023."

On 5/23/2023, I spoke to Mr. Altea via telephone. Mr. Altea stated, "I did agree to have two staff on duty prior to Resident A moving in. I was supposed to provide two staff for personal care of Resident A, but I was not able to afford to pay for two staff to work. I understand why Guardian A1 is upset with this situation and the fact that I did not

provide what I said I would. I was expecting these violations." Mr. Altea acknowledged that this allegation is true.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A's *Assessment Plan for AFC Residents*, signed by Mr. Altea and Guardian A1, indicated that Resident A required two-person assistance to meet Resident A's personal care needs. According to the *Staff Schedule*, the facility did not have two staff on duty during the time that Resident A was residing at the facility. Mr. Altea agreed to provide two-person assistance to Resident A for personal care needs and acknowledged that he did not provide this staffing ratio as agreed upon as specified in Resident A's written assessment plan. Based on the information above, Mr. Altea did not provide the specified staffing to meet Resident A's personal care needs, as specified and agreed upon in the written assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **On 3/9/2023, at approximately 8:20am, Resident A began having trouble breathing. Direct care staff, Adrian Najos and Olivia Torres, were directed by Mr. Altea to administer an unprescribed oxygen mask to Resident A and to not call 911 until he arrived at the facility, resulting in Resident A not receiving medical care from EMS until 9:10am.**
- **Direct care staff did not seek medical care for Resident A's pressure wounds.**

INVESTIGATION:

On 4/6/2023, a complaint was received, alleging that on 3/9/2023, at approximately 8:20am, Resident A began having trouble breathing. The complaint indicated that direct care staff, Adrian Najos and Olivia Torres, called Mr. Altea and informed him of the situation, at which time Mr. Altea directed them to administer unprescribed oxygen to Resident A, and to not call 911 until he arrived at the facility. Mr. Altea arrived at the

facility at 9:00am, resulting in 911 being called approximately 40 minutes after Resident A began displaying labored breathing. The complaint indicates that EMS arrived at the facility at 9:10am, resulting in a 50-minute delay of required emergent medical care. Upon arrival at the hospital, Resident A had pressure sores on her back. Direct care staff also did not seek medical care for Resident A's pressure wounds.

I reviewed the *Incident/Accident Report* dated, 3/9/2023, which indicated the following:

> *On 3/9/2023 at 8:20am; completed by Olivia Torres: Resident A had labored breathing, sp02 @ 85%. Notified admin. Oxygen provided; notified Guardian A1; called 911.*

I was unable to locate any documentation to confirm that Resident A had pressure wounds and/or was prescribed medication to treat pressure wounds, during the time that she resided at the facility. Due to Resident A being discharged from the facility prior to being discharged from the hospital, the facility did not obtain any discharge paperwork information.

While onsite at the facility on 4/9/2023, I interviewed Mr. Najos, who stated, "I was at the facility the day that Resident A was having trouble breathing. It was around 8:20 in the morning. We called Mr. Altea right away and he told us to put an oxygen mask on Resident A and wait for him to come to the home. The oxygen mask is here in case we need it but is not prescribed to Resident A. We were told to not call 911 and to wait for Mr. Altea to come to the home so he could see Resident A. When Mr. Altea got here, he told us to call 911. We called around 9am and the ambulance came a little while later. I never saw any pressure wounds on Resident A and was not aware of any issues related to pressure wounds. I provided personal and hygiene care to Resident A and never observed any pressure wounds or sores."

On 5/22/2023, I spoke to Ms. Beltran, via telephone. Ms. Beltran stated, "I was not working on 3/9/2023, so I cannot give you any information regarding that situation. But we are required to call Mr. Altea before we can call 911. That is a rule that Mr. Altea told us we have to follow. I provided care to Resident A during the three weeks that she was residing at the facility. I do not recall Resident A ever having a pressure wound. I assisted her with bathing and toileting for three weeks and never observed a pressure wound or sore that required medical care." Ms. Beltran denied knowledge of this allegation being true.

On 4/9/2023 and 5/23/2023, I interviewed Mr. Altea, via telephone. Mr. Altea stated, "I have a rule that all staff must call me first before they call 911, they need to let me know first. And then I will give them advice on what to do. On 3/9/2023, Mr. Najos and Ms. Torres called me and told me that Resident A was having trouble breathing. I told them to put an oxygen mask on her, and to wait for me to get there. I wanted to assess Resident A myself before 911 was called. When I got there, at 9:00am, I saw that Resident A was having labored breathing and I told the staff to call 911. The ambulance arrived 10 minutes later, at 9:10am. The oxygen mask that I told staff to administer to Resident A is not prescribed to her. It is an oxygen mask that I keep in the home in case

of emergencies, but I know now that I should not have told staff to administer that because it is not her specific prescribed medication. I understand why this was not an appropriate way to handle this situation. In regard to pressure wounds, I never observed any pressure wounds on Resident A. I do remember her having a small skin tear on her shin that was scabbing, but it cleared up and healed in a few days. She did not have any pressure wounds while at our facility."

On 5/23/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, "On 3/9/2023, I received a call from Mr. Altea at 9:00am. He told me he was at the facility and Resident A was having trouble breathing. Mr. Altea told me Resident A had been having trouble breathing since 8:00am and his staff had administered an oxygen mask to Resident A. I was concerned when I heard this because Resident A is not prescribed an oxygen mask and I didn't know where they got this mask from. Mr. Altea called me at 9:00am and told me they had just called 911. I was very upset when I heard this information. This means that Resident A was having breathing issues for an hour before they called 911. When Resident A arrived at the hospital, she had pressure sores on her back and around her spine. This is unacceptable. I believe the staff did not properly obtain needed medical care for Resident A related to the breathing issues and the pressure sores."

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:	According to the *Incident/Accident Report* dated, 3/9/2023, Mr. Najos and Ms. Torres observed Resident A displaying labored breathing at approximately 8:20am. According to Mr. Najos and Mr. Altea, on 3/9/2023, Resident A began displaying labored breathing at 8:20am. Mr. Najos stated did not call 911 and instead administered an unprescribed oxygen mask to Resident A, as advised by Mr. Altea. Mr. Najos and Mr. Altea acknowledged that 911 was not called until 9:00am, approximately 40 minutes after Resident A began displaying breathing difficulty. According to Mr. Altea, Mr. Najos and Ms. Beltran, Mr. Altea requires all staff to call him first prior to calling 911, in order for him to assess and determine if emergency medical care is needed. Mr. Altea, Mr. Najos and Ms. Beltran deny knowledge of Resident A having pressure wounds or sores during the time

	that she resided at the facility. Based on the information above, there is sufficient information to confirm that on 3/9/2023, the facility did not obtain needed medical care for Resident A when she began displaying labored breathing.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.**
ANALYSIS:	According to the *Incident/Accident Report and* Mr. Najos and Mr. Altea, on 3/9/2023, Mr. Najos administered an unprescribed oxygen mask to Resident A. Mr. Najos and Mr. Altea acknowledged that the oxygen mask was not a prescribed medication for Resident A and should not have been administered. Based on the information above, there is sufficient information to confirm that on 3/9/2023, the facility modified Resident A’s prescription medication by administering an unprescribed oxygen mask without instructions from a physician or pharmacist.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Direct care staff incorrectly administered to Resident A, Amlodipine 5mg when she was prescribed a 2.5mg dosage.

INVESTIGATION:

On 4/6/2023, a complaint was received, alleging that direct care staff incorrectly administered Resident A, Amlodipine 5mg blood pressure medication, when she was prescribed a 2.5mg dosage.

On 4/21/2023, while onsite at the facility, I reviewed Resident A's *Medication Administration Record* (MAR) for the dates of 2/13/2023 – 3/9/2023. The MAR indicated that Resident A was prescribed Amlodipine 5mg tablet, to be administered once daily. I reviewed Resident A's record, which included a medication prescription order for Amlodipine 5mg, prescribed to Resident A. The MAR documented that this medication was administered and initialed by staff accordingly. Due to Resident A no longer living in the home, I was unable to review medication label information.

While onsite at the facility, I spoke to Mr. Najos, who stated, "We provide good care to our residents. We always make sure we are administering medication correctly. We are trained to double-check labels and the MAR to make sure everything matches. I do not recall any issues with Resident A's medication or incorrect dosages." Mr. Najos denied knowledge of this complaint being true.

On 5/22/2023, I spoke to direct care staff, Ms. Beltran via telephone, who stated, "We always administer medication as prescribed. For Resident A, due to her blood pressure issues, we would take her blood pressure every day and we monitored it closely. We also gave her the prescribed blood pressure medication. I never had any medication issues or errors for Resident A." Ms. Beltran denied knowledge of this complaint being true.

On 5/23/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, "When Resident A moved into the facility, she had been discharged from a hospital. At the time of discharge, the hospital prescribed medications to Resident A, which were sent over to the pharmacy to be filled and then sent to the facility. I reviewed Resident A's medication information and orders. I didn't realize until Resident A moved out of the facility that the hospital made a mistake and prescribed to Resident A, Amlodipine 5mg when it should have been 2.5mg. The hospital is the one that made the error, not the facility. Resident A was prescribed 5mg, and the facility did administer this dose because it was what was prescribed." Guardian A1 acknowledged that the facility properly administered medication to Resident A based on the prescription order.

On 4/21/2023 and 5/23/2023, I spoke to Mr. Altea via telephone, who stated, "Resident A was prescribed 5mg daily and so we administered as prescribed. When I was informed by Guardian A1 that the medication dosage was not correct, I contacted the primary care doctor's office to address the issue, but I told Guardian A1 that we could not modify the prescription until we received a new order from the doctor. We did not improperly administer medication. We administered what was prescribed, which is what we are supposed to do." Mr. Altea denied knowledge of this complaint being true.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	According to the *Medication Administration Record,* for 2/13/2023 – 3/9/2023, Resident A was prescribed Amlodipine 5mg tablet, which was administered by staff daily, as prescribed, according to staff initials. According to Mr. Najos, Ms. Beltran, and Mr. Altea, Resident A was prescribed Amlodipine 5mg, which they administered daily as prescribed. Mr. Najos, Ms. Beltran, and Mr. Altea denied knowledge of improper medication administration for Resident A. According to Guardian A1, at the time of Resident A's admission to the facility, her Amlodipine was prescribed for 5mg dosage, to be administered daily. Based on the information above, there is not sufficient information to confirm that the facility incorrectly administered Resident A's medication while she resided at the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Direct care staff did not adhere to Resident A's prescribed special diet.

INVESTIGATION:

On 4/6/2023, a complaint was received, alleging that direct care staff did not adhere to Resident A's prescribed special diet.

On 4/21/2023, I conducted a walk-through of the facility, observed the meal menus for February 2023 and March 2023, and Resident A's record.

The *Health Care Appraisal* listed Resident A's special diet requirement as a Dysphagia diet. I reviewed the *Meal Menus* for February 2023 and March 2023, which listed three meals daily and snacks, including the following meal items: tuna sandwiches with potato, alfredo spaghetti with green beans, scrambled eggs, bacon and muffins, baked chicken with mashed potatoes, tuna/tilapia with veggies and mashed potatoes, etc. I reviewed the *Special Diet Instructions* for Resident A, which indicated the following:

> *Pureed/Dysphagia eating/feeding: Regular liquids – spoon; Offer liquids often, including in between meals; Offer food items one at a time; Fresh pureed meals and fruits/peaches/pears/blueberries; cottage cheese; orange juice/apple juice; Foods include fresh fruits and vegetables, will try to offer smoothies; Monitor quantity of foods and likes.*

While onsite at the facility, I interviewed Mr. Najos, who stated, "Resident A required a pureed diet. We pureed and/or mashed up all of her food items before serving to her. We served her the same food items that were on the menu, we just pureed or

smoothed/mashed it so she could eat it. Resident A ate well while she was here, and she never vocalized any complaints or concerns. I am not aware of a time when a staff did not follow Resident A's pureed diet requirement." Mr. Najos denied knowledge of this complaint being true.

On 5/22/2023, I spoke to Ms. Beltran, who stated, "We provided Resident A with a pureed diet. That means we put her food items in a blender or mashed it up, and then fed to her. We always gave Resident A pureed food, and she would eat all of her food that we served her. I never forgot to puree Resident A's food and I don't remember seeing anyone else served Resident A improper food either."

On 4/21/2023 and 5/23/2023, I spoke to Mr. Altea via telephone, who stated, "Resident A was prescribed a pureed diet. All staff were aware of Resident A's special diet. All of Resident A's meal items were either placed in a blender or smoothed/softened before served to her. Resident A ate all of her food at each meal time and there never a food issues that I am aware of."

On 5/23/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, "When I visited the home, I observed that the staff were pureeing Resident A's food. But it was disgusting. I tasted some of the pureed food and it tasted terrible." Guardian A1 was not happy with the pureed food items being served to Resident A but acknowledged that she observed staff were pureeing Resident A's food.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.
ANALYSIS:	According to the *Meal Menu, Special Diet Instructions,* Mr. Najos, Ms. Beltran, and Mr. Altea, Resident A was provided with a pureed diet while residing at the facility. Based on the information above, there is not sufficient information to confirm that the facility failed to provide Resident A with a pureed dysphagia diet as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

The facility served expired food to Resident A.

INVESTIGATION:

On 4/6/2023, a complaint was received, alleging that during the month of February 2023, the facility served expired food to Resident A. The complaint indicated that on an unknown date in February 2023, staff were observed serving Resident A pureed squash that was expired.

On 4/21/2023, I conducted a walk-through of the facility. I observed fresh fruits and vegetables in the kitchen area, as well as a fully stocked pantry with canned goods. I observed an ample amount of food items in the refrigerator and freezer. I did not observe any expired food items inside the home.

While onsite at the facility, I interviewed Mr. Najos, who stated, “We always have a lot of food items in the home, including fruits and vegetables. We stock the home weekly with food items. I have never observed any food items to be expired and I have never served anyone expired food.” Mr. Najos denied knowledge of this complaint being true.

While onsite at the facility, I interviewed Ms. Delontido, who stated, “We have food available in the home at all times, including fresh fruits and vegetables. We also have food stored in the cabinets and pantries, as well as the refrigerator and freezer area. If food, such as fruits and vegetables go bad, we do throw them away. But I have never served any resident expired food. I am not aware of any other staff serving a resident, including Resident A, expired food.” Ms. Delontido denied knowledge of this allegation being true.

On 5/18/2023, I spoke to Guardian B1, who stated he does not have any concerns related to the food and meals items being provided to Resident B.

On 5/22/2023, I spoke to Ms. Brown, via telephone, who stated, “The home always has fresh food, fruit and vegetables in the cabinets and refrigerator. I have never seen the home stocked with expired food and I have never served Resident A, nor any other resident, expired food.” Ms. Brown denied knowledge of this complaint being true.

On 5/23/2023, I spoke to Guardian A1 via telephone. Guardian A1 stated, “During the month of February 2023, I was at the facility, visiting Resident A. I saw staff serving Resident A squash and it looked old. I went over and observed that it was old and needed to be thrown away. They served Resident A expired squash.”

On 5/23/2203 and 6/14/2023, I conducted exit conferences with licensee designee/administrator, John Altea, via telephone. Mr. Altea acknowledged the significance of the allegations contained within this report and stated he is agreeable to the issuance of a provisional license.

APPLICABLE RULE	
R 400.14402	**Food service.**
	(1) All food shall be from sources that are approved or considered satisfactory by the department and shall be safe for human consumption, clean, wholesome and free from spoilage, adulteration, and misbranding.
ANALYSIS:	On 4/21/2023, I conducted a walk-through of the facility. I observed fresh fruits and vegetables in the kitchen area, as well as a fully stocked pantry with canned goods. I observed an ample amount of food items in the refrigerator and freezer. I did not observe any expired food items inside the home. According to Mr. Najos, Ms. Delontido, and Ms. Brown, they have never served expired food to Resident A, nor any other resident. Mr. Najos, Ms. Delontido, and Ms. Brown stated that the home always has adequate food, including fresh fruits and vegetables. Mr. Najos, Ms. Delontido, and Ms. Brown denied knowledge of this complaint being true. Based on the information above, there is not sufficient information to confirm that Resident A was served expired food by direct care staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the issuance of a six-month provisional license.

6/14/2023

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

06/14/2023

Denise Y. Nunn Date
Area Manager