GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 5, 2024

Denise Aleardi
The Aleardi Inn, LLC
34206 W. 13 Mile Rd.
Farmington Hills, MI 48331

RE: License #: AS630276214
Investigation #: 2024A0991004
Aleardi's Place of West Bloomfield I

Dear Denise Aleardi:

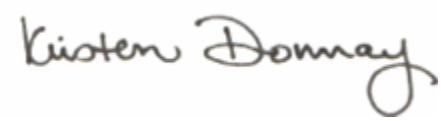
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS630276214
Investigation #:	2024A0991004
Complaint Receipt Date:	11/13/2023
Investigation Initiation Date:	11/13/2023
Report Due Date:	01/12/2024
Licensee Name:	The Aleardi Inn, LLC
Licensee Address:	34206 W. 13 Mile Rd. Farmington Hills, MI 48331
Licensee Telephone #:	(734) 788-3000
Licensee Designee:	Denise Aleardi
Name of Facility:	Aleardi's Place of West Bloomfield I
Facility Address:	6385 E. Norma Lee West Bloomfield, MI 48301
Facility Telephone #:	(248) 788-0829
Original Issuance Date:	09/23/2005
License Status:	REGULAR
Effective Date:	08/18/2022
Expiration Date:	08/17/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A passed away at the home. Staff attempted CPR and called the provider before calling 911. Staff could not provide any knowledge/background on Resident A to the police.	Yes
The smoke detectors in the home were chirping due to low battery life.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/13/2023	Special Investigation Intake 2024A0991004
11/13/2023	Special Investigation Initiated - Telephone Call to Detective Foster, West Bloomfield Police Department
11/13/2023	APS Referral Referral was not made to Adult Protective Services (APS) as the resident is deceased/no allegations of abuse/neglect
11/22/2023	Inspection Completed On-site Unannounced onsite inspection- interviewed staff, observed residents
11/22/2023	Contact - Document Received Copy of incident report
11/22/2023	Contact - Telephone call made Interviewed licensee designee, Denise Aleardi, via telephone
12/13/2023	Contact - Telephone call made Interviewed Roselande Sira via telephone
12/28/2023	Contact - Document Sent Requested training documentation and policy for emergency procedures
01/03/2024	Contact - Document Received Received training verification and emergency protocols

01/04/2024	Exit Conference Left message for licensee designee, Denise Aleardi

ALLEGATION:

- **Resident A passed away at the home. Staff attempted CPR and called the provider before calling 911. Staff could not provide any knowledge/background on Resident A to the police.**
- **The smoke detectors in the home were chirping due to low battery life.**

INVESTIGATION:

On 11/13/23, I received a complaint alleging that on 11/10/23, Resident A died at the facility. The direct care worker on shift, Roselande Sira, did not want to provide information to the responding law enforcement officers. She then stated that she only works on weekends and does not know much about the residents in the facility. She could not provide any information about Resident A. Ms. Sira attempted CPR and contacted her boss before calling 911. The complainant also noticed several smoke detectors chirping while in the facility. A referral was not made to Adult Protective Services (APS), as Resident A is deceased and there were no allegations of abuse or neglect.

On 11/13/23, I initiated my investigation by contacting Detective Foster with the West Bloomfield Police Department. Detective Foster stated that he arrived at Aleardi's Place of West Bloomfield I around 8:30pm on 11/10/23. Roselande Sira was the only staff person on shift. She stated that she arrived for her shift around 7:00pm and found Resident A deceased at 7:20pm. The West Bloomfield police dispatch received a call at 7:36pm. Detective Foster stated that it was 15-20 minutes before Ms. Sira called 911, because she attempted CPR and called her boss first. Detective Foster stated that there were no concerns regarding Resident A's cause of death. The autopsy showed he died of natural causes. He stated that he had concerns about the staff's response to the situation and her lack of knowledge regarding the residents. Detective Foster stated that Ms. Sira was unable to provide him with any information regarding Resident A. He told her that she was responsible for knowing about the residents, and Ms. Sira responded, "Not really, I only work on weekends." Detective Foster stated that the smoke detectors were chirping while he was at the home indicating the batteries needed to be replaced, and staff "seemed oblivious" that they were chirping.

On 11/22/23, I conducted an unannounced onsite inspection at Aleardi's Place of West Bloomfield I. The staff on shift, Larinda Olds, contacted the licensee designee, Denise Aleardi, and I interviewed Ms. Aleardi via telephone. Ms. Aleardi stated that Roselande Sira was working the evening shift when Resident A was found deceased. She stated that Ms. Sira found Resident A shortly after the start of her shift and noticed that his hand was cold. Ms. Sira called Ms. Aleardi and wanted her to call 911. Ms. Aleardi

stated that Ms. Sira is Haitian and was worried about her English because she speaks with an accent. Ms. Aleardi stated that she was out of town in Rapid City, South Dakota at the time, so she advised Ms. Sira to call 911 and she stayed on the line with her. She stated that staff are trained to call 911 before they contact her. She felt Ms. Sira was upset and panicked when she found Resident A. Ms. Aleardi stated that it was only a minute before 911 was contacted. She stated that there is a chart in the home for each resident and all the staff know where to locate the information. Ms. Aleardi stated that they have staff meetings regularly, and all the staff know what to do in an emergency. Ms. Aleardi stated that Resident A's death was ruled to be from natural causes. Resident A's brother was contacted, and an incident report was completed. Ms. Aleardi stated that she was aware that a smoke detector was chirping in the home that night, and the batteries were replaced the following day.

On 11/22/23, I interviewed direct care worker, Larinda Olds, Ms. Olds stated that she has worked in the home for 20 years. She stated that if there is an emergency with a resident, the staff are trained to call 911 first and then contact Denise Aleardi. Ms. Olds showed me where the resident files are kept, and she stated that all staff should know how to access their information. The home has a house cell phone that remains in the home at all times. Ms. Olds stated that she was not working when Resident A passed away, and Ms. Aleardi was out of town when Emergency Medical Services (EMS) came to the home. She did not recall the smoke detectors in the home chirping during the last shift she worked prior to Resident A passing away, but she stated that her husband went to the home and replaced the batteries that weekend. Ms. Olds stated that she did not have any concerns about the care of the residents in the home.

During the onsite inspection, I noted that the smoke detectors were no longer chirping. I observed the residents watching television in the living room. I reviewed a copy of the incident report, which was completed by Denise Aleardi. The incident report notes the date and time of the incident as 11/10/23 at 7:30pm. It indicates that Roselande went into the bedroom to check on Resident A and he was unresponsive. She started chest compressions and called 911. It notes that EMS was contacted at 7:40pm.

On 12/12/23, I interviewed direct care worker, Roselande Sira. Ms. Sira stated that she has worked at the home for five years. She typically works the night shift and only works on weekends. She was working the night shift on the weekend when Resident A passed away. She stated that she came in around 7:00pm. She went to Resident A's room shortly after her shift started and found him dead. She stated that Belinda, the staff who was previously on shift, was still outside, so she called her and asked her to come back, but Belinda stated she had to leave. Ms. Sira tried CPR and then called the licensee designee, Denise Aleardi. Ms. Aleardi asked her if she tried CPR. She told her yes, but it did not work. Ms. Aleardi told her to call 911. Ms. Sira stated that she was talking to Ms. Aleardi on her personal cell phone, and she used the house phone to call 911. She stated that EMS arrived and checked on Resident A. They told her he had died. She stated that they were asking her all the questions, but she told them that she did not know anything because she just came in for her shift. She stated that Ms. Aleardi gave information to the police over the phone because her English is not very good. She

stated that she did not know why she called Belinda or Ms. Aleardi before calling 911. She stated that they are supposed to call 911 first. She stated that she called Belinda because she was still outside, and Ms. Aleardi is her boss. Ms. Sira stated that the smoke detector was beeping when the police were at the home. She did not know how long it had been chirping for, but someone fixed it the following day.

I reviewed a copy of Roselande Sira's training verification dated 05/02/2018. It notes that Ms. Sira was fully trained and demonstrated what to do in an emergency, including contacts in a medical emergency and where important phone numbers are located. Competency was demonstrated in checking for vital signs, CPR & First Aid, and reporting requirements. I reviewed a copy of the home's emergency protocol. It notes that staff should stay calm and call 911 if a resident is non-responsive. Staff should go to the resident's chart and call a family member. Call Denise and/or the home manager. Make copies of the resident's medication sheets and identification page (first page in chart) to give to the EMS driver. The protocol notes that if staff are unsure about a resident's condition or what to do then they should call Denise, Lacie, or Larinda.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (b) Be capable of appropriately handling emergency situations.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that direct care worker, Roselande Sira, did not respond appropriately during an emergency situation on 11/10/23 when Resident A passed away at the home. Upon finding Resident A non-responsive, Ms. Sira did not immediately call 911. She tried to get the previous staff on shift to return to the home, attempted CPR, and then contacted the licensee designee, Denise Aleardi, who instructed her to call 911. Ms. Sira was unable to provide information about Resident A to the responding medical and law enforcement personnel. The detective at the scene stated that Ms. Sira told him she was not responsible for knowing about the residents because she only works on the weekends. Ms. Sira did not utilize the emergency protocol that she was trained to follow.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14505	**Smoke detection equipment; location; battery replacement; testing, examination, and maintenance; spacing of detectors mounted on ceilings and walls; installation requirements for new construction, conversions, and changes of category.**
	(3) The batteries of battery-operated smoke detectors shall be replaced in accordance with the recommendations of the smoke or heat detection equipment manufacturer.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that the smoke detector batteries were not replaced according to the manufacturer's instructions. The detective who responded to an emergency at the home on 11/10/23 observed the smoke detectors chirping throughout the home. He stated that staff "seemed oblivious" that the smoke detectors were beeping. The licensee designee and staff acknowledged that the smoke detectors were chirping, and the batteries were changed the following day.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my unannounced onsite inspection on 11/22/23, I observed a portable space heater being used in the living room. I informed the staff on shift, Larinda Olds, that portable space heaters are not permitted in licensed facilities. Ms. Olds unplugged the space heater and stated that it would no longer be used.

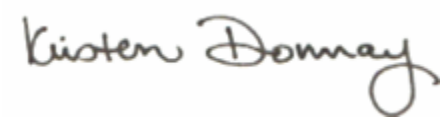
On 01/04/2024, I contacted the licensee designee, Denise Aleardi, to conduct an exit conference. Ms. Aleardi was not available, so I left a detailed voicemail message and requested a return phone call.

APPLICABLE RULE	
R 400.14510	**Heating equipment generally.**
	(5) Portable heating units shall not be permitted.

ANALYSIS:	During my unannounced onsite inspection, a portable space heater was being used in the living room area of the home.
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.



01/04/2024

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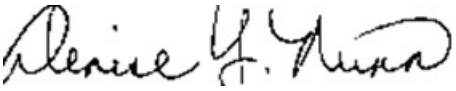
Kristen Donnay Date
Licensing Consultant

Approved By:



01/05/2024

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Denise Y. Nunn Date
Area Manager