

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

March 29, 2024

Jorge Garcia Aion Pineview LLC 11681 Whitehall Dr. Sterling Heights, MI 48313

#### RE: License #: AS630412937 Pineview Manor 2888 S Baldwin Rd Orion Township, MI 48360

Dear Mr. Garcia:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 licensee or licensee designee or home for the aged authorized representative and a date.

Upon receipt of an acceptable corrective plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result.

Please contact me with any questions. In the event that I am not available and you need to speak to someone immediately, you may contact the local office at (248) 975-5053.

Sincerely,

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Sheena Worthy, Licensing Consultant Bureau of Community and Health Systems Cadillac Place 3026 W. Grand Blvd, Suite 9-100 Detroit, MI 48202

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#### MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS BUREAU OF COMMUNITY AND HEALTH SYSTEMS RENEWAL INSPECTION REPORT

# I. IDENTIFYING INFORMATION

License #:	AS630412937
Licensee Name:	Aion Pineview LLC
Licensee Address:	11681 Whitehall Dr.
	Sterling Heights, MI 48313
Licensee Telephone #:	(248) 342-9015
Licensee/Licensee Designee:	Jorge Garcia
Administrator:	Jorge Garcia
Name of Facility:	Pineview Manor
Name of Facility:	
Facility Address:	2888 S Baldwin Rd
	Orion Township, MI 48360
Facility Telephone #:	(248) 342-9015
Original Issuance Date:	05/03/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED
	ALZHEIMERS
	AGED TRAUMATICALLY BRAIN INJURED

# **II. METHODS OF INSPECTION**

Date of On-site Inspection(s): 03/13/2024

Date of Bureau of Fire Services Inspection if applicable: N/A

Date of Health Authority Inspection if applicable: N/A

No. of staff interviewed and/or observed1No. of residents interviewed and/or observed4No. of others interviewedRole:

- Medication pass / simulated pass observed? Yes  $\boxtimes$  No  $\square$  If no, explain.
- Medication(s) and medication record(s) reviewed? Yes 🛛 No 🗌 If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ⊠ No □ If no, explain.
- Meal preparation / service observed? Yes 🛛 No 🗌 If no, explain.
- Fire drills reviewed? Yes 🛛 No 🗌 If no, explain.
- Fire safety equipment and practices observed? Yes  $\boxtimes$  No  $\square$  If no, explain.
- E-scores reviewed? (Special Certification Only) Yes No N/A If no, explain.
- Water temperatures checked? Yes 🛛 No 🗌 If no, explain.
- Incident report follow-up? Yes 🛛 No 🗌 If no, explain.
- Corrective action plan compliance verified? Yes ∑ CAP date/s and rule/s: SIR CAP Approved 10/31/23; 313(4), 313(1), 312(2), 312(1), 312(4)(c), 312(4)(b), 312(7), 312(4)(e), 306(2) N/A □
- Number of excluded employees followed-up?
   N/A ⊠
- Variances? Yes 🗌 (please explain) No 🗌 N/A 🖂

# **III. DESCRIPTION OF FINDINGS & CONCLUSIONS**

This facility was found to be in non-compliance with the following rules:

R 400.14201	Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.
	<ul> <li>(9) A licensee and the administrator shall possess all of the following qualifications:         <ul> <li>(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.</li> </ul> </li> </ul>

Throughout the onsite, I would ask direct questions regarding the resident's files to Mr. Garcia. However, Mr. Gross would consistently answer the questions for Mr. Garcia or interject while I was speaking to Mr. Garcia. As the licensee designee and administrator, Mr. Garcia is expected to answer questions directed to him and not allow others to answer for him.

R 400.14312	Resident medications.
	<ul> <li>(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:         <ul> <li>(b) Complete an individual medication log that contains all of the following information:</li></ul></li></ul>

According to Resident R's MAR, he is prescribed Vitamin D3 25 mcg. However, the bottle observed for Resident R's Vitamin D3 had a different dosage that is written on the MAR and on the doctor's order. The bottle observed was Vitamin D3 125mcg.

#### REPEAT VIOLATION ESTABLISHED Reference SIR #2024A0611002; CAP dated 10/31/23

R 400.14316	Resident records.
	<ul> <li>(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:</li></ul>

The resident records were not maintained in the home as Mr. Gross admitted to removing the files from the home shortly after the onsite on 03/13/24.

Resident J was discharged on 12/29/23. However, her resident identification record did not include her discharge date.

R 400.14304	Resident rights; licensee responsibilities.
	<ul> <li>(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:         <ul> <li>(q) The right to confidentiality of records as stated in section 12(3) of the act.</li> </ul> </li> </ul>
	When I returned to the home shortly after the onsite, William Gross returned to the home a few minutes later with Resident B and Resident D's files in his possession. Mr. Gross stated he placed the remaining resident's files in another room. I observed the remaining files in Resident D's bedroom on the floor. The remaining files were not safeguarded, and the resident's confidentiality was at risk. At this time, there was an activity person exercising with the residents in the living room next to Resident D's bedroom. Mr. Gross refused to answer as to why he placed the resident's file in another resident's bedroom.

# **IV. RECOMMENDATION**

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

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Sheena Worthy Licensing Consultant

03/19/24 Date