GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 25, 2024

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

RE: License #: AS630407930
Investigation #: 2025A0611004
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,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630407930
Investigation #:	2025A0611004
Complaint Receipt Date:	10/07/2024
Investigation Initiation Date:	10/08/2024
Report Due Date:	12/06/2024
Licensee Name:	Aion Silverbell LLC
Licensee Address:	11681 Whitehall Dr. Sterling Heights, MI 48313
Licensee Telephone #:	(586) 883-1932
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:	04/08/2024
Expiration Date:	04/07/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident M feels like he is not getting the medications that he is supposed to which is at least one narcotic.	Yes
Resident M is becoming sick because of the menu at the group home which only includes hot dogs and pizza.	No
They are using Resident M's shower bench. Resident M goes without showering for a few days because the bathroom is either not working or they are using his shower bench. The washer and dryer does not work.	No
Resident M has to figure out ways to lock his door so that others won't come in being aggressive. Resident M has taped his door shut.	No
Additional Findings	Yes

III. METHODOLOGY

10/07/2024	Special Investigation Intake 2025A0611004
10/08/2024	Special Investigation Initiated - Telephone I received a return phone call from the reporting source. The allegations were discussed.
10/08/2024	APS Referral The assigned Adult Protective Services worker is Estelita Horton.
10/18/2024	Inspection Completed On-site I completed an unannounced onsite. I attempted to interview Resident M however; he refused to speak to me. I interviewed staff member Asha Lewis. I interviewed Resident B, Resident R, and Resident M. I received copies of the menu, Resident M's MAR and his controlled substance record of administration.
10/18/2024	Contact - Document Received I received a text message from the house manager Abigail who provided additional pictures of meals for the residents.

10/22/2024	Contact - Telephone call made I left a voice message for the licensee designee Jorge Garcia requesting a call back.
10/23/2024	Contact - Telephone call made I left a voice message and sent an email to the licensee designee Jorge Garcia requesting a call back.
10/23/2024	Contact - Telephone call received I received a return phone call from the licensee designee Jorge Garcia. I attempted to discuss the allegations however; Mr. Garcia stated he decided to stop being the licensee designee a few months ago. It was explained to Mr. Garcia that he is still considered the licensee designee as he never submitted a request to select someone else to become the licensee designee. Mr. Garcia stated he will follow up with me regarding this issue.
10/24/2024	Contact - Telephone call made I made a telephone call to the home manager Abigail Colon. The allegations were discussed.
10/24/2024	Contact - Document Received I received a copy of Resident M's MAR for the month of July, and prescriptions for shower chair via text from the home manager.
10/24/2024	Contact - Telephone call made I made a telephone call to the home manager Ms. Colon to receive additional information regarding Resident M's MAR.
10/25/2024	Exit Conference I completed an exit conference with the licensee designee Jorge Garcia via telephone.

ALLEGATION:

Resident M feels like he is not getting the medications that he is supposed to which is at least one narcotic.

INVESTIGATION:

On 10/07/24, a complaint was received and assigned for investigation alleging that Resident M has sacral wounds and is a paraplegic. Resident M feels like he is not getting the medication that he is supposed to including at least one is a narcotic. Resident M is becoming sick because of the menu at the group home. It is basically only hot dogs and pizza on their menu. Resident M has a colostomy bag, so it is easy to

determine when he is not feeling well. There are other residents in the home with dementia and that are aggressive. They are using Resident M shower bench when they are not supposed to. They are dirty and no one is helping them. Resident M goes without showering for a few days because the bathroom is either not working or they are using his shower bench. If something is broken in the bathroom, it takes 3-4 days to be fixed. The washer and dryer does not work. Resident M has to figure out ways to lock his door so that others won't come in being aggressive. Resident M has taped his door shut. Resident M is fearful. It is unknown if anyone has hit him. If Resident M is in bed he can't get away.

On 10/08/24, I received a return phone call from the reporting source. Regarding the allegations, Resident M is his own guardian. The reporting source has been to the AFC group home about two times. The reporting source is not aware of the medications that are prescribed for Resident M. Resident M does not remember all of the medications that he is prescribed but he feels he is not administered all of his medications. The reporting source stated the staff is inconsistent as they work for a short period of time and then they are either transferred or terminated. The reporting source also stated the staff barely speaks English.

On 10/18/24, I completed an unannounced onsite. I attempted to interview Resident M however; he refused to speak to me. I interviewed staff member Asha Lewis. I interviewed Resident B, Resident R, and Resident G. I received copies of the menu, Resident M's MAR and his controlled substance record of administration.

On 10/18/24, upon arriving to the AFC group home. I observed Resident M sitting on the front porch smoking. Resident M immediately stated he did not want to talk to me nor did he want to answer any questions.

On 10/18/24, Ms. Lewis stated she is trained to administer medications. Ms. Lewis is only responsible for passing the morning medications. The majority of the residents only receive morning and evening medications. There are two residents who receive medications at 4:00pm. Resident M also receives midnight medications. Ms. Lewis denies Resident M not being administered any of his medications. Resident M is prescribed four narcotics. Ms. Lewis is explained that for narcotics the staff initial the MAR and their controlled substance administration record when a resident is administered a narcotic medication.

On 10/18/24, I received a copy of the controlled substance administration records for Resident M. Resident M is prescribed the following narcotics:

- Morphine Sulf ER 100mg 12:00am
- Diazepam 10mg 8:00pm
- Diazepam 10mg 12:00pm
- Diazepam 10mg 6:00am
- Morphine Sulf ER 100mg 6:00pm
- Morphine Sulf ER 100mg 12:00pm
- Morphine Sulf ER 100mg 6:00am

The controlled substance administration record includes the date, time, medication count on hand, and which staff member administered the narcotic. According to the controlled substance administration records, Resident M is receiving his narcotics as prescribed with the exception of his Morphine Sulf ER 100mg at 6:00pm on 10/11/24. The staff did not document whether or not this medication was given. According to Resident M's MAR, it appears Resident M is receiving all of his medications as prescribed with the exception of Morphine Sulf ER 100mg at 6:00pm on 10/10/24 and 10/11/24 as there were no staff initials documented.

On 10/18/24, I interviewed Resident B. Resident B has lived at the AFC group home for one month. Resident B stated it is hard for him to get use to living at the AFC group home because he has never lived in a group home before. Resident B stated he is administered medications every day.

On 10/18/24, I interviewed Resident R. Resident R has lived at the AFC group home since the beginning of this year. Resident R stated he likes living at the AFC group home as it is better than his last home. Resident R stated he is administered his medications every day. Resident R stated he is prescribed 22 pills. Resident R stated staff has forgotten to give him his medication before but he does not remember when.

On 10/18/24, I interviewed Resident G. Resident G has lived at the AFC group home for one year. Resident G is administered medications and staff ensure that he gets his medications. The staff never forget to administer Resident G's medications.

On 10/24/24, Ms. Colon denied any instances where staff forgot to administer Resident M his medications. Ms. Colon then stated if Resident M doesn't get his medications, he goes crazy and turns into a "demon". Ms. Colon reiterated that Resident M receives his medications and he receives them on time. Resident M is addicted to his narcotic medications and he doesn't care about his other prescribed medications. When asked to elaborate about what happens when Resident M becomes upset, Ms. Colon stated Resident M will start yelling and cursing at staff as well as slam doors when he wants his medications. Ms. Colon described an incident that took place on 07/31/24 involving a new staff member by the name of Sommer. Ms. Colon does not remember Sommer's last name. Sommer was working the midnight shift (11:00pm-7:00am) and Resident M was demanding to receive his midnight dosage of Morphine at 11:00pm. Resident M is prescribed Morphine at 12:00am, and Diazepam and Morphine at 6:00am. Resident M was also insisting that Sommer give him his 6:00am dosage of Morphine and Diazepam, and his 8:00am medication for the following day all at once at 11:00pm. Ms. Colon stated Sommer gave Resident M his 12:00am and 6:00am medications all at once and an extra pill of Diazepam on accident. Ms. Colon stated when shift change occurred, she was notified that Resident M was missing one of his medications. Ms. Colon contacted Sommer and Sommer told her that she gave Resident M an extra pill.

Ms. Colon then called Resident M and told him that she needed him to give that extra pill back when she arrives to the home. Ms. Colon stated when she got to the home,

Resident M did not have the extra pill and she does not know what he did with it. Ms. Colon informed Resident M that at the end of the month he is going to be short a pill.

Ms. Colon admitted that in June 2024, staff started giving Resident M his 12:00am and 6:00am narcotic medications early and all at once because Resident M started getting upset when staff would wake him up to administer his medications. The staff stopped giving Resident M's narcotic medications early and all at once in July after Sommer made the mistake and gave him an additional Diazepam and; Resident M then accused the staff of stealing his medications.

On 10/24/24, I received a copy of Resident M's MAR for the month of July, and prescriptions for shower chair via text from the home manager Ms. Colon. According to the MAR for July, Resident M is prescribed Diazepam 10mg at 6:00am, 12:00pm, and 8:00pm. The staff initial each day for each administration for this medication. However, there are missing staff initials for Resident M's silver sulfadiazine 1% topical on 07/11/24 at 8:00pm and 07/26/24 at 12:00pm.

On 10/24/24, I made a telephone call to the home manager Ms. Colon regarding Resident M's medications. Ms. Colon explained that since Sommer was working the midnight shift on 07/31/24, the extra pill of Diazepam that she gave to Resident M was documented on the August MAR. Ms. Colon provided a copy of the August MAR via text. I observed on 08/02/24, the letter "D" was documented for the 6:00am dose for Diazepam. Ms. Colon stated the letter D stands for the drug was not given. I observed the back of the MAR and saw the explanation that the 6:00am dose of Diazepam was not given on 08/02/24 because Resident M was given an "extra day before". The number 10 was documented as the staff initial next to the comment. Ms. Colon explained that the number 10 use to be Sommer's assigned number however; when Sommer was terminated on 08/11/24, Ms. Colon started using the number 10. Ms. Colon stated she wrote the comment on the back of MAR.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation and the information gathered, there is sufficient evidence to support this allegation. The home manager Abigail Colon confirmed an instance where Resident M was not administered his 6:00am Diazepam on 08/02/24 as a former staff member (Sommer) did not follow Resident M's label instructions for his medications nor did she follow the 5 medication rights as she gave Resident M a total of four pills at one time on 07/31/24.
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: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	According to Resident M's MAR for October, it is unknown if he received his Morphine Sulf ER 100mg at 6:00pm on 10/10/24 or 10/11/24 as there were no staff initials documented. Moreover, there are missing staff initials on the July MAR for Resident M's silver sulfadiazine 1% topical on 07/11/24 at 8:00pm and 07/26/24 at 12:00pm.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident M is becoming sick because of the menu at the group home which only includes hot dogs and pizza.

INVESTIGATION:

On 10/08/24, the reporting source stated he has not witnessed any of the meals served at the AFC group home. Resident M has informed the reporting source that the staff mainly serve pizza and hot dogs to eat. When the staff cook, the food is undercooked. Resident M uses a colostomy bag. There was an instance where Resident M's colostomy bag was full of diarrhea from eating too much pizza. The reporting source stated Resident M is not on a special diet.

On 10/18/24, I interviewed staff member Asha Lewis. Ms. Lewis has worked at the AFC group home for about three months. Ms. Lewis only works the day shift from 7:00am to 3:00pm. Regarding the allegations, there are six residents living in the AFC group home but, Resident F is currently in the hospital. Ms. Lewis denied the allegation regarding the residents only eat pizza and hot dogs. Ms. Lewis stated she likes to cook and bake. Ms. Lewis stated the staff members have a group chat and they share pictures of the residents meals. Today the residents were served cereal, and a banana for breakfast. Ms. Lewis stated yesterday the residents ate french toast, an omelet, and fruit for breakfast; for lunch they ate chicken, Puerto Rican rice, and potato salad; and for dinner

the residents were served chicken tenders, salad, and fries. Ms. Lewis sent me pictures of the residents meals via text message.

On 10/18/24, I observed the pictures of the residents meals and the menu for the week of October 14th through October 20th. I received the following pictures of meals:

- bowl of cereal, banana, and cup of milk
- omelet, french toast, plate of fruit, and a cup of milk
- waffles, bacon, strawberries
- french fries, salad, chicken, mash potato, muffin, and a beverage
- rice, chicken, potato salad

According to the menu, there is a variety of well-balanced nutritious meals listed. However, the meals on the menu do not match the meals Ms. Lewis reported was served on 10/17/24. There were no substitution listed on the menu.

On 10/18/24, Resident B stated he is served a variety of three meals a day. Resident B stated the majority of the time the food is good. Resident B stated he may have been served pizza two weeks ago. Resident B denied being served pizza all the time. Resident B stated he might eat hot dogs once a week. Resident B stated the meals are balanced and nutritious.

On 10/18/24, Resident R is served three meals a day. Resident R stated the food is good. Resident R stated he is served a lot of rice and noodles which is too many carbs for him. Resident R stated he drinks protein shakes to make up for all the carbs he is eating. Resident R stated he is not fed a lot of pizza or hot dogs. Resident R stated the last time he ate pizza was about 3-4 weeks ago.

On 10/18/24, Resident G is served three meals a day. Resident G stated the food is good. Resident G confirmed that he is served a variety of nutritious meals. Resident G stated he is not fed pizza all the time and he is not given hot dogs often.

On 10/18/24, I received a text message from the house manager Abigail Colon who provided additional pictures of meals for the residents. There were a variety of meals that were well balanced and nutritious.

On 10/24/24, I made a telephone call to the home manager Abigail Colon. Ms. Colon has worked at the AFC group home for two years. Regarding the allegations, Resident M has resided at the AFC group home for one year. Ms. Colon stated the residents are fed a variety of meals. Ms. Colon stated sometimes the staff do not follow the menu as they choose to cook something better than what is listed on the menu. The staff have a group chat where they send each other pictures of the meals that are served to the residents as proof in the event a family member accuses the staff of not feeding the residents. The menu is prepared by a different home manager from another AFC group home (Pineview Manor). Ms. Colon stated the pictures of the meals she sent me are from different weeks and she does not know the exact dates.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on my findings there is no evidence to support this allegation. The residents that were interviewed confirmed that they are fed three times a day which includes a variety of meals. I observed the menu and found there is a variety of well-balanced nutritious meals listed. Furthermore, Resident M refused to be interviewed therefore, the allegations could not be verified.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

They are using Resident M's shower bench. Resident M goes without showering for a few days because the bathroom is either not working or they are using his shower bench. The washer and dryer does not work.

INVESTIGATION:

On 10/18/24, Ms. Lewis stated that Resident M has a shower chair. Ms. Lewis stated no one else uses Resident M's shower chair. Resident M only uses the full bathroom that is next door to his bedroom. The other residents mainly use the other full bathroom but there is no particular reason as to why. I observed the bathroom near Resident M's bedroom and saw Resident M's shower chair with his name on it near the door and another shower chair inside the shower. Ms. Lewis stated the second shower chair is the "house shower chair". I observed another shower chair in the second full bathroom. Ms. Lewis could not locate a prescription for Resident M's shower chair. Ms. Lewis stated the toilet in the bathroom next to Resident M's bedroom may get clogged up because the residents will put too much toilet paper in the toilet. Ms. Lewis stated the toilet has only been clogged up two times. Ms. Lewis stated when she called maintenance to fix the toilet it was fixed the same day.

Ms. Lewis stated Resident M is independent and he insist on doing everything himself. The staff only cook Resident M's meals and administer his medications. Resident M takes his own shower without any staff assistance. Ms. Lewis stated the residents take a shower twice a week. I observed a board in the home that outlines which day a resident needs a shower. Ms. Lewis stated the showers in the home are always working. Ms. Lewis confirmed that the washer and dryer is operable. I observed Ms. Lewis turn on the dryer and washing machine.

On 10/18/24, Resident B stated the staff assist him with taking a shower every day. Resident B denied the shower or toilet ever being broken. Resident B stated his clothes are cleaned on a regular basis.

On 10/18/24, Resident R stated he takes a shower one to two times a week. Resident R stated the shower is always working. Resident R stated sometimes the toilet is clogged but it gets fixed the same day by a plumber. Resident R stated as far as he knows the washer and dryer works.

On 10/18/24, Resident G takes a shower twice a week. The shower and the toilet is always working. Resident G stated he stands up when he takes a shower and does not use a shower bench. Resident G does not know if anyone uses a shower bench. The staff completes Resident G's laundry on a regular basis.

On 10/24/24, Ms. Colon stated there was one instance when the toilet in the bathroom next to Resident M's bedroom was clogged because Resident P put too much toilet paper in it. Ms. Colon stated the toilet was fixed within 4-5 hours. Ms. Colon stated while the toilet was clogged up the other toilet in the second bathroom was still in working condition.

Ms. Colon stated she has a prescription for Resident M, Resident G, and Resident F shower chairs. Ms. Colon admitted that there are three additional shower chairs located in the basement of the AFC group home. The shower chairs in the basement do not belong to any of the current residents. Ms. Colon denied anyone using Resident M's shower chair. Ms. Colon stated no one touches or moves Resident M's shower chair. Resident G's shower chair is located in the bathroom next to his bedroom and; Resident M and Resident F shower chair is located in the bathroom next to Resident M's bedroom.

Ms. Colon stated the residents receive showers three times a week. Resident P and Resident G receive additional showers throughout the week because they easily develop an odor. Ms. Colon stated the showers are always working. There was an instance when the dryer was not working properly and it was replaced quickly.

On 10/24/24, Ms. Colon provided six prescriptions for shower chairs for each resident currently living in the home. Ms. Colon corrected herself and stated the three shower chairs in the basement belong to Resident P, Resident, R, and Richard and B. Resident B and Resident R do not use their shower chairs as they do not like to sit down. The staff will bring Resident P's shower chair upstairs for him to use it.

APPLICABLE RULE	
R 400.14314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	During my onsite, I observed a board in the home that outlines which day a resident needs a shower. The residents interviewed confirmed that they receive showers at least twice a week. I observed Resident M, Resident F, and Resident G's shower chairs in the home. Ms. Lewis and Ms. Colon denied anyone using Resident M's shower chair. Resident M refused to be interviewed therefore, this allegation could not be verified.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14403	**Maintenance of premises.**
	(6) All plumbing fixtures and water and waste pipes shall be properly installed and maintained in good working condition. Each water heater shall be equipped with a thermostatic temperature control and a pressure relief valve, both of which shall be in good working condition.
ANALYSIS:	There is no evidence to support this allegation. I observed the washer and dryer working during my onsite. The residents interviewed confirmed that the showers are always working. The toilet has been clogged up before but it was fixed the same day.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident M has to figure out ways to lock his door so that others won't come in being aggressive. Resident M has taped his door shut.

INVESTIGATION:

On 10/08/24, the reporting source stated Resident M has informed him that one or two of the residents have dementia and they are verbally and physically aggressive towards

the staff members. The reporting source does not know the names of the residents that Resident M is referring to. The reporting source stated Resident M's bedroom door shuts but it does not lock. The reporting source has not verified if Resident M's bedroom door locks or not.

On 10/18/24, I observed Resident M's bedroom. There is a non-locking against egress hardware on Resident M's bedroom door. Ms. Lewis stated Resident M received a new lock on his bedroom door in October because the previous doorknob was broken. Ms. Lewis does not know what happened to Resident M's previous doorknob. Ms. Lewis stated that sometimes Resident M will lash out when he gets mad and will threaten to call adult protective services. Ms. Lewis denied any of the residents being aggressive. Resident P has dementia and there was one instance when he went into Resident R's bedroom by mistake. Resident P has never been aggressive towards any of the residents. Ms. Lewis stated there was one instance when Resident P was aggressive towards her as he hit her hand when she tried to wake him up. Ms. Lewis further explained that Resident P is sundowning. Resident P's behavior has improved due to being placed on medication to address his dementia. Ms. Lewis denied any resident attacking or being aggressive towards Resident M.

On 10/18/24, Resident B denied any violence in the home. He confirmed that none of the residents are aggressive.

On 10/18/24, Resident R denied any residents being aggressive except Resident P. Resident P came into Resident R's bedroom and sat in his chair. Resident P hit a staff when the staff tried to get Resident P up from his chair. Resident R stated Resident P has also hit Resident M on his shoulder. Resident R stated he did not see Resident P hit Resident M. Resident R stated Resident P is not aggressive anymore. Resident P has dementia and he is medicated for it. Resident R stated he feels safe at the AFC group home.

On 10/18/24, Resident G denied any resident getting violent or aggressive with anyone. Resident G stated he has never seen anyone hit Resident M. While I was interviewing Resident G, I observed Resident P walking into the bathroom.

On 10/24/24, Ms. Colon denied any residents being aggressive or putting their hands on Resident M. Resident M was taping his bedroom door shut because he did not want Resident P wandering into his bedroom. Resident P wanders around and opens up doors due to his dementia. There was an instance when Resident P opened Resident M's bedroom door. Resident M then took his doorknob off the door to keep Resident P from opening it again. Resident M has a new doorknob on his door.

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:	There is no evidence to support this allegation. Per the interviews conducted, no resident has been physically aggressive towards Resident M. Although Resident R reported that Resident P has hit Resident M, Resident R did not see Resident P hit Resident M. Resident P has dementia and could not be interviewed. Resident M refused to be interviewed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/18/24, Ms. Lewis stated that on 10/17/24, the residents ate french toast, an omelet, and fruit for breakfast; for lunch they ate chicken, Puerto Rican rice, and potato salad; and for dinner the residents were served chicken tenders, salad, and fries. According to the menu for 10/17/24, the option for breakfast is cranberry juice, cream of wheat or dry cereal, milk, coffee, tea. The option for lunch on 10/17/24 was egg salad, slices of bread, fresh veggie, fruit cocktail, and beverage of choice. The option for dinner on 10/17/24 was pork cutlet, gravy, egg noodles, zucchini, bread and milk.

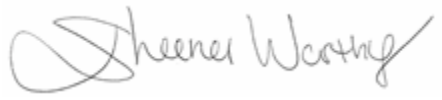
On 10/24/24, Ms. Colon stated she is aware that staff are expected to write a substitution on the menu when something different is prepared for the residents. It was brought to Ms. Colon attention that the menu for last week did not include any substitutions as the meals described by Ms. Lewis for 10/17/24 did not match what was listed on the menu.

On 10/25/24, I completed an exit conference with the licensee designee Jorge Garcia. Mr. Garcia was informed on which allegations will be substantiated. Mr. Garica was informed that a corrective action plan will be required. Mr. Garcia agreed to complete the CAP.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	Based on the pictures and the description provided by Ms. Lewis regarding what the residents ate on 10/17/24, the staff are not always following the menu nor are they documenting substitutions on the menu.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

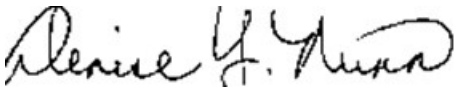


10/25/24

Sheena Worthy
Licensing Consultant

Date

Approved By:



10/29/2024

Denise Y. Nunn
Area Manager

Date