GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 15, 2022

Denise Aleardi
La Viva LLC
34206 W. 13 Mile Road
Farmington Hills, MI 48331

RE: License #: AS630394033
Investigation #: 2022A0602032
Nannie's Inn

Dear Ms. 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,

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 #:	AS630394033
Investigation #:	2022A0602032
Complaint Receipt Date:	05/04/2022
Investigation Initiation Date:	05/05/2022
Report Due Date:	07/03/2022
Licensee Name:	La Viva LLC
Licensee Address:	1750 Sherwood St. Sylvan Lake, MI 48320
Licensee Telephone #:	(734) 788-3000
Administrator:	Denise Aleardi
Licensee Designee:	Denise Aleardi
Name of Facility:	Nannie's Inn
Facility Address:	3050 Spring St. West Bloomfield, MI 48322
Facility Telephone #:	(734) 788-3000
Original Issuance Date:	08/01/2018
License Status:	REGULAR
Effective Date:	02/01/2021
Expiration Date:	01/31/2023
Capacity:	6
Program Type:	MENTALLY ILL TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are not washed up for days or changed on a regular basis.	No
Residents are not being fed.	No
Additional Findings	Yes

III. METHODOLOGY

05/04/2022	Special Investigation Intake 2022A0602032
05/05/2022	Special Investigation Initiated - Telephone
05/20/2022	Inspection Completed On-site Interviewed home manager, residents, and licensee designee.
05/20/2022	Exit conference Conducted with the licensee designee, Denise Aleardi in person at the facility.

ALLEGATION:

Residents are not washed up for days or changed on a regular basis.

INVESTIGATION:

On 5/04/2022, a complaint was made and assigned for investigation alleging that residents are not washed up for days, residents are not changed on a regular basis and residents are not being fed.

On 5/20/2022, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Alicia Hardville, Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, and the licensee designee, Denise Aleardi. Ms. Hardville stated she has worked as the home manager in the home for about two months but also works at another facility operated by Ms. Aleardi. Ms. Hardville said all residents are minimally bathed twice each week and their briefs are checked every two hours and changed if needed. She advised that I look at each resident to see if they are clean or not.

Resident A stated she does her own bathing and had no issues to report regarding the care she receives.

Although Resident B was very hard of hearing, she understood what was being said to her. Resident B said she receives at least two baths each week and that is sufficient for her.

I was unable to obtain any information from Resident C, Resident D or Resident F. Resident C and Resident F were asleep at the time the on-site investigation was conducted. Resident D was unable to provide any information due to cognitive impairment.

Resident E said she had no complaints regarding not being washed up or changed on a regular basis as staff wash her up every day.

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:	Based on the information received during the investigation and my own observations, I determined there is insufficient information to determine that residents are not being bathed, washed up or changed on a regular basis. I observed Resident A, B, C, D, E and F and found them to be neat, clean and without any odors. Resident A, B and E all stated they are bathed and/or washed up on a regular basis.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Residents are not being fed.

INVESTIGATION:

On 5/20/2022, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Ms. Hardville, Resident A, Resident B and Resident E. Ms. Hardville stated there are no menus but staff prepare whatever the residents want.

Resident A, Resident B, and Resident E all stated they receive three meals daily with Resident E acknowledging that the food is good.

At the time of the on-site, I observed fresh fruit, vegetables, eggs, milk, juice, and other staples in the refrigerator. There was meat in the freezer and canned goods in the cabinets. I did not observe any menus in the home.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) 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 the information obtained during the investigation, I determined there is insufficient information to determine that residents are not being fed. According to Residents A, B and E, stated residents are fed at least three meals daily. At the time of the on-site investigation (5/20/2022), I observed adequate fresh, frozen, and canned goods in the home.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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 information obtained during the investigation and from my own observation, there were no menus kept in the home. According to Ms. Hardville, there are no menus kept in the home as staff prepare what the residents want.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the unannounced on-site investigation, I requested from Ms. Hardville a copy of the resident register to determine who was residing in the home. Ms. Hardville said she did not know if there was a resident register kept in the home. She began providing me with the names of each resident. There was a total of seven resident

names she provided. Ms. Hardville said at one point there were seven residents residing in the home, but now there are only six residents as Resident H died in April 2022. She proceeded to contact Ms. Aleardi who stated she would be right over to the home.

At the time Ms. Aleardi arrived, I was interviewing each resident privately in their rooms. Ms. Aleardi came into the kitchen and provided me with a resident register that was not filled out completely. Resident C was not listed, Resident G's move out date was missing, and Resident H's death was not documented. I asked Ms. Aleardi if there were seven residents residing in the home at any time and she said yes. She stated there was an additional resident who resided in the home temporarily for respite care causing her to go over her licensed capacity of six. She stated the home is now operating at its licensed capacity of six as the seventh resident no longer resides in the home. I asked Ms. Aleardi if she submitted an incident report regarding the death of Resident H and she said yes. I informed her that I never received an incident report regarding the death of Resident H.

On 5/20/2022, while inspecting the food supply in relation to the allegation above alleging that residents are not being fed, I observed Resident C's medication, Morphine Sulfate 100mg/5ml stored in the refrigerator without being contained in a locked box.

On 5/20/2022, I conducted an exit conference with the licensee designee, Denise Aleardi in person while at the facility. I informed Ms. Aleardi that rule violations have been established during the investigation and she would receive a copy of the report once completed and approved.

APPLICABLE RULE	
R 400.14209	**Home records generally.**
	(1) A licensee shall keep, maintain, and make available for department review, all the following home records: (e) A resident register.
ANALYSIS:	Based on the information obtained during the investigation and my own observation, the resident register was not fully completed. Resident C was not listed, Resident G's move out date was missing, and Resident H's death was not documented.
CONCLUSION:	**VIOLATION ESTABLISHED**

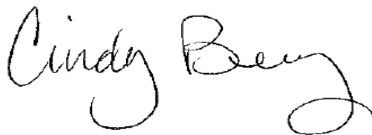
APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.
ANALYSIS:	Based on the information obtained during the investigation, I determined that Ms. Aleardi went over the capacity that is authorized by the license. Ms. Hardville said at one point there were seven residents residing in the home, but now there are only six. Licensee Ms. Aleardi stated there was an additional resident who resided in the home temporarily for respite care causing her to go over her licensed capacity of six.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on my own observation, I determined that Resident C’s medication, Morphine Sulfate 100mg/5ml was stored in the refrigerator without being contained in a locked box.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: (a) The death of a resident.
ANALYSIS:	Based on the information obtained during the investigation, I determined that Resident H died, and no incident report was received. According to Ms. Aleardi, Resident H died in April 2022 and an incident report was submitted to the department. I have no record of an incident report submitted to the department by fax or email.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



9/07/2022

Cindy Berry — Date
Licensing Consultant

Approved By:

09/15/2022

Denise Y. Nunn — Date
Area Manager