GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 30, 2019

Tina Miele
13809 Barcroft Way
Warren, MI 48088

RE: License #: AF500380548
Investigation #: 2019A0986013
The Gilbert Home

Dear Ms. Miele:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Roeiah Epps, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(586) 256-1776

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF500380548
Investigation #:	2019A0986013
Complaint Receipt Date:	04/08/2019
Investigation Initiation Date:	04/09/2019
Report Due Date:	06/07/2019
Licensee Name:	Tina Miele
Licensee Address:	13809 Barcroft Way Warren, MI 48088
Licensee Telephone #:	(586) 771-9389
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	The Gilbert Home
Facility Address:	13809 Barcroft Way Warren, MI 48088
Facility Telephone #:	(586) 771-9389
Original Issuance Date:	11/17/2016
License **Status:**	1ST PROVISIONAL
Effective Date:	05/18/2019
Expiration Date:	11/17/2019
Capacity:	3
Program Type:	AGED; ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
• The licensee Tina Miele smokes marijuana in her basement and speaks very mean and condescending to Resident A. • Ms. Miele lacks proper training and has no consistent routine in distributing residents' medications, serving meals, waking the residents or cleaning the house.	No
• Resident B is in bed for extended periods of time and has developed bed sores on her heels as a result. • Ms. Miele also does not wear gloves when she feeds Resident B through her peg tube.	No
• The licensee Tina Miele is pre-setting the resident's medications in unlabeled medication cups. • On several occasions, Ms. Miele has given the residents the wrong medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/08/2019	Special Investigation Intake 2019A0986013
04/09/2019	Special Investigation Initiated – Telephone Complainant
04/09/2019	Inspection Completed On-site Interviewed licensee Tina Miele, Resident A and observed Resident B
04/16/2019	Contact - Document Received Medical records from Resident B's physician's office
04/26/2019	APS Referral Adult Protective Services (APS) referral to Centralized Intake
04/29/2019	Contact - Telephone call received Adult Protective Services (APS) worker Shelly Anders
05/14/2019	Contact - Document Sent Email to APS worker Shelly Anders

05/15/2019	Inspection Completed On-site Interviewed Resident A's adult sibling (AS) 1 and Tina Miele; observed Residents A and B
05/15/2019	Contact - Document Sent Email to APS worker Shelly Anders
05/16/2019	Exit Conference Licensee Tina Miele
05/17/2019	Contact - Document Sent Email to APS worker Shelly Anders
05/28/2019	Contact - Document Sent Email to APS worker Shelly Anders
06/03/2019	Contact - Document Sent Email to APS worker Shelly Anders
07/10/2019	Contact - Telephone Call Made Resident B's adult sister (AS) 2

ALLEGATIONS:

- **The licensee Tina Miele smokes marijuana in her basement and speaks very mean and condescending to Resident A.**
- **Ms. Miele lacks proper training and has no consistent routine in distributing residents' medications, serving meals, waking the residents or cleaning the house.**

INVESTIGATION:

On 4/9/19, I interviewed the complainant. Complainant stated she observed the licensee Tina Miele for two days provide direct care to Residents A and B who are the only residents at the facility. Over the course of two days, complainant stated she observed Ms. Miele smoke marijuana in the basement and then provide care to the residents. Ms. Miele is very mean and disrespectful to Resident A, but she believes Resident A is afraid of Ms. Miele, so she may not say anything to licensing regarding the allegations. Further, Ms. Miele does not have adequate training to care for the residents evidenced by her lack of structure and organization. For example, complainant stated Ms. Miele does not pass medications at a specific time, serve meals to the residents, nor does she wake them up in the morning or clean the house on a schedule. Complainant stated she is an experienced direct care worker and is aware that medications and food should be served at appropriate times. However, complainant did not state a specific time that meals were served, nor did complainant

indicate medications were administered at a different time than the residents' medications are prescribed. Complainant also stated that Ms. Miele does not clean the facility properly, nor does she clean on a set schedule throughout the day.

On 4/9/19, I conducted an unannounced inspection at the facility and interviewed Tina Miele, Resident A and observed Resident B.

On 4/9/19, Ms. Miele stated that she does smoke marijuana for recreational purposes, and she is aware of the legal requirements of having no more than 10 ounces in her possession. Further, Ms. Miele stated if she does smoke marijuana, she smokes it in the basement when she is not providing direct care to the residents. Ms. Miele stated the residents are like family to her and she would never disrespect them. Ms. Miele stated although she may be relaxed in her approach in providing care to the residents, this gives a greater since of home and belonging, rather than the rigorous structure of a group home. Ms. Miele stated the facility is the resident's home, and they can sleep as long as they want and eat whenever they are hungry. Ms. Miele stated she serves Resident A her breakfast when she awakes and serves her lunch during traditional lunch hours. It should be noted that I conducted my inspection at approximately 5:30 pm, and Resident A was eating a sloppy joe for dinner, which was consistent with Ms. Miele's explanation of mealtimes for the facility. Because Resident B has a peg tube due to her current hospice state, her mealtimes are more structed and on a schedule.

On 4/9/19, Resident A stated she is pleased with her care at the facility and the allegations are not true. Resident A stated that Ms. Miele administers her medications on a daily basis as required.

On 4/9/19, I observed Resident B. Resident B was lying in bed at the time of my inspection and to be well-cared for despite her hospice medical condition.

On 5/15/19, I interviewed Resident A's adult sister (AS) 1 who was present at the facility. AS stated, the allegations are not true. AS stated, that Resident A has resided at the facility for more than a year and she has never had any issues or concerns for her sister's care at the facility. AS1 stated that she regularly visits the facility and has never witnessed or observed Ms. Miele under the influence of marijuana.

On 6/3/19, APS worker Shelly Anders stated she would not be substantiating the allegations for neglect to any of the residents at the facility.

On 7/10/19, I interviewed Resident B's adult sister (AS) 2. AS2 stated that her sister has resided at the facility for almost three years and she has never had any issues or safety concerns regarding Resident B's care. Further, AS2 stated that Resident B would not be alive this long had she been residing at another AFC home. AS2 stated that Resident B's health improved once she entered Ms. Miele's facility and she is pleased with the care that Resident B has received since she has been residing there. Moreover, AS2 visits the facility weekly, and she has never observed Ms. Miele under

the influence of marijuana and would not hesitate to complain if she believed Ms. Miele was inappropriate in providing care to any resident inside the home.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(3) A licensee or responsible person shall possess all of the following qualifications: (b) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.
ANALYSIS:	According to AS1, Resident A, and AS2 Ms. Miele has never been observed under the influence of marijuana while providing care to the residents, nor is she disrespectful to any of the residents inside the home. All individuals report that they are pleased with the care provided to the residents at the facility, which include meals, medication and supervision. Additionally, APS did not find any issues or concerns regarding neglect to either resident at the facility.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATIONS:

- **Resident B is in bed for extended periods of time and has developed bed sores on her heels as a result.**
- **Ms. Miele also does not wear gloves when she feeds Resident B through her peg tube.**

INVESTIGATION:

On 4/9/19, I observed Resident B as she laid in bed. Resident B rubbed her heels and banged her feet on her mattress. Ms. Miele explained the marks on the heels of Resident B's feet was not due to pressure or bed sores; rather, it was due to the friction of Resident B purposely rubbing her feet against her mattress. Ms. Miele explained as Resident B's dementia has gotten progressively worse, she has been displaying more behavioral issues that reflect agitation.

On 4/16/19, I received a letter from Resident B's physician Dr. Mikhaeil. According to Dr. Mikhaeil, he has been Resident B's physician since August 2017. Since that time, he has had no issues or concerns regarding abuse or neglect of Resident B in Ms. Miele's care. Further, Dr. Mikhaeil confirmed that Resident B rubs her heels against her mattress, and that she has recently been given heel protectors to create a barrier for this behavior. Dr. Mikhaeil also confirmed that Resident B is currently under hospice care, and the nurse has never reported any signs of abuse or neglect.

On 4/9/19, Ms. Miele stated sometimes she uses gloves sometimes and sometimes she doesn't when feeding Resident B through her peg tube. Ms. Miele explained it depends on the takes she is doing at the time Resident B needs to bed fed. Ms. Miele emphasized her hands are always clean when handles any residents' medication or food, and she assures no contamination.

On 7/10/19, AS2 stated she has never witnessed or observed Ms. Miele practice any unsanitary behavior. AS2 stated on her weekly visits to the facility, she has never witness or observe Ms. Miele do anything inappropriate when feeding Resident B through her peg tube. AS2 emphasized she has been pleased with Resident B's care the past three years at the facility and has no safety issues or concerns.

APPLICABLE RULE	
R 400.1404	**Licensee, responsible person, and member of the household; qualifications.**
	(3) A licensee or responsible person shall possess all of the following qualifications: (b) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.
ANALYSIS:	According to AS2, she has been very pleased with Resident B's care at the facility the past three years and visits the facility weekly and has never observed or witness Ms. Miele do anything inappropriate in providing care to her sister. Resident B's physician Dr. Mikhaeil stated that Resident B evidences no signs of abuse or mistreatment at the facility under Ms. Miele's care.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATIONS:

- **The licensee Tina Miele is pre-setting the residents' medications in unlabeled medication cups.**
- **On several occasions, Ms. Miele has given the residents the wrong medications.**

INVESTIGATION:

On 4/9/19, complainant stated she observed that both residents' medications were pre-set in paper Dixie cups. Additionally, Ms. Miele admitted that she has accidentally given Resident A Resident B's medication on more than one occasion.

On 4/9/19, Resident A stated that Ms. Miele ensures that she receives her medication every day. Resident A could not give specifics as to what each medication was but was adamant that its always the correct medication.

On 4/9/19, Ms. Miele stated that she does place the residents' medication in cups as she takes the medication out, but she assures that both residents have the correct medication because she is the only person that passes their medication. Specifically, Ms. Miele places Resident A's medications at the table with Resident A to consume as she eats her food. Because Resident B has a more weakened physical condition, Ms. Miele has to physically administer to them.

On 4/9 and 5/15/19, Ms. Miele denied that she ever mixes up the residents' medications or that that she has accidentally passed Resident A the wrong medication.

On 5/15/19, AS1 stated she has never had any issues or concerns with Ms. Miele giving her sister Resident A the incorrect medication, nor has she ever heard that something like this took place.

On 5/15/19, I observed both Resident A's and B's medications and their medication logs. Both residents' medications are being pre-set in medication cups, and not being kept in the original pharmacy container. Resident A did not have a physician's authorization for the following over the counter (OTC) medications:

- Iron;
- Tylenol;
- Melatonin;
- Magnesium;
- Vitamin D3;
- Vitamin B 12; and
- Colace/Stool softener.

Resident B was out of the following medications:

- Levisin 125 mg, as needed every four hours;
- Metoprolol 25 mg, twice daily;
- Carb/Levo 200 mg, three times daily;
- Senna, one to two tablets as needed;

Additionally, Resident B's Vitamin D was not logged correctly on the medication log (D1000 vs. D3); and her Quetiapine 50 mg was not recorded on the medication log.

Ms. Miele immediately called Resident B's pharmacy to find out what the delay was in her medications being filled and assured that Resident B would have all her medications right away. Ms. Miele also stated that she would notify Resident A's physician and assured that she would receive a physician's authorization from now on for all OTC medications.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being (33.1101 et. seq. of the Michigan Compiled Laws.
ANALYSIS:	On 4/9/19, Ms. Miele admitted that she pre-sets the residents' medications by taking them out of the original pharmacy container and placing them in small paper cups. On 5/15/19, resident's medications were observed in small paper cups, and Ms. Miele did not have a prescription or physician's authorization for Resident A's OTC medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(2) Medication shall be given pursuant to label instructions.
ANALYSIS:	On 5/15/19, Resident B was not given all her prescribed medications pursuant to the label instructions, due to her being out of several medications (Levisin, Metoprolol, Carb/Levo, Senna).
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(4) When a licensee or responsible person supervises the taking of medication by a resident, the licensee or responsible person shall comply with the following provisions: (a) Maintain a record as to the time and amount of any prescription medication given or applied. Records of prescription medication shall be maintained on file in the home for a period of not less than 2 years.

ANALYSIS:	Resident B's Quetiapine 50 mg was not recorded on her medication log, and her Vitamin D was not logged or recorded correctly (Vitamin D1000 vs. Vitamin D3).
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the licensee submitting an acceptable corrective plan, I recommend continuance of the provisional license.

Roeiah Epps 7/18/19

Roeiah Epps Date
Licensing Consultant

Approved By:

Denise Y. Nunn 07/30/2019

Denise Y. Nunn Date
Area Manager