GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 20, 2023

Alonzo Perez
1052 California St. NW
Grand Rapids, MI 49504

RE: License #: AF410290364
Investigation #: 2023A0340016
Romero Home

Dear Mr. Perez:

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 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 (616) 356-0183.

Sincerely,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF410290364
Investigation #:	2023A0340016
Complaint Receipt Date:	02/15/2023
Investigation Initiation Date:	02/15/2023
Report Due Date:	04/16/2023
Licensee Name:	Alonzo Perez
Licensee Address:	1052 California St. NW Grand Rapids, MI 49504
Licensee Telephone #:	(616) 724-5373
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Romero Home
Facility Address:	1052 California St. NW Grand Rapids, MI 49504
Facility Telephone #:	(616) 724-5373
Original Issuance Date:	09/12/2007
License Status:	REGULAR
Effective Date:	11/21/2022
Expiration Date:	11/20/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A was not home at the time dinner was served and was denied a meal when she arrived 30 minutes later.	Yes

III. METHODOLOGY

02/15/2023	Special Investigation Intake 2023A0340016
02/15/2023	APS Referral
02/15/2023	Special Investigation Initiated - Letter case manager
02/28/2023	Inspection Completed On-site
03/13/2023	Contact - Telephone call received Tiffany Kilt-case manager
03/13/2023	Contact - Telephone call received Resident A
03/13/2023	Inspection Completed-BCAL Sub. Compliance
03/20/2023	Exit conference completed with licensee Alonzo Perez
03/13/2023	Corrective Action Plan Requested and Due on 03/28/2023

ALLEGATION: Resident A was not home at the time dinner was served and was denied a meal when she arrived 30 minutes later.

INVESTIGATION: On February 4, 2023, I received a complaint from the BCAL Online Complaints which stated that Resident A came home from work between 4:30 and 5:00 pm and then was picked up by a friend to run errands. She returned to the AFC home around 5:30 pm. Licensee Alonzo Perez had made dinner while Resident A was gone. Resident A called Mr. Perez while she was gone to tell him she would not be home during dinner time and asked him to set a plate aside for her to eat when she got home. When Resident A returned home, she was informed that she would not be getting dinner because she missed the time it was served. Resident A's supports coordinator, Tiffany Kilt, called Mr. Perez and Mr. Perez told Ms. Kilt that, "they'll be okay if they miss a meal. Most of them are overweight."

On February 4, 2023, I contacted Resident A's supports coordinator, Tiffany Kilt. She discussed the situation and her concerns. She informed me that Resident A is able to move to independent living which they are looking into. Ms. Kilt acknowledged that Mr. Perez runs a very tight schedule and the other residents are not as capable as Resident A so it is not the most compatible home for her.

On February 28, 2023, I conducted an unannounced home inspection. Resident A was not home at the time of my visit. I did speak with Mr. Perez. Mr. Perez stated that he makes dinner at 5:00 pm and if residents are not there, they can have a snack at 7:00 pm but he will not keep the "kitchen open" at all times. He stated that residents know what time meals are served and if they choose to not be there at that time, that's their choice. I asked Mr. Perez when breakfast is served, and he told me 7:00 am. I advised Mr. Perez that he is required to make meals available to the residents when they choose. I informed him that if a resident is not home at regular mealtime, then he should keep a plate in the refrigerator the resident can heat up upon their return. I added that it is not acceptable for him to deny a meal or say that it's okay for them to "miss a meal".

On March 13, 2023, I spoke with case manager Ms. Kilt. A 30 day notice was received from Mr. Perez for Resident A and she is assisting Resident A in finding independent living. There has not been a reoccurrence of the incident, but she feels it is in Resident A's best interest to move elsewhere.

On March 13, 2023, I interviewed Resident A. She recounted for me the events of this investigation and confirmed that she was not provided a meal. I explained to Resident A that Mr. Perez is required to provide her with three meals per day. If she is not home at the arranged mealtime, he is not allowed to withhold food from her. Resident A thanked me for the information. She stated that it has not happened since the occasion being investigated and that she is making plans to move out of the home.

APPLICABLE RULE	
R 400.1419	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular nutritious meals daily. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	An allegation was made that Mr. Perez did not provide a meal to Resident A after she returned from running errands around 5:30 pm. Mr. Perez confirmed the allegation is true. Resident A confirmed that she was denied an evening meal.

CONCLUSION:	**VIOLATION ESTABLISHED**

On March 20, 2023, I conducted an exit conference with Mr. Perez. I informed him of the rule violation we had previously discussed, and I requested a corrective action plan.

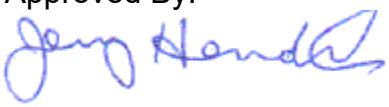
IV. RECOMMENDATION

Upon receiving an approved corrective action plan, I recommend no change to the current license status.

March 20, 2023

Rebecca Piccard — Date
Licensing Consultant

Approved By:



March 20, 2023

Jerry Hendrick — Date
Area Manager