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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 28, 2023

Rosalia Aiello
Roses Tender Home Care, LLC
43475 S. 94 Service Dr.
Van Buren Twp., MI 48111

RE: License #: AS820386195
Investigation #: 2023A0116026
Aiello Adult Foster Care

Dear Mrs. Aiello:

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 (313) 456-0380.

Sincerely,

Pandrea Robinson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 319-9682

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820386195
Investigation #:	2023A0116026
Complaint Receipt Date:	03/07/2023
Investigation Initiation Date:	03/07/2023
Report Due Date:	05/06/2023
Licensee Name:	Roses Tender Home Care, LLC
Licensee Address:	43475 S. 94 Service Dr. Van Buren Twp., MI 48111
Licensee Telephone #:	(734) 680-4216
Administrator:	Rosalia Aiello
Licensee Designee:	Rosalia Aiello
Name of Facility:	Aiello Adult Foster Care
Facility Address:	26071 Denning Rd New Boston, MI 48164
Facility Telephone #:	(734) 680-4216
Original Issuance Date:	09/06/2017
License Status:	REGULAR
Effective Date:	03/06/2022
Expiration Date:	03/05/2024
Capacity:	6
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 03/06/23, Resident A arrived for physical therapy and was observed restrained to her wheelchair with a gait belt which went around her right thigh and her waist and was buckled back to her wheelchair.	Yes

III. METHODOLOGY

03/07/2023	Special Investigation Intake 2023A0116026
03/07/2023	Special Investigation Initiated - Telephone Left a message for the complainant requesting a return call.
03/08/2023	Contact - Telephone call received Interviewed Complainant.
03/08/2023	APS Referral made.
03/14/2023	Inspection Completed On-site Interviewed Resident A and staff Gechelle Gamboa.
03/14/2023	Inspection Completed-BCAL Sub. Compliance
03/16/2023	Exit Conference With licensee designee Rosalia Aiello.

ALLEGATION:

On 03/06/23, Resident A arrived for physical therapy and was observed restrained to her wheelchair with a gait belt which went around her right thigh and her waist and was buckled back to her wheelchair.

INVESTIGATION: On 03/08/23, I interviewed the complainant and she reported that she observed Resident A restrained to her wheelchair with a gait belt. Complainant reported that she contacted licensee designee, Rosalia Aiello, and informed her that the policy prohibits the use of restraints. Complainant reported that Ms. Aiello reported being unaware of the policy and reported she has spoken with Resident A's

family, and they gave her permission to restrain her, due to her falling out of her wheelchair. Complainant reported that she and the social worker educated Ms. Aiello on the policy regarding restraints, and they ordered a chair alarm that can also be used as a bed alarm that will alert staff when Resident A is moving around or trying to get up.

On 03/14/23, I conducted an unscheduled onsite inspection and interviewed Resident A and staff, Gechelle Gambino.

Resident A reported that the staff were trying to help her from falling out of her wheelchair at times, so they were using a strap that went around her leg and waist and behind her wheelchair, so she stayed strapped into her wheelchair. Resident A admitted that she was unable to remove the strap on her own as it was latched behind her. Resident A denied being restrained to her bed or any place else. Resident A asked what the problem was and why was it such a problem. I explained to Resident A that she should have the ability to move freely and that if a device is used that she is unable to open/unlatch, then it is considered a restraint and that is prohibited in licensed group homes. Resident A reported understanding and stated that she likes living in the home, she is treated well and gets really good care. Resident A reported that the strap has not been used for over a week now.

I interviewed staff, Gechelle Gambino, and she reported that they were using a gait belt as a safety measure to secure Resident A in her chair so that she would not hurt herself falling out of the chair. Ms. Gambino reported that they were unaware that doing so was prohibited. Ms. Gambino admitted that Resident A was unable to open or remove the gait belt as it was secured behind the wheelchair. Ms. Gambino reported that since becoming aware of the policy the gait belt is no longer being used at all. Ms. Gambino reported that they have been using the chair/bed alarm that was ordered by Resident A's physical therapist at PACE and that it has been helpful.

On 03/16/23, I conducted the exit conference with licensee designee, Rosalia Aiello. Ms. Aiello reported that she thought she was doing right by Resident A and only wanted to make sure she was safe. Ms. Aiello reported that she believed that by contacting the family and obtaining permission from them to use to the gait belt to secure Resident A in the chair, she was doing the right thing. I informed Ms. Aiello of the specific rule that speaks about restraints and behavior intervention prohibitions and recommended she review it. Ms. Aiello reported that she would and reported that Resident A had fallen and couple of times and she was worried that she would hurt herself and believed using the gait belt to secure her in her chair would prevent a reoccurrence. Ms. Aiello reported that the staff are no longer using the gait belt and are using the chair/bed alarm that was ordered by Resident A's physical therapist at PACE.

I informed Ms. Aiello of the finding of the investigation and the specific rule violation cited. Ms. Aiello reported an understanding.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.**
ANALYSIS:	Based on the finding of the investigation, which included interviews of the complainant, Resident A, Ms. Gambino and Ms. Aiello, I am able to corroborate the allegation. The complainant observed Resident A with a gait belt around her right thigh and waist and strapped around to the back of the wheelchair. The complainant reported that the gait belt was being used a s a restraint. Resident A reported that the staff were using a strap to secure her in her wheelchair so that she wouldn't fall. Resident A admitted that she was unable to open or remove the strap as it was secured to the back of her wheelchair. Ms. Gambino confirmed that staff were using the gait belt to secure Resident A to her wheelchair and admitted that Resident A was unable to open or remove the gait belt independently. Ms. Aiello confirmed that she and the staff were using the gait belt to secure Resident A in her wheelchair. Ms. Aiello reported no ill intent and reported being unaware that this was prohibited. Ms. Aiello reported since becoming aware the staff are no longer using the gait belt to secure Resident A to her wheelchair.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

03/24/23

Pandrea Robinson
Licensing Consultant

Date

Approved By:

03/28/23

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Ardra Hunter
Area Manager

Date