GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 6, 2024

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

RE: License #: AS820386195
Investigation #: 2024A0116020
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 #:	2024A0116020
Complaint Receipt Date:	01/24/2024
Investigation Initiation Date:	01/25/2024
Report Due Date:	03/24/2024
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A reported that staff, Lea Simoneau, slapped her in the face in December 2023.	No
Resident A reported she is forced to take sleeping pills.	No
Additional Findings	Yes

III. METHODOLOGY

01/24/2024	Special Investigation Intake 2024A0116020
01/24/2024	APS Referral Received.
01/25/2024	Special Investigation Initiated - On Site Interviewed staff, Beth English and Lea Simoneau and Residents A-C, reviewed Resident A's medications and medication administration records (MARs).
01/25/2024	Inspection Completed-BCAL Sub. Compliance
01/26/2024	Contact - Telephone call made Interviewed Relative A.
01/29/2024	Contact - Telephone call received Spoke with Relative A and Guadian A.
01/30/2024	Contact - Telephone call made Interviewed Resident A's Hospice nurse, Rachel Vendal.
02/01/2024	Exit Conference With licensee designee, Rosalia Aiello.

ALLEGATION:

Resident A reported that staff, Lea Simoneau, slapped her in the face in December 2023.

INVESTIGATION:

On 01/25/24, I conducted an unscheduled onsite inspection and interviewed staff Beth English, Lea Simoneau and Residents A-C. Ms. English denied that Ms. Simoneau or any of the other staff slapped Resident A or any of the residents. She reported that Resident A hates Ms. Simoneau and reported to her that she wants her fired. Ms. English reported her belief that Resident A is jealous of the time that Ms. Simoneau puts in with the other residents as she is used to having a lot of her time and attention. Ms. English reported that there are new residents that have moved in who require more assistance than Resident A and she does not like that. Ms. English further reported that the change in Resident A's demeanor and temperament towards Ms. Simoneau could also be related to her Dementia diagnosis.

I interviewed staff, Lea Simoneau and she denied slapping Resident A or being physical with her in any way. Ms. Simoneau reported she has no idea why Resident A would say that about her. She reported that she and Resident A have had a really close relationship since she was admitted in the home a couple years ago. Ms. Simoneau reported that Resident A may be upset that she is unable to spend as much time with her during her shifts as there are new residents in the home that require more assistance. Ms. Simoneau reported that Resident A makes accusations up about her and blames her for things that were alleged to have happened during times that she was not on shift. Ms. Simoneau reported that this could be due to her Dementia and her recent decline.

I interviewed Resident A and she reported that Ms. Simoneau slapped her in the face while in the bathroom. She reported she believes it happened last month. Resident A reported that this was the first time something like this had happened. Resident A reported that she did not have any marks or bruises on her face. Resident A reported that she thinks she is being put out of the home and reported she does not want to the leave and wants to be treated like she was when she first moved in. Resident A reported the staff provide excellent care.

I interviewed Resident B and he reported that he is new to the home but so far things have been good. Resident B reported that the staff treat him and all of the other residents real nice and denied observing or hearing anything about Ms. Simoneau slapping Resident A.

I attempted to interview Resident C, however, due to her Alzheimer's diagnosis she was unable to answer my questions. She was neatly dressed and groomed.

On 01/26/24, I interviewed Relative A and she reported that she does not believe the allegations and reported that when Resident A doesn't get her way, she will do what she can to make your life miserable. Relative A reported that the day Resident A reported she was slapped by Ms. Simoneau, she was not at work and was being cared for by licensee designee, Rosalia Aiello. Relative A further reported that Resident A made up false accusations against staff in her previous placement

alleging that the staff stole her money. Relative A reported that she found the money hidden in Resident A's drawer, but the company had already terminated the employee. Relative A reported that Resident A makes up false accusations against her as well. Relative A reported that in the past six months these accusations have started, and she believes it could be in part the Dementia but reported it could also be because Resident A is jealous of the attention being given to other residents, after she has been spoiled for so long by all of the staff. Relative A reported that Resident A is not leaving the home at this point as Ms. Aiello reported that they are not requesting discharge.

Relative A added that a meeting has been scheduled for 01/29/24, with Ms. Aiello, Resident A, Resident A's hospice nurse, Ms. Vendal, the hospice social worker, herself and her husband, who is Resident A's guardian. Relative A reported the meeting is to further discuss the allegations and possible alternative placements if Resident A wants to move. Relative A reported she would contact me after the meeting.

On 01/29/24, I spoke with Relative A and Guardian A. They reported that during the meeting Resident A's story continued to change and after the meeting all parties were convinced that Resident A was never hit or mistreated by Ms. Simoneau or any of the other staff. Relative A reported for now, Resident A wants to stay in the home and Ms. Aiello is willing to keep her. Guardian A reported that they were all satisfied with the outcome of the meeting and hopes no additional accusations arise. Relative A reported that the hospice nurse is going to change one of Resident A's dementia medications and hopes that also helps.

On 01/30/24, I interviewed Rachel Vendal, hospice nurse with St. Croix Hospice. Ms. Vendal reported that Resident A is a newer patient of hers and reported she has seen her three times. She reported that after her initial assessment she deemed Resident A competent with some confusion. Ms. Vendal reported since that initial meeting, and her interviews with family and staff that have cared for Resident A, in addition to her meetings with her, she has altered her assessment. Ms. Vendal reported that when she spoke with Resident A on 01/29/24, she basically recanted the allegation she previously made about Ms. Simoneau and reported she misinterpreted Ms. Simoneau wiping her mouth with a white towel with being slapped in the face with a diaper. Ms. Vendal reported that Resident A had disclosed during their first meeting that Ms. Simoneau had slapped her in the face with a diaper. Ms. Vendal reported that Resident A is frustrated and is projecting her frustrations on to other people, she is struggling with her loss of independence, and her inability to control the situation. Ms. Vendal reported that she will be seeing Resident A twice per week and will looking into pyscho-social supports more so then clinical as the need appears to be more of an emotional one. Ms. Vendal reported at this point she has no concerns regarding the care provided in the home and believe the staff are doing a good job dealing with the changes that come with the disease.

I conducted the exit conference with licensee designee, Rosalia Aiello, and she reported that she knew that Resident A was not being truthful about being slapped by Ms. Simoneau. Ms. Aiello reported she believed the allegation was based in anger, as Resident A has become mean and very angry toward Ms. Simoneau since she has had to spend more time assisting the other residents that require more care than her. Ms. Aiello reported that the day Resident A expressed to her that Ms. Simoneau had slapped her, she was not on shift that day. Ms. Aiello reported that she was working in the home that day and caring for Resident A and reported when she expressed that to Resident A she was not hearing it. Ms. Aiello reported Resident A had made up in her mind that Ms. Simoneau was working and had slapped her and no one could tell her different. Ms. Aiello reported that she did speak to Ms. Simoneau about the allegation and reported that she denied ever slapping Resident A and reiterated that she did not work the day that Resident A alleged she was slapped. I informed Ms. Aiello of the findings of the investigation, and she agreed with them.

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:	During the course of the investigation, which included interviews with Ms. Simoneau, Resident A, Relative A and Hospice nurse, Ms. Vendal, there is insufficient evidence to substantiate the allegations. Although Resident A initially alleged being slapped by Ms. Simoneau, Resident A later recanted the allegation to Ms. Vendal. Further, Ms. Vendal believes that the dementia diagnosis also plays a role in some of the anger and frustration that Resident A is dealing with and believes she is projecting that onto others. Ms. Vendal reported that she will be assisting Resident A with additional supports to help her better cope with her emotions. Relative A also reported that Resident A has a history of making false accusations when things do not go her way. Relative A reported that she also believes that the Dementia plays a role in the changes happening in her behavior, and because she is frustrated and angry with Ms. Simoneau this is way to get back at her. Ms. Simoneau reported her belief that Resident A is upset and angry with her because she is having to spend more time caring for the other residents who require more care than she does. Ms. Simoneau reported Resident A was used to getting most of her attention. This violation is not established as Resident A is being treated with dignity and respect and her personal needs including protection and safety are attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A reported she is forced to take sleeping pills.

INVESTIGATION:

On 01/25/24, I conducted an unscheduled onsite inspection and interviewed staff Beth English, Lea Simoneau and Resident A. Ms. English and Ms. Simoneau both

denied the allegations and reported that all medications administered are prescribed. They both reported that Resident A is not prescribed sleeping pills and therefore is not being administered them.

I interviewed Resident A and she reported that she is given sleeping pills by the staff, and she knows it. I informed Resident A that I would be looking at the medication cabinet to make sure that there are no sleeping medications that are not prescribed in with her medications. Resident A reported that the sleeping medication is not in the medication cabinet so I will not locate it there. I asked Resident A if she knew where it was, and she reported that she did not. Resident A reported that she knows she is given sleeping pills because she is groggy and sleeping in the morning.

I reviewed the medication cabinet and observed Resident A's medication and MARs and did not observe any over the counter or prescribed sleep aids in the cabinet or on the MARs. I also reviewed the medications for the remaining five residents and did not observe any over the counter sleep medications in their individual bins.

On 01/26/24, I interviewed Relative A, and she reported that Resident A has alleged that she was given sleeping pills in the past, they addressed it and found that it was not true. Relative A reported that Resident A is groggy and sleeps late because she stays up all night watching television and when the staff tries to turn her television off so she gets a good night rest, she hides the remote control. Relative A reported that she and Guardian A will address the television issue at the meeting at the home on 01/29/24. Relative A reported that they are going to let Resident A know that she should be turning her television off by 10:00 p.m. each night so that she is not so tired and groggy, as she needs to get a good night rest on a consistent basis. Relative A reported that Resident A will not be happy about this, but they want to do what they feel is best for her, and maybe if she gets her needed rest she will feel better in the morning and stop thinking she is given sleeping pills.

On 01/30/24, I interviewed Hospice nurse, Rachel Vendal. Ms. Vendal reported that Resident A did not bring up anything to her pertaining being given sleeping pills.

On 02/01/24, I conducted the exit conference with licensee designee, Rosalia Aiello, and informed her of the findings of the investigation. Ms. Aiello agreed with the findings and reported that she is well aware of the licensing rules as they pertain to medication. Ms. Aiello reported that she and the staff know that no medication including over the counter medication can be given to a resident without a prescription from their doctor. Ms. Aiello reported that no one is giving Resident A sleeping pills.

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 S333.1101 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:	During the course of the investigation, which included interviews with staff, Ms. English and Ms. Simoneau, Relative A and consultant observation, there is insufficient evident to substantiate the allegation. Ms. English and Ms. Simoneau both deny that they have administered sleeping pills to Resident A. They both reported that Resident A is not prescribed any sleep aids and therefore is not receiving any. Relative A reported that Resident A has made this allegation in the past, it was addressed and found to be untrue. Relative A reported that Resident A is sleepy and groggy in the mornings because she stays up all night watching television. I reviewed all of the medications in each of the resident's medication bins and did not observe any over the counter or prescribed sleep aids. This violation is not established as Resident A is not being administered medication for which she is not prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 01/25/24 I conducted an unscheduled onsite inspection and while preparing to exit the home, was unable to open the front door. There was an additional locking device attached to the door by the knob that prevented egress. Staff, Ms. English reported that the device was added because Resident C has started to wander more and attempts to elope. I informed Ms. English that the locking device has to be removed as it violates the rules. I also informed Ms. English that if Resident C is wandering and attempting to elope it is the staff responsibility to supervise and ensure she does not. Ms. English reported an understanding and reported that she would contact Ms. Aiello to inform her.

On 02/01/24, I conducted an interview and the exit conference with licensee designee, Rosalia Aiello. Ms. Aiello reported that she was unaware that she was not able to use such a device and believed she was protecting the resident. I informed Ms. Aiello of the specific rule that speaks to means of egress and the types of locks that are required. Ms. Aiello reported that she will have the additional locking device removed immediately. I informed Ms. Aiello that she may need to increase her staffing levels if additional supervision is required for Resident C. I informed Ms. Aiello again of the rule violation and informed her that a corrective action plan will be required. Ms. Aiello reported an understanding.

APPLICABLE RULE	
R 400.14507	**Means of egress generally.**
	(5) A door that forms a part of a required means of egress shall be not less than 30 inches wide and shall be equipped with positive-latching, non-locking-against-egress hardware.
ANALYSIS:	This violation is established as the primary means of egress was no longer equipped with positive-latching, non-locking-against-egress hardware.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/05/24

Pandrea Robinson
Licensing Consultant

Date

Approved By:

02/06/24

Ardra Hunter
Area Manager

Date