GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 3, 2019

Shannon Aldrich
Ashley Court Of Brighton Inc.
7400 Challis Road
Brighton, MI 48116

RE: License #: AL470092981
Investigation #: **2019A0565006**
Ashley Court -Bldg # 3

Dear Ms. Aldrich:

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 (517) 284-9720.

Sincerely,

Dawn Campbell, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-9724

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL470092981
Investigation #:	2019A0565006
Complaint Receipt Date:	03/25/2019
Investigation Initiation Date:	03/26/2019
Report Due Date:	04/24/2019
Licensee Name:	Ashley Court Of Brighton Inc.
Licensee Address:	7400 Challis Road Brighton, MI 48116
Licensee Telephone #:	(734) 332-8773
Administrator:	Shannon Aldrich
Licensee Designee:	Shannon Aldrich
Name of Facility:	Ashley Court -Bldg # 3
Facility Address:	7400 Challis Road Brighton, MI 48116
Facility Telephone #:	(810) 225-7400
Original Issuance Date:	08/30/2000
License Status:	REGULAR
Effective Date:	06/16/2017
Expiration Date:	06/15/2019
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility and was gone for approximately 24 hours.	Yes

III. METHODOLOGY

03/25/2019	Special Investigation Intake 2019A0565006
03/26/2019	Special Investigation Initiated - Telephone Spoke with Resident Care Coordinator Ken Roehl regarding the complaint allegations.
03/27/2019	Inspection Completed-BCAL Sub. Compliance
03/27/2019	Contact - Telephone call made Interviewed direct care staff Jasmine Dortch regarding the complaint allegations.
03/27/2019	Contact - Telephone call made Interviewed Resident A's guardian regarding the complaint allegations.
03/27/2019	Contact - Telephone call made Left message for direct care staff Diamond Williams regarding the complaint allegations.
03/27/2019	Contact - Telephone call made Left message for direct care staff Daniel Walraven to discuss the complaint allegations.
03/29/2019	Contact - Telephone call made Left message for Livingston County Adult Protective Services Worker Tom Schmid regarding the complaint allegations.
03/29/2019	Contact - Telephone call received Spoke with Livingston County Adult Protective Services Worker Tom Schmid regarding the investigation.
04/01/2019	Contact - Telephone call made

	Spoke with direct care staff Daniel Walraven regarding the complaint allegations.
04/01/2019	Contact - Telephone call made Spoke with direct care staff Diamond Williams regarding the compliant allegations.
04/01/2019	Contact - Telephone call made Spoke with Wellness Director Lori Napier regarding the complaint allegations.
04/01/2019	Contact – Telephone call made Left a message for direct care staff Jacob Fisher regarding the complaint allegations.
04/12/2019	Exit Conference Spoke with Licensee Designee Shannon Aldrich regarding the complaint allegations.

ALLEGATION:

Resident A eloped from the facility and was gone for approximately 24 hours.

INVESTIGATION:

On 03/26/2019, I spoke with facility Resident Care Coordinator Ken Roehl who stated that on the evening of Saturday March 23rd, he received a telephone call from the facility Wellness Director, Lori Napier stating Mercy Medical transportation company called the facility to report that the house he was "dropping" Resident A off at was empty. Mr. Roehl stated that Ms. Napier reported to him that Resident A had a key to get into the house, but the house was empty. Mr. Roehl stated that Ms. Napier told him that the transporter left Resident A at the home. Mr. Roehl stated Ms. Napier told him that no arrangements had been made for Resident A to leave the facility. Mr. Roehl stated that at that point he called the DeWitt Police Department to request assistance in getting Resident A back to the facility. Mr. Roehl stated that he was told by the Dewitt Police Department that they could not remove Resident A from her home without a court order. Mr. Roehl stated that the DeWitt Police Department told him that they could not force Resident A out of her house. Mr. Roehl stated that the DeWitt Police Department told him that they would need a signed order from a judge to move Resident A from her home. Mr. Roehl stated that he called Clinton County Adult Protective Services (APS) for assistance. Mr. Roehl stated that APS would not provide any assistance in getting Resident A returned to the facility. Mr. Roehl stated that Resident A returned to the facility on Sunday the 24th with her guardian (G1).

Mr. Roehl stated that based on her history of making telephone calls for rides or to cancel appointments, Resident A's telephone use at the facility is to be supervised by staff and that she does not have a telephone in her room. Mr. Roehl stated that Resident A can receive telephone calls at the facility. Mr. Roehl stated that he does not know how Resident A gained access to a telephone, but Resident A made the telephone call to Mercy Medical for transportation.

On 03/27/2019, I conducted an unannounced inspection at the facility. I interviewed direct care staff Jasmine Dortch who stated that she came to work around 3:00 p.m. on the 23rd. Ms. Dortch stated that Resident A was in the main area of the facility waiting for her transportation. Ms. Dortch stated that she was told by staff that Resident A was going to visit her mother and her sister overnight. Ms. Dortch stated that at approximately 6:00 p.m. the transportation van arrived to pick up Resident A. Ms. Dortch stated when transportation arrived, staff helped Resident A onto the transportation van. Ms. Dortch stated that based on what Resident A and other staff were saying she thought it was already planned for Resident A to go to her mother and sister's home. Ms. Dortch stated she does not know who placed the call to arrange transportation for Resident A. Ms. Dortch stated that Resident A returned to the facility the next day with G1.

Ms. Dortch stated she has been told by other staff that Resident A has attempted to do something like this before. Ms. Dortch stated that now Resident A is on "15-minute checks" to insure she does not make any telephone calls. Ms. Dortch stated staff is aware that Resident A cannot make outgoing telephone calls and that staff is unsure how Resident A was able to make the telephone call arranging transportation.

On 03/27/2019, I attempted to interview Resident A. Resident A stated that she did not want to talk and refused an interview.

On 03/27/2019, I reviewed the file of Resident A. Resident A was admitted to the facility on 03/09/2018. Resident A's diagnoses include Type 2 Diabetes, Bi-Polar Disorder, Hypertension, Hyperthyroidism, Cognitive Deficits and Vascular Dementia. Resident A has a history of multiple right hip fractures, has had her right hip replaced and uses a walker for assistance with walking. Resident A also has a history of substance abuse.

On 03/27/2019, I spoke with G1 who stated that on Saturday, March 23rd at about 8:00 p.m. he received a telephone call from Ms. Napier stating that Resident A was at her home in DeWitt. G1 stated that Ms. Napier told him that Resident A used a telephone at the facility to schedule transportation to her home. G1 stated that Resident A used a medical transport company to get to her home in DeWitt. G1 stated that Resident A probably had a key hidden somewhere allowing her access to the house. G1 stated that he was unable to go to DeWitt to get Resident A because his mother was having surgery and he was with her. G1 stated that the police and

protective services in Clinton County were called but were not were not responsive and Resident A ended up staying at her home alone all night. G1 stated that Resident A did not have food nor medicine. G1 stated the next morning he went to Resident A's home and the police and the paramedics were at the home. G1 stated that Resident A called 911 for assistance. G1 stated that Resident A was transported to Sparrow Hospital. G1 stated he went to Sparrow Hospital and was able to convince Resident A to return to the facility. G1 stated he brought Resident A back to the facility.

G1 stated that Resident A has memory problems. G1 stated that he is Resident A's Court Appointed guardian and that his sister has Power of Attorney over Resident A's finances. G1 stated that Resident A went to a memory care facility in Howell and after that was placed at this facility. G1 stated that Resident A previously had caregivers at her home, but Resident A kept firing them, calling the police on them and would not let them assist her. G1 stated Resident A has had several psychiatric hospitalizations. G1 stated that Resident A appears to be very rational, but she is not. G1 stated that Resident A is very manipulative and smart. G1 stated that Resident A probably had a key hidden at her home. G1 stated that Resident A thinks that she can live on her own, but she cannot. G1 stated that Resident A is also very paranoid. G1 stated Resident A has had several surgeries on her right hip and has had her right hip replaced and walks with a walker.

G1 stated that this is first time that Resident A has left the facility. G1 stated that he does not understand why the facility did not call him to verify that Resident A had permission to leave the facility without him. G1 stated he did not authorize Resident A to leave the facility nor was he notified that Resident A was leaving. G1 stated the facility has been good at working with Resident A and he rates them highly as they have done good work with Resident A. G1 stated that after this incident he believes that the facility will take the appropriate steps to ensure that this does not occur again.

On 03/29/2019, I spoke with Livingston County Adult Protective Services Worker Thomas Schmid who stated that he is finding a preponderance of evidence that the facility neglected Resident A. Mr. Schmid stated that the facility did not do it's due diligence in making sure that Resident A was supervised. Mr. Schmid stated that Resident A "roamed" into the room of another resident and made a telephone call to arrange transportation home. Mr. Schmid stated that he is concerned that Resident A was able to call and schedule transportation and then allowed to leave the facility without staff intervening or verifying that Resident A could leave the facility. Mr. Schmid stated that the facility was very accommodating to Resident A and that based on her history, the facility should have done a better job of supervising her.

On 04/01/2019, Ms. Napier stated that on the evening of Saturday March 23rd she received a telephone call from facility staff Jacob Fisher telling her that Resident A left the facility and was at her home in DeWitt alone. Ms. Napier stated that Mr. Fisher reported that Resident A told facility staff that her mother had made

arrangements for her to spend the evening with she and her sister. Ms. Napier stated that Mr. Fisher reported that Resident A left the facility at about 6:00 p.m. in a medical transport van. Ms. Napier stated that she contacted Mr. Roehl to inform him about the situation with Resident A. Ms. Napier stated that she contacted G1 to inform him that Resident A was in DeWitt at her home after arranging her own transportation. Ms. Napier stated that the DeWitt Police Department was contacted to get assistance in bringing Resident A back to the facility. Ms. Napier stated the DeWitt Police Department would not remove Resident A from her home without a court order. Ms. Napier stated that APS in Clinton County was contacted for assistance as well but would not assist in getting Resident A back to the facility. Ms. Napier stated G1 was unable to go and get Resident A from her home in DeWitt and that Resident A stayed in her home alone that evening. Ms. Napier stated that the Brighton Police Department was also called to report Resident A as missing. Ms. Napier stated Resident A returned to the facility the next day with G1.

Ms. Napier stated that Resident A presents very well but is very manipulative and cannot make decisions on her own. Ms. Napier stated that Resident A cannot live on her own either. Ms. Napier stated that Resident A is still exit seeking.

Ms. Napier stated that she has told staff that no one is to leave the building unless they are with their guardians or POA. Ms. Napier stated after Resident A began stating that she was going to visit her sister and her mother, she told staff that Resident A was not to leave the building. Ms. Napier stated she told the first shift supervisor Jennifer that Resident A was not going to visit family but somehow that message did not get to all of staff.

On 04/01/2019, I interviewed direct care staff Daniel Walraven who stated that he was told by Jennifer the first shift supervisor and Diamond Williams, the second shift supervisor that Resident A was going to spend the evening with her mother and her sister. Mr. Walraven stated that “everyone thought that Resident A was going to visit her mother and her sister.” Mr. Walraven stated that no one thought to call and verify that Resident A was authorized to leave the facility. Mr. Walraven stated when the medical transport van arrived, staff assisted Resident A onto the transport van. Mr. Walraven stated later that evening, staff learned that Resident A was not supposed to have left the facility.

On 04/01/2019, I interviewed direct care staff Diamond Williams who stated that when she arrived for her shift on the March 23rd at 3:00 p.m., she was told that Resident A was going to spend the evening with her mother and her sister. Ms. Williams stated when staff changes from one shift to the next, they “talk about what is going on with the residents.” Ms. Williams stated that she “figured” that arrangements had already been made for Resident A to visit her mother and her sister. Ms. Williams stated that Resident A was in the main area of the facility waiting for her “ride.” Ms. Williams stated Resident A’s medications were not given to her because she was not scheduled to be gone overnight. Ms. Williams stated when the transport van arrived, she and other staff helped Resident A into the van.

Ms. Williams stated that the facility got a call later stating that the home Resident A was “dropped off at” was empty. Ms. Williams stated that Ms. Napier and Mr. Roehl were called.

On 04/12/2019, I conducted an exit conference with Licensee Designee, Shannon Aldrich. Ms. Aldrich stated that after this incident, no resident is to leave the building without clearance from Mr. Roehl, Ms. Napier or herself. Ms. Aldrich stated that she would submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15305	**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 statements from staff and G1, Resident A called to schedule transportation outside of the facility. When the transport vehicle arrived, staff helped Resident A onto the transport vehicle and Resident A was transported home. At no time did staff verify that Resident A was supposed to be leaving the facility. As a result, Resident A went to her home in DeWitt and was alone there overnight without care or supervision. There is sufficient evidence to support the allegation that Resident A’s protection and safety were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

 04/15/2019

Dawn Campbell Date
Licensing Consultant

Approved By:

 05/03/2019

Ardra Hunter Date
Area Manager