RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

February 24, 2018

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

RE: License #: AL470092981
Investigation #: **2018A0565009**
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 #:	2018A0565009
Complaint Receipt Date:	01/25/2018
Investigation Initiation Date:	01/26/2018
Report Due Date:	02/24/2018
Licensee Name:	Ashley Court Of Brighton Inc.
Licensee Address:	7400 Challis Road Brighton, MI 48116
Licensee Telephone #:	(810) 225-7400
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 AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are not being properly medicated for their pain and on some shifts are left in excruciating pain and agitation for hours.	Yes
Residents have been found to be still in bed at noon, missing their breakfast.	No

III. METHODOLOGY

01/25/2018	Special Investigation Intake 2018A0565009
01/26/2018	Special Investigation Initiated - Face to Face I interviewed facility nurse Lori Napier, direct care staff Jennifer Cook and direct care staff Marilyn Osiwala regarding the complaint allegations.
01/29/2018	Contact - Telephone call made Spoke with Kindred Hospice Nurse Marcia Regalado regarding the complaint allegations.
02/01/2018	Contact - Face to Face Spoke with the licensee designee Shannon Aldrich regarding the complaint allegations.
02/02/2018	Contact - Telephone call made Spoke with facility nurse Lori Napier regarding the complaint allegations.
02/02/2018	Contact - Telephone call received Spoke with Kindred Hospice Nurse Susan Sroka regarding the complaint allegations.
02/05/2018	Contact - Telephone call made Spoke with facility nurse Lori Napier regarding the complaint allegations.
02/09/2018	Exit Conference – Spoke with licensee designee Shannon Aldrich regarding the special investigation.
02/13/2018	Contact – Telephone call made. Spoke with direct care staff Ryan

	Cavazos regarding the special investigation.
02/13/2018	Contact – Telephone call made. Spoke with direct care staff Joseph Warlick regarding the special investigation.
02/13/2018	Contact – telephone call made. Left message for direct care staff Emelda Mandela regarding the special investigation.
02/13/2018	Contact – Telephone call made. Left message for direct care staff Leanne Martin regarding the special investigation.
02/13/2018	Contact – Received documents. Received additional documents from Resident A's file.
02/15/2018	Exit Conference – Spoke with licensee designee Shannon Aldrich regarding the results of the special investigation.

ALLEGATION:

Residents are not being properly medicated for their pain and on some shifts are left in excruciating pain and agitation for hours.

INVESTIGATION:

On 01/26/2018, I conducted an unannounced inspection at the facility. I interviewed facility nurse Lori Napier, direct care staff Jennifer Cook and direct care staff Marilyn Osiwala regarding the complaint allegations.

On 01/26/2017, facility nurse Lori Napier stated when she arrived at the facility on 01/22/2018, Resident A was in a great deal of pain. Ms. Napier stated she gave Resident A Morphine and Ativan as needed (PRN) according to her prescription to help with her pain and agitation. Ms. Napier stated she was not aware that Resident A was not given her Morphine until she reviewed Resident A's Medication Administration Record (MAR). Ms. Napier stated that she contacted hospice nurse Susan Sroka to inform her that the current prescription for Morphine was not controlling Resident A's pain and that she needed an increase in medication to help manage her pain. Ms. Napier stated Resident A's Morphine prescription was changed on 01/23/2018 to Roxanol Morphine Sul Sol 20m G/ML sublingually every 4 hours around the clock. Ms. Napier stated Resident A was also prescribed Morphine Sul Sol 20mg/ml sublingually every 1 hour as needed for pain.

Ms. Napier stated she was not aware of staff refusing to administer medication to residents for any reason.

On 01/26/2018, direct care staff Jennifer Cook stated she provides care to Resident A and she is able to recognize when Resident A is in pain. Ms. Cook stated she was present on Tuesday (January 23, 2018) when hospice came to bathe and provide care to Resident A. Ms. Cook stated after the appointment with the hospice nurse, Resident A's morphine was increased because the appointment with the nurse seemed to "set her off" meaning that her pain increased. Ms. Cook stated when she left her shift on the 23rd that Resident A "seemed comfortable" and did not appear to be in pain. Ms. Cook denied that she refused to administer medication to Resident A because she was not being paid to administer medication.

On 01/26/2018, direct care staff Marilyn Osiwala stated she worked "the weekend" (January 20-21, 2018). Ms. Osiwala stated Resident A was not eating and that staff had a hard time getting her to take liquids and swallowing. Ms. Osiwala stated she did not refuse to give Resident A medication for any reason and has given her medication to her as needed or when scheduled if she was on shift to work.

On 01/26/2018, I reviewed the file of Resident A. Resident A's medical diagnoses included Type 2 Diabetes, hyperlipidemia hypertension and macular degenerative dementia. Resident A died on 01/25/2018.

On 01/26/2018, I reviewed the MAR for Resident A. On 01/21/2018, Resident A was prescribed Morphine Sul Sol 20mg/ML sublingually every 6 hours around the clock. On January 21, 2018, Resident A was not given Morphine at 6:00 p.m. on January 22, 2018, at 12:00 a.m. and at 6:00 a.m. On January 22, 2018, Resident A's Morphine prescription was changed to Roxanol Morphine Sul Sol 20m G/ML sublingually every 4 hours around the clock. Resident A's MAR shows that on January 23, 2018, at 12:00 a.m. and at 4:00 a.m. Resident A was not given Morphine.

On 01/29/2018, I interviewed Kindred Hospice Nurse Marcia Regalado who stated she spoke with Kindred Hospice Nurse Susan Sroka regarding Resident A. Ms. Regalado stated Ms. Sroka stated she was concerned because when she arrived at the facility on 01/23/2018 at approximately 12:00 p.m., she walked into Resident A's room and found her highly agitated and in pain. Ms. Regalado stated Ms. Sroka told her that Resident A was gouging at her skin and was attempting to take her clothing off. Ms. Regalado stated Ms. Sroka reported that she increased Resident A's morphine and Ativan to decrease her pain and aggression. Ms. Regalado stated Ms. Sroka told her that staff refused to administer medication was because she was "not being paid" to do it.

Ms. Regalado stated she believes the facility does not do a good job of communication with hospice with things that are occurring with hospice patients at the facility. Ms. Regalado stated she has not logged any calls from Ashley Court in her on-call book requesting assistance from their on-call nurse for any of Ashley Court's hospice patients.

On 02/01/2018, I interviewed licensee designee Shannon Aldrich who stated there is a shift supervisor who administers medication during each shift during the day. Ms. Aldrich stated during the midnight shift direct care staff administer medication to residents. Ms. Aldrich stated Ms. Napier reviews all resident MARs to ensure that medication has been administered to them. Ms. Aldrich stated if the MAR indicates that a resident did not receive their medication, Ms. Napier follows up with the "med passer." Ms. Aldrich stated that staff will be "written up" if they do not administer medication to residents as scheduled.

On 02/02/2018, I interviewed Kindred Hospice Nurse Susan Sroka who stated when she arrived at the facility on 01/23/2018, Resident A appeared to be in excruciating pain. Ms. Sroka stated Resident A was pulling at her clothing and skin and was highly agitated. Ms. Sroka stated she spoke with facility staff and was told that Resident A did not receive her Morphine throughout the night. Ms. Sroka stated she was told by a staff member "she is not paid" to give medication so Resident A did not receive her Morphine during the night. Ms. Sroka stated she does not remember which staff member told her Resident A did not receive her medication during the night. Ms. Sroka stated she gave Resident A Morphine and Ativan for her pain and agitation. Ms. Sroka stated she was concerned because it took two doses of Morphine and Ativan as needed to comfort Resident A. Ms. Sroka stated she reviewed Resident A's plan of care and new medication order with Ms. Napier. Ms. Sroka stated she also spoke with Resident A's daughter regarding her plan of care.

02/02/2018, I reviewed Kindred Hospice's clinical notes and medication orders for Resident A. Kindred Hospice's clinical notes indicate Resident A began to receive hospice services on 01/18/2018. The clinical notes dated 01/21/2018, indicate Resident A was prescribed Morphine on 01/19/2018 and the medication was "not arrived" at the facility. The clinical notes indicate a call was placed to Dr. Eden and Dr. Cogswell, Resident A's physicians to obtain emergency pharmascrpit so that Resident A's Morphine would arrive at the facility on 01/21/2018. Kindred Hospice did not provide an order for Resident A's Morphine on the date of 01/19/2018.

On 02/05/2018, Ms. Napier stated she contacted Ms. Sroka via text message directly Regarding Resident A. Ms. Napier stated this would not "show up" on Kindred Hospice's on call message log.

On 02/13/2018, I interviewed direct care staff Ryan Cavazos who stated Resident A's medicine arrived at the facility on 01/21/2018. Mr. Cavazos stated that there was a delay in Resident A's Morphine arriving at the facility. Mr. Cavazos stated that he remembers giving Resident A her Morphine on the evening of 01/21/2018. Mr. Cavazos stated that the internet at the facility does not always work and when he enters medication into the computer, it does not always "sync" and show that the medication was administered to the resident. Mr. Cavazos stated that is possibly the reason Resident A's MAR shows that Resident A did not receive her medication.

On 02/13/2018, I interviewed direct care staff Joseph Warlick regarding the complaint allegations who stated he does not administer medication to residents at any time. Mr. Warlick stated only certain staff administer medication to Residents. Mr. Warlick stated he is not aware of any problems with staff administering medications to residents and he has not heard that staff is not giving medication to residents. Mr. Warlick stated that time has passed and Resident A has been gone "too long" for him to remember which direct care staff was giving medication to residents on January 21, 2018.

On 02/13/2018, I called direct care staff Emelda Mandela regarding the special investigation. Ms. Mandela did not return the telephone call.

On 02/13/2018, I called direct care staff Leanne Martin regarding the special investigation. Ms. Martin did not return the telephone call.

On 02/13/2018, Ms. Aldrich provided copies of orders the facility received for Resident A from Kindred Hospice. Facility records do not show a Morphine order for Resident A on the date of 01/19/2018.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	Based on the above statements and facility records Resident A was prescribed Morphine on 01/21/2018. Resident A's MAR shows that Resident A was prescribed Morphine Sul Sol 20m G/ML sublingually every 6 hours around the clock. Although Mr. Cavazos stated he gave Resident A her Morphine, Resident A's MAR shows that on January 21, 2018, Resident A was not given Morphine at 6:00 p.m. Resident A's MAR also shows that on January 22, 2018, at 12:00 a.m. and at 6:00 a.m. Resident A did not receive her Morphine. On January 22, 2018, Resident A's Morphine prescription was changed to Roxanol Morphine Sul Sol 20m G/ML sublingually every 4 hours around the clock. Resident A's MAR shows that Resident A was not given Morphine on January 23, 2018, at 12:00 a.m. and at 4:00 a.m. Resident A was not given her Morphine as prescribed. There is sufficient evidence to support this complaint allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents have been found to be still in bed at noon, missing their breakfast.

INVESTIGATION:

On 01/26/2018, Ms. Napier stated that Resident A was not eating and was actively dying. Ms. Napier stated Resident A was in her room at the time hospice arrived to provide care to her because due the fact that Resident A was dying, she was in her bed all of the time.

On 01/26/2018, I reviewed Resident A's ADL sheet. For the dates of January 18-25 2018, until her death she had 0-10% food intake.

On 01/26/2018, Ms. Cook stated Resident A was the only resident on hospice services that was in bed at the time the hospice nurse arrived to provide care to her. Ms. Cook stated Resident A was not given breakfast because she was not eating.

On 01/26/2018, Ms. Osiwala stated she was not at the facility at the time hospice arrived and does not know if Resident A was in her bed. Ms. Osiwala stated when she last worked with Resident A on the previous weekend, that Resident A was no longer getting out of her bed. Ms. Osiwala stated Resident A did not receive meals

because she was not eating or swallowing. Ms. Osiwala stated staff had a hard time getting Resident A to take liquids. Ms. Osiwala stated the medication given to Resident A was crushed and put in her cheek

On 02/13/2018, Mr. Cavazos stated Residents receive their meals at scheduled times. Mr. Cavazos stated that some hospice patients are “laid back down” after breakfast and at times in the bed when hospice arrives. Mr. Cavazos stated if a resident is declining or in pain, their meals are given to them in their bedrooms. Mr. Cavazos stated the residents are given a bed tray and are fed while they are in their bed.

On 02/15/2018, I held an exit conference with licensee designee Shannon Aldrich who stated Residents are given their meals at scheduled times. Ms. Aldrich stated residents who are not able to eat meals in the dining room are given meals in their bedrooms.

Ms. Aldrich stated she would submit a corrective action plan.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Based on the above statements, Residents are fed meals at scheduled times. Resident A is the only resident that was not provided breakfast due to her medical condition and was in bed at the time hospice arrived to provide care to her. There is insufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

 02/15/2018

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Dawn Campbell Date
Licensing Consultant

Approved By:

 2/24/2018

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Ardra Hunter Date
Area Manager