GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 2, 2021

Pamala Schmitt
Aspen Assisted Living LLC
32408 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AL820398863
Investigation #: 2021A0119025
Aspen Assisted Living LLC

Dear Ms. Schmitt:

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 (313) 456-0380.

Sincerely,

Shatonla Daniel, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-3003

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820398863
Investigation #:	2021A0119025
Complaint Receipt Date:	06/15/2021
Investigation Initiation Date:	06/16/2021
Report Due Date:	08/14/2021
Licensee Name:	Aspen Assisted Living LLC
Licensee Address:	32408 W Seven Mile Rd, Livonia, MI 48152
Licensee Telephone #:	(248) 987-4460
Administrator:	Pamala Schmitt
Licensee Designee:	Pamala Schmitt
Name of Facility:	Aspen Assisted Living LLC
Facility Address:	32408 Seven Mile Rd, Livonia, MI 48152
Facility Telephone #:	(248) 987-4460
Original Issuance Date:	03/08/2021
License Status:	TEMPORARY
Effective Date:	03/08/2021
Expiration Date:	09/07/2021
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff Erica Porter left the residents unsupervised during the evening of 6/13. Residents were without supervision until another staff arrived which was approximately twenty minutes later.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/15/2021	Special Investigation Intake 2021A0119025
06/15/2021	Contact - Telephone call received Licensing Consultant- Denasha Walker
06/16/2021	Special Investigation Initiated - Telephone Licensee Designee- Pamala Schmitt
06/17/2021	Contact - Telephone call made Staff- Erica Porter
06/24/2021	Inspection Completed On-site Linda Jaroos, business manager, Staff
07/15/2021	Contact - Telephone call made Staff- Diamond Primm and Shayla Hughes, Left message
07/27/2021	Contact - Telephone call made Administrator/ Licensee Designee- Pamala Schmitt Staff- Diamond Primm
07/30/2021	Contact- Telephone call made Staff- Shayla Hughes
08/02/2021	Exit Conference- Licensee Designee- Pamela Schmitt

ALLEGATION: Staff Erica Porter left the residents unsupervised during the evening of 6/13. Residents were without supervision until another staff arrived which was approximately twenty minutes later.

On 06/16/2021, I telephoned and interviewed Licensee Designee/ Administrator- Pamala Schmitt regarding the above allegation. Ms. Schmitt stated she believes staff Erica Porter left the building at 8:45pm, leaving residents unsupervised and the

next staff didn't report to the building until 20 minutes afterwards. She stated Ms. Porter was a "new hire" and was hired to work midnights every other weekend. Ms. Schmitt stated Ms. Porter was in the facility alone with the residents. Ms. Schmitt stated all of the residents were in their bedrooms. She stated Ms. Porter was scheduled to work midnights and had agreed on this day to work a double shift. Ms. Schmitt stated she was contacted by the business manager, Linda Jaroos and told that Ms. Porter had quit. She stated they immediately turned on the cameras in the building to be able to monitor the residents as best as possible. Ms. Schmitt stated they contacted another staff, Camille Jaroos to come into work and she arrived approximately 20 minutes later. Ms. Schmitt stated she estimates the residents were alone for about 30 minutes as Ms. Jaroos arrived around 9:20pm. Ms. Schmitt stated, "we really try hard to help the care staff and work with them with problems on their schedule".

On 06/17/2021, I telephoned and interviewed staff Erica Porter regarding the above allegation. Ms. Porter stated she was hired in May 2021 to work every other weekend but since she started has worked every weekend. She stated she informed the business manager, Ms. Jaroos that she has children and will need to care for them. She stated that day she was working a double shift which began at 3:00pm and was to end at 7:00am. Ms. Porter stated she texted Ms. Jaroos around 7:30pm and was told that she needed to speak with Pamala Schmitt regarding the schedule. Ms. Porter sent me the correspondence of the text messages. Then Ms. Porter received a response text from Ms. Jaroos that "you are on for Friday". After this text message, Ms. Porter informed Ms. Jaroos that she was quitting and leaving the facility. Ms. Porter stated she was alone with the residents at the time and acknowledged that when she left there was no responsible person in the home to supervise the residents.

On 06/24/2021, I completed an onsite inspection and interviewed Business manager, Linda Jaroos, and staff Camile Jaroos regarding the above allegation. Linda Jaroos stated Ms. Porter was hired on 06/01/2021 and had only trained and worked for a few days. Linda Jaroos stated at around 08:30pm, on 06/13/2021, she received a text from Ms. Porter. Linda Jaroos stated Ms. Porter requested to be off work on the following Friday. Linda Jaroos stated she asked Ms. Porter to make an attempt to find someone to replace her because midnights are a set schedule. Linda Jaroos stated she reminded Ms. Porter that she had recently done this for the prior day. Linda Jaroos stated Ms. Porter was scheduled to work a double shift on Sunday, the day of the incident. Linda Jaroos stated at 8:47pm, Ms. Porter texted her stating she was quitting. Linda Jaroos stated she contacted Ms. Schmitt and they were monitoring the residents on the facility cameras until another staff was able to come into the facility.

Camile Jaroos stated Ms. Porter worked for about a week. Camile Jaroos stated they had agreed to switch shifts and she worked a double on Saturday while Ms. Porter worked a double on Sunday. Camile Jaroos stated she did come into the facility on 06/13/2021 because Ms. Porter had left the residents alone.

On 07/27/2021, I telephoned and interviewed Staff- Diamond Primm regarding the above allegation. Ms. Primm stated she had no idea Ms. Porter was unhappy or would be leaving her shift early. Ms. Primm stated she stayed later in order to assist Ms. Porter on 06/13/2021 because she was a new staff person. Ms. Primm stated she worked from 7:00am to 7:00pm and left after medications were given to the residents.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident. (b) Be capable of appropriately handling emergency situations.
ANALYSIS:	Staff Erica Porter acknowledged that she left the residents alone in the home during the evening of 6/13/2021. Licensee Designee/ Administrator Pamela Schmitt stated the residents were left alone for approximately 30 minutes without staff in the facility. Therefore, Ms. Porter was not suitable to me the needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 06/24/2021, I completed an onsite inspection and interviewed Business manager Linda Jaroos, staff Camile Jaroos, and Administrator Pamela Schmitt regarding the above allegation. Linda Jaroos stated there are a total of thirteen residents in the facility. She stated two require wheelchairs, two occasionally use wheelchairs, four use walkers, and five are fully ambulatory. Linda Jaroos stated twelve residents need assistance with personal hygiene.

Camille Jaroos stated six residents need help with toileting. Camile Jaroos stated she worked alone on Saturday, 06/12/2021 and she did not need any additional staff helping her. Camile Jaroos stated the staff schedule has been two staff working in the morning, one staff on evenings and midnights. Camile Jaroos stated the residents are usually in bed by 9:30pm.

Ms. Schmitt stated she has worked as direct care staff frequently due to being short on staffing. She stated her cook is on vacation. Ms. Schmitt stated that staff have had to do everything to support the residents such as meal preparation and cleaning.

I received the staffing schedule for two weeks. This schedule shows only one staff working during the midnight shift.

On 07/27/2021, I telephoned and interviewed Administrator Linda Schmitt and Diamond Primm regarding the above allegation. Ms. Schmitt stated Linda Jaroos, the cook, and herself are serve safe approved for food preparation. It should be noted that serve safe is a training course for basic food and beverage handling.

Ms. Primm stated on 06/13/2021, she prepared breakfast, lunch, and dinner during her shift.

On 07/30/2021, I telephoned and interviewed staff Shayla Hughes regarding the above allegation. Ms. Hughes stated she worked with Ms. Porter on 06/13/2021 from 7:00am to 7:00pm. She stated she administered medications that day and Ms. Primm prepared the meals for the residents. Ms. Hughes stated there is usually two staff working during the day time: a cook and medication technician. She stated on the weekend there have been times when there is only one staff person working because the facility was short on staffing.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Linda Jaroos stated there are a total of thirteen residents in the facility. She stated two require wheelchairs, two occasionally use wheelchairs, four use walkers, and five are fully ambulatory. Linda Jaroos stated twelve residents need assistance with personal hygiene. Camille Jaroos stated six residents need help with toileting. Ms. Jaroos stated she worked alone on Saturday, 06/12/2021. Per staffing schedule, there is only one midnight staff working in the facility. Therefore, was not sufficient staffing for the supervision, personal care, and protection of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of the household; provision of names of employee, volunteer, or member of the household on parole or probation or convicted of felony; food service staff.**
	(14) A licensee shall employee at least 1 individual who is qualified by training, experience, and performance to be responsible for food preparation. Additional food service staff shall be employed as necessary to ensure regular and timely meals.
ANALYSIS:	On 06/12/2021 and 06/13/2021, Camile Jaroos, Shayla Hughes, Diamond Primm, and Erica porter worked as direct care staff. Diamond Primm stated she prepared the meals for the residents on 06/13/2021. On 06/12/2021, Camile Jaroos stated she was working alone and doing everything including preparing meals. Administrator Pamela Schmitt stated Linda Jaroos, the cook, and herself are serve safe approved for food preparation. On 06/12/2021 and 06/13/2021, neither the cook, Linda Jaroos, nor Pamela Schmitt were working in order to prepare meals for the residents. Therefore on 06/12/2021 and 06/13/2021, there was not a staff trained in serve safe working that was responsible for food preparation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/02/2021, I completed an exit conference with Pamela Schmitt regarding the violations contained in this report. Ms. Schmitt stated she has made adjustments to the staff schedule to ensure that there are two staff on daytime and afternoon shifts. She stated she will make another staff schedule adjustment for the midnight shift. Ms. Schmitt stated, “we are constantly hiring and training new staff in order to build staff roster” and “we are doing everything we can to ensure the residents are kept safe”.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend that the status of the license remains the same.

08/02/2021

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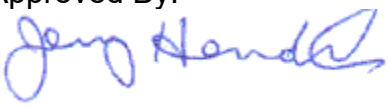
Shatonla Daniel — Date
Licensing Consultant

Approved By:



08/02/2021

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Jerry Hendrick — Date
Area Manager