GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 3, 2022

Jennifer Garcia
Aspen Grove Assisted Living
7515 Secor Rd
Lambertville, MI 48144

RE: License #: AH580356894
Investigation #: 2022A1027013
Aspen Grove Assisted Living

Dear Ms. Garcia:

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 authorized representative 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) 284-9727.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH580356894
Investigation #:	2022A1027013
Complaint Receipt Date:	11/12/2021
Investigation Initiation Date:	11/12/2021
Report Due Date:	01/12/2022
Licensee Name:	CSL Aspen Grove, LLC
Licensee Address:	Suite 160A 16301 Quorum Drive Addison, TX 75001
Licensee Telephone #:	(972) 770-5600
Administrator/Authorized Representative:	Jennifer Garcia
Name of Facility:	Aspen Grove Assisted Living
Facility Address:	7515 Secor Rd Lambertville, MI 48144
Facility Telephone #:	(734) 856-4400
Original Issuance Date:	03/28/2014
License Status:	REGULAR
Effective Date:	08/20/2021
Expiration Date:	08/19/2022
Capacity:	83
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Agency staff lacked training.	Yes
Additional Findings	No

III. METHODOLOGY

11/12/2021	Special Investigation Intake 2022A1027013
11/12/2021	APS Referral Referral emailed to APS
11/12/2021	Special Investigation Initiated - Letter Email sent to AR/administrator Sarah Marsh requesting staff member's training records
11/16/2021	Contact - Document Received Email received from Ms. Marsh with requested documentation
12/17/2021	Contact - Document Sent Email sent to administrator/authorized representative Ms. Garcia and Ms. Mullins to request facility training records for Ms. Foster
12/20/2021	Contact - Document Received Email received from Jennifer Garcia with employee's dates of employment.
12/27/2021	Contact - Document Sent Email sent to AR/Administrator Jennifer Garcia requesting staff training documents
12/29/2021	Inspection Completed – BCAL Sub Compliance
01/03/2022	Exit Conference Conducted with authorized representative Jennifer Garcia

ALLEGATION:

Agency staff member lacked training.

INVESTIGATION:

On 11/10/21, the department received an incident report which read a staff member wrapped their arms round Resident A. The report read:

> "Staff members A.L. & L.F reported staff member R.F. wrapped their arms over residents arms from behind while A.L. & L.F were providing care to resident. Resident was sitting on his bed in the process of kicking off his pants/wiggling and the resident and staff member R.F fell over on the bed."
>
> "Staff member A.L. told staff member R.F. to stop and R.F. let go of the resident. No injury noted."
>
> "Staff member R.F. who was working through Med1Care Staffing Agency was asked not to return to the facility. Staff education initiated on Abuse & Neglect Policy. Additional residents interviewed no trend of abuse/neglect identified."

I reviewed a written statement from caregiver/medication technician Alexis Lovell on 10/19/21. The statement read:

> "(Resident A) was in his room & Lauren & I already had his pants halfway off. He was being cooperative. Raphael from agency came in & got involved. He looked at her & told her to get out. She then went behind him & grabbed him from behind. She told us to pull his pants off & we told her no when he stood up he's [sp] pants fell down d/t being too big. We put a brief on his ankles & gave him a pair of pants to put on & he pulled the pants up but not the brief. (Another resident) was screaming for someone to fix his machine so I left the room to go fix it for him. I seen Raphael leave & go back to Magnolia Trails."

I reviewed written documentation from Ms. Marsh asking Ms. Lovell additional questions which read consistent with Ms. Lovell's written statement. The documentation read how did Ms. Lovell know Resident A need to be changed and she responded, "he came out of his room & his pants were wet." The documentation read "At anytime did you tell her to stop or let him go?" and Ms. Lovell responded "yes, I said stop & she let him go."

I reviewed a written statement and additional questions documentation from caregiver Lauren Finley on 10/19/21 which read consistent with Ms. Lovell's written statements.

I reviewed documentation of resident interviews regarding facility care conducted by Ms. Marsh. Resident B's interview read staff treat her "very well – they like to keep it like family" and staff are treating her "very polite and quite nice." Resident C's interview read staff say "hi sir" and staff are treating other residents "ok." Resident C's interview read staff treat her "very well" and treat other residents "alright." Resident E's interview read staff treat him "good" and treat other residents "I don't know." Resident F's interview read staff treat her "fine" and treat other residents "sometimes they are rude to others – not to me." Resident G's interview read staff treat her "they have been good" and treat other residents "I don't know."

I reviewed a list of all staff educated regarding the Abuse and Neglect Policy provided administrator Sarah Marsh. The list read in addition to all staff, five agency staff were also educated.

Per email correspondence with Jennifer Garcia, Ms. Foster's first day of work was 8/11/21 and her last day worked was 10/18.

I reviewed Med1Care training for agency staff Raphael Foster. The agency training documentation read Ms. Foster was trained on 5/10/19 by the Med1Care which including education quizzes regarding resident care as well as training regarding The Patient Bill of Rights, Understanding Abuse and Neglect, Customer service.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**

ANALYSIS:	Review of facility documentation revealed although Ms. Foster had been trained by her agency, the facility was unable to provide their staff training documentation. It is assumed the facility did not assess Ms. Foster's competency per their training program.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/3/22, I shared the findings of this report with authorized representative Jennifer Garcia. Ms. Garcia verbalized understanding of the findings.

IV. RECOMMENDATION

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

1/3/2022

Jessica Rogers Date
Licensing Staff

Approved By:

12/29/2021

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section