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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 30, 2022

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

RE: License #: AL470080554
Investigation #: 2022A1029025
Ashley Court -Bldg # 2

Dear Ms. Aldrich:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL470080554
Investigation #:	2022A1029025
Complaint Receipt Date:	02/03/2022
Investigation Initiation Date:	02/04/2022
Report Due Date:	04/04/2022
Licensee Name:	Ashley Court Of Brighton Inc.
Licensee Address:	7400 Challis Road Brighton, MI 48116
Licensee Telephone #:	(734) 622-0074
Administrator:	Shannon Aldrich
Licensee Designee:	Shannon Aldrich
Name of Facility:	Ashley Court -Bldg # 2
Facility Address:	7400 Challis Road Brighton, MI 48116
Facility Telephone #:	(810) 225-7400
Original Issuance Date:	08/06/1999
License Status:	REGULAR
Effective Date:	05/13/2020
Expiration Date:	05/12/2022
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided personal care regularly because her dentures were caked with food and her briefs were not changed regularly.	No
Resident A was not bathed regularly.	No
Resident A's resident bedroom had a dehumidifier left for too long, a piece of molding coming off the wall, and a bathroom light that did not work.	No
The facility was not cleaning Resident A's clothes on a regular basis.	No

III. METHODOLOGY

02/03/2022	Special Investigation Intake 2022A1029025
02/04/2022	Special Investigation Initiated – Telephone with complainant-returned message regarding building / license
02/07/2022	Contact - Telephone call received from complainant
02/18/2022	Contact - Telephone call made to Relative A1
02/24/2022	Contact - Face to Face with Lisa Vanderhoof, Resident A at Ashley Court, and Direct care staff member Leann Martin
02/24/2022	Inspection Completed On-site
03/23/2022	Contact – Telephone call to Kelly Schrader. Left a message for her and she returned the call.
03/23/2022	Contact – Telephone call to Shawna Kuehnel. Left a message.
03/23/2022	Contact – Document sent – Email to Lisa Vanderhoof requesting documentation
03/23/2022	Contact – Telephone call to Jerry Massey. Left a message.
03/27/2022	Exit conference with Shannon Aldrich. Sent email to Licensee designee.

ALLEGATION:

Resident A was not provided personal care regularly because her dentures were caked with food and her briefs were not changed regularly.

INVESTIGATION:

On February 3, 2022, a complaint was filed via the online BCHS complaint system. There were concerns that Resident A was not receiving proper care according to her assessment plan because her dentures/teeth were not being cleaned since they were caked with food and her adult briefs not being changed regularly.

On February 24, 2022, I interviewed Lisa Vanderhoof at Ashley Court. Ms. Vanderhoof stated the direct care staff members assist with the personal care for Resident A. She stated that one of Resident A's top dentures are missing. She stated the denture was too big for Resident A when she arrived and Polydent was used to help secure this in Resident A's mouth. Ms. Vanderhoof stated she informed Resident A's relative about the missing denture. Ms. Vanderhoof stated Resident A is able to eat fine without it and does not seem to notice it is gone.

Ms. Vanderhoof further stated Relative A1 cut Resident A's hair short and it stands up in the back if it's not washed regularly and she lies down a lot causing it to stand up in the middle of the night. Ms. Vanderhoof stated Resident A uses adult incontinence briefs and is currently on a two hour check and brief change schedule for personal care.

I reviewed Resident A's resident record. According to Resident A's *Health Care Appraisal* completed on February 24, 2021 she is fully ambulatory and is diagnosed with dementia. According to Resident A's *Assessment Plan for AFC Residents* completed in February 2021 she needs "stand by assistance, cues and reminders for all ADL's" under toileting, bathing, grooming, dressing, and hygiene. There is also information documenting that Resident A wears upper and lower dentures.

On February 24, 2022, I interviewed direct care staff member Leann Martin who has worked at Ashley Court for two years. She stated Resident A's adult incontinence briefs are changed every two hours. Ms. Martin stated she typically works on twelve hour shifts and has never noticed Resident A's incontinence brief not being changed. Ms. Martin stated she is changed every two to three hours. Ms. Martin has never observed any direct care staff member not provide Resident A with the personal care she needs. Resident A will typically use the toilet in addition to wearing a brief and does not inform the direct care staff members if she needs to be provided personal care so she is automatically checked on a two hour schedule.

On February 24, 2022, I observed Resident A and attempted to interview her. Due to her diagnosis of dementia, she was unable to complete an interview with detail. She stated she enjoys living at Ashley Court and did not have any concerns about any of the

direct care staff members there. Resident A stated she wears adult incontinence briefs but did not recall any details about who changes them or how often.

On March 23, 2022, I interviewed to assistant to the maintenance director, Jerry Massey. He stated that the direct care staff members are very concerned about the residents and believed residents are changed on a regular basis. He stated he has never observed any of the residents to need personal care and not be attended to or noticed any odors with a resident not receiving personal care.

On March 23, 2022, I interviewed direct care staff member, Kelly Schrader. She has worked there for two years in July. She is familiar with Resident A but has not worked in the building with Resident A per the preference of Relative A1. Ms. Schrader stated she has provided Resident A with showering and assistance with toileting and brief changes. Ms. Schrader stated she was aware Resident A had dentures and that direct care staff member helped her with taking them in/out each day, cleaning them, and using Polydent to affix them in Resident A's mouth. Ms. Schrader believes that Resident A may have thrown them out because she did not like wearing them. When she worked with her, she never noticed her dentures to be caked with food. In the beginning they kept the Polydent in her room but after it was kept in the medication room locked it in the medication room.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	There is no indication that Resident A was not provided personal care on a regular basis. The direct care staff members Ms. Schrader and Ms. Martin denied seeing Resident A's dentures caked with food or her briefs not changed timely.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was not bathed regularly.

INVESTIGATION:

On February 3, 2022, a complaint was filed via the online BCHS complaint system. There were concerns that Resident A was not bathed on a regular basis.

On February 24, 2022, I interviewed direct care staff member Lisa Vanderhoof at Ashley Court. She stated there is a schedule for showers and all showers are completed for Resident A by the direct care staff members. Ms. Vanderhoof stated direct care staff

members at Ashley Court track of all activities of daily living including showers for all residents. She stated at times Resident A's Relative A1 would give her a shower during her visits but those are not documented. She stated that she would have Resident A scheduled for a shower, tell Resident A she was going to have a shower and then Relative A1 stated she was going to give her a shower instead. Resident A is scheduled for showers twice per week on Wednesday and Saturday according to her services plan which I reviewed at Ashley Court. Ms. Vanderhoof stated direct care staff members all complete their personal care. She stated sometimes Resident A likes to get ready for bed but she will need prompting to do this. Resident A is fully ambulatory and has a hard time remembering due to her diagnosis of dementia. She stated Resident A gets at least two showers per week and would receive more if necessary.

I reviewed Resident A's resident record. Resident A's *Health Care Appraisal* completed on February 24, 2021 documented she is fully ambulatory and is diagnosed with dementia.

Resident A's *Activities of Daily Living* (ADL) tracking sheets for September 2021-February 2022 were reviewed which included documentation Resident A had a shower at least one time per week during that time frame. Resident A's *Assessment Plan for AFC Residents* indicated she needs "stand by assistance, cues and reminders for all ADL's" with these tasks.

On February 24, 2022, I interviewed direct care staff member Leann Martin who has worked at Ashley Court for two years. She stated she has never noticed that Resident A did not receive an adequate number of showers. She stated Resident A's hair is short they make sure to brush it daily and because it is short and thin without regular showers and blow drying it, her hair will look oily.

On February 24, 2022, I observed Resident A and attempted to interview her. Due to her diagnosis of dementia, she was unable to complete an interview with detail. She stated she enjoys living at Ashley Court and did not have any concerns about any of the direct care staff members there. Resident A stated she wore showered at the facility but was unable to recall details regarding how often these are done. She appeared to be free of any odor and her hair was brushed.

On March 23, 2022, I interviewed direct care staff member, Kelly Schrader. The residents receive showers two times per week and each resident has set shower days. Ms. Schrader stated Resident A received her showers on a regular basis and enjoyed receiving shower assistance from Ms. Schrader. Ms. Schrader stated Resident A told her that she liked her so she let Ms. Schrader give her a shower.

APPLICABLE RULE	
R 400.15314	**Resident hygiene**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and

	personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	There is no indication Resident A was not afforded the opportunity for daily bathing and personal hygiene. Resident A bathed at least weekly according to the activities of daily living tracking system used by Ashley Court and interviews with staff members.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's resident bedroom had a dehumidifier left on for too long, a piece of molding coming off the wall, and a bathroom light that did not work.

INVESTIGATION:

On February 3, 2022, a complaint was filed via the online BCHS complaint system.

On February 24, 2022, I interviewed direct care staff member Lisa Vanderhoof at Ashley Court. Ms. Vanderhoof stated she does not know if Resident A's bathroom light has issues turning on. She stated she has not noticed any issues with the trim on Resident A's door causing a safety issue. Ms. Vanderhoof was able to show Resident A's bedroom. There were no issues with the trim, however, the bathroom light flashed when first turning it on and then went to a solid light. There were no other concerns regarding the maintenance of the facility and no safety issues. I conducted an unannounced on-site investigation and inspected Resident A's resident bedroom. I did not observe a dehumidifier, any loose molding, or a malfunctioning bathroom light.

On February 24, 2022, I interviewed direct care staff member Leann Martin who has worked at Ashley Court for two years. She stated she has noticed Resident A's bathroom light flashed at times. She said that she has noticed that even after it's fixed, the light will flash at times. Ms. Martin thought maybe it was because they were using two different kinds of lights in the fixture. Ms. Martin stated she noted the maintenance personnel are frequently doing repairs and trying to improve the appearance of Ashley Court. She pointed out the new flooring in the dining room and denied noticing anything that would be a trip hazard to the residents.

On March 23, 2022, I interviewed to assistant to the maintenance director, Jerry Massey. He stated that he would have fixed an issue with a light if he received a ticket for it. He denied that it would have been left without repair. He denied seeing any concerns in her room including any that would create a safety hazard. Mr. Massey stated a dehumidifier was placed in the room in the past because Relative A1 was concerned that there was water on the walls from the shower however the dehumidifier was not left in the room for several months. Resident A had a fall around this time but he stated that she fell away from the dehumidifier and that was not the cause of the fall.

He has never noticed any trim coming off her door that would have created a trip hazard.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(1) A home shall be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	There were no concerns regarding the maintenance of Ashley Court. All living areas were clean and orderly. Resident A's bathroom light flashed when it was first turned on but then went to a solid light. Direct care staff member, Ms. Martin stated this was changed in the past, and continued to do this. Although the light was flashing at the time of the on-site inspection, this was addressed again by maintenance and did not appear to be affecting the health, safety, and well being of Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility was not cleaning Resident A's clothes on a regular basis.

INVESTIGATION:

On February 3, 2022, a complaint was filed via the online BCHS complaint system. There were concerns that Resident A's clothes were not being cleaned on a regular basis because there was a smell like dried urine on the clothes and the facility staff stated the laundry detergent did not work well.

During the unannounced on-site inspection on February 24, 2022, I did not observe large amounts of unclean laundry in Resident A's bedroom, or any resident bedroom, nor did I observe any foul odors.

On March 23, 2022, I interviewed to assistant to the maintenance director, Jerry Massey. He does not manage the laundry service but knows resident laundry is done at least every other day. He stated he has never noticed laundry piled up in any of the resident bedrooms nor did he voice any concerns that it was not being done.

On March 23, 2022, I interviewed direct care staff member, Kelly Schrader. The residents' clothes are laundered during their shower day. She stated that if the bedding or clothes are soiled before the shower day, the bedding is laundered as needed. She has never noticed clothes piling up in Resident A's rooms that was not cleaned on a regular basis.

APPLICABLE RULE	
R 400.15404	**Laundry.**
	A home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	Ms. Shrader stated the laundry is done during each resident's shower day. There is no indication that Resident A did not have her laundry done regularly. During the onsite inspection, there was no evidence of a full laundry basket in any of the resident bedrooms, including Resident A's, or a smell in any of the resident bedrooms indicating the laundry was piling up.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend no change in the license status.

Jennifer Browning _____3/27/22_____

Jennifer Browning Date
Licensing Consultant

Approved By:

Dawn Timm 03/30/2022

_____

Dawn N. Timm Date
Area Manager