GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 23, 2022

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

RE: License #: AL470080554
Investigation #: 2022A0466050
Ashley Court -Bldg # 2

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) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL470080554
Investigation #:	2022A0466050
Complaint Receipt Date:	06/27/2022
Investigation Initiation Date:	06/27/2022
Report Due Date:	08/26/2022
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:	05/13/2022
Expiration Date:	05/12/2024
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATIONS:

	Violation Established?
The facility is not meeting the residents' hygiene needs.	Yes
The facility over medicates residents.	No
Additional Findings	Yes

III. METHODOLOGY

06/27/2022	Special Investigation Intake- 2022A0466050.
06/27/2022	APS Referral- Intake received from APS as denied intake
06/27/2022	Contact - Telephone call made to Complainant, message left.
06/27/2022	Special Investigation Initiated – Telephone call, Complainant interviewed.
06/29/2022	Inspection Completed On-site.
08/17/2022	Contact- Document sent to licensee designee Shannon Aldrich.
08/18/2022	Exit Conference with licensee designee Shannon Aldrich, message left.

ALLEGATION: The facility is not meeting the residents' hygiene needs.

INVESTIGATION:
On 06/27/2022, a denied adult protective service (APS) intake was received alleging the facility does not properly care for residents. Complainant reported facility direct care workers do not require residents to brush their teeth and many of them do not even own a toothbrush. Complainant reported facility administrators tell the workers to fake documents to appear as though the residents are being checked on, changed, and bathed more frequently than what actually occurs. Complainant reported residents are often wet as they are not changed frequently enough. Complainant reported facility administrators often disregards requests from family members about how to treat the residents. Complainant reported facility direct care workers frequently do not ensure residents are getting enough water and on 5/26/22 one of the residents went to the hospital due to dehydration. Complainant reported direct care workers (DCWs) have been observed showering residents in cold water.

On 06/27/2022, I interviewed Complainant who reported resident family members supply toothbrushes for the residents not the facility.

On 06/29/2022, I conducted an unannounced investigation and I interviewed DCW Ashlee Vanderhoof who reported she has worked at the facility for over a year. DCW Vanderhoof reported residents require assistance with brushing their teeth and DCWs provide that assistance. DCW Vanderhoof reported facility DCWs have toothbrushes for the residents. DCW Vanderhoof reported she has never falsified any activity of daily living (ADL) sheets nor has heard that any other DCWs falsify records/documents. DCW Vanderhoof reported residents are provided with fluids thought-out the day and at mealtimes. DCW Vanderhoof reported residents do have toileting accidents and at times are wet but she has never found residents soaked as DCWs check on the residents frequently, minimally every two hours during both waking and sleeping hours. DCW Vanderhoof reported all of the residents are diagnosed with Alzheimer's disease or dementia and are not accurate reporters of information. DCW Vanderhoof reported no resident has complained to her about showering in cold water nor has she ever showered a resident in cold water.

On 06/29/2022, I interviewed DCW Kelly Schrader who reported she has worked at the facility for two years. DCW Schrader reported residents require assistance with brushing their teeth and DCWs provide that assistance and families provide toothbrushes for the residents. DCW Schrader reported all of the residents have toothbrushes and the facility does have toothbrushes available if the resident's family members do not provide them. DCW Schrader reported she has never falsified any ADL sheets nor has heard that any other DCWs falsify records/documents. DCW Schrader reported that residents are provided with fluids thought-out the day and at mealtimes. DCW Schrader reported Resident E was sent to the hospital on 05/26/2022 for not feeling well, was diagnosed for dehydration, and returned to the facility the same day. DCW Schrader reported residents do have toileting accidents but she has never found residents soaked as residents are checked every two hours during both waking and sleeping hours. DCW Schrader reported the residents living in the facility are aged and diagnosed with Alzheimer's or dementia and therefore are not reliable historians. DCW Schrader reported no resident has ever complained that the water was cold when she assisted them with a shower. DCW Schrader reported the water temperature is lukewarm. DCW Schrader reported residents will complain it is chilly in the facility when the air conditioning is running.

On 06/29/2022, I interviewed DCW Leann Martin who reported she has worked at the facility for a year and a half. DCW Martin reported the residents require assistance with brushing their teeth, DCWs provide that assistance and families provide toothbrushes for the residents. DCW Martin reported some residents will not open their mouth or some that will refuse oral care. DCW Martin reported that all of the residents have toothbrushes and the facility does have toothbrushes available if the resident family members do not provide them or if they become lost. DCW Martin reported she has never falsified any ADL sheets nor has heard that any other

DCWs falsify records/documents. DCW Martin reported residents are provided with fluids thought-out the day and at mealtimes. DCW Martin reported DCWs encourage residents to drink water throughout the day and water is taken to residents in their room thought out the day. DCW Martin reported Resident G was sent to the hospital on 05/24/2022 for a fall, was diagnosed with dehydration and returned to the facility. DCW Martin reported residents have toileting accidents but she has never found residents soaked as DCWs check on the residents at least every two hours during both waking and sleeping hours. DCW Martin reported residents complain that the water in the facility is cold. DCW Martin reported residents are diagnosed with dementia and that they are not accurate reporters of information as they can become easily confused.

On 06/29/2022, I interviewed DCW Darla Warden who stated residents require assistance with cueing/brushing their teeth, DCWs provide that assistance and families provide toothbrushes for the residents. DCW Warden reported all of the residents have toothbrushes and the facility does have toothbrushes available if the resident's family members do not provide them. DCW Warden reported she has never falsified any ADL sheets nor has heard that any other DCWs falsify records/documents. DCW Warden reported residents are provided with fluids thought-out the day and at mealtimes. DCW Warden reported many residents ask for fluids throughout the day, DCWs encourage residents to drink water by taking water to the residents throughout the day. DCW Warden was not aware of any residents that had been hospitalized/treated for dehydration recently but reported dehydration can be a side effect of certain prescribed medications. DCW Warden reported residents have toileting accidents but she has never found residents soaked as DCWs check on the resident frequently throughout the day/night. DCW Warden reported residents complain the water in the facility is cold and many residents do not like to shower. DCW Warden reported residents are all diagnosed with dementia and that they are not accurate reporters.

On 06/29/2022, I interviewed DCW Jamie Walters who reported residents require assistance with cueing/brushing their teeth, DCWs provide assistance with oral care and families provide toothbrushes for the residents. DCW Walters reported all residents have toothbrushes and the facility has toothbrushes available if needed. DCW Walter reported she has never falsified any ADL sheets nor has heard that any other DCWs falsify records/documents. DCW Walter reported residents are provided with fluids thought-out the day and at mealtimes. DCW Walters reported at mealtimes there is a pitcher of water on each table for resident consumption. DCW Walters reported many residents ask for fluids throughout the day and residents ask for additional water with medication passes. DCW Walters was not aware of any residents that had been hospitalized/treated for dehydration recently. DCW Walters reported residents have toileting accidents but that she has never found residents soaked as DCWs check on the resident frequently throughout the day. DCW Walters reported some residents are "heavy wetters" due to medications such as Lasix. DCW Walters reported all residents are checked minimally every two hours during both waking and sleeping hours. DCW Walters reported if a resident is wet it is not

due to lack of care as all of the DCWs take really good care of the residents and check on them often. DCW Walters reported residents do not complain that the water for showering in the facility is cold. DCW Walters reported that the residents are all diagnosed with dementia and that they are not accurate reporters.

On 06/29/2022, I observed the residents at the facility who appeared well groomed, they were all in clean clothing and without any foul odor.

On 06/29/2022, I reviewed the *Shower Assignment* list which documented each resident was listed for two separate shower days per week.

On 06/29/2022, I reviewed the *Day Shift Routine* and the *Afternoon Shift Routine* which documented it was the DCWs responsibility to provide residents assistance with showers and that DCWs were to assist residents with toileting and/or brief check/changes every two hours.

On 06/29/2022, I tested the water in the bathroom and the water temperature was above 120 degrees Fahrenheit.

On 06/29/2022, I reviewed June 2022 *ADL Sheets* which contained documentation of food intake for breakfast, lunch, dinner and snacks. The *ADL Sheets* also documented BM's 7a-7pm, 7p-7a and Bladder 7a-7pm, 7p-7a and showers. All Resident ADL Check List were completed except for the following dates when a portion of the sheet was left blank:

- Resident A had blank entries on 06/02, 06/03, 06/04, 06/05, 06/08, 06/11, 06/12, 06/20, 06/24 and 06/28.
- Resident B had blank entries on 06/02, 06/03, 06/04, 06/09, 06/11, 06/12, 06/20, 06/24 and 06/28.
- Resident C had blank entries on 06/02, 06/03, 06/04, 06/05, 06/07, 06/08, 06/10, 06/11, 06/19, 06/20, 06/24 and 06/27.
- Resident D B had blank entries on 06/02, 06/03, 06/04, 06/07, 06/09, 06/11, 06/12, 06/19, 06/24 and 06/28.
- Resident E had blank entries on 06/02, 06/03, 06/04, 06/05, 06/06, 06/07, 06/10, 06/11, 06/12, 06/13, 06/19, 06/20, 06/24, 06/27 and 06/29/2022.
- Resident F had black entries on 06/02, 06/03, 06/04, 06/09, 06/11, 06/12, 06/19, 06/20, 06/24 and 06/29.

On 06/29/2022, I reviewed the June 2022 *ADL Sheets* for Resident A, Resident B, Resident C, Resident D, Resident E and Resident F. All residents had showers at least weekly except for the following:

- Resident A recevied a shower on 06/02/2022 and 06/14/2022.
- Resident C recevied a shower on 06/02/2022 and 06/13/2022.
- Resident D recevied a shower on 06/03/2022, 06/06/2022, 06/13/2022,06/16/2022, 06/20/2022.
- Resident F received a shower on 06/03/2022, 06/07/2022 and 06/17/2022.

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:	I reviewed the June 2022 *ADL Sheets* for Resident A, Resident B, Resident C, Resident D, Resident E and Resident F. Despite interviews with multiple direct care workers stating resident personal care needs were met, many residents had portions of the *ADL Sheets* that were blank meaning if personal care was provided it was not documented. Additionally, Resident A, Resident C and Resident D's June 2022 *ADL Sheet* documented Resident A did not receive a weekly shower between 06/02/2022 and 06/14/2022, which is a 12-day time span. Resident C's *ADL Sheet* documented Resident C did not receive shower between 06/02/2022 and 06/13/2022 which is an 11-day time span. Resident D's *ADL Sheet* documented Resident D did not receive a shower between 06/07/2022 and 06/17/2022 which is a 10-day time span and between 06/17/2022 and 06/28/2022 which is an 11-day time span. Residents A, C, and E did not receive a shower as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility overmedicates residents.

INVESTIGATION:
On 06/27/2022, a denied APS central intake denial was recevied alleging facility direct care workers frequently over medicate residents so they will sleep 14 or more hours a day.

On 06/27/2022, Complainant suggested that I review Resident A's record as a part of my investigation. Complainant reported that all medications that are administered to the residents are prescribed by a doctor. Complainant reported that residents are also prescribed PRN's (pro re nata) on as needed basis for when they become combative. Complainant reported residents are all always tired and seem to have low energy all of the time. Complainant reported PRNs are administered frequently.

On 06/29/2022, I conducted an unannounced investigation and I interviewed DCW Vanderhoof, DCW Martin, DCW Warden and DCW Walters who all reported that they are trained as medication passers and administer medications to the residents. DCW Vanderhoof, DCW Martin, DCW Warden and DCW Walters all reported residents are not over medicated and are administered medications prescribed by a physician. DCW Vanderhoof, DCW Martin, DCW Warden and DCW Walters all

reported PRN medications are not administered daily, just as needed. DCW Vanderhoof, DCW Martin, DCW Warden and DCW Walters reported residents at the facility are diagnosed with dementia and/or Alzheimer's disease. DCW Vanderhoof, DCW Martin, DCW Warden and DCW Walters reported most of the residents have prescribed PRN's for when they are aggressive, anxious or exit seeking. DCW Vanderhoof DCW Martin, DCW Warden and DCW Walters reported some residents will ask for PRN's or if the resident has been crying for a long time or is exiting seeking, the medication passer may offer the resident a PRN if one has been prescribed.

DCW Vanderhoof, DCW Martin, DCW Warden and DCW Walters reported residents are not on prescribed medication for the purpose of having them sleep 14 hours day nor do they think that any resident is being over medicated. DCW Vanderhoof reported Resident C tends to stay up all night and sleep all day, Resident D sleeps a lot and Resident F is on hospice and will sleep/stay in bed for days when she is not feeling well. DCW Schrader reported that Resident D and Resident F sleep a lot. DCW Warden and DCW Walters both reported that the residents do go though cycles when they do sleep a lot based on the stage of dementia that they are in plus it they are dealing with any concurrent medical issues or declines the residents tend to sleep more. DCW Warden and DCW Walters reported that the residents sleep patterns/sleep cycles change and some residents sleep all day and stay up all night.

On 06/29/2022, I reviewed June 2022 medication administration records (MAR)s for Resident A, Resident B, Resident C, Resident D, Resident E and Resident F. I did not find any evidence on the June 2022 MARs that any medication was not being administered pursuant to label instructions**.** Resident B, Resident C, Resident D, Resident E and Resident F are all prescribed Lorazepam Tab .5 mg, "take 1 tablet by mouth three times a day as needed for anxiety." Resident B, Resident D and Resident E all have the same prescribing physician. All residents did have prescribed PRN's that were administered sporadically with the reason for why the medication was administered noted. More specifically, Resident B's MAR documented that the PRN Lorazepam was discontinued on 06/15/2022 and therefore was not administered since. Resident C's MAR, documented PRN Lorazepam was administered to Resident C at least once daily between 06/01/2022 through 06/29/2022 with either "anxiety or agitation" noted as the reason for medication administration. Resident D was administered prescribed PRN Lorazepam every day between 06/01/2022 through 06/29/2022 except 06/28/2022 with either "anxiety or agitation" noted as the reason for medication administration. Resident E was administered PRN Lorazepam once daily 11 times and twice daily on 3 days in June 2022 due to "anxiety and agitation" noted. Resident F was administered PRN Lorazepam once daily four times due to "anxiety and agitation "noted.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Although Complainant reported that residents were being overmedicated, I reviewed June 2022 medication administration records for Resident A, Resident B, Resident C, Resident D, Resident E and Resident F and did not find any evidence any medication was not being administered as prescribed. Resident B, Resident C, Resident D, Resident E and Resident F are all prescribed Lorazepam Tab .5 mg, “take 1 tablet by mouth three times a day as needed for anxiety” was being administered pursuant to label instructions. There was not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 06/29/2022, I tested the water in the bathroom at the faucet and the water temperature was above 120 degrees Fahrenheit.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(2) Hot and cold running water that is under pressure shall be provided. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the faucet.
ANALYSIS:	The water temperature at the facility exceeded 120 degrees Fahrenheit at the faucet therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in the status of the license.

08/18/2022

_____

Julie Elkins Date
Licensing Consultant

Approved By:

08/23/2022

_____

Dawn N. Timm Date
Area Manager