STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 1, 2023

Carmin Harris
32408 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AL820398863
Investigation #: 2023A0992025
Aspen Assisted Living LLC

Dear Ms. Harris:

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 (313) 456-0380.

Sincerely,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820398863
Investigation #:	2023A0992025
Complaint Receipt Date:	05/02/2023
Investigation Initiation Date:	05/04/2023
Report Due Date:	07/01/2023
Licensee Name:	Aspen Assisted Living LLC
Licensee Address:	32408 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 987-4460
Administrator:	Carmin Harris
Licensee Designee:	Carmin Harris
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:	REGULAR
Effective Date:	09/08/2021
Expiration Date:	09/07/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
• There are concerns regarding sufficient staffing and supervision. Resident A was observed with no oxygen on, which she requires. Resident A was seen slouched down in her Lazyboy chair, about to fall. • There were no sheets on the bed when visiting.	No Yes
Additional Findings	Yes

III. METHODOLOGY

05/02/2023	Special Investigation Intake 2023A0992025
05/04/2023	Special Investigation Initiated - Telephone Complainant
05/15/2023	Inspection Completed On-site Carmen Harris, licensee designee; Raquel Rivers, health and wellness coordinator; and Alize Grant, resident care coordinator.
05/25/2023	Contact - Telephone call made Relative A, Resident A's power of attorney

ALLEGATION:

- **There are concerns regarding sufficient staffing and supervision. Resident A was observed with no oxygen on, in which she requires. Resident A was seen slouched down in her Lazyboy chair, about to fall.**

- **There were no sheets on the bed when visiting.**

INVESTIGATION:

On 05/04/2023, I contacted the Complainant and addressed the allegations. The Complainant made me aware that Resident A passed away two weeks ago. The Complainant stated Resident A previously lived in building 2 and while visiting her in the past, several deficiencies were observed. The Complainant said Resident A was observed slouching in her Lazyboy recliner to the point that she almost fell. The

Complainant said to his knowledge, she never fell but the staff did not reposition her often. The Complainant stated Resident A had bed sores and there were instances when there was not adequate linen on her bed. I explained to the Complainant that due to Resident A being deceased, I am unable to determine if there were bedsores and/or the cause. I made the Complainant aware that the other allegations will be investigated.

On 05/15/2023, I completed an on-site inspection and interviewed Carmen Harris, licensee designee; Raquel Rivers, health and wellness coordinator; and Alize Grant, resident care coordinator regarding the allegations. Ms. Harris denied having knowledge of Resident A slouching and the staff not tending to her. She said Resident A did not utilize the common area after she returned to the facility from the hospital, so she never observed her slouching or not being properly cared for by staff. She said she did sit in the Lazyboy recliner in her room and the staff would check on her every hour. Ms. Harris said it is very unlikely that she did not have adequate linen on her bed because she spent a great deal of her time in the bed when she returned from the hospital. Ms. Harris explained that Resident A broke her hip in the past and when she was discharged from the hospital, she did not come out her room as much; other than for dinner, but it was rare. Ms. Harris said Resident A was placed on hospice on 04/06/2023 and she received oxygen as a comfort measure. Ms. Harris denied having any knowledge of Resident A not receiving oxygen as needed. She denied it was ever brought to her attention that Resident A was not receiving her oxygen as required. Ms. Harris suggested I ask Ms. Rivers regarding the specifics. According to Resident A's assessment plan dated 02/28/2023, oxygen was documented as equipment needed/used. As it pertains to Resident A's hospice certification and plan of care dated 04/06/2023, she was prescribed 2.5 liters of oxygen on a continuous basis. As far as the orders of discipline and treatments, the hospice nurse is to instruct in safe use of oxygen and monitor its effectiveness. Ms. Harris escorted me around the facility to observe several of the resident bedrooms as it pertains to having adequate bedding. I observed six bedrooms, one was a double. Three beds out of seven did not contain adequate bedding. Bedrooms 216, 207 and 211 had bedding that did not contain a fitted sheet. The beds contained a blanket, fitted sheet, pillow/pillowcase and mattress protector. I observed several residents in the common area with staff. Some residents were participating in arts/crafts lead by staff; others were visiting with family/friends, and some were sitting and/or maneuvering through the facility. Ms. Harris stated there are 15 residents, two direct care staff per shift, a medication coordinator, along with Ms. Rivers and Ms. Grant; all of which have direct care worker training and experience.

Raquel Rivers said Resident A did slouch in her Lazyboy recliner. She further explained that on 12/07/2022, Resident A broke her hip and once she returned from the hospital/rehabilitation she would try to avoid putting pressure on that side when sitting. Ms. Rivers said as a corrective measure, Ms. Rivers said staff would prop a pillow on her side to straighten her up, but overall, she started to favor one side over the other. As far as Resident A having adequate linen, she said she always had

adequate bedding to her knowledge. As far as oxygen, Ms. Rivers confirmed Resident A received oxygen. She said her oxygen requirements changed throughout her various hospitalizations as far as levels, but it was administered as required to her knowledge. Ms. River denied having any knowledge of her not receiving oxygen.

Alize Grant stated she has observed Resident A slouching in the past but never fell to her knowledge. She stated that Resident A favored one side more than the other following her hip surgery. Ms. Grant said she would often reposition her or add a pillow for comfort. When asked how often she checked on the residents, Ms. Grant said every thirty minutes to an hour. She said if they are a fall risk, she checks every thirty minutes and if not typically an hour or less. Ms. Grant said they provide linen, and the residents have adequate bedding. Ms. Grant showed me the linen closet, which contained ample blankets, comforters, flat sheets but minimal fitted sheets.

Prior to leaving the facility, I conducted an exit conference with Ms. Harris. I made her aware that based on the findings there is insufficient evidence to support the allegation of insufficient staffing to meet the residents needs. However, as it pertains to inadequate linen, there is evidence to support the allegations. Ms. Harris said she understand, and she will order more linen. I made her aware due to the violation, a written corrective action plan is required, which she agreed to submit.

On 05/25/2023, I contacted Relative A, Resident A's power of attorney and interviewed her regarding the allegations. Relative A denied having any knowledge of the reported allegations. She said there was an occasion when the residents were being served two tacos and she was concerned about the meal not being nutritious. However, Relative A reiterated she was not aware of the reported allegations.

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:	During this investigation, I interviewed Carmin Harris, licensee designee; Raquel Rivers, health and wellness coordinator; Alize Grant, resident care coordinator; the Complainant and Relative A regarding the allegations. All of which denied the allegations except for the Complainant. I reviewed the staff schedule and observed the staff-to-resident ratio. While onsite there were 5 staff on shift and there are 15 residents admitted in building #2. I reviewed Resident A's assessment plan and hospice plan of care and confirmed she required oxygen. However, I was unable to determine her usage because she is deceased. Based on the investigative findings there is insufficient evidence to support the allegation that the licensee failed to have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents. The allegation is unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15411	**Linens.**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	During this investigation I observed six bedrooms. Three beds out of seven only contained 1 sheet, 1 blanket, pillow/pillowcase, and mattress protector. Based on the investigative findings, there is sufficient evidence to support the allegation. The allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 05/15/2023, I observed medication (Ammonium Lactate 12%; apply to the following (areas) lower extremities) in Resident B's bathroom. The medication was not kept in a locked cabinet or drawer.

On 05/15/2023, I completed an exit conference with Ms. Harris and made her aware that all medication is supposed to be locked at all times. She said she is aware and will address it with staff. I further explained that due to the violation, a written corrective action plan is required, which she agreed to submit.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	During this investigation, I observed medication (Ammonium Lactate 12%; apply to the following (areas) lower extremities) in Resident B's bathroom. The medication was not kept in a locked cabinet or drawer.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/01/2023

Denasha Walker Date
Licensing Consultant

Approved By:

06/01/2023

Ardra Hunter Date
Area Manager