GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 21, 2024

Carmin Harris
Aspen Assisted Living LLC
32408 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AL820403228
Investigation #: 2024A0901021
Aspen Assisted Living

Dear Carmen 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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820403228
Investigation #:	2024A0901021
Complaint Receipt Date:	01/27/2024
Investigation Initiation Date:	01/29/2024
Report Due Date:	03/27/2024
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
Facility Address:	32406 Seven Mile Rd Livonia, MI 48152
Facility Telephone #:	(248) 987-4460
Original Issuance Date:	03/08/2021
License Status:	REGULAR
Effective Date:	03/02/2022
Expiration Date:	03/01/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 07/27/2023, the facility was without power, and a pipe burst in Resident A's bedroom.	Yes
Resident A fell in his room and was unconscious for 6 hours. Staff failed to check on him.	No

III. METHODOLOGY

01/27/2024	Special Investigation Intake 2024A0901021
01/29/2024	Special Investigation Initiated - Telephone Resident A's son
01/30/2024	Contact - Telephone call received Resident A's son
02/13/2024	Contact - Telephone call made Resident A's son
02/14/2024	Contact - Document Sent Emailed Licensee Designee, Carmen Harris
02/20/2024	Contact - Telephone call made Staff, Rachel Brooks
02/20/2024	Contact - Telephone call made Staff, Daysia Bell
02/20/2024	Contact - Telephone call made Staff, Dominique Williams
02/27/2024	Contact - Telephone call made Licensee Designee, Carmen Harris
03/01/2024	Contact - Telephone call made Resident A's Daughter
03/13/2024	Contact - Document Received

	Medical Records from Trinity Health Livonia (formerly known as St. Mary's Hospital)
03/20/2024	Exit Conference Licensee Designee, Carmen Harris

ALLEGATION:

On 07/27/2023 the facility was without power, and a pipe burst in Resident A's bedroom.

INVESTIGATION:

On 01/29/2023, consultant Kara Robinson, in my absence, made a telephone call to Resident A's son (Son A). The call was returned on 01/30/2023. It was reported that on 07/27/2023 the facility was without power, and a pipe busted in Resident A's bedroom. As a result, Resident A slipped and fell and was taken to the hospital, St. Mary's in Livonia.

On 02/13/2024, I made a telephone call to Son A. Son A reported the power was out at the facility due to a storm in the Livonia area. The facility was without power for approximately 3 days. There was also standing water on Resident A's bedroom floor. When he got up during the night, assuming to go to the bathroom, he fell and was taken to the hospital. When he arrived at the hospital his pajamas were soaking wet. Son A went to the facility and saw that Resident A's whole room floor was wet. The licensee designee, Carmen Harris and staff, stated he had a leaking pipe in his room, and he fell on the standing water. It is unknown when he fell, but he was found by the day shift staff the morning of 07/28/2024. Prior to the incident, Son A last saw his father at the facility on 07/27/2023 around 6:00 p.m. The facility did not have power at that time and when staff was asked why there was not a generator, no one had answers. Resident A and other residents were given flashlights to see in their rooms. Son A further said Resident A is deceased. While hospitalized at St. Mary's, he fell again and was sent to St. Mary's rehabilitation center. He never fully recovered and died at the rehabilitation center on 08/09/2023.

On 02/14/2024, I emailed Carmen, requesting a copy of the incident report. I received it on 02/15/2024. It was dated for 07/28/2023 at 6:55 a.m. and was completed by staff, Daysia Dell. It confirmed he fell but did not document the conditions of his fall. Based on the incident report, other staff on duty that day were Rachel Brooks and Dominique Williams.

On 02/16/2024, I did a web search and confirmed via the Click On Detroit website that there was a power outage in the City of Livonia on 07/26/2023 due to high winds.

On 02/20/2024, I made a telephone call to Rachel but had the wrong number. The number belonged to someone else.

On 02/20/2024, I made a telephone call to Daysia. Daysia reported working the day shift the morning of 07/28/2023. When doing rounds, upon the start of the shift, Resident A was found lying face down on the floor in his room. He did not know how he fell, but his floor was wet. Daysia did not know where the water came from. Daysia also stated the power was out for 2 days and the generator was not working.

On 02/20/2024, I made a telephone call to Dominique. Dominique reported working the midnight shift on 07/27/2023 and was still there when Daysia found Resident A on the floor. Dominique assisted Daysia. Dominique reported that Resident A's bedroom floor was wet. Dominique believed that a pipe busted in the wall. Prior to this, Dominique reported checking on Resident A around 6:00 a.m. Dominique denied seeing water at that time but did not fully enter the room. Dominique opened the door and saw Resident A sleeping in his chair. Dominique did not fully enter the room and therefore was unsure if the water was present. In addition to this, Dominique reported not being able to see the water, due to the lack of light in the room. Dominique also stated the power was out 2-3 days due to the weather. They have a generator, but it was not strong enough to give power to the whole building. The front entrance had power and the halls had power, but it was going in and out. Resident A's room did not have any power. Carmen gave them lanterns to put in all the bedrooms to help the residents see.

On 02/27/2024, I made a telephone call to Carmen. Carmen confirmed the power was out. It was reported that they had a generator, but it only gave power to the fire suppression system, appliances in the kitchen, hallway lights, and emergency plugs in the laundry room. They used extension cords for residents' oxygen machines. The residents' bedrooms and bathrooms, which are located in their bedrooms, had no lights. Lanterns were placed in each room. They are having a new generator installed on 04/02/2024 that would give power to the whole building. Carmen also confirmed that Resident A's bedroom floor was wet with water. Initially, they thought a pipe busted in the wall. After further investigation, it was discovered that an outside pipe from the air conditioner condenser was leaking and flooded Resident A's room. This occurred overnight on 07/27/2023 because the water was not present during the day. The problem has since been fixed by maintenance. Based on the position Resident A was laying, Carmen believed he was trying to go the bathroom when he slipped and fell. During this telephone call with Carmen, I also inquired about an alternate contact number for Rachel, but there was not another number.

On 03/01/2024, I made a telephone call to Resident A's daughter, who was also his Power of Attorney (Daughter A). Daughter A reported being notified of the power outage and Resident A's fall. Initially, staff thought the refrigerator in his room caused the leak, but it was later reported it came from a pipe.

On 03/20/2024, I made a telephone call to Carmen and informed her of my investigative findings. She stated in addition to having a new generator installed, she is making changes to their emergency protocols to ensure staff do a more thorough check of the residents and their rooms.

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:	Based on the information obtained during this investigation, the facility did not adequately provide for the health, safety, and well-being of the occupants. The facility experienced a power outage 07/26/2023-07/29/2023. During this time, the facility had limited power and the resident bedrooms did not have lighting. In addition to a lack of light, Resident A's room had standing water on the floor due to issues with a pipe. Resident A subsequently fell and was taken to the hospital. Adequate provisions were not made during the time of the power outage to ensure the safety and wellbeing of the residents. Although alternate lighting was provided, it was not sufficient. Dominique reported when checking on Resident A, not being able to see well enough due to the lack of light in the room, and therefore not detecting the water sooner. She also failed to fully enter the room and do a more thorough check.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A fell in his room and was unconscious for 6 hours. Staff failed to check on him.

INVESTIGATION:

On 01/29/2024, consultant Kara Robinson, in my absence, made a telephone call to Resident A's son (Son A). The call was returned on 01/30/2023. Son A reported Resident A was unconscious in standing water for an estimated 6 hours after he fell in his room.

On 02/13/2024, I made a telephone call to Son A. He reported that based on Resident A's CK serum level, which is a blood test that was done at the hospital, Resident A was unconscious in his room for 6 or more hours. Son A felt staff did not do hourly bed checks as they claimed. Son A also stated his daughter-in-law works at the hospital and explained the lab results.

On 02/15/2024, I received a copy of the incident report from the licensee designee, Carmen Harris. Based on the incident report, Resident A was found in his room on the floor by staff, Daysia Dell at 6:55 a.m.

On 02/20/2024, I made a telephone call to staff Daysia Dell. Daysia reported finding Resident A lying face down on the floor in his room. He was alert and conscious. He could not get up and did not want her to touch his leg.

On 02/20/2024, I made a telephone call to staff Dominique Williams. Dominique stated when she went to assist Daysia, Resident A was on the floor and could not get up but was awake and conscious. She also reported that they normally do bed checks on the night shift every 2 hours but due to the power being out, bed checks were done every hour. Dominique stated she last checked on Resident A around 6:00 a.m. and he was sitting in his chair sleeping.

On 02/27/2024, I made a telephone call to Carmen. Carmen was reportedly not present when Resident A was found and taken to the hospital. Carmen explained that due to the power outage, staff did hourly rounds to check on the residents and stated she would send me the log. The Watch Log was initialed hourly by staff starting 07/26/2023 at 4:00 p.m. until 07/29/2023 at 10:00 a.m.

On 03/01/2024, I made a telephone call to Resident A's daughter, who was also his Power of Attorney (Daughter A). Daughter A had no knowledge of Resident A being unconscious after the fall. She reported he was conscious at the hospital. Daughter A agreed to send me copy of Resident A's death certificate, which I received on 03/05/2024. It listed the cause of death as Alzheimer's Dementia and Atrial Fibrillation as being a contributing condition.

On 03/13/2024, I received a copy of Resident A's medical records from Trinity Health Livonia (formerly known as St. Mary's Hospital). It confirmed Resident A was seen in the emergency department due to a fall. He did not know how he fell or know long he was on the floor. He was alert and oriented to person, place, and time. There was no fracture of injuries, but he had bruising on the right side of his face, right shoulder, and knees. He was able to move everything and denied neck and head pain and had good range of motion. Resident A was admitted to the hospital due to being diagnosed with acute rhabdomyolysis. Although his lab work included CK serum levels, there was no documentation in his medical regards noting or drawing a correlation between his CK serum levels being an indication of him being unconscious for several hours.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on the information obtained during investigation, there is a lack of evidence to confirm the allegations. Although Resident A fell, resulting in a change in his physical condition (he could not get up). Staff acted appropriately. As soon as he was discovered on the floor, 911 was called and he was taken to the hospital. There was a lack of evidence to confirm that he was unconscious and not checked on by staff. Staff reported he was alert when they entered the room. They also reported doing hourly checks which was supported by the Watch log. In addition to this, it was documented Resident A was alert when he arrived at the hospital.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

03/20/2024

Regina Buchanan — Date
Licensing Consultant

Approved By:

03/21/2024

Ardra Hunter — Date
Area Manager