GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 14, 2024

Kim Graber
Aspen Grove Assisted Living
7515 Secor Rd
Lambertville, MI 48144

RE: License #: AH580356894
Investigation #: 2024A0585023
Aspen Grove Assisted Living

Dear Ms. Graber:

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) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH580356894
Investigation #:	2024A0585023
Complaint Receipt Date:	02/06/2024
Investigation Initiation Date:	02/06/2024
Report Due Date:	04/07/2024
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:	08/20/2023
Expiration Date:	08/19/2024
Capacity:	83
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive pain medication.	Yes
Additional Findings	No

III. METHODOLOGY

02/06/2024	Special Investigation Intake 2024A0585023
02/06/2024	Special Investigation Initiated - Telephone Contacted complainant by telephone to discuss the allegations.
02/06/2024	APS Referral Referral was sent to Adult Protective Services (APS).
02/09/2024	Contact - Document Sent Emailed administrator to request resident roster.
02/09/2024	Contact - Document Received Requested documents received.
03/14/2024	Exit Conference. Conducted via email to Authorized Representative Kim Graber.

ALLEGATION:

Resident A did not receive pain medication.

INVESTIGATION:

On 2/5/2024, the department received the allegations via the BCHS Online Complaint website. The complaint alleged that Resident A missed two doses of Ativan and eleven doses of Morphine.

On 2/6/2024, a referral was made to Adult Protective Services (APS).

On 2/9/2024, I contacted the complainant by telephone. The complainant stated that Resident A was not given his medication. The complainant stated that Resident A missed eleven doses of morphine. The complainant stated that early evening of

1/31/2024, the hospice medical director approved oral morphine hourly, along with Ativan every 4 hours and the nurse gave Resident A his dose at 7:45 PM and was back at 8:45 with another dose. She said that it made Resident A more comfortable and able to rest. The complainant alleged that when they arrived around 9:00 AM Thursday 2/1/2024 Resident A was writhing and groaning, partially off his bed. The complainant said that she went to the nurses' station to ask when his last morphine was given, and the nurse told her 8:45 PM the night before. The complainant said that Resident A missed 11 doses of morphine and two doses of Ativan.

On 3/12/2024, I interviewed administrator Kim Graber by telephone. Ms. Graber stated that Resident A was on hospice. She explained that hospice changed Resident A's order for Ativa from once every four hours to once every hour. She said that Resident A missed two doses of the new orders due to it not being available yet from the pharmacy. She stated that Resident A was given medication as prescribed. She said the medication administration record (MAR) did not show any missed doses.

On 3/12/2024, I spoke with Employee #1 by telephone. She stated that the new prescription was not given because it was not available yet from the pharmacy because it was a new order. She said that hospice managed all Resident A's medication. Employee #1 stated that on 1/31/2024 at 9:00 p.m., the new order was entered after hospice changed it, but pharmacy did not put it in the system until the next day on 2/1/2024. She stated the Resident A passed away on 2/1/2024.

On 3/1/2024, I interviewed Employee #2 by telephone. Employee #2 stated that hospice changed Resident A's medication. She stated that hospice discontinued morphine every two hours to morphine every hour around the clock. She said that once the medication was discontinued out of the system, they could not give it until it showed up in the system from pharmacy.

Hospice notes for Resident A:

PRN visit for restless, patient transitioning to active. Was restless prior to arrival. Family members present very concerned about patient safety due to trying to self Exit bed. Patient is nonresponsive. Family members times 2 present and others Were informed to be aware death is imminent and want patient to be comfortable Discussed end life, are accepting, says other family members have been informed. Question answered. Therapeutic listening and support given. BP left Arm low indicated, right arm BP 111/81, pulse 121, RR 32 with Cheyne strokes apnea 15 to 20 second. Unable to get 02 Sat. Hands cool, mottling, no signs or Symptoms of pain at present. Edema of bilateral lower extremities. Brief is clean and dry. Nurse entered room at approximately 7:45 pm and discussed with family present patient condition and plans for increasing dose and frequency of pain medication once I get an order from doctor and giving Haldol as soon as arrives from pharmacy and if needed given Levsin. They suggested every hour dosing around the clock. No other needs voiced. New orders for morphine

concentrate 0.5 ml to be given around the clock (scheduled) every 1 hour by mouth or inside cheek for pain/shortness of breath. Son spoke to nurse about concern of staff response. Reminded of hospice availability. Signed by hospice 1/31/2024 at 10:03 p.m.

01/31/2024 - discontinue morphine concentrate 100 mg/5 ml every four hours as needed PO or cheek of mouth for pain/shortness of breath.
Add morphine concentrate 100 mg/5 ml every hour by mouth or cheek of mouth, around the clock/schedule for break through pain/shortness of breath.
Signed and approved by hospice on 2/1/2024.

Discontinue Ativan .5 mg tab as needed every 4 hours as needed for restlessness. Add Ativan 1 mg take one tab by mouth every 4 hours for restlessness. Signed by hospice 1/31/2024, approved by hospice 2/1/2024.

A review of Resident A's MAR show that Resident A morphine was discontinued at 10:00 p.m. on 1/31/2024 and the new prescription was given at 7:00 a.m. every hour with last dose given at 1:00 p.m. on 2/1/2024.

Service plan for Resident A read, "admitted to the facility on 1/13/2023. Medication will be provided per physician order. Note dated 1/26/2023, resident change of condition, checks of 1 hour per hospice. Need help dressing and all other ADLs."

Chart notes for Resident A read, new orders d/c morphine concentrated 0.25 ml, new orders morphine concentrated 100 mg/5 ml (20 mg/ml) 0.5 ml – every one hour (scheduled).

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(a) Assume full legal responsibility for the overall conduct and operation of the home.**

ANALYSIS:	Based on interview with staff, review of documents, including hospice notes and MAR, Resident A did not receive medication during the night of 1/31/2024 through the next morning. A review of Resident A's MAR show that Resident A morphine was discontinued at 10:00 p.m. on 1/31/2024 to increase the frequency or dose of the medication and the new prescription was not given until 7:00 a.m. The facility lacked an organized program to ensure that the residents are not going without medication when there is a medication change.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/14/2024

Brender Howard　　Date
Licensing Staff

Approved By:

03/14/2024

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