GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 24, 2025

Sheilah Readmond
Sabra Midwest Operations, LLC
18500 Von Karman Avenue Suite 550
Irvine, CA 92612

RE: License #: AL690414035
Investigation #: 2025A0360009
Aspen Ridge Retirement Village

Dear Sheilah Readmond:

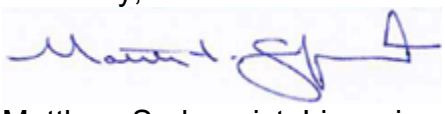
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (616) 356-0100.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW Unit #13
Grand Rapids, MI 49503
(989) 370-8320

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

I. IDENTIFYING INFORMATION

License #:	AL690414035
Investigation #:	2025A0360009
Complaint Receipt Date:	12/26/2024
Investigation Initiation Date:	12/27/2024
Report Due Date:	02/24/2025
Licensee Name:	Sabra Midwest Operations, LLC
Licensee Address:	Suite 550 18500 Von Karman Avenue Irvine, CA 92612
Licensee Telephone #:	(989) 705-2500
Administrator/License Designee:	Sheilah Readmond
Name of Facility:	Aspen Ridge Retirement Village
Facility Address:	1261 Village Parkway Gaylord, MI 49735
Facility Telephone #:	(989) 705-2500
Original Issuance Date:	10/31/2022
License Status:	REGULAR
Effective Date:	04/30/2023
Expiration Date:	04/29/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident had six falls, two requiring hospitalizations.	Yes
Resident assistive devices were not used properly.	Yes
Resident medications were not locked.	Yes
Resident was not administered medication as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/26/2024	Special Investigation Intake 2025A0360009
12/27/2024	Special Investigation Initiated - Telephone Relative A
12/31/2024	Contact - Document Received Relative A
01/09/2025	Inspection Completed On-site Sheilah Readmond Administrator, Luis Lopez Resident Care Director
01/09/2025	Contact - Document Received Luis Lopez, HCA and Assistive Device Policy
02/19/2025	Contact - Telephone call made DCS Jordan Luckett
02/20/2025	APS Referral online
02/20/2025	Contact – Telephone call made DCS Tee Brown
02/24/2025	Exit Conference

ALLEGATION:

Resident had six falls, two requiring hospitalizations.

INVESTIGATION:

On 12/27/24, I contacted Relative A. Relative A stated Resident A had six falls during her stay at Aspen Ridge Retirement Village. She stated Resident A was admitted on 6/12/24 through 11/29/24. She stated two of the falls required hospital admissions and the fall on 10/05/24 resulted in a hip fracture and a nursing home admission following surgery. Relative A stated due to the frequent falls the family placed a camera in Resident A's room on 11/12/24. Relative A stated that when viewing the camera there were several issues witnessed including bed rails not being used properly, bed mattress alarms and chair cushion not secured, the magnet clothing alarm not consistently used and secured, safety belts not used, wheelchair wheellocks not used. Relative A stated that Resident A would be out of her room for hours and suspected that Resident A was not toileted. She stated that she had a photo of a soiled brief she found in Resident A's bathroom that was completely saturated on 11/22/24 at 6 a.m. Relative A denied that Resident A had any skin breakdown due to not being changed. Relative A stated she posted "Friendly Reminders" in Resident A's room on 11/15/24. A copy of the "Friendly Reminders" was provided and included directions for bed use, wheelchair use, and that Resident A's curtains be closed and TV is off when in bed at night. Relative A stated Resident A was often woken up at 4 a.m. by staff after being assisted to bed late at night, 10-11 p.m. Relative A stated she called the facility often and reminded staff including Ms. Readmond and Mr. Lopez about the staff concerns. Relative A stated she had video surveillance of staff entering Resident A's room at 4:30 a.m. on 11/29/24 and scolding Resident A for taking her pajama bottoms off. She stated on 11/19/24 at 5:50 a.m. staff entered Resident A's room for morning care, and she was left uncovered, lying in bed fully exposed while the staff are laughing and talking to each other. Relative A stated she moved Resident A out of the facility on 11/29/24 and Resident A passed away on 12/6/24.

On 12/31/24, I received an email from Relative A providing a photo of a saturated brief dated 11/22/24 at 6:34 a.m. A photo of Resident A lying in bed with just a brief on with two staff at the bed on 11/19/24. Also, a video dated 11/29/24 in which a direct care staff later identified as Tee Brown entering Resident A's room at 4:32 a.m., turning on the lights and Ms. Brown finding Resident A with her pajama pants down around her ankles and stated to Resident A, "What are you doing? Why are you naked? Why are you naked?" Also, a photo of a medication cart that appears to be unlocked and unattended in the hallway of the facility dated 11/24/24 at 7:52 p.m.

On 1/9/25, I made an unannounced onsite inspection at the facility. The administrator Sheilah Readmond stated that Resident A had had several falls at the facility including one that required surgery and a nursing home stay before Resident A returned to the facility. Ms. Readmond stated Relative A then placed a camera in the room on 11/12/24 and both her and the resident care coordinator started getting numerous phone calls regarding issues with staff providing care to Resident A. The resident care coordinator Luis Lopez stated that he was very responsive to Relative A's requests and discussed concerns with staff regarding daily care. He stated that Resident A would often be out of her room for a large portion of the day. He stated staff would toilet Resident in the bathroom outside of her bedroom and Relative A would express concern about her not being toileted because it wasn't done in her room. Mr. Lopez stated Resident A was checked frequently and changed as needed. Mr. Lopez and Ms. Readmond were shown the video from 11/29/24. In the video there is a sitting chair pushed up next to the bed which appears to block Resident A from getting out of bed. Ms. Readmond stated that the chair is not usually in that spot and is back in the corner.

On 2/19/25, I contacted direct care staff Jordan Luckett by telephone. Mr. Luckett stated that several of the staff have pushed the chair up against the bed to stop Resident A from getting out of bed without knowing what they were doing. He stated Ms. Readmond has discussed with the staff that was not appropriate.

On 2/20/25, I contacted direct care staff Tee Brown by telephone. Ms. Brown stated that she was aware of one of the falls Resident A had. She stated it was after Resident A returned to the facility from the nursing home but could not remember the exact date. She stated she came into Resident A's room for an hourly check and Resident A had seemed to have slid out of her wheelchair and was sitting on the floor. Ms. Brown stated Resident A was checked for injuries and was not injured. She stated after this incident hospice had ordered a strap for the wheelchair so she would not slide out of it. Ms. Brown stated the family had requested that Resident A be allowed to sleep in later than 4 a.m. which is when she would start getting residents up from bed. Ms. Brown stated regarding the video on 11/29/24 at 4:30 a.m. that Resident A may have been awake during her bed check which is why she turned on the lights and discovered that her pajamas bottoms were down around her ankle. Ms. Brown stated she asked Resident A why she was naked and Resident A told her that she was hot. Ms. Brown denied being disrespectful to Resident A and was just asking her why she was naked.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	While the complainant was able to furnish pictures of saturated briefs, the timeframe and circumstances around the picture are not verifiable. Therefore, I cannot conclude confidently that the resident was consistently in wet briefs. However, staff purposely prohibiting the resident freedom of movement by placing a chair against the bed is not consistent with the intent of this rule and posed a significant risk of harm to Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident assistive devices were not used properly.

INVESTIGATION:

A stated that when viewing the camera there were several issues witnessed including bed rails not being used properly, bed mattress alarms and chair cushion not secured, the magnet clothing alarm not consistently used and secured, safety belts not used, and wheelchair wheellocks not used.

Ms. Readmond stated that Resident A had several assistive devices including a wheelchair, walker, bed rails and bed alarms. She stated she was not aware of any instances in which the assistive devices were not being used properly. Mr. Lopez stated there were numerous assistive devices being used by Resident A. I then showed them the video of the chair pushed up against the bed below the bed rail that looked like it was being used to restrain Resident A. Mr. Lopez stated that sometimes the magnet alarm would be clipped to the chair so that is the only reason he would think that the chair would be moved to the bottom of the bed area blocking Resident A from being able to get out of bed.

Mr. Luckett stated that several of the staff have pushed the chair up against the bed to stop Resident A from getting out of bed without knowing what they were doing. He stated Ms. Readmond has discussed with the staff that was not appropriate as it could be seen as a restraint.

Ms. Brown stated that a couple days before Resident A left the facility that Relative A had spent the night at the facility and had pushed the sitting chair next to the bed to keep Resident A from getting out of bed. Ms. Brown stated that she thought that was a good idea and her and several other staff continued to push the chair against the end of the bed to prevent Resident A from getting out of bed.

I reviewed the Resident Assessment plan dated 7/30/24. It did refer to Resident A's use of a walker but had no reference to the use of bed rails, bed mattress alarms, magnet clothing alarm, safety belts, and wheelchair wheellocks.

I reviewed Resident A's record and found no physician order for the use of bed rails, bed mattress alarms, magnet clothing alarm, safety belts, and wheelchair wheellocks.

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	During the inspection and while I reviewed video, I witnessed multiple assistive devices provided to Resident A's to ensure her protective needs. Review of Resident A's assessment plan revealed that none of the assistive devices were listed as methods for staff to use to ensure her continued protection from harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Resident A's record did not contain any physician orders authorizing the frequency and safe use of each assistive device.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident medications were not locked.

INVESTIGATION:

Relative A stated while she was at the facility on 11/24/24 that the medication cart was left unattended across the hallway from Resident A's bedroom. Relative A stated she observed medication was left on the cart and a drawer was left open. She stated that the laptop was also open and exposed. Relative A stated she observed a resident near the medication cart but stayed near it until the staff person returned. Relative A stated she did not remember who the staff were that was administering medications. Relative A stated she took a photo of the unlocked cart.

On 12/31/25, I received a photo dated 11/24/24 at 7:52 p.m. in which there is a medication cart in the facility hallway that appears to be unlocked, and the narcotics drawer is halfway open with a laptop and a small cup on the top of the cart.

On 1/9/25, I conducted an unannounced onsite inspection at the facility. I showed the photo of the unlocked medication cart to Ms. Readmond and Mr. Lopez. Ms. Readmond stated that the cart does appear to be unlocked and that is not their practice. Ms. Readmond stated the medication administrators for that day were Jordan Luckett, Deztiny Short, Matthew Trugillo, and Thomas Thompson. Mr. Lopez then brought me to the nurse's station where the medication cart is kept. The medication cart was locked.

On 2/19/25, I contacted direct care staff Jordan Luckett by telephone. Mr. Luckett stated he was the medication passer on the evening of 11/24/24. He stated he did not remember leaving the medication cart unlocked in the hallway. He stated that they have since changed their practice to leave the medication cart in the nurse's station and lock it in between medication administrations.

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 S333.1101 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:	Interviews with Relative A, Ms. Readmond, Mr. Lopez and Mr. Luckett revealed that the medication was not secured and easily accessible on the evening of 11/24/24.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident was not administered medication as prescribed.

INVESTIGATION:

Relative A stated Resident A's medication Risperidone 2mg was not given on 11/19/24, 11/24/24, and 11/25/24. She stated Resident A's Donepezil 10 mg was not given on 11/19/24, 11/24/24, and 11/25/24. She stated Resident A's Memantine 5 mg doses were not given on the evening of 11/19/24, morning of 11/25/24 and evening doses for 11/21/24-11/25/24. Relative A stated Resident A's Zithromax were only given one day and then missed doses 11/23/24-11/27/24. She stated that Resident A's physician ordered Guaifenesin-Codeine 10 mls three times per day for seven days and staff administered 20mls on 11/22/24 in which Resident A became lethargic, hospice was notified, and the medication was discontinued. Relative A stated that Resident A had been prescribed Guaifenesin 10 mls every 6 hours as needed and that staff administered 5 mls as an incorrect dose on 11/20/24 at 9:40 pm, 11/21/24 at 1:38 a.m., 11/21/24 at 5:55 a.m., and 11/21/24 at 1:16 p.m. Relative A also stated that Resident A was ordered Ativan PRN and that Resident A would be observed restless, anxious and agitated but they would not administer the PRN. Relative A stated the medications were ordered to be crushed and they would not always be crushed.

Ms. Readmond stated there was a medication error on 11/22/24 in which Resident A was given 20 mls of Guaifenesin with codeine and had a negative reaction. She stated after looking into the error it was discovered that a previous medication had been prescribed at 20 mls and they contacted hospice and got clarification that the Guaifenesin with codeine was supposed to be at 10 mls. She stated hospice discontinued the Guaifenesin with codeine on 11/23/24. Ms. Readmond then provided me with the medication administration record for November 2025 for Resident A. The missed doses of Risperidone, Memantine, and Donepezil had notes that the facility was out of the medications. Mr. Lopez stated that they had been working with the pharmacy to get the prescriptions filled but there were a couple days when the medications were not administered. Mr. Lopez stated that the Zithromax prescribed on 11/22/24 was given on the first day and then was unable to be found in the medication cart until 11/26/24. He stated when they discovered that the medication was present they contacted the physician who stated to discontinue the medications. I reviewed the medication administration for the Zithromax and it

was documented as administered on 11/22/24 and then noted 11/23/24-11/26/24 that the medication couldn't be found.

Mr. Luckett stated he was the medication administrator on 11/23/24 and 11/24/25 and that he could not locate Resident A's medication for Zithromax in the medication cart but stated that he was told that it was found in the cart on 11/26/25.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Interviews with Relative A, Ms. Readmond, Mr. Lopez, and Mr. Luckett revealed that Resident A's medications were not given pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 1/9/25, while at the facility I requested a copy of Resident A's health care appraisal. Ms. Readmond was not able to find a copy of a completed health care appraisal for Resident A.

On 1/9/25, I received an email from Mr. Lopez who stated they could not find a copy of a completed health care appraisal, so they sent one to her primary care physician who completed one dated 1/9/25.

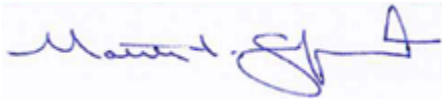
APPLICABLE RULE	
R 400.15301	**; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days

	after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Interviews with Ms. Readmond and Mr. Lopez revealed that a health care appraisal was not completed at admission.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/24/25 I conducted an exit conference with administrator Sheilah Readmond. Ms. Readmond stated she would submit a corrective action plan for approval and has already provided staff educations and implemented several changes within the facility.

IV. RECOMMENDATION

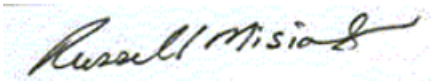
Upon receipt of an acceptable corrective action, I recommend no change in the status of the license.



2/24/25

Matthew Soderquist Date
Licensing Consultant

Approved By:



2/24/25

Russell B. Misiak Date
Area Manager