GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 25, 2025

Lisa Alford
Ashley Court Of Brighton Inc.
7400 Challis Road
Brighton, MI 48116

RE: License #: AL470092981
Investigation #: 2025A0466037
Ashley Court -Bldg # 3

Dear Ms. Alford:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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) 335-5985.

Sincerely,

Julie Elkins

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 #:	AL470092981
Investigation #:	2025A0466037
Complaint Receipt Date:	05/13/2025
Investigation Initiation Date:	05/14/2025
Report Due Date:	07/12/2025
Licensee Name:	Ashley Court Of Brighton Inc.
Licensee Address:	7400 Challis Road Brighton, MI 48116
Licensee Telephone #:	(734) 622-0074
Administrator:	Lisa Alford
Licensee Designee:	Lisa Alford
Name of Facility:	Ashley Court -Bldg # 3
Facility Address:	7400 Challis Road Brighton, MI 48116
Facility Telephone #:	(810) 225-7400
Original Issuance Date:	08/30/2000
License Status:	REGULAR
Effective Date:	06/16/2023
Expiration Date:	06/15/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION:

	Violation Established?
Resident A's medical needs were not met.	No

III. METHODOLOGY

05/13/2025	Special Investigation Intake 2025A0466037.
05/14/2025	Special Investigation Initiated – Letter Licensing Consultant Jennifer Browning.
05/19/2025	APS Referral not required resident is deceased.
06/04/2025	Inspection Completed On-site.
06/04/2025	Exit Conference with Lisa Alford.

ALLEGATION: Resident A's medical needs were not met.

INVESTIGATION:
On 05/13/2025, Complainant reported that a resident was admitted to Ashley Court on 12/12/2024, was sick in January 2025 for a couple weeks and seemed to be in a lot of pain. Complainant reported that she let the nurse know but nothing was done and Resident A continued to get worse. Complainant reported that on 02/03/2025, the facility doctor checked on Resident A and ran tests. Complainant reported that on 02/05/2025, Resident A's physician called and reported Resident A's labs did not look good and the physician thought it was from dehydration. Complainant reported Resident A was sent to the hospital and Resident A's blood sugar measured at 38. Complainant reported Resident A had severe sepsis, influenza A, multiple fractured ribs, a very bad UTI, signs of pneumonia on the x-ray, kidney failure, and a kidney injured from severe dehydration. Complainant reported Resident A should never have gone through all that pain and suffering.

On 05/14/2025, licensing consultant Jennifer Browing contacted Complainant by email and Complainant provided the name of the resident. Complainant reported that she had additional information to provide but never provided any information via email or phone after being instructed to do so by Ms. Browning.

On 06/04/2025, I conducted an unannounced investigation and I interviewed licensee designee Lisa Alford who reported that Resident A is 80 years was admitted to the facility on 12/12/2024 and was discharged on 03/26/2025 to another facility. Licensee designee Alford reported that Resident A was hospitalized from

02/05/2025 through 02/11/2025 at St. Joseph Mercy Hospital and Resident A returned to the facility on hospice care. Licensee designee Alford reported that Resident A had routine lab work done on 02/03/205. On 02/05/2025, Resident A's physician contacted that facility and requested Resident A be taken to the hospital. Licensee designee Alford reported facility direct care staff met all Resident A's medical needs. Licensee designee Alford reported that Resident A never had any change in condition rather Resident A was sent to the hospital on 02/05/2025 per the direction of her physician based on lab results. Licensee designee Alford denied that Resident A was sick in January 2025. Licensee designee Alford reported that Relative A1 contacted Jodi Crow, marketing and admission director, in May 2025 to let her know that Resident A had passed away and Relative A1 requested some paperwork which was provided.

I interviewed Lori Napier, registered nurse (RN), director of health and wellness who reported that Resident A was not a good eater nor would she drink fluids. RN Napier reported that this was a baseline behavior and her family was aware of this as they reported that she did not eat well prior to being admitted. RN Napier reported that Resident A would pull hair from the top of her head and she had bald spots from that, and she would pick at scratches, so they tried putting mittens on her hands to address these were baseline behaviors. RN Napier reported that she discussed these behaviors with Relative A1 who reported that she was aware of these behaviors as Resident A has always been that way. RN Napier reported that since Resident A's admission getting her to eat and drink was a struggle. RN Napier denied that Resident A was sick in January 2025. RN Napier reported that Resident A never had any change in condition and her only hospitalization was from 02/05/2025 through 02/11/2025 when her physician took routine lab work on 02/03/2025 and then wanted her seen at the hospital after the results of the lab work were received. RN Napier reported that she was surprised when Resident A moved out of the facility on 03/26/2025. RN Napier reported that the facility met Resident A's medical needs and followed all physician orders.

I reviewed Resident A's *Assessment Plan for Adult Foster Care (AFC) Residents* (assessment plan) which documented that she required assistance with toileting, bathing, grooming, dressing and personal hygiene. The assessment plan documented that Resident A was able to feed herself and ambulate independently. Resident A's *Assessment Plan for AFC Residents* documented that Resident A "does not know where she is. Used to say she wants to go home." In the "diet" section of the report it stated, "diabetic on metformin, sugar free, loves bananas and meatloaf." In the "assistive devices" section of the assessment it stated, "has a cane, walker and wheelchair but never uses it."

Resident A's *Health Care Appraisal* completed on 11/27/2024 documented that she was 5'3" tall and weighs 173 pounds.

I reviewed an *AFC Licensing Division Incident/Accident Report* that was dated 02/05/2025 at 3:10pm and signed by licensee designee Alford. In the "explain what

happened" section of the report it stated, "Dr. Allision called and advised that resident needs to be sent to the hospital due to extremely abnormal lab results (kidney). POA was on cite and aware of the situation." In the "action taken by staff" section of the report it stated, "POA advised that she would like her transported to St. Joe's Howell. Transported by EMS at 4:05pm."

I reviewed *IHA Hospital Medicine History and Physical* which stated under the chief complaint stated "AKI (acute kidney injury). Under the history of present illness it stated, "80 y.o.female with dementia, CAD, hypothyroidism, afib, CVA, DM2 and hypertension presenting with abnormal labs from her AFC home. She has been having decreased oral intake and decreased urine output. She is unable to provide any history due to her dementia which is baseline. Family was no longer present bedside therefore history obtained from RN and chart review. She has not been having diarrhea, no vomiting, no cough, congestion or difficulty breathing."

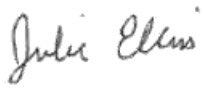
I reviewed Resident A's *Discharge Summary* that was dated 02/11/2025 which documented "home with hospice. Follow up items for PCP, monitor repeat labs/adjust meds as needed."

Resident A could not be interviewed as she was discharged from the facility on 03/26/2025 and passed away at another facility in May 2025.

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:	Licensee designee Alford and RN Napier both reported that Resident A never had any change in health condition, Resident A was hospitalized per the direction of her physician based on lab results. There is not enough evidence to support that Resident A's medical needs were not met nor is there any evidence to support that Resident A had a change in condition that was not addressed therefore a violation has not been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend no change in license status.



06/24/2025

Julie Elkins Date
Licensing Consultant

Approved By:

06/25/2025

Dawn N. Timm Date
Area Manager