STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

September 20, 2021

Diane Vondette
Tender Care of Michigan, LLC
4130 Shrestha Drive
Bay City, MI 48706

RE: License #: AH090371811
Investigation #: 2021A1019052

Dear Ms. Vondette:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 authorized representative and a date.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH090371811
Investigation #:	2021A1019052
Complaint Receipt Date:	08/26/2021
Investigation Initiation Date:	08/26/2021
Report Due Date:	10/25/2021
Licensee Name:	Tender Care of Michigan, LLC
Licensee Address:	4130 Shrestha Drive Bay City, MI 48706
Licensee Telephone #:	(734) 355-6050
Administrator:	Elyse Al-Rakabi
Authorized Representative:	Diane Vondette
Name of Facility:	Bay City Comfort Care, LLC
Facility Address:	4130 Shrestha Drive Bay City, MI 48706
Facility Telephone #:	(989) 545-6000
Original Issuance Date:	10/24/2016
License Status:	REGULAR
Effective Date:	04/24/2021
Expiration Date:	04/23/2022
Capacity:	67
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A’s falls aren’t reported to her family.	No
Improper medication administration procedures.	Yes
It is unknown when Resident A showers.	No
Resident A’s laundry is not getting done timely.	No
Menu alternatives are not available, and food is served cold.	No
Facility staff are not cleaning Resident A’s room.	No
Additional Findings	No

III. METHODOLOGY

08/26/2021	Special Investigation Intake 2021A1019052
08/26/2021	Special Investigation Initiated - Letter Notified APS of the allegations via email referral template.
08/26/2021	APS Referral
08/30/2021	Contact - Telephone call made Call placed to complainant, interview conducted.
09/09/2021	Inspection Completed On-site
09/09/2021	Inspection Completed-BCAL Sub. Compliance
09/20/2021	Exit Conference

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Resident A's falls aren't reported to her family.

INVESTIGATION:

The complainant stated that falls have occurred, but facility staff have neglected to inform Resident A's family. The complainant did not provide dates of when falls occurred without notification.

On 9/9/21, I conducted an onsite inspection. I interviewed administrator Elyse Al-Rakabi at the facility. Ms. Al-Rakabi stated that Resident A's family is very involved in her care and that her two daughters are co-powers of attorney (POA). Ms. Al-Rakabi stated that facility staff are informed to notify one or both of the daughters of any reportable incident, including falls. Ms. Al-Rakabi stated that Resident A is independent with mobility and ambulation and it is possible that she has fallen without staff's knowledge.

Ms. Al-Rakabi provided incident reports and staff chart notes. Incident reports reviewed identified that Resident A had a fall on 8/16/21and 8/24/21. Both incident reports identified that one or both POAs were notified. Chart notes reviewed also listed a fall on 8/7/21. The note read "All parties were contacted. Primary POA VM was full".

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.

ANALYSIS:	Review of incident reports and chart noting reveal Resident A's family was contacted after the documented falls. Given that Resident A ambulates independently, there could have been times where she has fallen without staff knowledge.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Improper medication administration procedures.

INVESTIGATION:

The complainant stated that loose pills have been found on the ground in Resident A's room four times and brought to the attention of staff. The complainant could not provide dates that this occurred on.

Ms. Al-Rakabi stated that there were two occasions (roughly about two months ago) that she was notified of medication being found in Resident A's room. Ms. Al-Rakabi stated that one of the pills was partially dissolved and appeared to have been spit out by the resident. Ms. Al-Rakabi stated that a whole pill was found on another occasion, but it was not identified. Ms. Al- Rakabi stated that staff are taught to observe the resident swallow the medication as part of their training, and they receive constant reminders of this.

While onsite, I interviewed Relative A who was visiting Resident A. Relative A stated that she was informed by another relative that pills were found on the ground while vacuuming Resident A's room. Relative A stated that there have been multiple times when she has been on the phone with Resident A and "could tell" staff brought the medication to her and walked out of the room without observing her take it. Relative A stated recently that a male staff member came in and dropped Tylenol off in Resident A's room. Relative A stated that Resident A was in the bathroom at the time and placed the medication on top of her walker tray and left. Relative A stated that the incident occurred around 1:00pm

Review of Resident A's medication administration record (MAR) for September 2021 was received. Resident A has a prescription for Tylenol to be administered "every four hours as needed for pain". The MAR revealed only one administration of the medication, which occurred on 9/7/21 at 1:30pm documented as administered by staff Tanner Vaillancourt. Ms. Al-Rakabi stated that the Tylenol incident was not brought to her attention, however she was in the process of writing Mr. Vaillancourt up for a similar situation that occurred on 9/9/21. On 9/14/21, Ms. Al-Rakabi provided the employee corrective action for Mr. Vaillancourt that read "While in the dining room, resident had 2 med cups full of meds & no med passer around to watch

resident take medication accordingly. You have already received a verbal warning on this matter."

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	While the facility has a training protocol that includes observation of the resident taking the medication, it could not be demonstrated that this always occurred as evidenced by loose pills being found and the witnessed accounts from Relative A and Ms. Al-Rakabi.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

It is unknown when Resident A showers.

INVESTIGATION:

The complainant stated that the facility is not providing Resident A with the necessary assistance during showers and that they do not keep track of when she showers. The complainant stated that there are times when Resident A's family provides the showers and that Resident A showers on her own without staff.

Ms. Al-Rakabi stated that Resident A receives stand by assistance with showers and is on the shower schedule twice weekly. Ms. Al-Rakabi acknowledged that there are times when Resident A's daughter completes bathing tasks for her. Ms. Al-Rakabi stated that Resident A is independent with mobility and ambulation (with a walker) and will at times, shower herself and not notify facility staff. Ms. Al-Rakabi stated that if Resident A showers herself without notifying staff and she is not directly seen by staff, it would be difficult to know it occurred. Ms. Al-Rakabi stated that even if Resident A showered herself, staff will still provide shower assistance to her twice weekly.

Ms. Al-Rakabi stated that facility staff document when showers are completed and will notate when Resident A's family assist with bathing her. Review of the facility's shower log for the previous five weeks revealed showers on the following dates:

9/7/21, 9/3/21, 8/31/21, 8/27/21, 8/24/21, 8/20/21, 8/17/21,8/10/21, 8/6/21 and 8/3/21. Staff documented that Resident A refused a shower on 8/13/21.

Resident A's service plan reads:

> Resident will shower on her own and will not ask for assistance. Staff remind resident that she needs to ask for the assistance. Family will also assist with showers when they are here. Resident also will shower multiple times a day and not remember she took a shower. Staff are to track self showers by chart noting.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Staff documentation established that Resident A bathes at least weekly as this rule requires.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's laundry is not getting done timely.

INVESTIGATION:

The complainant stated that Resident A is often seen in dirty clothing and alleged that her sheets are not changed weekly.

Ms. Al- Rakabi stated that each resident is assigned two laundry days weekly. Ms. Al-Rakabi stated that laundry can be done more frequently as needed. Ms. Al-Rakabi stated that Resident A can dress herself and stated that she does at times, put on clothing that is soiled. Ms. Al-Rakabi stated that they will provide reminders and prompting to Resident A when this occurs, but ultimately cannot force her to change her clothing.

While onsite, I observed that Resident A's clothing was clean and the clothing hung up in her closet appeared to be laundered. Resident A's dirty clothes hamper was not found in her room, which Ms. Al-Rakabi stated meant that her clothing was being

laundered at that time. Ms. Al-Rakabi stated that one of Resident A’s daughters approached her with concerns that the sheets weren’t being changed. Ms. Al-Rakabi stated that the daughter reported to have put tape on her sheet and noticed that the tape was still present some time later. Ms. Al-Rakabi stated that staff are not required to document when laundry is completed and she is unsure what happened in that specific instance but has since required that staff come to her and physically show her when Resident A’s sheets are changed. Ms. Al-Rakabi stated that she has scheduled a reoccurring calendar reminder twice weekly for this task to be completed.

Resident A’s service plan reads that laundry is to be completed at least weekly and reads that the resident can select her own clothing and dress/undress herself with occasional reminders or staff supervision. The service plan also acknowledges that Resident A will wear dirty clothing that she has taken out of her hamper and that staff are to prompt her to change when that occurs.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(1) Bedding shall be washable, in good condition, and clean, and shall be changed at least weekly or more often as required. **(3) The home shall make adequate provision for the laundering of a resident's personal laundry.**
ANALYSIS:	The facility demonstrated that there is scheduled laundry protocol in place. Direct observation of Resident A and the clothing in her closet reveal the clothing items were clean and laundered. Additionally, Resident A’s service plan identifies that she independently dresses and will sometimes wear dirty clothing out of her hamper. Given this fact, if Resident A is observed in dirty clothing it cannot be assumed that the facility is not washing her clothing and could be attributed to Resident A herself having chosen to wear a soiled article of clothing.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Menu alternatives are not available, and food is served cold.

INVESTIGATION:

The complainant stated that there are times when menu choices run out and alternatives are not provided to Resident A. The complainant alleged that in these cases, Resident A will only be served a peanut butter and jelly sandwich. The complainant also stated that when food is brought to Resident A's room it is cold.

Ms. Al-Rakabi stated that she is unaware of a time when the facility has run out of menu choices, however stated that if a resident does not like what it on the menu there are always alternative options.

Ms. Al-Rakabi provided a copy of the facility menu, where a variety of meal options were observed. The menu listed daily alternatives as grilled cheese, egg salad and peanut butter & jelly sandwich. Ms. Al-Rakabi stated that soups, salads and sandwiches are always available upon request as well as any leftovers from the previous day.

Ms. Al-Rakabi stated that dietary staff record food temperatures prior to serving. Review of that *Daily Food Temp* log for the previous five weeks revealed overall consistent temperatures as recommended by U.S. Department of Agriculture. Ms. Al-Rakabi stated that when room trays are served for residents who choose not to go down to the dining room, the hot food is covered in saran wrap and a metal topper is placed over the dish to keep the heat trapped inside. Ms. Al-Rakabi stated that Resident A typically attends meals in the dining room, except for when she has visitors.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	Facility menus were reviewed which contained alternate meal choices. Additional documentation provided demonstrated meal temperatures are recorded before each meal is served.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility staff are not cleaning Resident A's room.

INVESTIGATION:

The complainant stated that Resident A's room is filthy and stated that staff have told her they are not responsible for cleaning Resident A's room.

Ms. Al-Rakabi stated that staff are responsible for cleaning Resident A's room and is unaware why anyone would report to the complainant that it is not the facility's responsibility. Ms. Al-Rakabi stated that the facility has a housekeeper three days per week and she conducts deep cleans on the resident rooms at that time. Ms. Al-Rakabi provided a cleaning list for each resident room which identifies the following tasks for housekeeping:

Bathroom

- Toilet scrubbed
- Bathroom sink and table top
- Bathroom shelves are straightening [sic] up, empty products are thrown away
- Shower is cleaned
- Bathroom floor is scrubbed
- Wipe mirror

Closet

- Clothing is placed on the hangers
- Dirty clothes are placed in the hamper
- Closet shelve [sic] is below the red line

Kitchenette

- Old food is thrown out
- Unnecessary products in drawers are thrown out
- Any facility dishes removed
- Sink is scrubbed down
- Countertop is wiped down
- Check refrigerator for old food if needed

Living Area

- Bed is made (sheets are changed if needed)
- Bedside table is cleaned up (old food, napkins, unnecessary items throw out)
- All countertops wiped down
- Vacuumed
- Wipe down windowsill for bugs

Ms. Al- Rakabi stated that care staff also complete light cleaning tasks in between the weekly deep cleans by housekeeping, typically completed on the resident's assigned shower days. Ms. Al-Rakabi stated that housekeeping staff do not

document their services, but care staff document when they complete the light cleaning tasks. Review of the 2nd *Shift Room Clean* report for the previous five weeks revealed staff documented this task was completed on 9/7/21, 9/3/21, 8/31/21, 8/27/21, 8/24/21, 8/20/21, 8/17/21, 8/13/21, 8/10/21, 8/6/21 and 8/3/21.

While onsite, I went into Resident A's room. I observed that the room and bathroom was neat and orderly. Resident A's clothes were all hung up in her closet, the garbage receptacles were not full, no dirty dishes were present in the sink and no crumbs or dust were observed on the hard surfaces.

Resident A's service plan reads that housekeeping services will be completed on a weekly basis.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	The facility demonstrated a scheduled cleaning protocol and direct observation of Resident A's room/bathroom revealed that it was clean and in good condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 9/20/21, I shared the findings of this report with authorized representative Diane Vondette. Ms. Vondette verbalized understanding and did not have any additional questions.

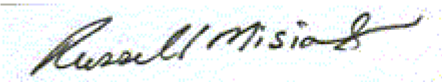
IV. RECOMMENDATION

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

9/15/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



9/15/21

Russell B. Misiak Date
Area Manager