GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 12, 2022

Diane Vondette
Shields Comfort Care
9140 Gratiot Rd
Saginaw, MI 48609

RE: License #: AH730395008
Investigation #: 2022A0585038
Shields Comfort Care

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. 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.

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 #:	AH730395008
Investigation #:	2022A0585038
Complaint Receipt Date:	03/08/2022
Investigation Initiation Date:	03/09/2022
Report Due Date:	05/07/2022
Licensee Name:	Shields Comfort Care LLC
Licensee Address:	9140 Gratiot Rd. Saginaw, MI 48609
Licensee Telephone #:	(989) 607-0003
Administrator:	Danille Conway
Authorized Representative:	Diane Vondette
Name of Facility:	Shields Comfort Care
Facility Address:	9140 Gratiot Rd Saginaw, MI 48609
Facility Telephone #:	(989) 607-0003
Original Issuance Date:	12/18/2019
License Status:	REGULAR
Effective Date:	06/18/2021
Expiration Date:	06/17/2022
Capacity:	65
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's locked himself in the bathroom and was discovered slumped over deceased with pills found on the floor.	No
Additional Findings	Yes

III. METHODOLOGY

03/08/2022	Special Investigation Intake 2022A0585038
03/09/2022	Special Investigation Initiated - Letter Emailed referral to Adult Protective Services (APS).
03/16/2022	Inspection Completed On-site Completed interview and record review.
05/12/2022	Exit conference Conducted with authorized representative Diane Vondette.

ALLEGATION:

Resident A's locked himself in the bathroom and was discovered slumped over deceased with pills found on the floor

INVESTIGATION:

On 3/7/2022, incident report with an attachment was received from the administrator Danille Conway. The incident read, "On 3/6/2022 at approximately 6:00 p.m., Resident [A] was in his bathroom with his door locked. Staff asked resident to assist with bathroom needs and resident refused. Approximately 6:30 p.m., Resident [A] was still in the bathroom with his door locked, Resident [A] was still in his bathroom with his door locked. Resident [A] refused any assistance and stated, fuck off. At 7:15 p.m., staff made decision to open resident's bathroom door with master key. Resident [A] found in wheelchair in the bathroom slumped over-nonresponsive, number of pills found on the floor. At 7:16 p.m., staff called for supervisor, pulse checked none, CPR initiated. 911 called, attempted to reach POA with no success. 7:21 p.m., management called. 7:46 p.m., spoke to family member who stated, that

they are aware that he had meds in his room. Med was identified as Carbidopa/levodopa. Bottle was identified as filled at Walmart Pharmacy."

On 3/16/2022, an onsite was completed at the facility. I interviewed Ms. Conway. She stated that they had no indication that this would happen. She stated that Resident A was only at the facility for a week. She stated that staff did not know he had the Carbidopa/levodopa (treat Parkinson) pills. She stated that it was found in the drawer of his bathroom, but they did not know how long it had been there. She stated, Resident A was on two-hour checks. She stated that the facility had a script for the carbidopa/levodopa and don't know where the family got the other script from.

On 4/1/2022, I interviewed medication technician Monica Garcia by telephone. She stated that Resident A was checked on around 5:15 p.m. because that was after dinner. She stated that she gave Resident A his 3:00 p.m. medication and at that time he seemed fine.

4/1/2022, I interviewed, caregiver Antinesha Crayton at the facility. Ms. Crayton stated Resident [A] is checked on every two hours. She stated that at 6:00 p.m., she went to his room and discovered that Resident [A] was in the bathroom with the door locked. She stated that she asked Resident [A] if he needed assistance with his bathroom needs and he refused. She stated that she went back at 6:30 p.m. and Resident [A] was still in the locked bathroom and refused help again and told her to "fuck off". She stated that she left Resident [A] and went to get the master's key because she felt something was "off". She stated that when she opened the door with the master's key, she found Resident [A] slumped over in his wheelchair. She stated that the pills were found on the floor, and she didn't know how many Resident [A] had taken. She stated that the pills Resident [A] had were hidden from them because they never seen them when they were in the room. She stated Resident [A] was "really grumpy" earlier, but she did not think anything about it.

Resident A's service plan read, "admitted to the facility on 2/24/2022, with diagnoses that includes anxiety, debility, hypertension, Parkinson's disease, history of alcohol abuse, personal history of non-compliance with medical treatment and sleep apnea syndrome. In the section marked *Family Support* it reads, Resident has history of seeking drugs and alcohol from son. Resident is to not to have unsupervised visits from son. In the section marked *Medication Management*, reads, pharmacy will deliver all meds, according to an agreed-upon schedule, after coordinating with the facility.

Ms. Conway emailed me a copy of Resident A's death certificate which read, cause of death was from natural causes.

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: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	This was an unfortunate incident. The facility had no way of knowing that Resident A had pills in his room. Staff checked on Resident A every two hours. The cause of death on the certificate list the cause as cardiovascular disease with manner of death as natural. Therefore, the facility reasonably complied with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Ms. Garcia stated that when she took Resident A his 3:00 p.m. medication and he didn't want to take it then. She explained that Resident A told her to leave the medicine and he will take it later with his dinner. She stated that she left the pills with him, and she left the room.

Resident A's service plan in the section *Medication Management* it reads, staff to ensure resident takes all medication and writes detailed documentation/notes.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	Medication was left with Resident A. Staff did not wait to ensure that Resident A took his medication. The facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/12/2022, I conducted an exit conference with licensee authorized representative Diane Vondette by telephone.

IV. RECOMMENDATION

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

Brender L. Howard 05/12/2022

Brender Howard Date
Licensing Staff

Approved By:

Andrea L. Moore 05/11/2022

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