GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Kory Feetham
Tender Care of Michigan, LLC
4130 Shrestha Drive
Bay City, MI 48706

December 1, 2022

RE: License #: AH090371811
Investigation #: 2022A1022021
Bay City Comfort Care, LLC

Dear Kory Feetham:

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 authorized representative 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.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

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

I. IDENTIFYING INFORMATION

License #:	AH090371811
Investigation #:	2022A1022021
Complaint Receipt Date:	08/17/2022
Investigation Initiation Date:	08/17/2022
Report Due Date:	09/16/2022
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:	Kory Feetham
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:	04/24/2022
Expiration Date:	04/23/2023
Capacity:	67
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) did not receive appropriate personal care. She was found in a soiled and wet incontinence brief.	No
The facility did not have enough caregivers to ensure that residents received appropriate care.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/17/2022	Special Investigation Intake 2022A1022021
08/17/2022	Special Investigation Initiated - Telephone Spoke with complainant by phone
09/01/2022	APS Referral
09/01/2022	Inspection Completed On-site
09/02/2022	Contact - Telephone call made Spoke to a family member
11/09/2022	Contact - Telephone call made Additional information received from the administrator
12/01/2022	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) did not receive appropriate personal care. She was found in a soiled and wet incontinence brief.

I**NVESTIGATION:**

On 8/17/2022, the Bureau of Community and Health Systems received a complaint that read "… [Name of complainant] saw [name of the Resident of Concern (ROC)], a resident at the facility. When [name of complainant] arrived, [name of the ROC] was sitting in her wheelchair completely saturated in urine through her clothing. Her face was covered in food as well as her clothing. [name of the ROC]'s hands were so sticky, [name of complainant] had to pry them apart. [Name of the ROC] was very smelly from the urine and food. Her wheelchair was saturated in old food…"

On 8/17/2022, I interviewed the complainant by phone. The complainant stated that she was employed by the hospice agency contracted to provide hospice services to the ROC and was very distressed to find her patient, the ROC, in the condition that she described in her initial complaint. The complainant attributed the lack of care as evidenced by the ROC's condition to inadequate staffing levels in the facility. According to the complainant, the ROC lived in the Memory Care (MC) unit of the facility and was completely dependent on staff for the completion of activities of daily living (ADLs). The ROC moved out of the facility on 8/15/2022 and had expired on 8/16/2022, at her home.

The complainant further identified a number of concerns related to infection control procedures that are not addressed in licensing rules and statutes for a home for the aged. Those allegations were not considered in this investigation.

On 9/1/2022, a referral was made to Adult Protective Services.

On 9/1/2022, during the onsite visit, I interviewed the administrator. According to the administrator, care staff were to provide care as indicated on each resident's service plan and then document that the care was provided to the resident on their respective administration records. The ROC's service plan documented that she was "toileting-moderate," with "X1 person assist," wore incontinent briefs "24/7" and was "placed on the toileting program assist with toileting every two hours or as needed…" Review of the ROC's ADLs administration record indicated that the ROC had received "1X person assist for all toileting needs" every two hours from 7/1/2022 to 8/15/2022, as documented on the record.

At the time of the onsite visit, I interviewed two residents, Resident A and Resident B, both who were alert and oriented but due to physical limitations were incontinent and dependent on staff for incontinence care. When asked about incontinence care, neither Resident A nor Resident B felt that the care was insufficient. On 9/2/2022, I interviewed the family member of Resident C by phone. Resident C, who was also incontinent, resided on the MC unit and was unable to speak for herself. According to Resident C's family member, "incontinence care is spotty." The family member went on to say that between herself and other members of Resident C's family there was almost always one of them in the facility to help provide care to Resident C, so they just "took care of it."

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(1) A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan.
ANALYSIS:	The facility had documentation that the care was appropriately provided.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not have enough caregivers to ensure that residents received appropriate care.

INVESTIGATION:

According to the complainant, “The caregiver, by the name of [name of caregiver], began crying saying that she has made complaints to the owners about the care and being understaffed. [Name of caregiver] stated how overwhelmed she was working alone.”

At the time of the onsite visit, the administrator stated that the care staff worked 8-hour shifts. Since all of the caregivers were trained to pass medications, medication passers were not scheduled separately from caregivers. According to the administrator, optimal scheduling was 5 caregivers on the day shift; 5 on the afternoon shift; and 4 on the midnight shift. For the MC unit, there was always at least 1 caregiver scheduled. At the time of the onsite visit, the administrator reported the census of the MC unit to be 8 residents.

At the time of the onsite visit, when Resident A and Resident B were asked if the facility was understaffed and their caregivers were overworked, neither resident thought so. Both Resident A and Resident B resided in the general assisted living portion of the facility. When the family member of Resident C was asked about staffing in the MC unit, she stated that frequently the facility was short-staffed, especially on weekends. The family member went on to say that the staff were frequently mandated overtime, so they began to get frustrated and quit their jobs. “Turnover is tremendous,” she said.

The administrator submitted a staffing sheet that was to document all employees working the week of 7/31/2022 through 8/6/2022, all three shifts. The staffing sheet

revealed that for 7/31/2022, there was no staff assigned to the MC unit for the afternoon or the overnight shifts; for 8/1/2022, there was no staff assigned to the MC unit for the afternoon or the overnight shifts; for 8/2/2022, there was no staff assigned to the MC unit for the afternoon shift; for 8/5/2022, there was no staff assigned to the MC unit for the afternoon shift; and for 8/6/2022, there was no staff assigned to the MC unit for the morning shift. Additionally, for the overnight shifts of both 7/31/2022 and 8/5/2022, there were only 3 caregivers scheduled, including the shift supervisor. When the administrator was asked about the shortfall of staffing on the affected shifts, she stated that “it clearly states in our handbook that we can make adjustments as deemed fit. So, if 4 and 2 are scheduled for 100 hall, one of those caregivers are going back to memory for it to have the coverage it needs.”

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The administrator expected one of the care staff to voluntarily taken on all care on the MC unit in addition to whatever other tasks they had already been assigned. The administrator was unable to show that this had happened.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Initial review of the facility’s staffing sheet for the week of 7/31/2022 through 8/6/2022 indicated there were several shifts that fell far short of the staffing numbers the administrator had described as the facility’s standard. When this was first brought to her attention, she said, “That is one of the downsides to the current scheduling app we use. Once a staff quits, shifts that are picked up disappear because they fall into a different category. We are in the process of switching systems.” The administrator then marked-up the staffing sheet with some additional information she said came from her payroll book. When it was pointed out that Administrative Rule required the facility to maintain documentation to show the staff who actually worked, the administrator stated that she had been informed by the usually assigned Home for the Aged Health Care Surveyor that “as long as I have schedule where the hours are covered, even written in, it was fine.”

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(2) The home shall prepare a work schedule showing the number and type of personnel scheduled to be on duty on a daily basis. The home shall make changes to the planned work schedule to show the staff who actually worked.
ANALYSIS:	The adjusted schedule was not established on the dates the schedule was supposed to document, but only retrospectively when the administrator was asked to present it. There was no way to verify this document.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 12/1/2022. When asked if there were any comments or concerns with the investigation, the AR stated that he did not.

IV. RECOMMENDATION

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

12/01/2022

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

11/21/2022

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