GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

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

October 12, 2023

RE: License #: AH090371811
Investigation #: 2023A1022011
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.

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
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH090371811
Investigation #:	2023A1022011
Complaint Receipt Date:	11/04/2022
Investigation Initiation Date:	11/07/2022
Report Due Date:	01/04/2023
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:	04/24/2023
Expiration Date:	04/23/2024
Capacity:	67
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

The complainant identified concerns that are not related to or addressed in 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.

	Violation Established?
The facility does not have sufficient staffing.	Yes
Residents receive inadequate incontinence care.	No
A resident with pressure sores did not receive repositioning.	No
The facility does not keep enough resident care supplies on hand.	No

III. METHODOLOGY

11/04/2022	Special Investigation Intake 2023A1022011
11/07/2022	Special Investigation Initiated - Telephone No answer when called; left message to return call
02/02/2023	APS Referral
02/02/2023	Inspection Completed On-site
05/02/2023	Contact - Document Received Information exchanged with the facility via email.
10/12/2023	Exit Conference

ALLEGATION:

The facility does not have sufficient staffing.

INVESTIGATION:

On 10/23/2022, the Bureau of Community and Health Systems (BCHS) received a complaint that read, “I recently got a job at this facility and only worked there for 3 days. They are neglecting all of their residents, the staff does not care about the residents or seem to even see them as human beings. The management does not care about the facility, staff, or their residents. They are doing nothing to help. They are very short staffed. For example in memory care they only ever have one staff member with 9 dementia residents.”

On 11/7/2022, I interviewed the complainant by phone. The complainant reiterated her allegations that the facility did not have enough caregivers. The complainant stated that there was only one caregiver available to transfer from his chair into his bed, but that the resident required a 2-person transfer.

At the time BCHS received the complaint, the facility was not in compliance with R 325.1931(5), requiring sufficient staffing. On 12/13/2022, BCHS received an acceptable Corrective Action Plan for the violation. The facility verified that compliance was achieved by 1/3/2023.

On 2/2/2023, a referral was made to Adult Protective Services.

On 2/2/2023, during the onsite visit, I interviewed the administrator and the wellness director. The administrator stated that the facility had slightly reduced the number of caregivers in the building because the resident population was now more independent in their respective abilities and did not need as much physical assistance. According to the administrator, optimal staffing was now 5 caregivers on the 7 am to 3 pm AM shift, 4 caregivers on the 3 pm to 11 pm PM shift, and 3 caregivers on the 11 pm to 7 am overnight shift. There were to always be at least 1 caregiver assigned to the memory care unit from the total number of caregivers per shift.

Review of the staffing attendance for 01/22/2023 through 01/28/2023 revealed:

01/22/2023:
7 am to 3 pm, the AM shift: 3 caregivers
3 pm to 11 pm, the PM shift: 3 caregivers until 6 pm, 2 caregivers from 6 pm to 11 pm.
11 pm to 7 am, the overnight shift: 3 caregivers

01/23/2023:
7 am to 3 pm, the AM shift: 4 caregivers
3 pm to 11 pm, the PM shift: 3 caregivers until 6 pm; 4 caregivers from 6 pm to 11pm
11 pm to 7 am, the overnight shift: 3 caregivers

01/24/2023:
7 am to 3 pm, the AM shift: 4 caregivers
3 pm to 11 pm, the PM shift: 3 caregivers until 6 pm and 4 caregivers from 6 pm to 11 pm
11 pm to 7 am, the overnight shift: 2 caregivers

01/25/2023:
7 am to 3 pm, the AM shift: 3 caregivers
3 pm to 11 pm, the PM shift: 5 caregivers
11 pm to 7 am, the overnight shift: 3 caregivers

01/26/2023:
7 am to 3 pm, the AM shift: 4 caregivers
3 pm to 11 pm, the PM shift: 4 caregivers
11 pm to 7 am, the overnight shift: 3 caregivers

01/27/2023:
7 am to 3 pm, the AM shift: 4 caregivers
3 pm to 11 pm, the PM shift: 3 caregivers
11 pm to 7 am, the overnight shift: 3 caregivers

01/28/2023:
7 am to 3 pm, the AM shift: 4 caregivers
3 pm to 11 pm, the PM shift: 4 caregivers until 6 pm and 3 caregivers from 6 pm to 11pm
11 pm to 7 am, the overnight shift: 2 caregivers

At the time of the onsite visit, I made observations of Resident B, who required a 2-person transfer from chair to toilet. Resident B lived on the memory care unit, where only caregiver #1 was present to provide care. When I asked the administrator how caregiver #1 would get Resident B back into her chair, the administrator stated that caregiver #1 had been issued a “walkie-talkie” and that she would call for help when needed.

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:	Although the administrator initially stated that the optimal number of caregivers scheduled for the 7 am to 3 pm AM shift was 5, none of the AM shifts reviewed had 5 caregivers working. There were 2 overnight shifts where only 2 caregivers present. When the administrator was asked to explain these staffing numbers that were less than optimal, she replied (by email on 5/2/2023) that on Saturday, 1/28/2023, she came into the facility during the overnight shift to help. Additionally, “from 1/23-1/27, management is here until 5:00-6:00 pm to help if needed.” The facility did not have adequate staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents receive inadequate incontinence care.

INVESTIGATION:

According to the complaint received, “When bringing residents to dinner I was told not to change them, we would literally have to leave people sitting in their urine and feces for hours because the staff said "we have to change them after dinner anyway"… They use Quick Mar (an electronic health information record keeping system) for documentation there and they hardly do any of the ADL's (activities of daily living) but they mark them off in the system at the end of the night anyway. People lie on (the) Quick Mar and are not putting (in) accurate information…” When interviewed, the complainant reiterated these concerns about incontinence care.

At the time of the onsite visit, Resident A, Resident B and Resident C were all observed for incontinence care, one right after the other from about 10:50 am until about 11:05 am. According to the wellness director, residents were to be checked and changed for incontinence at about 8 am and again at 10 am. All three of the residents had minor wetness in their respective incontinence briefs.

Resident C’s Quick MAR was reviewed. There was no documentation that care of any kind, including incontinence care had been provided to her. When asked about the lack of documentation in the Quick MAR, the wellness director explained that it was not a concern to her. According to both the wellness director and the administrator, care staff members could do their documentation when they had the time to do it, even if it was done at the end of their shift.

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:	Direct observation indicated that adequate incontinence care was being provided.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A resident with pressure sores did not receive repositioning.

INVESTIGATION:

According to the complaint received, “My second day working there a resident passed away from having such severe bed sores because the staff had not been taking care of him or turning him every two hours.” When interviewed, the complainant supplied a first name of a resident with pressure sores who was not turned by staff.

At the time of the onsite visit, when the wellness director was asked about residents who had pressure sores, the administrator gave the name of Resident D, whose first name matched the name given by the complainant. The wellness director then said that Resident D’s pressure sore areas were “healed” before his death, but at the time of death, Resident D had an “ulcer” in his rectum. Review of Resident D’s Progress Notes indicated that Resident D had long standing wounds to his groin and perineal area as well as a complex medical history that included hydrocephalus, diabetes, and encephalopathy. Documentation provided by the facility dated back to August 2021. On 8/18/2022, Progress Notes from the Home Health Care nurse documented, “D/C (discharge) from home care today. Wound remains closed.” After an admission to a local hospital for treatment for sepsis at the end of August 2022, Resident D was noted to have skin impairment of the buttock on 9/9/2022. On 9/16/2022, the health care provider ordered wound care for a rectal fistula (anal abscess). Resident D was admitted to hospice care on 10/3/2022 and passed away on 10/21/2022.

When the wellness director was asked if there any current residents with pressure sores, the wellness director identified Resident B, Resident C and Resident E. Resident B was not kept in bed but was up in a wheelchair in the memory care unit

for a significant part of the day. Resident C, who was enrolled in a day treatment program, was out of the building one time weekly and was seen by the day treatment staff at least one other day each week. Resident E was alert and able to make his needs known. His pressure wounds were heeling. He had been a hospice patient, but "graduated" out of the program. At the time of my visit, he was in bed, but stated that the staff got him up on a regular basis.

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:	While it was not possible to verify the care that had been provided to Resident D, there was no evidence that current residents were not being gotten out of bed or turned.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility does not keep enough resident care supplies on hand.

INVESTIGATION:

According to the complaint received, "They are lacking supplies, staff literally told me to stop wiping and cleaning up a lady because we did not have enough wipes."

When the administrator was asked about incontinence supplies, she stated that the facility did not provide any incontinence supplies other than gloves. If an individual resident was there on a "Medicaid waiver," or other specialized program such as the Michigan Program of All-Inclusive Care for the Elderly (PACE), and the health care provider ordered incontinence care, the individual would receive wipes and briefs from a medical supply company. Otherwise, the resident or resident family were obligated to bring in their own briefs and wipes. According to the administrator, wipes were a "coveted" item and she sometimes needed to keep a resident's individual supply locked up in her office so that others would not take them.

Resident C had been admitted to the facility on the Michigan PACE program. There were numerous packages of wipes in Resident C's room. According to the director of wellness, these wipes were for Resident C's use only.

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:	There was no evidence that items that were to be supplied by the facility were lacking.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 10/12/2023. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

10/12/2023

Barbara Zabitz Date
Licensing Staff

Approved By:

10/04/2023

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