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

January 17, 2024

RE: License #: AH090371811
Investigation #: 2023A1022034
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
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH090371811
Investigation #:	2023A1022034
Complaint Receipt Date:	06/23/2023
Investigation Initiation Date:	06/23/2023
Report Due Date:	08/23/2023
Licensee Name:	Tender Care of Michigan, LLC
Licensee Address:	4130 Shrestha Drive Bay City, MI 48706
Licensee Telephone #:	(734) 355-6050
Administrator:	Morgan Harrington
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)

	Violation Established?
The Resident of Concern (ROC) was served food that had not been modified to a texture she could safely swallow.	Yes

III. METHODOLOGY

06/23/2023	Special Investigation Intake 2023A1022034
06/23/2023	Special Investigation Initiated - Telephone Complainant interviewed by phone.
06/27/2023	Inspection Completed On-site
06/28/2023	APS Referral
01/17/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) was served food that had not been modified to a texture she could safely swallow.

INVESTIGATION:

On 06/21/2023, the Bureau of Community and Health Systems (BCHS) received a complaint that read, “The wrong food was served to her (the Resident of Concern/ROC) multiple times, but she choked only this one time.” The complainant had attached a legal filing and a police report to the complaint.

According to the police report, “On 04/18/2022, at approximately 1300 hours, I, Deputy [name of the police officer] was dispatched to Comfort Care Senior Living in reference to a resident who was suspected to be deceased after choking on food.” According to the physician’s order sheet provided to the officer, the ROC was to be served a “mechanical soft, cut up, nectar thick liquids” diet. The officer determined that the food served to the ROC “didn’t appear to be chopped up or cut for someone who requires it. According to the report, the ROC had been served “a fairly large potato wedge fry and what appeared to a piece of toast with meat on it as well as cheese.” The report included a written description of the events leading up to the ROC’s death that had been captured on the facility’s dining room surveillance camera. According to this description, the wheeled herself in her wheelchair into the facility’s dining room and is served a plate of food. The ROC is seen eating, but “at approximately 1147 hours… [Name of the ROC] rocks her body back and forth and lifts her head upward and appears to cough. This happens multiple times. [Name of the ROC] appears to be looking around as she is coughing…” The ROC is seen coughing for roughly 2 minutes, while staff members come in and out of the view of the camera, but do not appear to notice that the ROC could be in distress. The ROC is not seen to move after the 1149-hour mark of the surveillance footage. The police officer indicates in the report that he was present for the county medical examiner’s autopsy, concluding that the ROC died from accidental asphyxia due to choking.

On 06/23/2023, I interviewed the complainant by phone. The complainant stated that the ROC had been served a ham sandwich with cheese that had not been cut-up or chopped as it should have been. The complainant further stated that when the facility first called to say that her mother was deceased, they only told her that her mother had been found unresponsive in the dining room. The complainant then disclosed that she wouldn’t have questioned the facility about the circumstances of the ROC’s death, but the police told her that those circumstances “were suspicious.” The family had filed a legal suit against the facility.

On 06/28/2023, a referral was made to Adult Protective Services.

On 06/27/2023, at the time of the onsite visit, I interviewed the administrator and the previous administrator, available by phone. The administrator stated that at the time of the occurrence, an incident report as required at the time had been filed with BCHS, but no one came onsite to review the specifics of what had happened to the ROC. Review of the incident report dated 04/18/2022 revealed that the description of the incident was documented as “Resident observed at dining room table, unresponsive and not breathing…” Review of the ROC’s charting notes dated 4/19/2022 revealed the incident had been documented as “On 4/18/2022 resident

was fond unresponsive at dining room…" There was no documentation indicating what food the ROC had been served and subsequently choked upon.

According to the administrator, there were five residents currently living in the facility who had modified textured food diet orders: Resident A, Resident B, Resident C, and Resident D were to receive mechanical soft food and Resident E was to receive pureed food. According to the kitchen, the lunch meal for 06/27/2023 was a taco, Spanish rice, refried beans, and a brownie for dessert.

Resident A and Resident B lived in the facility's memory care section and ate in the memory care dining room. Observation of their food revealed that both residents were served food to be almost pureed in consistency. Resident E was fed by staff in his room. Prior to the meal service, he was being bathed by staff members and at the time of service, he was sleeping. His meal was not observed. Resident C and Resident E were seated in the 100-hall dining area. Resident E was served a bowl of food that appeared to be all food items scheduled for the meal pureed together, but Resident C was served a same meal as all the other residents, a full taco, including the shell. The taco had not been cut up, chopped, or otherwise modified.

According to the administrator, the chef/food service manager was responsible for all modification of food texture. All residents had a card with their name and their diet type used by kitchen staff to make up the plate served to each resident. When the chef was asked why Resident C did not receive food that was modified to an appropriate texture, he stated that Resident C was very picky about her food and would not eat it if he gave her the chopped-up version.

Review of Resident C's Physician's Orders indicated that her diet order was "Mechanical Soft, Thin Liquids." Her service plan directed "Staff are to assist the resident with cutting up her food at times."

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.**
For Reference: R325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety,

	and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The facility is not protecting their residents from physical harm if they continue to serve residents food that is contraindicated by their physician orders. The ROC choked on unmodified food served to her. Resident C was placed at risk when unmodified food was served to her.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 01/17/2024. 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.

01/17/2024

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

01/11/2024

_____

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