GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

March 19, 2024

RE: License #: AH090371811
Investigation #: 2023A1022055
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 #:	2023A1022055
Complaint Receipt Date:	09/12/2023
Investigation Initiation Date:	09/12/2023
Report Due Date:	11/12/2023
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?
Resident A is sexually aggressive towards Resident B and caregivers do not intervene.	No
Resident C waited almost 30 minutes for a staff person to answer her call light. By the time she received assistance, both the resident and the wheelchair she was seated in were saturated with urine.	No
The residents are not repositioned on a regular basis, resulting in skin breakdown, including Resident D, who was observed with a "bedsore" on her face.	No
Resident E has uncontrollable behavior issues that the caregivers do not know how to handle.	Yes
Additional Findings	Yes

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 items listed above were those that could be considered under the scope of licensing.

III. METHODOLOGY

09/12/2023	Special Investigation Intake 2023A1022055
09/12/2023	Special Investigation Initiated - Telephone Complainant interviewed by phone.
10/03/2023	Inspection Completed On-site
03/19/2024	Exit Conference

ALLEGATION:

Resident A is sexually aggressive towards Resident B and caregivers do not intervene.

INVESTIGATION:

On 09/12/2023, the Bureau of Community and Health Systems (BCHS) received a referral from Adult Protective Services (APS) that in part read, “There is a resident in the memory care unit who faces attempts of sexual abuse by another resident resulting in her being fearful to sleep in her room.” The referral was marked, “Denied,” signifying that APS had determined they would not be investigating the allegations.

On 09/12/2023, I interviewed the complainant by phone. The complainant stated that Resident B, who lived in the facility’s memory care (MC) unit did not sleep in her room but slept on a couch in the dayroom. The complainant stated that other than allowing Resident B to sleep on a couch, the facility staff did nothing to protect Resident B from Resident A, a male resident who engaged in sexual behaviors directed to Resident B. The complainant was not able to identify either resident by name.

On 10/03/2023, at the time of the onsite visit, I interviewed the administrator, who denied the allegation that there was a female resident in the MC unit who slept on the couch in the day room because she was “scared” to sleep in her bed. The administrator acknowledged that a male resident identified as Resident A was known to hug and holds hands with a female resident, Resident B. Resident A was also known to rub Resident B’s back. Resident A’s wife was frequently in the facility with Resident A and was aware of his attachment to Resident B. According to the administrator, neither Resident A’s wife nor any of Resident B’s family members found the relationship between the two residents to be problematic and there were no objections to his behavior.

At the time of the onsite visit, observations were made in the MC unit. Caregiver #1 had just finished providing Resident B her morning care. Resident B, who was seated in a wheelchair, was not able to reliably answer questions. When asked if Resident B ever slept on the couch in the day room, Caregiver #1 stated that she occasionally worked the overnight shift and had never seen Resident B sleeping on the couch. Resident A, who participated in the PACE program, was out of the facility, attending the program’s clinic.

According to his service plan, Resident A needed little physical assistance, but needed to be supervised due to his impaired cognition. The service plan acknowledged that Resident A “has a history of aggressive behaviors towards staff when staff attempt to redirect the resident. Resident wanders daily in other residents’ rooms, has history of sleeping in other residents’ bed. Resident enjoys the company of other female residents. Resident has history of aggressive behaviors when staff attempt to assist other female residents with daily ADLS (activities of daily living). Resident experience aggression with male residents, staff are to assist the resident with redirection.”

According to her service plan, Resident B needed a moderate amount of physical assistance for transfer and other weight bearing activities. She used a wheelchair for locomotion. Resident B was known to be combative with ADLs and was known to frequently express anxiety.

When the administrator was asked to provide documentation or other evidence that the staff observed and discussed the interaction between Resident A and Resident B with their respective family representatives or Power of Attorney, the administrator stated that there was no documentation or other evidence.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse**
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 investigation could not substantiate the allegation that Resident A was sexually abusing Resident B.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident C waited almost 30 minutes for a staff person to answer her call light. By the time she received assistance, both the resident and the wheelchair she was seated in were saturated with urine.

INVESTIGATION:

According to the written complaint, “Residents present completely saturated in urine, including wheelchair bound residents resulting in their wheelchair becoming saturated.” When interviewed, the complainant clarified this allegation, describing an incident in which Resident C sat for approximately 20 minutes before receiving care. The complainant alleged that caregivers frequently ignored Resident C in favor of residents who were easier to care for.

At the time of the onsite visit, Resident C was observed in her room. Although Resident C displayed both cognitive and physical impairments, she was able to make her needs known. According to the administrator, Resident C was a two-person transfer requiring the use of a mechanical (Hoyer) lift and did not use the toilet. When I asked Resident C if she needed to have the staff change her brief, she stated that yes, she did need to be changed by staff. When the administrator heard Resident C’s answer about needing to have the staff change her brief, she asked Resident C if she had called for help. Resident C acknowledged that she had not. Resident C then started to explain that the facility was short of staff and that she couldn’t get help when she needed it. As Resident C continued to explain the kind of care she needed from staff, the details of the story began to change. At first, she stated that she waited “hours” at times for there to be two staff members to come to help her, but as she continued, she clarified that she occasionally waited only an hour. Two caregivers then arrived in the room to provide care for Resident C. They expressed surprise that Resident C wanted care then because it was just before lunch. According to the administrator, Resident C usually preferred having lunch, then receiving care, because then she could take a nap after the caregivers changed her brief.

According to her service plan, Resident C was dependent on the assistance of 2 caregivers for all transfers. The service plan provided contradictory information regarding Resident C’s ability to sit on a toilet but was clear that she was totally

incontinent and wore briefs. The service plan indicated that Resident C "will refuse toileting at times" but it was not clear if that notation was regarding staff placing Resident C on a toilet or bedside commode, or if it was in regard to Resident C refusing a brief change in bed. The service plan did not detail Resident C's preferences regarding the time of day in which she preferred to be placed back into bed for a brief change. Resident C's charting notes intermittently documented notations such as the one dated 09/20/2023, "Checks and changes completed along with creams…" There was no documentation in September 2023 that documented any refusals of toileting or incontinence care from Resident C.

I then visited with Resident G, who was in the dining room, waiting for the noon meal to be served. According to the administrator, Resident G was unable to use the toilet and was dependent on staff for all of her care. When her brief was removed, it was observed to be only slightly wet, and it was clear that Resident G had received timely incontinence care.

According to her service plan, Resident G was required the assistance of 2 caregivers for all transfers and incontinence care. Resident G had impaired cognitive function and memory loss and was not able to reliably answer questions.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(2) 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:	Based on direct observation of Resident G, the investigation could not substantiate that residents in general did not receive timely incontinence care. Due to the preferences of Resident C, keeping her continuously clean and dry appears to be a challenge.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The residents are not repositioned on a regular basis, resulting in skin breakdown, including Resident D, who was observed with a "bedsore" on her face.

INVESTIGATION:

According to the written complaint, “The residents have various diagnoses including wheelchair bound from paralysis, Alzheimer's, dementia, etc… residents currently have bedsores due to not being turned by staff every two hours including one resident having a bedsore on her face that is in memory care.” When interviewed, the complainant acknowledged that she had not provided care to this resident and was not able to identify her by name. The complainant reiterated that the sore was due to this resident not being repositioned.

At the time of the onsite visit, the administrator denied that there was a resident in the MC unit with a sore or a skin impairment of any kind. At the time of the onsite visit in the MC unit, there were no residents with any facial sores. Resident D did have a small scratch on her nose.

According to a physician’s order dated 09/21/2023, “Cleanse abrasion on nose with soap and water, rinse, pat dry and apply thin lay of TAO (triple antibiotic ointment) twice daily…” The facility did not supply any additional information about the injury.

Resident D was a hospice patient. She had severely impaired cognition and was known to display behavioral symptoms such as wandering, sleeping in the beds of other residents, and becoming emotional. Resident D needed minimal physical assistance with activities of daily living, mainly “stand-by” assistance related to her cognitive status.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(3) 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 Resident D had a “bedsore.”
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident E has uncontrollable behavior issues that the caregivers do not know how to handle.

INVESTIGATION:

According to the written complaint, “Residents call 911 which leads to the staff unplugging the phones so no calls can be made. An employee [employee name] has locked a resident in her room so she will not access a phone. That resident was bed bound…” When interviewed, the complainant explained that there had been a situation with Resident E on the weekend of 09/08/2023 when Resident E had become belligerent. According to the complainant, after Resident E removed the facility’s front door, she went to the facility’s reception desk and used the main line to call 911. The complainant stated that in general, when residents such as Resident E became belligerent, caregivers would stop providing care for them. The complainant further alleged that [name of the operations manager] who was a facility manager, told her (the complainant) that she should disconnect the phone at the reception desk so that Resident E would be unable to try to reach 911.

At the time of the onsite visit, Resident E was lying in her bed. She was alert, able to make her needs known and could reliably answer questions. When asked if she was “doing okay,” she indicated that she was.

When the administrator was asked about Resident E becoming belligerent, taking the front door off the front entrance, and calling 911, she stated that she did not know anything about Resident E becoming belligerent and taking off the front door. She acknowledged that there was one occasion when Resident E called 911, but mainly Resident E used the reception desk phone to call her mother. The administrator explained that there had been occasion when a conversation between Resident E and her mother had resulted in Resident E getting “riled-up.” The administrator explained that the mother would advise Resident E to leave the building and walk around as a way to calm herself. The administrator explained that this was too unsafe for the staff to do. The administrator further acknowledged that the operations manager was the manager who was authorized to give care staff directions, and that they would be directed to disconnect the reception desk phone to prevent further anxiety to Resident E.

The administrator was asked to provide charting notes or other documentation regarding Resident E’s phone use, including any occasion when she either called 911 or when the operations manager advised caregivers to disconnect the reception desk phone. According to the administrator, there was no documentation or other evidence.

According to her service plan, Resident E needed minimal assistance with activities of daily as she was able to transfer, walk, and use the toilet independently.

According to her service plan, Resident E had no behavioral issues. The service plan did indicate that Resident E's "…family is somewhat involved with the physical and emotional needs of the resident…Resident's mother is allowed to have information of the resident's care."

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(4) 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:	The administrator detailed behaviors displayed by Resident E but had not used that knowledge to establish interventions that caregivers could use to provide care to the resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the onsite visit, the administrator acknowledged that Resident A was known to hug and holds hands with a female resident, Resident B and to rub her back. According to the administrator, neither Resident A's wife nor any of Resident B's family members found the relationship between the two residents to be problematic and there were no objections to his behavior. When the administrator was asked to provide documentation or other evidence that the staff observed and discussed the interaction between Resident A and Resident B with their respective family representatives or Power of Attorney, the administrator stated that there was no documentation or other evidence.

When the administrator was asked about Resident E's behaviors, the administrator acknowledged that there was one occasion when Resident E called 911, but mainly Resident E used the reception desk phone to call her mother. The administrator explained that there had been occasion when a conversation between Resident E and her mother had resulted in Resident E getting "riled-up." The administrator explained that the mother would advise Resident E to leave the building and walk around as a way to calm herself. The administrator explained that this was too

unsafe for the staff to do. The administrator further acknowledged that the operations manager was the manager who was authorized to give care staff directions, and that they would be directed to disconnect the reception desk phone to prevent further anxiety to Resident E. When asked for documentation or other evidence of these episodes, the administrator stated that there was no documentation or other evidence.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	The facility was not documenting observations made of behaviors displayed by Resident A, Resident B and Resident E.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 03/19/2024. 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.

03/19/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

03/11/2024

_____

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