GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Alison Bickford
Shelby Comfort Care
51831 VanDyke Ave.
Shelby Township, MI 48315

June 17, 2024

RE: License #: AH500413843
Investigation #: 2024A1022042
Shelby Comfort Care

Dear Alison Bickford:

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

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|---|---|
| **License #:** | AH500413843 |
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| **Investigation #:** | 2024A1022042 |
| | |
| **Complaint Receipt Date:** | 05/03/2024 |
| | |
| **Investigation Initiation Date:** | 05/06/2024 |
| | |
| **Report Due Date:** | 07/02/2024 |
| | |
| **Licensee Name:** | Shelby Comfort Care, LLC |
| | |
| **Licensee Address:** | 2635 Lapeer Road<br>Auburn Hills, MI 48326 |
| | |
| **Licensee Telephone #:** | (989) 607-0001 |
| | |
| **Administrator:** | Kassandra Thurlow |
| | |
| **Authorized Representative:** | Alison Bickford |
| | |
| **Name of Facility:** | Shelby Comfort Care |
| | |
| **Facility Address:** | 51831 VanDyke Ave.<br>Shelby Township, MI 48315 |
| | |
| **Facility Telephone #:** | (586) 333-4940 |
| | |
| **Original Issuance Date:** | 02/16/2023 |
| | |
| License **Status:** | REGULAR |
| | |
| **Effective Date:** | 08/16/2023 |
| | |
| **Expiration Date:** | 08/15/2024 |
| | |
| **Capacity:** | 77 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident medications are being improperly administered. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 05/03/2024 | Special Investigation Intake<br>2024A1022042 |
| 05/06/2024 | Special Investigation Initiated - Letter<br>Arrangements made with facility for a remote videoconference interview. |
| 05/16/2024 | Contact - Telephone call made<br>Instigation conducted remotely via videoconference. |
| 06/17/2024 | Exit Conference |

**ALLEGATION:**

**Resident medications are being improperly administered.**

**INVESTIGATION:**

On 05/03/2024, the Bureau of Community and Health Systems (BCHS) received an anonymous complaint that read, “Facility does not seem to be passing medications appropriately. Residents not getting medications as ordered, medications being skipped, or missing.  facility nurse and med passers do not seem to communicate with one another regarding medications that are being skipped.”

On 05/16/2024, I interviewed the administrator and the authorized representative (AR), remotely, in a videoconference.

The facility provided the April 2024 medication administration records (MARs) for three randomly chosen residents. The MARs were reviewed for appropriate administration.

Resident A was prescribed 4 medications to be taken on a daily basis and 6 medications to be taken on an “as needed" (prn) basis. The daily medications were low dose aspirin, Lopressor (blood pressure), Zoloft (anti-depressant) and Maxzide (anti-hypertensive agent). Resident A’s MAR reflected that on 04/28/2024, Zoloft was not administered, but noted as “not in cart,” but also as “Resident Refused.” When the administrator was asked to clarify the reason why Resident A was not administered the medication, the administrator acknowledged that this was a medication error. Additionally, Resident A’s medications were frequently administered late. For example, on 04/02/2024, the medications that were scheduled to be administered at 8 am were given at 11:17 am, 3 hours late.

Resident B was prescribed 2 medications to be taken on a daily basis and 2 medications to be taken prn. The daily medications were Remeron (depression) and Seroquel (anti-psychotic). Resident B’s medications were occasionally administered late, similar to medication administered to Resident A, but none were missed.

Resident C was prescribed 13 medications to be taken on a daily basis and 2 medications to be taken prn. The daily medications were low dose aspirin, Lipitor (elevated blood cholesterol), Plavix (blood thinner), Avodart (enlarged prostate), Lexapro (depression), Lasix (blood pressure), Namenda (dementia), Toprol (blood pressure), Protonix (gastric reflux), Exelon (dementia), and Flomax (enlarged prostate). Resident C’s medications were occasionally administered late and occasionally early, but none were missed.

According to the facility’s medication administration policies, “Medications are to be given within one hour before or one hour after the prescribed time, unless otherwise noted by the physician.” Under the section labeled “Determining Medication Errors,” the definition was given as “A medication error is any preventable event that may cause or lead to inappropriate medication use or Resident harm while the medication is in the control of the health care professional.”

When the administrator and the AR were asked about medications being outside the scheduled time frame, the AR stated that the facility did not consider those to be “medication errors.” This was not in accordance with the facility's own policy.

| **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:** | Documentation review found that medications were not administered as ordered by the licensed health care professional and in accordance with the policy of the facility. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## ADDITIONAL FINDINGS:

### INVESTIGATION:

When the administrator and the AR were asked if the prescriber of Resident A's Zoloft, the facility nurse practitioner (NP), had been informed when Resident A did not receive her prescribed medication, the AR stated that the NP "didn't want to be bothered" with that type of information.

According to the facility's medication administration policies, "All medication errors will be reported immediately to the Attending Physician and Administrator and recorded in the resident's clinical record. A medication incident report will be completed by the nurse who made the error or the nurse who discovered the error."

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions:**<br><br>**(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.** |
| **ANALYSIS:** | The facility was not informing the medication prescriber when medications were not being administered as ordered or refused by residents. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

I reviewed the findings of this investigation with the authorized representative (AR) on 06/17/2024. 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.

06/17/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

06/12/2024

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