GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Elyse Al-Rakabi
Shields Comfort Care Assisted Living
9140 Gratiot
Saginaw, MI 48609

June 24, 2024

RE: License #: AH730412298
Investigation #: 2024A1022040
Shields Comfort Care Assisted Living

Dear Elyse Al-Rakabi:

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 Zabitz, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 296-5731

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730412298
Investigation #:	2024A1022040
Complaint Receipt Date:	04/19/2024
Investigation Initiation Date:	04/29/2024
Report Due Date:	06/19/2024
Licensee Name:	Shields Comfort Care Assisted Living and Memory Care LLC
Licensee Address:	Suite B, 3061 Christy Way Saginaw, MI 48603
Licensee Telephone #:	(989) 607-0001
Administrator/Authorized Rep:	Elyse Al-Rakabi
Name of Facility:	Shields Comfort Care Assisted Living
Facility Address:	9140 Gratiot Saginaw, MI 48609
Facility Telephone #:	(989) 607-0003
Original Issuance Date:	06/01/2023
License **Status:**	REGULAR
Effective Date:	12/01/2023
Expiration Date:	11/30/2024
Capacity:	65
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) does not receive appropriate care.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/19/2024	Special Investigation Intake 2024A1022040
04/29/2024	Special Investigation Initiated - Letter Request sent to APS worker for additional information.
05/21/2024	Inspection Completed On-site
06/17/2024	Contact - Document Received Email exchange with administrator.
06/24/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) does not receive appropriate care.

INVESTIGATION:

On 04/19/2024, the Bureau of Community and Health Systems (BCHS) received a referral from Adult Protective Services (APS) that read, “[Name of the Resident of Concern (ROC)] lives in Shields Comfort Care and has Huntington's Disease. For several weeks [name of the ROC] has been getting neglected and he does not want to stay there. He eats food off the table like a dog because he cannot feed himself. He wears adult briefs and he is left wet for long periods of time. This past Sunday, (04/14/2024) [name of the ROC] attempted suicide by putting his head in the bathroom sink with the water running and put his head under the water. He was transported to Covenant Hospital and released the same day. The water has been turned off in his room so it will not happen again. Monday he was left in the room unattended. Staff does not feed him because he will not answer them when they ask him if he needs help.” When contacted, the APS worker assigned to this case had no additional information to add to the written narrative.

On 05/21/2024, at the time of the onsite visit, I interviewed the administrator/authorized representative (AR). According to the AR, the ROC no longer lived in the facility. Although she knew a little bit about the ROC, the individual who worked most closely with him was the previous wellness director, who was no longer employed by the facility. The AR stated that the ROC had lived in the facility about 4 months and had moved in as a participant in a Michigan Medicaid Waiver program. He also received hospice services. The AR stated that she had never heard that the ROC had put his head into a sink with the water running but acknowledged that the ROC had been found in his room, under a blanket on his bed, with the emergency call cord wrapped around his neck.

The AR went on to say that at some point the ROC became aggressive and agitated towards caregivers and he was sent to the local emergency room (ER), but the hospital did not keep him. Instead of returning to the facility, his stepmother took him to her home. According to the AR, the ROC's stepmother was attempting to have him admitted into a local inpatient psychiatric hospital.

The facility provided documentation regarding the ROC. He moved into the facility in mid-January 2024. Due to his diagnoses that included late-stage Huntington's Disease and an abdominal mass, he was admitted to hospice care. Prior to living in the facility, he lived with family, but in December 2023, it was determined that he could not live there any longer due to problematic behavioral symptoms and decreased ability to participate in the completion of activities of daily living (ADLs). According to his assessment and service plan, the ROC was totally dependent on caregivers for the completion of his ADLs. His ability to swallow food was impaired and he required pureed food. Although he was known to have problems with judgement, aggression, anxiety, and inappropriate behavior, there were no behavior-related interventions on the service plan for staff to use if the ROC began to show problematic behaviors, despite the notation stating that "Resident has hit his previous caregivers."

NP note on 02/21/2024, "Pt (patient) has been increasingly aggressive…Start Ativan…"

Although the facility provided very little in the way of charting, many of the charting entries related to problematic behaviors. On 02/2/4/2024, "When last change (of brief) was done, he got upset and yelled because…his pants has to come off due to them being soiled." On 03/06/2024, "…Being rude to staff. Tried to redirect resident. . . (to be patient for) his meal was coming…" On 03/15/2024, "Refused to be changed (out of brief) tried 3 times to get him out of bed…he just yelled and refused to be changed." On 03/17/2024, "Resident keeps cussing at staff and tells another staff member he will feed his self and then staff asked him does he need help, he says no and he (is) calling us dumb (B word)." On 03/31/2024, "Combative and suicidal thoughts. Contacted POA (power of attorney) and hospice."

The facility provided an incident report (IR) dated 04/14/2024, “Resident was observed putting his head under the bathroom sink water, saying he was suicidal having thoughts. Staff turned the water off. Resident was sent (to local hospital emergency room), family, responsible agencies was notified…No discharge instructions provided. Discuss discharge with hospice. Monitor behaviors…”

The facility did not provide the IR documenting the incident described by the administrator at the time of the onsite visit, when the ROC was found with the emergency call card wrapped around his neck. According to the administrator, the former wellness director was responsible for that IR and the administrator could not account for it.

On 06/17/2024, via an email exchange with the administrator, the administrator was asked if there were any actions or interventions into place after 03/31/2024, when the ROC displayed “combative and suicidal thoughts,” and a caregiver indicated that the facility “…contacted POA and hospice.” The administrator responded, “He (the ROC) was to be monitored and placed in common areas. I (the administrator) do know there were continued talks about moving him at that time, but there were issues finding him placement.” The administrator did not indicate why the ROC was found on two subsequent occasions alone in his room, acting out in ways that demonstrated he was thinking about ending his life.

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: **(e) A patient or resident is entitled to receive adequate and appropriate care**
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 did not provide the ROC with adequate supervision or behavioral interventions to address his thoughts of suicide.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the onsite visit, the administrator described an incident when the ROC was found with the emergency call card wrapped around his neck, but she was unable to provide the incident report (IR) written at the time of the incident. On 06/17/2024, via an email exchange with the administrator, responded, “Like I (administrator) said upon the (onsite) visit, the former RCD (resident care director) seemed to have failed in many duties. I have not found an IR.”

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(5) Records must be maintained that demonstrate incident reporting to the team, analyses, outcomes, corrective action taken, and evaluation to ensure that the expected outcome is achieved. These records must be maintained for 2 years.
For Reference: R325.1901	**Definitions.**

	(k) "Incident" means an intentional or unintentional event including, but not limited to, elopements and medication errors, where a resident suffers physical or emotional harm.
ANALYSIS:	The facility did not complete an incident report to document when the ROC was found displaying unambiguous suicidal behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 06/17/2024, via an email exchange with the administrator, the administrator was asked to provide descriptions of observations that the facility staff may have made between 04/14/2024, when the ROC was found with his head in the sink, and the facet on running onto his head. According to the IR provided that described the incident, the corrective measure to be used going forward for the caregivers to "monitor behaviors." The administrator replied, "From my (the administrator) knowledge from the last week or so investigating things, [name of the former wellness direction] had preferred staff to write things out and submit them to her. We did not find anything in her former office. It is possible she threw out any documents."

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 did not document observations of the ROC's behavior in his health record as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 06/24/2024. 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.

06/24/2024

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Barbara Zabitz Date
Licensing Staff

Approved By:

06/20/2024

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