GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 14, 2024

Kory Feetham
Shields Comfort Care Assisted Living
9140 Gratiot
Saginaw, MI 48609

RE: License #: AH730412298
Investigation #: 2024A1019073

Dear Licensee:

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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730412298
Investigation #:	2024A1019073
Complaint Receipt Date:	09/23/2024
Investigation Initiation Date:	09/24/2024
Report Due Date:	11/23/2024
Licensee Name:	Shields Comfort Care Assisted Living and Memory Care LLC
Licensee Address:	3061 Christy Way, Suite B Saginaw, MI 48603
Licensee Telephone #:	(989) 607-0001
Administrator:	Kristy Tomlinson
Authorized Representative:	Kory Feetham
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?
Resident A is being abused.	No
Resident A missed doses of her pain medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/23/2024	Special Investigation Intake 2024A1019073
09/24/2024	Special Investigation Initiated - Letter Emailed APS worker for additional information.
10/03/2024	Inspection Completed On-site
10/03/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A is being abused.

INVESTIGATION:

On 9/23/24, the department received a complaint alleging that Resident A has been verbally and physically abused by staff. The complaint alleged staff were rough when “rolling” Resident A and she suffered a knee injury.

On 10/3/24, I conducted an onsite inspection. I interviewed authorized representative Kory Feetham at the facility alongside Employees 1 and 2. Staff reported that Resident A is bed bound, requires the use of a Hoyer lift for transfers and needs staff assistance with most activities of daily living (ADLs). Staff reported that Resident A can verbalize her needs and is outspoken when making her needs known. Staff reported that Resident A has a history of making false allegations against staff and frequently calls Adult Protective Services (APS) to make reports against facility staff. Employee 2 reported that APS was recently in the building on 9/20/24 after Resident A made a call that she didn’t like how staff were repositioning her. Employee 2 reported that Resident A never informed facility management of the allegations and that she only became aware once APS was in the building. Employee 2 reported that she could not verify any wrongdoing on behalf of staff but

held an in-service with staff on how to properly turn residents (sign in sheet from the in-service was provided to licensing staff). Employees 1 and 2 reported that there was a recent incident in which Resident A had complained about hitting her knee while staff were assisting her. Employee 2 reported that she had staff write up statements about the incident and Resident A was taken to the hospital to have her knee examined after experiencing persistent pain. Employee 2 reported that the cause of Resident A's injury was undetermined and again, could not attribute it to staff wrongdoing.

While onsite, I interviewed Resident A. Resident A reported that she felt staff have verbally abused her in the past, however she could not recall what the staff said to her that constituted abuse, could not recall the staff members who she felt was abusive towards her but reported that they no longer work for the facility. Regarding physical abuse, Resident A reported that about two weeks ago two staff were moving her in her bed and she injured her knee. Resident A reported that the staff were adjusting her by "*Pulling me up with a draw sheet and my foot went one way and my knee went another way.*" Resident A reported that she did not believe that staff intentionally caused injury but reports "*They left me in a mess*". Resident A was unsure which staff were involved in the incident.

While onsite, progress note documentation, staff statements and hospital discharge paperwork were obtained pertaining to Resident A's knee injury. On 9/18/24, Employee 3 noted "*Resident started crying in pain saying we are hurting her knee but we didn't even touch her knee. We were holding on to the bed pad to pull her up*." Employee 4 noted "*Checked and changed x3 she was c/o her knee hurting but I gave her pain med and didn't hear nothing else about pain*".

Employee 3's statement read "*I [Employee 3] worked 9/18/24 after resident was changed at 7:30pm I went back in at 10:20pm that night to do last changed & changed resident didn't complained [sic] about her changed [sic] didn't show any signs of pain resident even crossed her feet together and left leg up for me to put pillow under her knee."*

Employee 4's statement read "*I [Employee 4] worked 3rd shift 9/18/24 took care of [Resident A] she c/o knee hurting one time but still swinging back and forth and also put one foot in front of the other & lifted her feet every time I changed her."*

Employee 5's statement read:

> *On 9/18/24 I was training [Employee 6] in [Resident A's room. We started to lift her up in the bed by holding the bed pad on all 4 corners. [Employee 6] didn't realize how heave she is so we had to start over. [Resident A] started saying her knee hurt and I stated we haven't even started care yet. She started crying and screaming in pain. She let us finish lifting her up and we left the room.*

The hospital discharge paperwork was reviewed. The documentation dated 9/19/24 confirmed that Resident A's knee was x-rayed, but no new orders were written. Resident A was given a diagnosis of "*acute pain of left knee*". Her discharge instructions read for Resident A to continue taking norco for pain as needed and use ice and heat to help reduce swelling; no follow up appointments were made.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(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 and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	The allegations lacked detail pertaining to verbal abuse allegations and Resident A herself could not provide more information. During Resident A's interview, she reported that she did have a recent knee injury while staff were assisting her with case, but believes it was accidental. Given this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A missed doses of her pain medication.

INVESTIGATION:

The complaint alleged that three doses of Resident A's pain medication were missed on 9/18/24. Mr. Feetham, along with Employees 1 and 2 confirmed that Resident A ran out of her pain medication, Norco because it was not reordered on time. Employee 1 reported that she was notified of the medication being out on 9/21/24 and she had to put in a request with Resident A's physician for a new prescription which caused a slight delay. Employee 1 reported that the medication was delivered to the facility on 9/23/24.

Resident A's medication administration records (MAR) were reviewed for the month of September 2024. The MAR instructs that Resident A is to *"take 1 tablet by mouth every 6 hours*". On 9/18/24, staff indicated that the medication was administered as prescribed, but I observed that Resident A missed one or more doses of Norco on the following dates: 9/13/24, 9/14/24, 9/21/24, 9/22/24, 9/23/24 and 9/24/24. On 9/14/24, staff notated that the resident was "*physically unable to take*" the medication. Employee 1 clarified that the medication was not on the cart and staff failed to notify the nurse timely to get the medication replenished on that date. On 9/22/24 staff notated "*not in cart right now, waiting for the order*", "*this med is not in the cart*" and on 9/23/24 staff notated "*was not in cart".* This again was due to staff failing to notify the nurse in a timely manner before the medication ran out and five consecutive doses were missed.

Review of Resident A's MAR also showed that she missed additional doses of the following medications:

- Aquaphor ointment on 9/13/24 and 9/21/24
- Azo cranberry tablet on 9/10/24
- Baclofen on 9/13/24, 9/14/24 and 9/21/24
- Bethanechol on 9/13/24, 9/14/24 and 9/21/24
- Eliquis on 9/13/24
- Ferrous Sulfate on 9/10/24
- Gabapentin on 9/13/24, 9/14/24 and 9/21/24
- Glipizide on 9/13/24, 9/14/24 and 9/21/24
- Lantus on 9/13/24 and 9/21/24
- Nystatin powder on 9/13/24
- Senna on 9/13/24 and 9/21/24
- Simethicone on 9/13/24 and 9/21/24

Medication administration records were left blank in the above-mentioned instances and it could not be determined why the medications were not admisntiered to Resident A.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional. **(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:** **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	Resident A was not administered her pain medication as prescribed in September 2024, as staff did not obtain a new prescription before the medication ran out. Numerous other medications were not administered as prescribed, and staff failed to document why the medications were missed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

While onsite, it was discovered that the administrator on file quit, and her last day worked was 9/18/24. The licensee failed to notify the department when this change occurred and as of the date of this report has not appointed a new person to this role.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application

	pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	The licensee did not provide timely notification to the department when there was a change in the administrator appointment designation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/09/2024

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

10/14/2024

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