GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

December 3, 2024

RE: License #: AH500413843
Investigation #: 2024A1022079
Shelby Comfort Care

Dear Alison VanRyckeghem:

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
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500413843
Investigation #:	2024A1022079
Complaint Receipt Date:	08/21/2024
Investigation Initiation Date:	08/26/2024
Report Due Date:	10/20/2024
Licensee Name:	Shelby Comfort Care, LLC
Licensee Address:	2635 Lapeer Road Auburn Hills, MI 48326
Licensee Telephone #:	(989) 607-0001
Administrator:	Kassandra Thurlow
Authorized Representative:	Alison VanRyckeghem
Name of Facility:	Shelby Comfort Care
Facility Address:	51831 VanDyke Ave. Shelby Township, MI 48315
Facility Telephone #:	(586) 333-4940
Original Issuance Date:	02/16/2023
License **Status:**	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	77
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents do not receive appropriate care.	Yes
The overnight shift did not have enough caregivers to meet resident needs.	No
Medications are administered late.	Yes

Please note: this complaint included allegations of a male resident displaying inappropriate sexual behaviors including sexually assaulting a female resident that were separately investigated in 2024A1022078 and not included in this investigation.

III. METHODOLOGY

08/21/2024	Special Investigation Intake 2024A1022079
08/26/2024	Special Investigation Initiated - Letter Arrangements made with facility for a remote videoconference interview.
09/04/2024	Contact - Telephone call made Investigation conducted remotely via videoconference.
11/06/2024	Contact - Document Received Email exchange with administrator
12/03/2024	Exit Conference

ALLEGATION:

Residents do not receive appropriate care.

INVESTIGATION:

On 08/21/2024, the Bureau of Community and Health Systems (BCHS) received an anonymous complaint that read in part, “Residents (are) falling… People (residents) being (transferred by) hoyered (mechanical lift) from the hallways into rooms… Wound care (for residents) not being kept up on. Some people (residents) go 12-14 days without showers. Not having proper care for their obese resident who requires

a special shower chair, they did not provide one that fit her… She only received bed baths maybe once a week, if that... Residents falling…"

On 09/04/2024, I interviewed the administrator and the authorized representative (AR) remotely, in a videoconference.

The facility provided documentation for Resident A and Resident B, who were identified as having wounds and documentation for Resident C and Resident D, who were identified as having falls. Additionally, I requested documentation regarding bathing assistance for all 4 residents.

The administrator described Resident A as having a "stage 3 (pressure wound) located on (her) middle back…" According to her service plan, dated 05/10/2024, Resident A was described as being able to communicate her needs. Her skin was intact when the service plan was created. She used a wheelchair for mobility and was not able to walk, even with assistance. Caregivers were to transfer her using a mechanical (Hoyer) lift. She was unable to use the toilet unassisted and used incontinence briefs. Her service plan indicated, "Resident states being able to feel when she has to go but it's easier for her to use the bathroom in her brief and then get changed." She was to receive 2 showers weekly. According to skin check shower sheet, dated 08/05/2024, an opened area was noted on Resident A's back, "oozing brown pus." The resident care director (RDC) documented that Resident A's wound was cleaned and covered with a foam pad, with Resident A being sent out to a local hospital for evaluation. The skin check sheet was signed by the RCD, signed on 08/05/2024 at 9:00 am. An incident report (IR), dated 08/05/2024 at 9:47 pm, documented, "Resident was crying out in pain. Stated that her lower ack was hurting right where her open wound is. Asked to be sent out because she can't tolerate the pain…" The administrator stated that Resident A had not returned to the facility.

According to the AR, Resident A was extremely obese and needed an oversized wheelchair, the widest wheelchair available. Resident A's wheelchair was so large, that when opened, it would not fit through the door of Resident A's room. Resident A preferred to take her meals in the dining room and not spend all day in her room. To accomplish this, when she wanted to leave the room, the caregivers would place her wheelchair in the hallway, just beyond the doorway. Then the caregivers use the Hoyer lift to transfer Resident A through the doorway of her room and into her wheelchair. The AR stated that although Resident A's wheelchair was too large to fit through the doorway, the doorway was 34 inches wide, wide enough to be compliant with ADA (Americans with Disabilities Act) requirements. When asked about showers, the administrator stated that Resident A's preference for bathing was for one shower and one bed bath each week. Although not able to use the shower in her apartment, she was able to use the shower in the facility's spa room.

Review of Resident A's charting notes indicated that she received a bed bath only twice during the month of July 2024, on 07/10/2024 and on 07/30/2024.

The administrator described Resident B as having a “Stage 1 (pressure wound) located on (her) sacrum.” According to a progress note written by the nurse from contracted home health care agency dated 08/27/2024, “stage I sacrum; current order calmo (calmoseptine)/foam pad (change) 3 times weekly; palliative (care) consult (scheduled for) September 6…Monitor sacrum for breakdown.”

According to her service plan, dated 06/20/2024, Resident B was described as being able to communicate her needs. Her skin was intact. She was able to independently ambulate with either a cane or a walker. Her service plan further described her as being independent for dressing and needing supervision from a caregiver for grooming. She needed physical assistance from a caregiver for toilet use and wore briefs. The service plan noted, “may have occasional accidents.” She was to receive 2 baths weekly.

According to her charting notes, Resident B received 2 showers and 2 bed baths during the month of August 2024.

According to his service plan, dated 05/01/2024, Resident C was also described as being able to communicate his needs, but had a history of falls. Resident C needed the assistance of a caregiver for most activities of daily living (ADLs) including eating. He could ambulate with a walker but needed assistance for transfers when standing. He was to receive 2 showers weekly. Despite having a history of falls, the service plan did not specify instructions for the caregivers in preventing falls. His service plan stated only that “Staff to follow fall prevention program.” Resident C had 2 falls in August 2024. According to the incident report (IR) dated 08/13/2024, Resident C “walked out of bed to the door and fell.” The corrective measure to prevent recurrence of this situations was to “remind resident to use pendant and ask for help when getting up.” The second fall was on 08/15/2024, when “a scream was heard from (Resident C’s room number) and when found, the resident was found on his back on the floor. After urinating on the floor, he explained he attempted to walk to the restroom.” The corrective measure to prevent recurrence of this situations was “Frequent checks.”

The facility provided progress notes from the contracted home health care provider for Resident C, documenting the facility’s requests for a floor matt and a bed alarm. When the administrator was asked via an email exchange if these interventions had been implemented for Resident C, the administrator did not answer.

According to the home health care provider’s progress notes, on 06/05/2024, the home health care nurse recommended that Resident C restrict bathing activities to bed baths for safety reasons. For the month of August 2024, Resident C was bathed twice during the week of 08/19/2024 and twice during the week of 0/26/2024 by an employee of the home health care agency. The facility provided a Shower Refusal Form, indicating Resident C refused a shower on 08/09/2024.

According to her service plan, dated 07/23/2024, Resident D was able to communicate her needs and had a history of falls. Resident D was unable to ambulate, even with assistance and used a wheelchair for mobility. She needed the assistance of 1 caregiver using a gait belt for transfers. She needed full assistance from a caregiver for most of her ADLs and was incontinent. She was to receive 2 showers weekly. Under the heading of Fall Risk, the service plan indicated that Resident D had "recent falls prior to moving into facility," but otherwise, "Staff to follow fall prevention program." No fall prevention interventions were listed.

According to the IR dated 08/10/2024, Resident D "fell out of bed rolled in between the bed and nightstand." The IR did not specify any corrective measures. When the facility was asked to explain the lack of fall interventions, the administrator replied, "We do not have any fall interventions through hospice for [name of Resident D] and/or our facility given that was her only isolated fall." On 11/14/2024, the administrator acknowledged that there were interventions for falls that were initiated by the hospice provider and were placed on the service plan at some point after 11/06/2024.

For bathing, the facility provided 1 shower sheet dated 08/22/2024 for Resident D. The administrator went on to explain that bathing assistance was provided by contracted hospice employees.

According to the facility's Fall Prevention Program written guidelines, the facility was to initiate a written plan of care, "based on resident's assessed condition, fall history, needs, behaviors, medications and preferences…If the interventions have not been effective in reducing falls, initiated alternative approaches and update as necessary… (Caregivers were to) follow the interventions as outlined on the service plan…"

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:	Record review revealed that residents who did not have a contracted provider such as home health care or hospice did not receive bathing assistance as indicated on their service plan. Record review also revealed that the facility did not follow their own fall policy for formulating fall interventions and entering them on residents' service plans.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The overnight shift did not have enough caregivers to meet resident needs.

INVESTIGATION:

According to the anonymous complainant, resident falls were "because there's only 3 people (caregivers) for all the residents in the whole building on night shift…"

When the AR and the administrator were asked about overnight staffing, they stated that 4 employees as caregivers were scheduled each overnight shift. Review of the staffing schedule for the week 08/11/2024 through 08/1/2024 indicated that 4 employees worked each overnight shift on that week.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	There was no evidence that the facility did not have enough employees to meet the needs of residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications are administered late.

INVESTIGATION:

According to the anonymous complainant, “Medications (are) being passed super late.”

On 06/17/2024, the facility was issued the State of Michigan Special Investigation Report 2024A1022042, that found “that medications were not administered as ordered by the licensed health care professional and in accordance with the policy of the facility” because they were given either too early or too late. 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.” On 07/18/2024, the facility alleged that they had achieved compliance with the rule on 07/15/2024 and were maintaining compliance by reviewing the medication variance report on a daily basis.

The facility provided their August 2024 medication logs for Resident B, for Resident C, and for Resident D.

Resident B had medications scheduled for 8 am that were administered as late as 10:45 am. She had medications scheduled for 5 pm that were administered as early as 2:35 pm. Resident C had medications scheduled 7 am that were administered as late as 10:29 AM and medications scheduled for 9 pm that were administered as early as 5:55 pm. Resident D had Tramadol HCL, a pain medication, scheduled at 9 am, 2 pm, and at 9 pm. The 9 am dose was administered as late as 10:52 am.

On 11/06/2024, via an email exchange with the administrator, the administrator was asked to explain why the facility's medication administration was once again not in compliance with their own policy. The administrator replied, "sometimes emergencies happens, and the staff have to navigate through those issues when passing medications."

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.
ANALYSIS:	Medications continue to be administrated outside of the timeframe of the orders of the licensed health professional and in accordance with the policy of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the administrator on 12/03/2024. When asked if there were any comments or concerns with the investigation, the administrator stated that there were none.

IV. RECOMMENDATION

12/03/2024

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

11/25/2024

_____

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