GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 18, 2025

Alison VanRyckeghem
Livonia Comfort Care
34020 Plymouth Rd
Livonia, MI 48150

RE: License #: AH820402086
Investigation #: 2025A1027030
Livonia Comfort Care

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.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.
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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820402086
Investigation #:	2025A1027030
Complaint Receipt Date:	01/28/2025
Investigation Initiation Date:	01/29/2025
Report Due Date:	03/27/2025
Licensee Name:	Livonia Comfort Care, LLC
Licensee Address:	34020 Plymouth Rd Livonia, MI 48150
Licensee Telephone #:	(989) 607-0001
Authorized Representative/ Administrator:	Alison VanRyckeghem
Name of Facility:	Livonia Comfort Care
Facility Address:	34020 Plymouth Rd Livonia, MI 48150
Facility Telephone #:	(734) 743-2300
Original Issuance Date:	01/24/2023
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	88
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care consistent with her service plan.	Yes
Resident A did not receive her medications as prescribed.	Yes
Additional Findings	No

III. METHODOLOGY

01/28/2025	Special Investigation Intake 2025A1027030
01/29/2025	Special Investigation Initiated - Letter Email sent to Alison VanRyckeghem requesting documentation for Resident A
01/30/2025	Contact - Telephone call made Telephone interview conducted with authorized representative Alison VanRyckeghem
02/03/2025	Contact - Document Received Requested documentation received by email.
02/18/2025	Exit Conference Conducted by email with Alison VanRyckeghem

ALLEGATION:

Resident A lacked care consistent with her service plan.

INVESTIGATION:

On 1/28/2025, the Department received a complaint through the online complaint system which read Resident A, who passed away on 01/07/25 after 11 months, was in hospice care starting on November 1, 2024. Following this, the resident's condition worsened rapidly due to inadequate care, and the resident's care was neglected. Family members found Resident A on the floor multiple times, soiled, with facility workers failing to assist.

On 1/30/2025, I conducted a phone interview with authorized representative Alison VanRyckeghem. She explained that Resident A had been rolling out of bed, and as a result, fall mats were put in place. Additionally, the resident was moved to memory

care for increased support. Email correspondence with Ms. VanRyckeghem dated 2/4/2025 read Resident A did not pass away at the home.

A review of Resident A's face sheet indicated she moved into the home on 1/22/2024, with Relative A1 listed as her primary contact. Her service plan, also dated 1/22/2024, outlined that her pain was less than daily, she did not require oxygen, followed a regular diet, and needed supervision with meals for safety. It also noted that she required moderate assistance with bathing, one-person minimal assistance for dressing, standby assistance for grooming, minimal assistance with a gait belt for ambulation, and was a fall risk.

A review of Resident A's Medication Administration Records (MARs) from 11/1/2024 through 12/27/2024 showed staff were instructed to perform two-hour supervision/safety checks, and she required one-person total assistance with activities of daily living tasks. The MARs also specified that staff should document supervision/safety monitoring by initialing when completed and record Resident A's pain every two hours, then three times per day. However, some documentation was left blank. The MAR indicated that Resident A was at risk of choking and required a mechanical soft diet. For November and December 2024, the MARs noted oxygen use at 2-4 liters via nasal cannula as needed for shortness of breath. The December 2024 MAR included instructions for staff to check that Resident A was wearing her oxygen properly, reapply tubing if displaced, and document whether oxygen was on or off during checks.

A review of chart notes from 11/1/2024 to 12/27/2024 revealed that on 11/20/2024, Resident A experienced a change in condition, prompting staff to contact her hospice nurse, who responded. The notes also indicated that on several occasions, Resident A's oxygen was found to be off, and staff re-applied it. A note dated 12/9/2024, written by the hospice nurse, read that Resident A had been "antsy" over the weekend and had several falls out of bed, with medications administered as noted by the hospice nurse. A note from 12/11/2024 mentioned that Resident A was observed sitting on the mat next to her bed; staff assisted her back to her bed, and both the hospice agency and her power of attorney were notified. The notes indicated that Resident A occasionally removed her oxygen in which staff documented when her oxygen was on or off. On 12/16/2024, the notes mentioned that Resident A moved to memory care.

A review of incident reports for Resident A were consistent with the chart notes. Specifically, an incident report dated 12/11/2024 matched the chart note for that day. Incident reports from 12/6/2024, at 6:20 PM and 6:50 PM, noted Resident A was found on the floor. An incident report dated 12/7/2024 indicated that Resident A was observed on the floor during room checks, and both the on-call nurse and her power of attorney were notified.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	A review of Resident A's records revealed that while it could not be confirmed that her condition worsened rapidly due to inadequate care or neglect, there were inconsistencies between her medication administration records and service plan. For example, her medication administration records reflected that she frequently received pain medications throughout the day, required oxygen, needed total assistance with care, and was on a mechanical soft diet. Additionally, the medication administration records showed that staff did not consistently initial tasks such as supervision/safety monitoring to confirm they were completed. While her service plan reflected, her pain was less than daily, she did not require oxygen, followed a regular diet, and was on standby to moderate assistance for activities of daily living. Additionally, Resident A's records revealed she had several falls, and her hospice agency was notified; however, it could not be determined she was left on the floor. As a result, due to the discrepancies between her service plan and medication administration records, as well as incomplete documentation in the medication administration records, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive her medications as prescribed.

INVESTIGATION:

On 1/28/2025, the Department received a complaint through the online complaint system which read the resident did not receive necessary medications and developed severe thrush.

On 1/30/2025, I conducted a phone interview with authorized representative Alison VanRyckeghem. She shared that Resident A1 was upset about the delay in medications on Christmas day. The authorized representative explained that towards the end of Resident A's time at the home, she required hourly medications, which were not providing adequate comfort. The authorized representative also mentioned that Resident A's hospice team recommended a transfer to a hospice home, and ultimately, Resident A was moved from the home.

I reviewed Resident A’s medication administration records (MARs) from 11/1/2024 through 12/27/2024.

The MAR indicated that Midodrine was prescribed to be taken one tablet by mouth twice daily, with instructions to hold the medication if Resident A's systolic blood pressure was greater than 140. The MAR showed that Midodrine was initialed as administered for one or more doses on the following dates when Resident A’s systolic blood pressure was over 140: 11/2/2024, 11/8/2024, 11/9/2024, 11/16/2024, 11/18/2024, 11/23/2024, 11/27/2024, 12/2/2024, 12/7/2024, and 12/8/2024.

Resident A was also prescribed Hyoscyamine as needed for secretions, and on 11/22/2024, staff documented that it was administered for pain.

The December 2024 MAR showed that Bumetanide, prescribed to be taken one tablet by mouth twice daily for edema, was to be held if the systolic blood pressure was less than 100. Despite this, staff initialed the medication as administered on 12/6/2024 for the 7:00 PM to 9:00 PM dose, even though Resident A's blood pressure was 97/58.

The December 2024 MAR also included Morphine Sulfate, prescribed as one prefilled syringe sublingually every three hours for pain or shortness of breath. On 12/9/2024, a dose was left blank. Additionally, on 12/11/2024, 12/13/2024, 12/16/2024, 12/17/2024, and 12/19/2024, one or more doses were not documented for Morphine Sulfate when it was prescribed every two hours. On 12/23/2024, 12/24/2024, and 12/26/2024, one or more doses were left blank when the prescription was for every hour.

The MAR also listed Senna Plus, prescribed to be taken two tablets by mouth daily at bedtime. Doses for Senna Plus were left blank on 12/19/2024 and 12/22/2024. Additionally, a dose of Lorazepam was left blank on 12/19/2024.

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:	A review of Resident A's medication administration records showed that while there was no indication of Resident A developing thrush, staff did not consistently administer her medications as prescribed by the licensed healthcare professional. In some cases, the records were left blank, making it unclear whether the medications were administered. As a result, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remains unchanged.

02/13/2025

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Jessica Rogers Date
Licensing Staff

Approved By:

02/18/2025

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