GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 14, 2025

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

RE: License #: AH820402086
Investigation #: 2025A0585025
Livonia Comfort Care

Dear Ms. 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 responsible party 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 (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820402086
Investigation #:	2025A0585025
Complaint Receipt Date:	01/15/2025
Investigation Initiation Date:	01/16/2025
Report Due Date:	03/14/2025
Licensee Name:	Livonia Comfort Care, LLC
Licensee Address:	34020 Plymouth Rd Livonia, MI 48150
Licensee Telephone #:	(989) 607-0001
Administrator:	Denell Bruyere
Authorized Representative:	Alison Bickford
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 B went into Resident A's room rambling through her things and staff did not response to call light for 20 minutes.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/15/2025	Special Investigation Intake 2025A0585025
01/16/2025	Special Investigation Initiated - Letter Referral made to Adult Protective Service (APS).
01/16/2025	Inspection Completed On-site Completed with observation, interview and record review.
01/16/2025	Inspection Completed – BCAL Sub. Compliance
01/23/2025	Contact -Telephone call made.
03/14/2025	Exit Conference Conducted via email to authorized representative Alison Bickford.

ALLEGATION:

Resident B went into Resident A's room rambling through her things and staff did not response to call light for 20 minutes.

INVESTIGATION:

On 12/11/2024, a complaint was received via BCHS online complaint. The complaint alleged that on 1/14/2025, Resident B entered Resident A's room, and it took over 20 minutes for staff to answer her call button while the resident was going through things.

On 01/16/2025, an onsite visit was completed at the facility. I interviewed Employee #1 stated that there are 34 residents in the facility. She said that there are three shifts which consist of care staff on the morning and afternoon shift, as well as two on the midnight shift. She said that Resident B went into Resident A's room and was rumbling through her things. She said that they did not know about the incident

until the next day because the staff on duty (Employee #2) did not complete an incident report. Employee #1 stated that Resident B is a wanderer. She said that Resident B was in another resident's room, but staff was able to get him out.

On 1/16/2025, I spoke to authorized representative Alison Bickford by telephone. She said that they were not notified by the employee on duty when the incident occurred. She said they started to investigate the incident. She said they questioned Employee #2 and decided to terminate her. She said the expected response time to call light is five minutes, if possible, and staff make adjustments as needed.

On 1/23/2025, I interviewed the complainant by telephone. The complainant statement was consistent with what was written in the complaint. The complainant stated that this was not the first time that a resident had come into her room. She said that on 1/14/2025, at 5:30 a.m., another resident entered Resident A's apartment. She said that Resident A was asleep. She said that Resident A couldn't get out of bed because she is bed bound due to her multiple sclerosis (MS). She said that resident hit the call button for assistance multiple times and continued to hit it, but no one came for about 20-30 minutes. She said that the other residents started going through Resident A's things, along with opening and digging in her food containers. She said that Resident A called her about the incident. She said that she never received a call from the facility about the incident.

During the onsite, I interviewed Resident A at the facility. Resident A stated that Resident B came into her room around 5:30 a.m. She said that she had never been so scared. She said that she has MS and is not able to move. She said that she pressed the call pendant repeatedly, but staff didn't come. Resident A said that Resident B asked her where he was. She said that she told him that he was in her room. She said he asked her for some water. She said that she really got scared because she couldn't move. She said that she pressed the call pendant again for help. She said Resident B picked her water up and then he started going through her food. She said that she continued to press the call pendant for help and finally after 20-30 minutes the staff came into her room. She said that she had staff to throw all her food out because Resident B went through it.

Service plan for Resident A read, admitted to the facility on 4/14/2023. In the section marked *Safety* it read, "staff will check on the resident's whereabouts and safety regularly throughout the day, around the clock."

ADL log for Resident A notes in section *2025 Supervision Checks: Safety Checks Every 4 hours:* On 1/2 checks were not completed 5:00 am – 6:30 am, 10:00 am - 11:30 am or 1:00 pm – 2:30 pm; 1/3 checks were not completed at 12:00 am – 1:00 am, 5:00 am – 6:30 am; 1/4 checks were not completed 5:00 am – 6:30 am, 10:00 am -11:30 am or 1:00 pm – 2:30 pm, 1/5 checks were not completed 6:00 pm – 8:30 pm; 1/8 checks were not completed 12:00 am – 1:00 am, 5:00 am – 6:30 am, 10:00

am – 11:30 am, 1:00 pm – 2:30 pm; 1/13 checks were not completed 6:00 pm – 8:30 pm; 1/14 checks were not completed 10:00 am -11:30 am or 1:00 pm – 2:30 pm.

Service plan for Resident B read, admitted to the facility 1/27/2023. The plan read in the section marked *History of falls*: "The resident has a history of falls, which may indicate a need for closer monitoring and fall prevention measures.

The ADL log for Resident B notes in the section *2025 Supervision Checks: Safety Checks Every 4 hours:* On 1/2 checks were not completed at 6:00 pm; on 1/4 checks were not completed at 12:00 am., 4:00 am., or 6:00 pm., checks were not completed on 1/5 at 6:00 pm; not completed on 1/8 at 10:00 am and 2:00 pm; on 1/11 at 12:00 am, 4:00 am and 6:00 pm; on 1/13 at 6:00 pm.

APPLICABLE RULE	
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.**

R 325.1901	Definitions.
	(p) "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:	Resident B went into Resident A's room while she was lying in bed. He was there long enough to ramble through her belongings. Resident A indicated that she was frighten due to staff not responding quickly after she pressed the call light pendant. Resident B had a history of going into other residents' rooms. There was nothing written in Resident B's service plan regarding his behavior. The service plan notes that Resident B had a history of falling and requires close monitoring. Resident A's service plan notes that staff will check on the resident's whereabouts regular throughout the day. According to Resident A and Resident B's ADL report, there were times when safety checks were not completed. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

During the onsite, the administrator was not present. Employee #1 stated that the administrator on record, Denell Brayere is no longer employed at the facility as of 10/22/2024.

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 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 facility did not notify the department in 5 days with an administrator's change.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I reviewed Resident A and Resident B's service plans.

APPLICABLE RULE	
R 325.1922	**Admissions and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
	(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 service plan notes that there were no updates completed since the initial plan was completed on 4/14/2023. Resident B's service plan does not reflect his current mood or behavior change of him wandering in other residents' rooms.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the inspection of Resident A's room, there were bed rails on both sides of her bed.

APPLICABLE RULE	
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.**
ANALYSIS:	The owner, operator, governing body did not assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents as evidenced by the following: At the time of my inspection, Resident A had bed rails attached to both sides of the bed. There was nothing in the service plan about the bed rails and the monitoring of the bed rails. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/14/2025

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Brender Howard Date
Licensing Staff

Approved By:

03/14/2025

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