GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 18, 2025

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

RE: License #: AH730412298
Investigation #: 2025A1019074

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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) 335-5985.

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 #:	2025A1019074
Complaint Receipt Date:	07/23/2025
Investigation Initiation Date:	07/23/2025
Report Due Date:	09/22/2025
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:	Curtice Farrow
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:	12/04/2024
Expiration Date:	07/31/2025
Capacity:	65
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A isn't receiving the right medication.	Yes
Additional Findings	No

III. METHODOLOGY

07/23/2025	Special Investigation Intake 2025A1019074
07/23/2025	Special Investigation Initiated - Letter Emailed APS for additional information and status update.
07/30/2025	Contact - Document Sent Emailed licensee requesting documentation.
07/31/2025	Contact - Document Received Requested documentation received.
07/31/2025	Inspection Completed-BCAL Sub. Compliance

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged or did not provide enough information for the allegations to be investigated. Therefore, only identifiable items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION: Resident A isn't receiving the right medication.

INVESTIGATION:

On 7/23/25, the department received a complaint about Resident A's medications. The complaint read that Resident A is not getting the correct medication but did not indicate which medications were incorrect. The complaint also alleged inadequate supervision and abuse of the resident; however Adult Protective Services (APS) has investigated those allegations and is not substantiating them. Due to the anonymous nature of the complaint, additional information could not be obtained.

In correspondence with the administrator, Curtice Farrow and the licensee authorized representative, Kory Feetham, Resident A's physician's orders were obtained along with a copy of her medication administration records (MAR) for June

and July 2025. The physician's orders listed all the medications that Resident A is prescribed, which were compared with the medications listed on her MAR; no discrepancies were observed.

While all medications listed on the physician's orders aligned with the medications listed on the MAR, Resident A did not receive medications as prescribed, and her MAR contained several documentation errors. For example, Resident A is prescribed lavender oil and is instructed to "*apply lavender essential oils to pulse points three times daily*". Staff repeatedly documented that the oil was not at the facility to administer, despite intermittently documenting that the oil was administered. In follow-up correspondence with the administrator, it was reported that the oil ran out sometime near the end of May and staff were working to get the oil discontinued through hospice. The administrator confirmed that any documented administrations of the oil after that are considered to be documentation errors. I observed on Resident A's MAR that these documentation errors occurred on the following dates during the timeframe reviewed: 6/1/25-6/14/25, 6/17/25-6/24/25, 6/25/25-7/6/25, 7/12/25, 7/15/25-7/21/25, 7/23/25-7/28/25 and 7/30/25. Resident A is prescribed lorazepam and is instructed to "*take 1 tablet by mouth four times daily*". I observed on Resident A's MAR that she missed one or more scheduled dose, as staff documented she was "*physically unable to take*" on the following dates: 6/11/25 (2 doses), 6/16/25 (1 dose), 6/17/25 (1 dose), 6/20/25 (3 doses), 6/21/25 (2 doses), 6/22/25 (2 doses), 6/23/25 (4 doses), 6/24/25 (3 doses), 6/25/25 (4 doses), 6/26/254 doses), 6/27/25 (2 doses), 6/28/25 (2 doses), 6/29/25 (4 doses), 6/30/25 (2 doses), 7/1/25 (2 doses), 7/2/25 (3 doses), 7/3/25 (1 dose), 7/11/25 (2 doses), 7/12/25 (1 dose) and 7/27/25 (1 dose). In some instances, I observed that staff made an additional notation on the MAR that the medication was given, despite documenting for that same scheduled dose/time that the resident was physically unable to take the medication. In follow-up correspondence with the administrator, it was reported:

> *She is often asleep during the designated med pass times. Per her hospice nurse, if she is asleep, staff may document "physically unable to take" at that time. The medication can then be administered later when she is awake and alert, and recorded as passed. So if both "physically unable to take" and "meds passed" appear in the notes, it means she was initially asleep, but the medication was given once she was up and able to take it. This is consistent with hospice guidance.*

In the instances where staff documented the resident was "*physically unable to take"* the medication and there aren't additional notations, the administrator could not confirm the reason for the missed doses. I also observed that in some instances from 7/1/25-7/3/25, staff documented that the medication was not on the cart, however, the administrator reported that the medication never ran out and those entries are documentation errors.

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:** **(i) The name of the prescribed medication.** **(ii) The prescribed required dosage and the dosage that was administered.** **(iii) Label instructions for use of the prescribed medication or any intervening order.** **(iv) The time when the prescribed medication is to be administered and when the medication was administered.** **(v) The initials of the individual who administered the prescribed medication.** **(vi) A record if the resident refuses to accept prescribed medication and notification as required in subdivision (c) of this subrule.** **(vii) A record of the reason for administration of a prescribed medication that is on an as-needed basis.** **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.**
ANALYSIS:	While it cannot be confirmed that Resident A is receiving the incorrect medication as the complaint alleged, she is not receiving her lavender oil or lorazepam as prescribed. Additionally, numerous documentation errors were observed on Resident A's MAR throughout the timeframe reviewed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/04/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

08/18/2025

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