GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 3, 2025

Ashley Mcloughlin
Shelby Comfort Care
51831 VanDyke Ave.
Shelby Township, MI 48315

RE: License #: AH500413843
Investigation #: 2025A1035062
Shelby Comfort Care

Dear Ashley Mcloughlin:

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.
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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500413843
Investigation #:	2025A1035062
Complaint Receipt Date:	06/13/2025
Investigation Initiation Date:	06/13/2025
Report Due Date:	08/13/2025
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:	Ashley Mcloughlin
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's care needs had not been met.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

06/13/2025	Special Investigation Intake 2025A1035062
06/17/2025	Contact - Telephone call made
06/17/2025	Contact - Telephone call made call made to complainant.
06/23/2025	Contact - Face to Face
07/29/2025	Contact – Additional information requested.
08/14/2025	Contact – Additional information requested.
08/20/2025	Contact – Additional information requested.
8/27/2025	Inspection Complete. BCAL
9/3/2025	Exit conference.

ALLEGATION:

Resident A's care needs had not been met.

INVESTIGATION:

On June 16, 2025, the Department received a complaint through the online complaint system which read:

> "Resident A fell and didn't have a buzzer or no way to call for help. Resident A was almost out of facility. Resident A's sheets would be ripped, and toilet would be

clogged for 3 days. Family A needed a care giver and couldn't find staff then found 2 staff members sleeping. Resident A would have untaken medication on his bed. Staff didn't update Resident A's meds in their system. Staff will show up late and patient will miss breakfast."

On June 16, 2025, a phone interview was conducted with the complainant. The complainant stated that "the care was horrible we had to move Resident A out." Complainant continued to state Resident A is unable to ambulate and the staff would "scream" at him to stand and move his feet. The complainant states she attempted to work with the facility without success. Complainant provided multiple photographs of a staff member sitting in the hallway slumped in chair appeared to be sleeping, staff in common areas on their cell phones, ripped bed sheet, Resident A with dried blood on lips and floor, soiled brief in dresser drawer with snacks, and dirty silverware.

On June 23, 2025, an onsite investigation was conducted. While onsite I interviewed Kassandra Thurlow Administrator who states she is aware of concerns related to Resident A's care and that Family A provided multiple pictures of staff who appear to be sleeping, staff of personal cell phones in common area, and concerns within Resident A's room. The Administrator states she was unable to confirm staff sleeping or being inattentive to residents.

Through record review of Resident A records:

12/28/24 Resident A fell scratches noted to legs, hospice and Family A notified. No noted corrective measures were taken to prevent further occurrences.
12/23/24 Resident A was observed on floor, corrective measure taken at this time was to remind Resident A to not transfer himself and he needs to ask for help if he would like to get up. Hospice and POA notified.
12/13/24 Resident A was observed on floor, small skin tear noted, no corrective measures implemented at this time. Hospice and POA notified.
12/6/24 Resident A observed taking pendant off and placing on the dresser. Resident A proceeded to stand and fell to the floor landing on buttocks. Resident A complained of hip pain, hospice was notified; voice mail left for POA. No corrective measure was implemented at this time.
12/5/24 Resident A observed on floor, no injuries noted. Bed alarm placed under Resident A as a corrective measure. Resident A was reminded to ask for staff assistance and not to get up unless assisted.
12/1/24 Resident A fell from wheelchair, no injuries noted. Resident A was reminded to utilize pendant when trying to transfer. Hospice and POA notified.
11/29/2024 Resident A "slid out of bed, no visible injuries, hospice and family notified." No noted corrective measures taken to prevent recurrence.

Through record review, Shelby Comfort Care Fall Prevention Program states: "*The Fall Prevention Program is to develop, implement, monitor, and evaluate a fall prevention management strategies that foster resident independence and quality of life while ensuring safety for the resident and other residents and staff. The program focuses on*

reducing the incidents of residents' fall through a resident focused team approach which ensures that a residents environment and social, physical, cognitive, and emotional strengths are supported."

Additional information was requested from facility on 7/29/25, 8/14/2025, and 8/20/2025 related to medication administration for the months of November and December 2024, progress notes, point of care documentation, and service plan. The facility did not provide additional information as of the time of issuance of this report.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level.
ANALYSIS:	Resident A experienced 7 documented falls in 30 days at the facility. The facility did not consistently implement interventions to prevent future fall occurrences and ensure resident safety. Based on this information, the violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/21/2025

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing
Section

Approved By:

08/27/2025

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