GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Kory Feetham
Tender Care of Michigan, LLC
4130 Shrestha Drive
Bay City, MI 48706

September 23, 2022

RE: License #: AH090371811
Investigation #: 2022A1022004
Bay City Comfort Care, LLC

Dear Kory Feetham:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH090371811
Investigation #:	2022A1022004
Complaint Receipt Date:	06/17/2022
Investigation Initiation Date:	06/21/2022
Report Due Date:	08/17/2022
Licensee Name:	Tender Care of Michigan, LLC
Licensee Address:	4130 Shrestha Drive Bay City, MI 48706
Licensee Telephone #:	(734) 355-6050
Administrator:	Elyse Al Rakabi
Authorized Representative:	Kory Feetham
Name of Facility:	Bay City Comfort Care, LLC
Facility Address:	4130 Shrestha Drive Bay City, MI 48706
Facility Telephone #:	(989) 545-6000
Original Issuance Date:	10/24/2016
License Status:	REGULAR
Effective Date:	04/24/2022
Expiration Date:	04/23/2023
Capacity:	67
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents who are smokers are taken to an outside, locked patio area to smoke and have no way to get back into the building by themselves. Residents who are smokers are mistreated by staff because they have to wait a long time for staff to remember they are outside to come back and let them back into the building.	Yes
The facility has bedbugs, drain flies, bugs trapped in the windows, and spider webs.	No

III. METHODOLOGY

06/17/2022	Special Investigation Intake 2022A1022004
06/21/2022	Special Investigation Initiated - Telephone Call to complainant. No answer. Left message to call back.
06/21/2022	Contact - Telephone call received Spoke to complainant
06/22/2022	Inspection Completed On-site
07/07/2022	APS Referral
07/13/2022	Contact - Telephone call made Spoke with contracted pest exterminator
09/23/2022	Exit Conference

ALLEGATION:

Residents who are smokers are taken to an outside, locked patio area to smoke and have no way to get back into the building by themselves. Residents who are smokers are mistreated by staff because they have to wait a long time for staff to remember they are outside to come back and let them back into the building.

INVESTIGATION:

On 6/21/2022, I interviewed the complainant by phone. According to the complainant, she had been a resident of the facility from 6/3/2022 until 6/6/2022 under the Michigan Medicaid waiver program because her apartment was not habitable. The complainant stated she was a smoker and had been informed that she could only smoke while sitting in an outside patio that was the facility's designated smoking area. The door from inside the facility leading to the patio was routinely kept locked. Staff were able to open the door using an electronic key fob. The complainant went on to say that she was "locked outside" after smoking each day that she was in the building. The complainant then explained that due to her physical condition, which included degenerative joint disease and a bilateral hip replacement, she was not able to ambulate independently, but needed a walker or a wheelchair. It was the complainant's impression that the staff "disliked me. They did not want to push (the wheelchair) back into the building. They didn't want to be bothered. But after sitting up for 20 to 30 minutes, I get very uncomfortable and need to lay down."

The complainant referenced three other residents who were smokers. The complainant stated that Resident A had been issued a key fob, so if Resident A was on the patio smoking, the other residents were able to get back into the building. The complainant stated that Resident A was not always out on the patio when she wanted a cigarette. The complainant stated that eventually, she figured out that if she left the patio area, she could wheel herself (or self-ambulate with her walker) to the entrance to the Memory Care unit. If she was able to get inside the foyer, she could get the staff's attention to open the door of the Memory Care unit.

On 7/7/2022, a referral to was sent to Adult Protective Services.

On 6/22/2022, I interviewed the administrator during an onsite visit. The administrator acknowledged that residents were only able to smoke cigarettes while outdoors in the facility's designated smoking area. The administrator further acknowledged that the door to this area was kept locked and that residents were not able to enter the building on their own once they were outside. According to the administrator, there were four residents currently living in the building who were known to be smokers; however, one of those residents was on a leave of absence from the building. The administrator went on to say that all of the residents who were allowed to smoke must be "their own responsible persons," and that all current smokers were living in the building under the Michigan Medicaid waiver program. They all had the ability to smoke whenever they chose, as long as the activity was restricted to the designated smoking area. The administrator went on to say, "if a resident is on a Medicaid waiver, they have the right to do whatever they want." There were no smoking assessments for any of the current smokers and their service plans simply reflected that the resident was a smoker, with no additional instructions provided to care staff, for example, set smoking schedules, additional safety precautions, or access instructions.

When asked about access into and out of the designated smoking area, the administrator stated that the facility had recently issued call pendants to all residents and that residents could simply press their pendent and a staff member would respond. The administrator went on to say that the facility had elected to issue an electronic key fob to Resident A, who was deemed to be “very responsible.” The administrator went on to say that the three residents currently in the building frequently went out as a group to smoke, so there should not be any issue with those residents getting in or out of the building.

When asked specifically about the complainant, the administrator stated that the complainant was in the facility over a weekend, and she (the administrator) had no direct knowledge of her. The complainant was admitted late on a Friday and displayed disruptive behaviors. Staff reported that the complainant did not seem to want to stay in the facility, called a taxi service first thing on Monday morning, and left the building. According to the administrator, the complainant told staff she had been promised a room close to the exit onto the designated smoking area and was angry when that turned out not to be the case.

At the time of the onsite visit, observation of the smoking area revealed that it was a gated patio located in-between the main facility entrance and the entrance to the Memory Care unit. Resident B was observed seated in a chair by the access door, smoking. When Resident B was asked if she could get back in the building by herself if she needed to, Resident B said she could not. When Resident B was asked if she had her call pendant with her, Resident B denied having a pendant.

A short time later, Resident C was observed seated in a wheelchair in the hallway outside his room. Resident C informed a staff member that he wanted to be taken to the designated smoking for a cigarette. Once outside in the designated smoking area, Resident C was asked if he could get back in the building by himself if he needed to. Resident C answered no he could not. Resident C said that if Resident A was out smoking, Resident A would let him back into the building with his key fob. At this time, Resident A was not in the designated smoking area. When Resident C was asked if he had his call pendant with him, Resident C said he did not realize that he had a call pendent. Resident C stated that while he did not smoke as many cigarettes as Residents A or B smoked, he did smoke on a regular basis and had difficulty getting back into the building if Resident A was not there as well. Resident C estimated that on a recent occasion, he had to wait as long as two hours for a staff member to get him back into the building. He went on to say that sometimes it depended upon whichever staff member had let him out onto the patio, since there were staff members who knew he only wanted to be out on the patio for about 10 minutes at a time.

When the administrator was asked about Resident C’s assertion that he had to wait two hours for a staff member to let him into the building, the administrator said that

she found that assertion to be unlikely because Resident A went out to smoke so frequently, she could not imagine Resident C being there by himself for so long.

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:	Although the residents who are smokers are assumed to be "their own responsible persons," when the facility transfers supervision responsibility from their staff members to individual residents, they are no longer providing protection for those residents. It is not reasonable to expect Resident A to be responsible for other residents regardless of how "responsible" he might be.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility has bedbugs, drain flies, bugs trapped in the windows, and spider webs.

INVESTIGATION:

On 6/21/22, when I interviewed the complainant, the complainant stated that she had been admitted to the facility only while her apartment was being fumigated for bedbugs. When I asked her if it was possible that any bedbugs she saw were from her apartment, she acknowledged that could easily be the case. But the complainant went on to say that there were infestations of drain or sewer flies in the building and evidence of spiders.

When the administrator was asked about insects and similar pests, she reported that the facility has a contracted pest extermination who comes into the building on a monthly basis and who is also able to come in "as needed." According to the administrator, the facility usually dealt with spiders, occasionally ants, but had no reports of drain flies or sewer flies since "there was snow on the ground."

Observation of resident rooms and shower rooms, including the room the complainant occupied, did not reveal any evidence of drain flies, spiders, or other types of pests.

The pest exterminator was interviewed by phone on 7/13/2022. The exterminator confirmed that he serviced the building on a monthly basis and covered both the interior and the exterior of the property. According to the exterminator, the only recurring pest problem had been the presence of ants and that was limited to a specific room, room 304 and to a specific time period, the middle of the month of June 2022. The exterminator went on to say that at the present time, the facility needed only preventative pest control services.

APPLICABLE RULE	
R 325.1978	**Insect and vermin control.**
	(1) A home shall be kept free from insects and vermin.
ANALYSIS:	There was no evidence that the facility did not have an effective pest control program.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 9/23/2022. When asked if there were any comments or concerns with the investigation, the AR stated there were none.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

9/23/2022

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

09/16/2022

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