GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Richard Fritz
Shelby Comfort Care
51831 VanDyke Ave.
Shelby Township, MI 48315

October 6, 2023

RE: License #: AH500413843
Investigation #: 2023A1022046
Shelby Comfort Care

Dear Richard Fritz:

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.

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 #:	AH500413843
Investigation #:	2023A1022046
Complaint Receipt Date:	08/15/2023
Investigation Initiation Date:	08/15/2023
Report Due Date:	10/14/2023
Licensee Name:	Shelby Comfort Care, LLC
Licensee Address:	2635 Lapeer Road Auburn Hills, MI 48326
Licensee Telephone #:	(989) 607-0001
Administrator:	Alison Bickford
Authorized Representative:	Richard Fritz
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:**	TEMPORARY
Effective Date:	02/16/2023
Expiration Date:	08/15/2023
Capacity:	77
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) was not receiving the assistance that he required.	No
The entry to the facility is unsafe.	No
The facility is not kept clean.	Yes
A family member was barred from visiting with the ROC.	Yes

III. METHODOLOGY

08/15/2023	Special Investigation Intake 2023A1022046
08/15/2023	Special Investigation Initiated - Telephone Phone call placed to complainant.
08/16/2023	Inspection Completed On-site
08/22/2023	Contact - Telephone call received Phone call received from APS referral source, who added additional detail to her written allegations.
08/31/2023	Contact - Document Received Information exchanged with the facility via email.
09/29/2023	Contact - Document Received Information exchanged with the facility via email.
10/06/2023	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) was not receiving the assistance that he required.

INVESTIGATION:

On 8/15/2023, the Bureau of Community and Health Systems (BCHS) received a referral from Adult Protective Services (APS) that read, “[Name of Resident of Concern (ROC)] has no known health concerns at this time. He is bedridden. There's concern for the treatment [name of the ROC] is experiencing in the assisted living facility. The staff are withholding food because they are stating he's choking. [Name of the ROC] has to be fed and is being rushed which is causing him to choke. [Name of the ROC] is also a picky eater and isn't given other options of meals to eat. [Name of the ROC] is often time told he has to wait until the next meal to see if he prefers that one. On an unknown date, a staff member was sharing with [name of the ROC]'s sister that he hadn't eaten in 5 days then when she noticed the sister getting upset, she recanted and said he had eaten. The staff have been known to give him pain medication when it's not needed causing him to be drowsy resulting him missing meals. They claim they aren't able to wake him for meals but there's been times where he had been sleeping right before meals and family members were able to wake him up. It's believed they are slowing trying to kill [name of the ROC]. [Name of the ROC] has pushed his call light and has had to wait more than 1 hour for someone to respond. Family members have had to leave out from visiting with him to find someone to help him… [Name of the ROC] has expressed that the staff will not take him out of bed, nor will they put on his CPAP (continuous positive airway pressure machine) at night to assist with his breathing… “

The referral was marked, “Denied,” signifying that APS had determined they would not be investigating the allegations.

On 08/15/2023, a phone call was placed to the APS referral source (RS). The call was not answered, and a message was left for the RS to return the call. The APS RS did not return the call.

On 08/16/2023, at the time of the onsite visit, I interviewed the administrator, who described the ROC as being highly dependent on the physical assistance of 2 caregivers for most of his activities of daily living (ADLs) due to issues related to his lungs. He was able to express himself verbally, but due to memory loss was not able to reliably answer questions. The ROC had moved into the facility in January 2023, but had fallen several times with resulting injuries. In May 2023, on the advice of the resident care director, he was admitted to hospice care. The administrator went on to say that the ROC had experienced several cycles of an overall decline in his

health, even to the point where it had been the hospice nurse manager's opinion that he was "transitioning" on his way to death, only to "snap back."

According to the hospice documentation, the ROC was admitted to hospice on 05/06/2023 with the hospice diagnosis of congestive heart failure. On 07/23/2023, the hospice-ordered medications included two medications to be administered as needed: nitroglycerin for chest pain and morphine sulfate for either pain or shortness of breath. On 08/04/2023, the hospice order was for the ROC to receive a pureed diet with one-to-one feeding and aspiration precautions. On 08/10/2023, the hospice order was to discontinue all medications except for the morphine sulfate to be given as needed, nitroglycerin as needed, oxygen via nasal cannula as needed, hyoscyamine under the tongue to control oral secretions as needed and at bedtime, lorazepam antianxiety medication every 6 hours and as needed, Dulcolax laxative daily and Compazine antinausea medication, as needed. The medication order of 08/10/2023 reflected the hospice's anticipation of the ROC's imminent death.

According to the administrator, at the time of the onsite visit, the ROC had "snapped back" from his most recent health decline. I was able to visit with the ROC in the facility dining room. He was dressed and sitting at one of the tables with a coffee cup and a partially eaten container of yogurt in front of him. He was receiving oxygen from a nasal cannula inserted into his nostrils. He responded when greeted and stated that he didn't much like the yogurt he had been served. The administrator explained that the ROC had been placed on pureed diet by the hospice nurse manager, because he had been pocketing food in the side of his cheek when presented with food. When the administrator was asked about the allegations that the ROC was unable to eat due to sedating pain medications, the administrator went on to say that while the facility was following the orders given by the hospice provider, members of the ROC's family had expressed disagreement with the care he was receiving. According to the administrator, a family member brought the ROC fast food hamburgers and tried to cut off small pieces and placed them into his mouth.

At the time of the onsite visit, two of the ROC's sisters came into the facility, family member #1 and family member #2. Both of these family members expressed their belief that the ROC did not need hospice care, but a decision to leave hospice could not be made without the agreement of the POA (power of attorney), which was held by one of the ROC's sons. Family member #2 stated that ROC needed more care than the facility was prepared to give him. Family member #1 wanted the ROC to use his CPAP machine. The administrator explained that when he entered hospice care, the hospice nurse manager discontinued the CPAP because he was getting the oxygen with the nasal cannula. The administrator then reminded the two family members that the hospice nurse manager had attempted to convene a meeting held by videoconference for all the interested family members including the son who held the POA as well as the ROC's sisters and members of the hospice team, but the meeting had been cancelled at the last minute by the POA.

When asked about long wait times for after when the ROC activated his pendant call button, the administrator stated that her goal was to have the call answered within 5 minutes. Review of pendant response times documenting the response time for 122 calls for the time period 07/01/2023 until 08/17/2023 revealed the following occurrences of a response time greater than 15 minutes:

07/07/2023: 51 min at 7:37 pm
07/19/2023: 43 min at 12:31 am
07/22/2023: 29 min at 1:13 am
07/24/2023: 25 min at 1:29 am
07/30/2023: 26 min at 1:11 am
08/02/2023: 27 min at 2:52 am
08/03/2023: 21 min at 11:04 pm

There were no occurrences where the ROC waited more than the 51 minutes noted on 07/07/2023. The response log indicated that most of the time, the response time was less than 10 minutes, although there were approximately a dozen occurrences that were more than 10 minutes, but less than 15 minutes.

On 08/22/2023, the APS RS returned the initial phone call of 08/15/2023. At that time, the RS stated that the ROC's caregivers had refused to feed the ROC. On 08/31/2023, via an email exchange with the administrator, the administrator explained that the APS RS had been "screaming at staff that we are starving him (the ROC)," and demanding that "we force him to eat…" According to the administrator, "Our caregivers were following hospice orders, if the resident was not alert and oriented and able to safely consume food then we were not to force him."

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:	Other than the long wait time for pendant call response, the allegations seem to represent the family's disagreement with orders that have originated with the hospice provider. Since the ROC's POA made the decision to place the ROC on hospice care, the facility has no choice but to follow through with whatever orders the hospice provider gives. Although there were a handful of long wait times for pendant activation response, most times the calls were answered in a timely fashion.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The entry to the facility is unsafe.

INVESTIGATION:

According to the APS referral, "The entry to the facility door has a bump. One day, [name of the ROC]'s sister took him outside for some fresh air when return [name of the ROC] fell out of his wheelchair causing his face to be bloody, the entry way should be a flat surface."

At the time of the onsite visit, family member #2, who was visiting the ROC, acknowledged that there had been an incident when she wheeled the ROC while he was seated in his wheelchair from the courtyard back into the facility. There was a rise in the threshold of the door, and she stated that she knew she "had to exert some force" to get his chair over the threshold and gave the wheelchair "an extra shove," that caused the ROC to lean forward. She went on to explain that she attempted to stabilize him by grabbing him by his shirt but lost her balance herself and fell on top of the ROC.

Observation of the courtyard door revealed that the threshold, while not flush with the courtyard patio, was not excessively high.

APPLICABLE RULE	
R 325.1964	**Interiors.**
	(1) A building shall be of safe construction and shall be free from hazards to residents, personnel, and visitors.

ANALYSIS:	There was no evidence that any of the facility's entrances were not safely constructed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is not kept clean.

INVESTIGATION:

According to the APS referral, "The facility overall is dirty, the filthy floors were pointed out to staff and only then were they cleaned."

At the time of the onsite visit, observation revealed that although the common areas were clutter-free and the furnishings had no visible soil, a good deal of debris was left on the floors. Almost all waste cans were full with trash. All the hallway floors had visible debris. In both the main dining and the memory care unit dining room, there was visible food debris as well as paper wrappings on the floor, but not all residents had left the rooms after breakfast. The administrator explained that the overnight shift staff were responsible for mopping the floors of the dining rooms. The home theater room was not well maintained. There was food debris on the lounge chairs and in the chair beverage holders. The administrator went on to explain that she had only 1 housekeeper for the facility, who worked Mondays through Fridays, but had been off ill for the past 3 days. A part time housekeeper had just been hired but had not yet started work.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Direct observation at the time of the onsite visit revealed that the facility was not kept clean.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

A family member was barred from visiting with the ROC.

INVESTIGATION:

On 08/22/2023, when the APS RS returned the phone call of 08/15/2023, she stated that the facility had told her she could not come into the facility to visit with the ROC, her brother, and the facility had not told her why she was barred.

On 08/31/2023, via the email exchange with the administrator, the administrator explained that the APS RS "was removed from the building with police escort after several interactions that caused distress to not only [name of the ROC] but other residents, staff and visiting family members. She had been force-feeding [name of the ROC] non puree food, against hospice order. Slamming doors in staff's face, screaming at staff that we are starving him, video recording the staff even when they asked her to stop, yelling at management about his care and demanding information that is only available to the DPOA and raising her voice in the hallways and common areas with no concern that this is the residents' home." According to a second email also received on 08/31/2023, the administrator explained, "I (the administrator) made a typo in the above (previous) message and wanted to clarify. [Name of the APS RS] was removed from the building with police escort and is banned from the facility.

On 09/29/2023, in a subsequent email exchange, in response to my question whether the ROC's POA had indicated that the APS RS should not be allowed to visit the ROC, the administrator sent the ROC's signed Residency Agreement that contained the following clause: "The Resident acknowledges and understands that the Resident's Guests are subject to the Company's rules and regulations, and if the Resident Guests become disruptive to the operations of the Facility and/or are verbally or physically abusive to staff, resident or others, the Company may request that they leave the Facility until their behavior is under control or may place limitations upon the location and time of their visitation. The Resident understands that, where circumstances warrant, the Company may exclude such individuals from the Facility." The administrator went on to say that the ROC moved out of the facility on 09/18/2023 and did not clarify further.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant to whom the physician has delegated the performance of medical care services, attorney, or any other person of his or her choice. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.**
ANALYSIS:	The facility acted within its authority to ask the APS RS to leave the building on the occasion when she was disruptive; however, there was no evidence that the facility offered her an opportunity to visit her brother under control circumstances and no evidence that either the ROC or the ROC's POA objected to her visits.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 10/06/2023. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

10/06/2023

Barbara Zabitz Date
Licensing Staff

Approved By:

10/04/2023

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