GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 11, 2023

Elyse Al-Rakabi
Shields Comfort Care Assisted Living and Memory Care LLC
9140 Gratiot
Saginaw, MI 48609

RE: License #: AH730412298
Investigation #: 2023A1027085
Shields Comfort Care Assisted Living

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. 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.

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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730412298
Investigation #:	2023A1027085
Complaint Receipt Date:	08/07/2023
Investigation Initiation Date:	08/07/2023
Report Due Date:	10/06/2023
Licensee Name:	Shields Comfort Care Assisted Living and Memory Care LLC
Licensee Address:	Suite B 3061 Christy Way Saginaw, MI 48603
Licensee Telephone #:	(989) 607-0001
Administrator:	Shannon Moriarity
Authorized Representative:	Elyse Al-Rakabi
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:	TEMPORARY
Effective Date:	06/01/2023
Expiration Date:	11/30/2023
Capacity:	65
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her medications as prescribed.	Yes
Staff left soiled linens on the floor, changed the trash once daily and the carpet smelled like urine. There were not snacks available.	No
Additional Findings	No

III. METHODOLOGY

08/07/2023	Special Investigation Intake 2023A1027085
08/07/2023	Special Investigation Initiated - Letter Email sent to administrator Shannon Moriarity to request documentation pertaining to Resident A
08/08/2023	Contact - Document Received Fax received with requested documentation
08/09/2023	Contact - Document Received Fax received with additional documentation
08/28/2023	Inspection Completed On-site
08/28/2023	Inspection Completed-BCAL Sub. Compliance
09/19/2023	Exit Conference Conducted with Elyse Al-Rakabi by email

ALLEGATION:

Resident A did not receive her medications as prescribed.

INVESTIGATION:

On 8/7/2023, the Department received a complaint forwarded from Adult Protective Services (APS) which read Resident A had resided at the facility for two weeks. The complaint read the facility lost Resident A's bag of diabetic supplies on 8/1/2023 or 8/2/2023. The complaint read Resident A did not receive insulin for lunch that day. The complaint read on 8/3/2023, Resident A's bag of diabetic supplies was found by

a staff member in another resident's room. The complaint read Resident A was not receiving her medications as scheduled, specifically her "Norco." APS did not open an investigation regarding the allegations.

On 8/28/2023, I conducted an on-site inspection at the facility. I interviewed administrator Shannon Moriarity who stated Resident A's glucose meter was misplaced in which she purchased another one that day; however, it was found. Ms. Moriarity stated Resident A's prescribed medication "Norco" ran out today due to needing a written prescription from the physician.

While on-site, I interviewed Resident A who stated four medications ran out and staff told her pharmacy was not letting the facility know. Resident A stated her medications were left at bedside and pills were found in her bed. Resident A showed a picture on her phone dated 8/3/2023 of a medication cup with pills in it on her bedside table.

While on-site, I did not observe medications on the floor in Resident A's apartment, nor in the hallways or space where the medication cart was locked.

While on-site, I interviewed Employee #1 who stated the pharmacy usually informed them when they needed a prescription to refill a medication; however, for Resident A, she called the pharmacy to inquire what was needed for her medications to be refilled. Employee #1 stated the pharmacy needed a new prescription for Resident A's "Hydrocodone" or "Norco" in which she called her physician to request a written prescription. Employee #1 stated she trained staff to observe each resident take their medications prior leaving the room. Employee #1 stated she had not observed medications in Resident A's apartment or other residents' apartments.

While on-site, I reviewed a written prescription for Resident A dated 7/19/2023 for "Norco 5/325 mg one tablet by mouth every six hours" for 30 tablets and no refills.

While on-site, I reviewed the facility's narcotic count logs with Employee #1. We reviewed a form titled *Controlled Drug Receipt/Proof-Of-Use/Disposition Form* for Resident A's prescribed Hydrocodone from 7/20/2023 through 8/20/2023 in which read consistent with her MAR; however, the records were not always completed. Employee #1 stated staff were required to document the following for each resident's narcotic medication administered: the date, time, amount given, amount left and sign their name; however, some staff left the documentation incomplete. The *Controlled Drug Receipt/Proof-Of-Use/Disposition Form* for Resident A's prescribed Hydrocodone medication was incomplete on the following dates 7/23/2023, 7/26/2023, 8/5/2023, 8/8/2023, and 8/11/2023 and the narcotic count was incorrect on 8/11/2023. Additionally, Employee #1 and I reviewed the *Controlled Substance Shift Inventory* form which was incomplete on one or more shifts from 8/1/2023 through 8/28/2023. Employee #1 stated each change of shift, the on-coming shift conducted a count of all narcotic medications with the staff going off-duty, then they documented the count on the *Controlled Substance Shift Inventory* form, and both

staff signed that the task was completed. Employee #1 stated although she educated staff to complete the *Controlled Substance Shift Inventory* form, staff left it incomplete.

I reviewed Resident A's face sheet which read in part she admitted to the facility on 7/20/2023.

I reviewed Resident A's admission contact dated 7/20/2023 and signed by Resident A which read in part that the facility would provide medication management assistance.

I reviewed Resident A's service plan which read in part staff would assist with routine medications and "PRN" (as needed) medications two times per day. The plan read in part Resident A had continuous pain and required scheduled pain relief medication.

I reviewed Resident A's August 2023 medication administration records (MARs) which read in part she was prescribed:

> Novolog, inject subcutaneously per sliding scale before meals and at bedtime, 150-200= 2 Units, 201-250 = 4 Units, 251-300 = 6 Units, 301-350 = 8 Units, 351-400 = 10 Units, greater than 400 call medical doctor at 8:00 AM, 12:00 PM, 5:00 PM and 8:00 PM.
>
> Lantus Solos, inject 20 units subcutaneously daily at bedtime 8:00 PM, hold for blood glucose less than 120.
>
> Hydrocodone (Norco), take one tablet by mouth every six hours, daily at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM.

The MARs read on 8/2/2023, the 12:00 PM dose for Novolog was held for reason "physically unable to take." The MARs read on 8/2/2023 at 5:00 PM, Resident A's blood sugar was 257 and six units of Novolog was administered. The MAR read on 8/2/2023 at 8:00 PM, the Novolog dose was held for reason "resident refused" and comment read "he [sp] meter was not in the cart, but resident did have the meter in her room and that how we checked the sugar in the evening and this time she regused [sp] her shot." The MARs read on 8/1/2023 and 8/2/2023 staff initialed Hydrocodone (Norco) and Lantus were administered as prescribed by the licensed healthcare professional.

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.
ANALYSIS:	Review of Resident A's medical records revealed the facility was responsible for administration of her medications. There was insufficient evidence to support staff left Resident A's medications at bedside. Review of Resident A's medication administration records revealed staff documented her medications as administered or reasons why they were not administered. However, the medication administration record read consistent with the allegations and Resident A was not administered her Novolog on 8/2/2023 at 12:00 PM. Additionally, staff attestations revealed her medications were not always available for administration. Additionally, narcotic count logs for Resident A's medications, as well as the narcotic inventory of the medication cart, were incomplete or left blank. Based on the aforementioned concerns, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff left soiled linens on the floor, changed the trash once daily and the carpet smelled like urine. There were not snacks available.

INVESTIGATION:

On 8/7/2023, the Department received a complaint forwarded from Adult Protective Services (APS) which read staff left soiled linens on the bathroom floor and soiled briefs in the trash cans. The complaint read trash bags were changed once daily. The complaint read Resident A's carpet smelled like urine.

On 8/28/2023, I conducted an on-site inspection at the facility. I interviewed Resident A whose statements were consistent with the complaint. Resident A stated on 7/29/2023 there were wet sheets left on the carpeted floor. Additionally, Resident A stated there no snacks available after the kitchen closed at night and she was diabetic. Resident A stated she purchased some of her own snacks to have at bedside.

While on-site, I observed Resident A's apartment had no linens on carpeted or bathroom floors. I observed Resident A's dirty laundry was in a basket. I observed Resident A's trash can was empty. I observed Resident A's apartment was not odorous.

While on-site, I interviewed Employee #1 who stated snacks were available and passed out around 8:00 PM. Employee #1 stated each nurses' station maintained a bucket of snacks. Employee #1 stated the kitchen staff premade sandwiches which were kept in the dining area refrigerators. Employee #1 stated each medication technician had a key to access the kitchen if needed. Additionally, Employee #1 stated bed linens were changed twice weekly on resident's shower days or when soiled. Employee #1 stated staff were trained to take soiled linens out of the resident's apartment immediately to be laundered. Employee #1 stated soiled briefs were placed in the trash, then the trash was removed from the resident's apartment.

While on-site, I observed snacks at the nurse's station and pre-made sandwiches in the dining refrigerator.

I reviewed Resident A's admission contract dated 7/20/2023 and signed Resident A which read in part that snacks and assorted beverages are provided throughout the day. The contract read in part weekly housekeeping, laundry and bed linen change was provided, as well as bi-weekly bath linen change.

I reviewed Resident A's service plan which read consistent with admission contract. The plan read in part the facility will provide all meals and regular snacks three times per day. The plan read in part laundry services for her personal clothing and linens would occur on shower days.

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:	Review of facility documentation, observations, staff interviews and Resident A's interview; there was insufficient evidence to support allegations of soiled linens left on floor, trash left unchanged, odorous carpet, nor snacks unavailable.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

09/11/2023

Jessica Rogers Date
Licensing Staff

Approved By:

09/18/2023

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