GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 16, 2023

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

RE: License #: AH090371811
Investigation #: 2023A0784082
Bay City Comfort Care, LLC

Dear Kory Feetham:

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH090371811
Investigation #:	2023A0784082
Complaint Receipt Date:	08/14/2023
Investigation Initiation Date:	08/14/2023
Report Due Date:	10/13/2023
Licensee Name:	Tender Care of Michigan, LLC
Licensee Address:	4130 Shrestha Drive Bay City, MI 48706
Licensee Telephone #:	(734) 355-6050
Administrator:	Morgan Harrington
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:	04/24/2023
Expiration Date:	04/23/2024
Capacity:	67
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate protection for Resident A.	Yes
Inadequate Care	No
Residents were administered medications late.	Yes
Resident B was not provided meals in a timely manner.	No
Additional Findings	Yes

III. METHODOLOGY

08/14/2023	Special Investigation Intake 2023A0784082
08/14/2023	APS Referral
08/14/2023	Special Investigation Initiated - Letter APS Referral
08/15/2023	Inspection Completed On-site
08/16/2023	Contact - Telephone call made Interview with adult protective services (APS) worker Chris Shores
TBA	Exit

ALLEGATION:

Inadequate protection for Resident A

INVESTIGATION:

On 8/14/2023, the department received this online complaint. Due to the anonymous nature of the complaint, additional information could not be obtained. A referral was made to adult protective services (APS).

According to the complaint, Resident A fell out of her wheelchair due to not being properly supervised. Resident A passed away “3-4 days” after this fall.

On 8/15/2023, I interviewed administrator Morgan Harrington at the facility. Ms. Harrington confirmed that Resident A passed away sometime at the end of July 2023. Ms. Harrington stated Resident A was on hospice at the time and passed away at the facility. Ms. Harrington stated Resident A did have a fall shortly before passing. Ms. Harrington stated Resident A was kept in the common area of the facility in order to make sure she was more visible to staff when she was out of her room due to her high risk for falling and low safety awareness. Ms. Harrington stated Resident A would likely fall if she attempted to get up on her own and that Resident A was, at times, unpredictable in that she would randomly attempt to get up on her own without understanding she needed staff assistance. Ms. Harrington stated that on the day Resident A fell, staff had assisted her into her recliner and left to assist another resident. Ms. Harrington stated that during this time, Resident A appeared to have made an attempt to pick something up off the ground and fell out of her chair causing some bruising to her right arm.

I reviewed an incident report for Resident A, provided by Ms. Harrington. The report was dated 7/20/2023 with a time of 8:40pm. According to the report, the location of the incident was in “residents room”. Under a section titled *Explain what happened/Describe Injury*, the report read “Resident observed on floor, resident unable to state what happened. Resident stated no pain”. Under a section titled *Action Taken by Staff*, the report read “Assessment completed, bruising observed on right hand, resident stated no pain, resident refused PRN. All parties notified”. Under a section titled *Corrective Measures Taken to Remedy and/or Prevent Recurrence*, the report read “Follow up with hospice/MD, Request UA”.

I reviewed Resident A’s service plan, provided by Ms. Harrington. Under a section titled *Fall Risk*, the plan reads, in part, “Totally dependent on staff to provide assistance (total lift) transfer in the case of a fall”. Within this section was a sub-section titled *Additional information regarding fall risk/assistive devices*, the plan read “Resident does not always remember to ask staff for assistance when she is weak and will self-transfer”. Under a section titled History of Falls, the plan read “Resident has falls in past. If resident is weak assist with care needs”. Under a section titled Transferring, the plan reads, in part, X1 person assist with all transfers, resident self-transfers often without asking for assistance. Resident is highly encouraged to ask for assistance. Resident Refuses often to ask for assistance with ADLs. Resident is able to stand and pivot”. Under a section titled Safety, the plan reads, in part, “Unable to use call system. Resident is resistant to asking for assistance. Resident will not wear her pendent. Resident self-transfers often without asking for assistance. Resident is highly encouraged to ask for assistance when transferring”.

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.**
For Reference R 325.1901	**Definitions.**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The complaint alleged inadequate protection of Resident A due to a lack of appropriate supervision when Resident A fell out of her wheelchair. When interviewed, administrator Morgan Harrington reported Resident A was a person who was a high fall risk and had a low awareness of her safety as she would often attempt to get up on her own not understanding she was unable to support herself. Ms. Harrington confirmed Resident A had a fall from her chair while staff had left her room to assist another resident, which was also confirmed via facility incident reporting. Review of Resident A's service plan confirmed Resident A's propensity for falls and need for transfer assistance by at least one staff. Although the plan indicated that when Resident A needs assistance for transfers, she is encouraged to request such assistance from staff, Ms. Harringtons reported Resident A was unpredictable having a propensity to get up on her own as she often did not understand that she needed to request staff help due to her low safety awareness. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Inadequate care

INVESTIGATION:

According to the complaint, residents are being left in soiled clothing for an extended period of time. Call lights are not responded to in a timely manner as it often takes over 20 minutes for staff to respond. No dates, times, staff or resident names were provided in relation to this complaint.

When interviewed, Ms. Harrington stated she was not aware of any issues with residents being left in soiled clothing for extended periods of time. Ms. Harrington stated Residents that require staff assistance with toileting are assisted regularly. Ms. Harrington stated that, residents who are incontinent and require a higher frequency of brief checks ande changes are placed on a specific “toileting program” designed specifically to their need. Ms. Harrington stated resident “toileting” is tracked in the facilities computer system. Ms. Harrington stated that when staff provide toileting to residents, they note this in the system and that the time of care is tracked. Ms. Harrington identified Residents B, C, D, E, F and G as those on a frequent toileting program. Ms. Harrington stated she reviews call light response times regularly and has not observed an issue regarding staff responding to the call lights in an appropriate amount of time. Ms. Harrington stated the expectation for staff response time is between five and seven minutes, but that the ultimate goal is to respond in under four minutes. During the onsite, I observed multiple residents throughout the facility which appeared clean and well groomed.

I reviewed August 2023 *Admin History* tracking documentation as it pertains to Toileting for Residents B, C, D, E, F and G, provided by Ms. Harrington. The documentation read consistently with Ms. Harringtons statements indicating frequent and consistent assistance with toileting.

I reviewed the facilities call response report for 8/11/2023, 8/12/2023 and 8/13/23, provided by Ms. Harrington. The report indicated staff consistently respond to call lights according to expectations. According to the report, there were 135 calls made to summon staff assistance on those three days. Of the calls made, all but 11 calls were responded to within the expected response time frame, notably within three to five minutes. Of the 11 calls taking over 7 minutes, all were responded to in less than 10 minutes.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Based on the findings, there is insufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents were administered medications late.

INVESTIGATION:

According to the complaint, residents are not getting medications administered on time. No dates, times, resident or staff names were provided in relation to this complaint.

When interviewed, Ms. Harrington stated all resident medication data is tracked within the facilities computer data system. Ms. Harrington stated that when medication technicians (med techs) pass medications, there is a data entry point in the system which staff must mark to denote that they have passed the medication. Ms. Harrington stated the system tracks the scheduled and administered time of each medication for each resident. Ms. Harrington stated she can generate a report showing when medications were administered against when the medication was scheduled. Ms. Harrington stated she reviews these reports regularly and is not aware of any late medication administration issues. Ms. Harrington stated that on occasion, a medication may get passed a few minutes late depending on various number of reasons, or a resident may refuse a medication and not receive it, but that staff are consistent in passing medications within the allotted time frame, between one hour before and one hour after the scheduled time.

I reviewed the *Med Pass Details* report, from 8/01/2023 to 8/15/2023 for Residents H through Q, provided by Ms. Harrington. The report provided the *Scheduled* time for each resident's medication to be administered as well as the *Recorded* time of medication administration reflecting the time each medication was administered. The report revealed multiple medications were administered late for these residents spanning the 15-day period reviewed. According to the report, on 8/04/2023, Resident H was administered his 8am medications after 10pm. On 8/05/2023, Residents I, J and K were administered their 5pm medications at approximately 6:45pm. On 8/08/2023, Resident H was administered his 8pm meds at 9:44pm. On

8/11/2023, Resident M was administered his 8am meds at 10:11am, Resident N was administered her 8am meds at 10:18am, Resident L was administered his 8am meds at 10:21am, Resident O was administered her 8am meds at 10:29am, Resident P was administered his 8am meds at 10:32am and Joan Holbrook was administered her 8am medications at 11:24am. On 8/14/2023, Residents L and N were administered their 8pm meds at 9:16pm and Resident J was administered his 8pm meds at 10:08pm. On 8/15/2023, Resident Q was administered her 8am medications at 9:44am and Resident L was administered his 8am medications at 9:51am.

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:	The complaint alleged residents were administered medications late. While administrator Morgan Harrington reported late medication administration was not a known issue based on her review of med pass reports, investigative review of the med pass reports for just a two-week period revealed multiple residents on multiple dates receive numerous medications more than an hour past the scheduled time with some meds administered over two hours after the scheduled time. Based on the findings, the facility is not compliant with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B was not provided meals in a timely manner.

INVESTIGATION:

According to the complaint, Resident B, who is on a puree diet, does not receive meals in a timely manner, often getting several hours after normal mealtimes.

When interviewed, Ms. Harrington stated that because Resident B requires staff to directly assist him with meals, staff do generally get residents to lunch first that can be on their own, but that Resident B does not have to wait several hours after normal mealtimes to get his meals. Ms. Harrington stated she is not aware of any concerns from Resident B. During the onsite, I observed Resident B in the dining

area during breakfast hours with a staff sitting near him around approximately 9am. Ms. Harrington stated Resident B had already had his breakfast.

I reviewed Resident B's service plan. Under a section titled Eating, the plan read, in part, "Resident placed on pureed diet due to history of choking. Resident must be supervised for all meals".

On 8/16/2023, I interviewed adult protective services (APS) worker Chris Shores by telephone. Mr. Shores stated he had recently been to the facility on a few occasions to observe Resident B due to allegations he received that Resident B was not being fed timely. Mr. Shores stated he did not observe any issues in this regard as he stated he observed staff providing Resident B meals close to normal mealtimes. Mr. Shores stated he has attempted to interview Resident B; however Resident B was non-responsive.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	The complaint alleged Resident B was not provided meals in a timely manner. The investigation did not uncover sufficient evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

When interviewed Ms. Harrington stated Resident A was a high fall risk person with very low safety awareness. Ms. Harrington stated Resident A would often attempt to get up out of her chair on her own without staff assistance. Ms. Harrington stated that due to Resident A's high fall risk and low safety awareness, when she was in her reclining chair, staff would keep the recliner tilted back to try and keep her from falling out.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents**
	(2) (*l*) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	During the investigation, the administrator, Morgan Harrington, reported Resident A spent a lot of time in her recliner and was considered a high fall risk with low safety awareness. Ms. Morgan reported that Resident A was physically able to get out of her chair if she wanted to and would often attempt to do so without staff assistance, even though she would likely fall. Ms. Harrington stated that due to this, staff would recline Resident A's chair to try and keep her from getting out and falling as staff were not always able to stay close enough to her to intervene as necessary. Such a means of attempting to keep a resident from getting up, who otherwise wants to and can do so, in lieu of staff's ability to provide appropriate supervision to keep her from falling, is considered a restraint and not appropriate within an HFA. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

10/10/2023

Aaron Clum — Date
Licensing Staff

Approved By:

10/16/2023

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