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

February 7, 2024

RE: License #: AH500413843
Investigation #: 2023A1022027
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 responsible party 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 #:	2023A1022027
Complaint Receipt Date:	05/25/2023
Investigation Initiation Date:	05/26/2023
Report Due Date:	07/24/2023
Licensee Name:	Shelby Comfort Care, LLC
Licensee Address:	4180 Tittabawassee Saginaw, MI 48604
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:	NONE
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) is not being providing appropriate assistance for his personal care.	Yes
The ROC was given medication and received medical testing for an unknown medical condition without notifying the ROC's wife.	No

III. METHODOLOGY

05/25/2023	Special Investigation Intake 2023A1022027
05/26/2023	Special Investigation Initiated - Telephone Complainant interviewed by phone.
05/30/2023	APS Referral
05/30/2023	Inspection Completed On-site
06/21/2023	Contact - Document Received Information exchanged with the facility via email.
02/07/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) is not being providing appropriate assistance for his personal care.

INVESTIGATION:

On 5/24/2023, the complainant called the Bureau of Community and Health Systems complain hotline with allegations regarding her spouse, the Resident of Concern (ROC). According to the intake unit's interview, "On 05/23/2023 [name of complainant] went to visit her husband around 10am and he was asleep in a chair wearing multiple layers of clothes. While she was there, she learned from him and the administrator that he had not eaten and that he had been skipping and missing meals. She also determined that he had to be missing showers because he smelled so bad. So, the complaint is that the resident is not being fed enough and the facility was skipping meals… The facility is also not making sure the resident is properly dressed and showered."

On 05/26/2023, I interviewed the complainant by phone. The complainant stated that she had been to the facility twice in the past 5 days to visit the ROC and he had missed breakfast both days. She stated that she was skeptical that the ROC was being reminded to come to the dining room to eat. According to the complainant, when she arrived in the facility, the ROC was found in his room, fully dressed in both street clothes as well as a coat, and with tie shoes on his feet. The complainant stated that it was her opinion that the ROC had spent the night, fully clothed while sleeping in the chair. The complainant went on to say that the ROC had an odor about him that had begun to permeate the room. She believed that he had not received a shower in more than the past week, although she had been assured that he would be assisted to shower once per week.

On 05/30/2023, a referral was made to Adult Protective Services.

On 05/30/2023, at the time of the onsite visit, I interviewed the administrator and the resident care director. When I asked them about the ROC, the administrator stated that the ROC would appear to those who did not know him as being an individual who was independent in his life, but it would not take very long for a new acquaintance to realize that the ROC had impaired cognition. Although the ROC was able to stand and walk independently on his own, was continent of bowel and bladder, and could feed himself, he needed verbal assistance to complete other activities of daily living (ADLs). According to the administrator, the ROC needed "prompting, cueing, and coaching" to dress appropriately, to come to meals, and to bathe.

Accompanied by the administrator, I visited the ROC in his room. The ROC was seated in a recliner, fully dressed, and wearing a heavy jacket. At first, his eyes were closed, but he responded when the administrator called out his name. The ROC denied being cold asked (prompted by the heavy jacket), however, the ROC was not able to explain why he was wearing the jacket. When the ROC was asked if he was hungry, he said he was always ready to eat. The administrator asked him if he would

like to walk down to the dining room and she would have the staff fix him something, but the ROC appeared to be reluctant to get up out of the chair. He stated that he would come down after he used the restroom.

When the administrator was asked if the ROC had breakfast that morning, she stated that she had not seen him in the dining room. She then asked the unit medication technician, who also denied seeing the ROC out of his room. According to the administrator, the facility kept a “meal census,” a “check-off” listing of all the residents by name in the general assisted living portion of the facility. Care staff had been instructed to check off the names of residents served for each meal. The listing for the breakfast meal on 05/30/2023 had not yet been completed. Review of the meal census listing for the previous 7 days showed documentation that the ROC “refused” the breakfast meal on at least 3 days.

Review of the ROC’s service plan revealed that the ROC was “able to independently take shower with minimal assistance,” was able to “dress/undress and select clothing without assistance or supervision…can independently dress self,” and was “able to eat independently.” According to the caregivers’ general morning care instructions, in the morning, they were to remove the resident’s nighttime clothing, provide a wash up of face, hands and peri-area. Dress the resident according to their clothing preference…” and repeat at bedtime, substituting daytime clothes as appropriate.

Review of documentation reflecting assistance provided to the ROC indicated that caregivers had signed-off that this assistance was provided to the ROC, but that it had been accomplished in less than 60 seconds. Review of documentation that reflected showers revealed that no showers were noted after 05/09/2023 until the end of the month. On both 05/19/2023 and 05/26/2023, caregivers charted that the ROC stated he would take a shower before bed, but there was no documentation indicating that caregivers followed up to ensure that he had.

On 6/21/2023, via an email exchange with the administrator, the administrator was asked to explain the lack of ADL documentation. The administrator stated, “…we do not require the time spent for each ADL to be documented, that is simply an optional feature on QuickMar (electronic medication administration record and ADL documentation) that we cannot turn off… [Name of the ROC] is capable of taking a shower on his own and at times does so. However, you are correct that we do not have follow up documentation to confirm if he did or did not complete the showers for the dates in question.”

When the administrator was asked to explain the discrepancies in the ROC’s service plan as compared to the care that she verbalized during the initial interview, she said, “Because we are under a temporary license, for the past few months we have been in the process of renewing our contracts to reflect the name change and update all of our care plans. His had not been updated yet and will need to reflect the changes in his care such as the prompting, cueing and coaching I mentioned.

We had verbally instructed our staff to do as well as instructed them using the ADL's in quickmar."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	The service plan had not been updated to reflect the ROC's true care needs and it is questionable that he received the "prompting, cueing and coaching" that was required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The ROC was given medication and received medical testing for an unknown medical condition without notifying the ROC's wife.

INVESTIGATION:

According to the intake unit's interview, "…the facility was putting him (the ROC) on meds (medications) without notifying the caller (the complainant) and lied saying that the caller's daughter had approved the medication. Overall, the facility is neglecting the resident."

When interviewed, the complainant referred to the billing statement sent to her by her insurance company that detailed her financial obligations for the ROC. According to this statement, the ROC received several services on or about 03/21/2023 that included an electrocardiogram (ECG) as well as x-rays of the ROC's hand and wrist. Also, about that time, according to the billing statement, the ROC was prescribed two new medications. The complainant stated that she had asked both the nurse practitioner as well as (the wellness director) about these medications and got inconsistent answers, but apparently something had happened with the ROC's hand.

At the time of the onsite visit, the resident care director was asked if the ROC sustained some kind of injury at the end of March 2023. The resident care director stated that sometime in that timeframe, the ROC's daughter came to her, asking about the ROC's right hand, that the hand was red and swollen, with a scabbed area. According to the internal incident report (IR), dated 3/20/2023, the ROC's daughter reported to the caregiver that the ROC's hand was swollen. When the caregiver asked the ROC what happened, he said that he could not remember, but

that “his hand hurt when touched.” According to the IR, the ROC’s nurse practitioner (NP) health care provider ordered an X-ray if the ROC’s hand when she was notified on 3/20/2023 at 3 pm. The complainant, the ROC’s spouse, was called at 3:30 pm. The IR documented that the complainant did not pick up the call and that no message was left as “VM (voice mail) not available.”

According to the NP’s documentation, dated 4/4/2023, the X-ray taken on 3/21/2023 only showed degenerative joint disease with no evidence of dislocation or fracture. Her assessment was “likely bursitis of hand after fall…localized swelling to wrist and knuckles…will start Keflex (antibiotic) X (for) 7ays…Naprosyn (nonsteroidal anti-inflammatory pain reliever) …BID (twice daily) X 10 days…elevate and ice or warm compress for comfort.”

When asked about the ECG, the resident care director stated that was a “billing error.”

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident’s authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident’s record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	There was no evidence that the facility was not following its policy and procedure for responsible family member notification.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 02/07/2024. 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.

02/07/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

01/16/2024

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