GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 13, 2024

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

RE: License #: AH730412298
Investigation #: 2024A1027067
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) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730412298
Investigation #:	2024A1027067
Complaint Receipt Date:	06/06/2024
Investigation Initiation Date:	06/07/2024
Report Due Date:	08/06/2024
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
Authorized Representative/ Administrator:	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:	REGULAR
Effective Date:	12/01/2023
Expiration Date:	11/30/2024
Capacity:	65
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not administered her prescribed medications.	Yes
Resident A's pacemaker was broken.	No
Resident A had photos taken without consent.	Yes
There was an unknown male sex offender in the facility.	No
Additional Findings	No

III. METHODOLOGY

06/06/2024	Special Investigation Intake 2024A1027067
06/07/2024	Special Investigation Initiated - Letter Email sent to APS worker requesting additional information
06/11/2024	Inspection Completed On-site
06/17/2024	Contact - Document Received Email received from APS worker with additional information
06/21/2024	Inspection Completed – BCAL Sub. Compliance
06/25/2024	Exit Conference Conducted by email with Elyse Al-Rakabi
07/19/2024	Contact – Telephone call received Voicemail received from Relative A1 with additional information regarding investigation report. Telephone call returned to Relative A1 requesting invoices for medications.
7/29/2024	Contact – Document Received Email received from Relative A1 with requested documentation
08/06/2024	Inspection Completed – BCAL Sub. Compliance
08/13/2024	Exit Conference Conducted by email with Elyse Al-Rakabi

ALLEGATION:

Resident A was not administered her prescribed medications.

INVESTIGATION:

On 6/6/2024, the Department received allegations forwarded from Adult Protective Services (APS) which read concerns about Resident A not receiving prescribed Megace for appetite since 11/27/2023, and not receiving her eye drops.

On 6/11/2024, an on-site inspection was conducted at the facility and staff were interviewed.

Administrator Elsye Al-Rakabi indicated that Resident A's hospice team was managing her care. She reported that Resident A ate independently, and there had been no observed decline in her appetite. According to Ms. Al-Rakabi, Resident A's medications were being administered as prescribed to the best of her knowledge.

Employee #1 corroborated Ms. Al-Rakabi's statements during the interview. He demonstrated the process of medication re-ordering and confirmed that Resident A's Megace and eye drops were stored in the medication cart, consistent with the medication administration records (MARs). The Megace bottle read in part there were six refills, and it was last dispensed on 6/10/2024. The Megace medication in the bottle appeared to have been used and was not full.

I reviewed Resident A’s November 2023 through June 2024 MARs which read staff documented the administration of her medications or reasons for non-administration. The MAR read in part her medications were ordered through Pharmascript Pharmacy, and on a monthly cycle.

The MARs read in part Resident A was prescribed Megace (Megestrol suspension 40mg/mL) give 5 mL by mouth once daily since 3/19/2021, with an updated order on 10/19/2023.

The MARs read in part there were six eye drop medications prescribed, some were to be administered twice daily.

Chart notes spanning from November 1, 2023, to June 11, 2024, highlighted Resident A's eating patterns and medical evaluations. The notes read in part a nurse practitioner evaluated Resident A monthly, and sometimes more often. Staff reported multiple instances of Resident A participating in meals and occasionally consuming her meals fully. Note dated 2/22/2024 read Resident A was “*not eating like usual*.” Further notes on 3/9/2024 mentioned a lack of appetite, leading to an assessment by hospice services, after which Resident A was enrolled in hospice care.

Note dated 4/18/2024 by the nurse practitioner documented a request from Relative A1 to increase Resident A's Megace dosage due to decreased eating habits, which was declined by hospice services due to coverage of medication.

Addendum:

On 7/29/2024, additional documentation was received from Relative A1 by email. A review of Resident A's PharmaScript of MI invoices from 9/30/2023 to 6/1/2024 shows that Megestrol (Megace) was ordered monthly, except for December 2023 through March 2024. The invoices also list four eye drop medications—Prednisolone, Alphagan, Sodium Chloride, and Bimatoprost—that were ordered monthly in September and October 2023. After this period, various eye drop medications were ordered on a less consistent basis: three bottles in November 2023, two bottles in December 2023, one bottle in January 2024, two bottle in February 2024 and March 2024, four bottles in April 2024, and no bottles in May or June 2024.

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:	While there were discrepancies in Resident A's appetite, the facility's documentation revealed staff documented her Megace as administered and lacked sufficient evidence it was not available for administration. Additionally, review of the MARs, as well as observations of the medication cart, revealed her eye drops were available and documented as administered. Previous review of the MARs indicated that staff documented the administration of Resident A's prescribed Megace and eye drops. However, those medications were not consistently ordered and billed; therefore, evidence confirmed that the facility documented administration of medications without having a sufficient supply. Thus, a violation was substantiated for these allegations.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's pacemaker was broken.

INVESTIGATION:

On 6/6/2024, the Department received allegations forwarded from APS which Resident A had a pacemaker in her room which was found broken under her bed on 5/25/2024. In response, an email was sent to the APS worker on the same day seeking clarification, given that a pacemaker is a device implanted in the heart.

On 6/11/2024, I an on-site inspection was conducted at the facility and staff were interviewed.

Administrator Ms. Al-Rakabi confirmed that Resident A had a device associated with her pacemaker to provide readings to the physician. She explained that the device had broken during a carpet change but was promptly replaced the following day. Ms. Al-Rakabi further mentioned that she had contacted Resident A's cardiology, who confirmed the next follow-up appointment was scheduled for July 2024 with no concerns raised.

During the inspection, the device in Resident A's apartment, known as the Merlin@home transmitter, was observed to be functioning properly, indicated by a green light.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	Rule 21. (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:	In conclusion, the investigation revealed that the device related to Resident A's pacemaker was broken but replaced timely. Staff attestations revealed communication with Resident A's medical providers, as well as, ongoing monitoring and scheduled follow-up appointments, ensuring appropriate management of her medical device. Thus, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A had photos taken without consent.

INVESTIGATION:

On 6/6/2024, the Department received allegations from APS that Resident A, who had signed a form in 2018 indicating she did not want her photos taken, had several of her photos posted on the facility's Facebook page.

On 6/11/2024, an on-site inspection was conducted at the facility and staff were interviewed.

> Administrator Ms. Al-Rakabi confirmed during the interview that Resident A's picture had indeed been posted on the facility's social media account. Ms. Al-Rakabi reviewed Resident A's admission contract, which did not include a photo release. Upon discovering the issue, Ms. Al-Rakabi promptly informed the activities director that photos of Resident A were not to be taken. Additionally, she communicated with Relative A1 via email regarding a photo release form, which Relative A1 declined to sign.

I reviewed Resident A's Residency Agreement dated 8/22/2018 and signed by Resident A on 8/19/2018. The agreement read in part Resident A was her own responsible party. However, the agreement did not include a provision for photograph consent.

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: **(d) A patient or resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.**

ANALYSIS:	In conclusion, Ms. Al-Rakabi's statements confirmed Resident A's photos were posted on the facility's social media account without explicit consent, as there was not signed photo release in her Residency Agreement. Although the facility attempted to obtain consent promptly upon being informed of the issue, the facility lacked protection of Resident A's rights to privacy and therefore, this violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There was an unknown male sex offender in the facility.

INVESTIGATION:

On 6/6/2024, the Department received allegations forwarded from APS regarding the presence of an unknown male sex offender at the facility. Subsequently, email correspondence with the APS worker on the same day requested additional information concerning this individual.

On 6/11/2024, an on-site inspection was conducted at the facility and staff were interviewed.

Administrator Ms. Al-Rakabi addressed concerns regarding Resident B, disclosing an incident in which the details were unknown from his former facility. Ms. Al-Rakabi stated upon Resident B's arrival to the facility, he received close monitoring through a 1:1 caregiver funded by the Program for All-Inclusive Care for the Elderly (PACE). Ms. Al-Rakabi stated that all residents, including Resident B, underwent a Michigan Sex Offender Registry search prior to admission, and he was not found on the list. She emphasized that Resident B exhibited no aggressive behavior or inappropriate actions.

While on-site, I observed Resident B who seemed pleasant and was helping around the facility.

On 6/17/2024, email from the APS worker lacked additional information pertaining to a male sex offender.

A review of Resident B's service plan dated 3/29/2024 highlighted his cognitive impairment, independence with ambulation, and the requirement for staff to conduct checks six times daily and provide toileting reminders.

A Michigan Sex Offender search conducted for Resident B corroborated Ms. Al-Rakabi's statements that he was not listed as a sex offender.

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: **(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 or a physician's assistant to whom the physician has delegated the performance of medical care services 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 or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	In conclusion, the investigation confirmed that Resident B was not identified as a sex offender through the Michigan registry and had no reported incidents of inappropriate behavior at the facility. The facility's protocols, including close monitoring and screening procedures, were found to be consistent with regulatory standards and aimed at ensuring resident safety and well-being. Therefore, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

06/21/2024 and updated on 08/06/2024

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Jessica Rogers Date
Licensing Staff

Approved By:

06/24/2024 and updated on 8/13/2024

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