Alison VanRyckeghem
Livonia Comfort Care
34020 Plymouth Rd
Livonia, MI 48150

September 24, 2024

RE: License #: AH820402086
Investigation #: 2024A1022072
Livonia Comfort Care

Dear Alison VanRyckeghem:

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 #:	AH820402086
Investigation #:	2024A1022072
Complaint Receipt Date:	07/30/2024
Investigation Initiation Date:	07/31/2024
Report Due Date:	09/29/2024
Licensee Name:	Livonia Comfort Care, LLC
Licensee Address:	34020 Plymouth Rd Livonia, MI 48150
Licensee Telephone #:	(989) 607-0001
Administrator:	Denell Bruyere
Authorized Representative:	Alison VanRyckeghem
Name of Facility:	Livonia Comfort Care
Facility Address:	34020 Plymouth Rd Livonia, MI 48150
Facility Telephone #:	(734) 743-2300
Original Issuance Date:	01/24/2023
License **Status:**	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	88
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) does not receive appropriate care.	No
Additional Findings	Yes

III. METHODOLOGY

07/30/2024	Special Investigation Intake 2024A1022072
07/31/2024	Special Investigation Initiated - Letter Referral from APS. APS worker contacted for any additional information.
08/06/2024	Inspection Completed On-site
09/13/2024	Contact - Document Received Email exchange with authorized representative
09/24/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) does not receive appropriate care.

INVESTIGATION:

On 07/30/2024, the Bureau of Community and Health Systems (BCHS) received a referral from Adult Protective Services (APS) that read, “[Name of the Resident of Concern/ROC] was sent from the facility on 4/20/24 to Trinity health Livonia hospital for an EKG procedure. She went back to the hospital on 4/30/24 and still had the sticky marks from her procedure on her body and had a bad odor. Hospital staff were concerned with the lack of care [name of the ROC] is receiving in the home.”

On 08/06/2024, at the time of the onsite visit, I interviewed the administrator. The wellness director was not in the building but was interviewed by telephone. When the administrator was asked about the ROC, she stated that she did not know the ROC because the ROC had moved out from the facility before she (the administrator) had been hired. According to the wellness director, the ROC lived in the facility for only a few weeks, moving out at the end of April 2024 and exhibited

very problematic behavior during the time she was a resident. The wellness director described the ROC as very resistant to care, aggressive, and eventually combative. The ROC would become combative when caregivers attempted to assist her with toileting and with showers. The facility had called upon family members to help them, but they were not successful either. The ROC was sent out to the local emergency room (ER) several times, and had caused injuries to staff, to the family member who came in to assist with a shower, as well as other residents. The wellness director acknowledged that given the ROC's resistance to incontinence care and for bathing, it was very believable that when the ROC went to the local ER on 04/30/2024, she emitted a bad odor and still had evidence on her body of the adhesive used to affix the EKG leads from the previous hospital visit. The wellness director stated that she did not know why the ROC had left the facility.

The administrator identified medication technician (med tech) #1 as an employee who would have known the ROC while the ROC lived in the facility. Med tech #1 was working in the building at the time of the onsite visit. Med tech #1 stated that she had administered medications to the ROC and remembered her as being combative. According to med tech #1, the ROC had hit another resident with a wheelchair arm, resulting in the other resident needing emergency care. The ROC had bit the family member who attempted to help her with a shower. According to med tech #1, the ROC had been asked to move out of the facility as a result of unmanageable behaviors.

The facility provided the ROC's charting/progress notes and incident reports. Review of this documentation revealed the following notations.

- On 04/16/2024, "Resident (the ROC) demonstrated some aggressive behavior today when approached by staff (who attempted to provide care)…"

- On 04/20/2024, "Caregiver [name of caregiver #2] reported confusion and aggressive behavior towards staff and resident [identified by room number] …"

- On 04/20/2024, "Resident transferred to (acute care hospital) via ambulance due to combative behavior threatening resident [identified by room number] …"

- On 04/23/2024, "…Resident d/c'd (discharged) back to community … Resident became aggressive and was placed in 2 pt (point) restraints…"

- On 04/25/2024, "midnight caregiver [name of caregiver #3] resident (the ROC) refused all care and denied entry (of caregiver #3) in (to) room. Increased agitation and aggressive behavior reported… POA (power of attorney) informed. POA working on 1:1 (one-on-one) companion increase in hours…"

- On 04/27/2024, “(staff member reported) [name of the ROC] attacked [name of Resident A] which resulted in injury. [Name of Resident A] was sent to hospital via ambulance. Livonia police called… POA (power of attorney) for [name of the ROC] sent private duty caregiver out (to facility) …”

- On 04/30/2024, “Increased combative behavior by resident (the ROC). Staff reported [name of the ROC] attacked [name of Resident B]. No injury…threatening behavior towards staff… [Name of the ROC] chased [name of caregiver #4] off unit while holding a fork… Petition for mental health treatment completed by admin, given to police when transported resident (the ROC) to hospital… Resident will not be accepted back (into facility). POA will be informed.”

The facility was unable to provide a service plan for the ROC.

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: **(e) A patient or resident is entitled to receive adequate and appropriate care**
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: R325.1901	**Definitions.**

	(16) "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:	Due to the ROC's aggressive and combative behaviors, the facility was unable to provide care for her. There was no evidence to support a lack of attempt to provide ROC with necessary care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

When the facility was asked to provide the ROC's service plan, the Authorized Representative (AR) responded in an email message dated 09/13/2024, "I have not been able to find record of a service plan for her."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(1) A home shall have a written resident admission contract, program statement, admission and discharge policy, and a resident's service plan for each resident.
For Reference: R325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	The facility did not have a service plan for the ROC.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 09/24/2024. 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.

09/24/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

09/19/2024

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