GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 14, 2024

Kory Feetham
Bay City Comfort Care
4130 Shrestha Drive
Bay City, MI 48706

RE: License #: AH090371811
Investigation #: 2024A1027096
Bay City Comfort Care

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
REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AH090371811
Investigation #:	2024A1027096
Complaint Receipt Date:	09/23/2024
Investigation Initiation Date:	09/24/2024
Report Due Date:	11/22/2024
Licensee Name:	Bay City Comfort Care LLC
Licensee Address:	2635 Lapeer Road Auburn Hills, MI 48326
Licensee Telephone #:	(989) 607-0001
Administrator:	Morgan Ralph
Authorized Representative:	Kory Feetham
Name of Facility:	Bay City Comfort Care
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	67
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was evicted.	No
Resident A's belongings were stolen.	No
Additional Findings	Yes

III. METHODOLOGY

09/23/2024	Special Investigation Intake 2024A1027096
09/24/2024	Special Investigation Initiated - Letter Email sent to Morgan Ralph and Kory Feetham requesting information and documentation
09/24/2024	Contact - Document Received Email received from Ms. Ralph with information and documentation
09/26/2024	Contact - Document Sent Email sent to Ms. Ralph requesting additional documentation and information
09/27/2024	Contact - Document Received Email received from Ms. Ralph with requested documentation and information
10/10/2024	Contact - Document Sent Email sent to Ms. Ralph with request for additional information
10/10/2024	Contact - Document Received Email received from Ms. Ralph with requested information
10/10/2024	Inspection Completed-BCAL Sub. Compliance
10/14/2024	Exit Conference Conducted by email with Kory Feetham and Morgan Ralph

ALLEGATION:

Resident A was evicted.

INVESTIGATION:

On 9/23/2024, the Department received allegations from Adult Protective Services (APS) indicating that Resident A was transferred to the hospital on 9/13/2024, and subsequently evicted from the home. APS did not initiate an investigation regarding these claims.

On 9/24/2024, email correspondence from administrator Morgan Ralph read:

> "[*Resident A] will no longer resign at Bay City Comfort Care as of 9-30-24. As a 30 day notice was provided to the resident on 8-30-24. Due to "harm to himself or others, or has demonstrated behaviors that pose a risk of serious harm to himself or others". Police were contact (sp) on 9-14-24 due to the resident extreme behaviors. Resident went willingly went with the police to McLaren Hospital."*

I reviewed Resident A's Residency Agreement signed by Resident A and dated 7/22/2024 read in part:

> "*It is agreed that when a Resident becomes or is physically or mentally ill so as to jeopardize the health or comfort of themselves or other residents. The Resident will be required to leave the Facility and the Authorized Representative will be notified.*
>
> *Company. The Company may terminate this Agreement and Discharge or Transfer the Resident upon thirty (30) days' written notice to the Resident and/or Resident's Authorized Representative and/or a government agency under the following conditions:*
>
> 1) *Medical Reasons*
> 2) *His or her welfare or that of other residents*
> 3) *Nonpayment of his or her stay*
> 4) *Transfer or discharge sought by resident or authorized representative"*

I reviewed the discharge letter dated 8/30/2024 addressed to Resident A which read in part the reason for discharge was *"where the Resident has harmed himself/herself or others, or has demonstrated behaviors that pose a risk of serious harm to himself or herself or others."* The letter noted that the facility would assist in finding a new placement.

I reviewed Resident A's chart notes from August and September 2024.

> Note dated 8/30/2024 read Resident A was in the parking lot, then walked to the store. Another note from the same day read Resident A had multiple increased behaviors over the past few days including threatening to break out the windows and was combative towards staff. A 30-day notice was provided. There were reports of Resident A taking a Gordon's grocery cart and refusing medications.

Note dated 9/4/2024 read Resident A was evaluated by his physician who was aware that he was refusing medications. Another note on the same day read Resident A was going in and out of the facility without shoes on and had a shopping cart from Gordon's in his room.

Note dated 9/5/2024 read Resident A was outside smoking.

Note dated 9/6/2024 read the facility contacted Adult Protective Services due to him not caring wellbeing of himself.

Note dated 9/6/2024 read Resident A was recording staff, claiming to do so by the state police. Staff contacted the local police for a wellness check and the police officer recommended a petition for mental health care.

Note dated 9/7/2024 read Resident A was in another resident's room using his coffee pot to make coffee.

Note dated 9/8/2024 read Resident A received money from another resident and was informed by staff that he could not take the money. Another note on the same day read Resident A climbed out the window around 1:07 PM, police were contacted and escorted him back to the facility around 2:30 PM.

Note dated 9/9/2024 read Resident A stated he was his own person and that he was leaving the facility. Another note for the same day read that Resident A left food on his apartment floor and told staff that housekeeping would clean it. Another note for the same date read Region VII case worker and APS were contacted again.

Note dated 9/11/2024 read Resident A refused for the physician to evaluate his right toe wound.

Note dated 9/13/2024 read a Region VII social worker attempted to setup a time to visit with Resident A and he stated he would call on his own time. Another note for the same day read Resident A was using foul language and yelling, as well as asking for his stuff before he left.

Note dated 9/14/2024 read Resident A entered another residents' room while the staff were changing the resident and refused to leave. Additionally, the note read Resident A went into another resident's room while the resident was out the facility, and he told staff "*oh fuck off*." Staff contacted the police and Resident A was agreeable to going with the police to the hospital. Staff completed a petition.

As of 9/27/2024, communication with Ms. Ralph confirmed that Resident A remained in the psychiatric unit at McLaren Hospital.

As of 10/10/2024, communication with Ms. Ralph read Resident A remained at hospital and would transition to an Adult Foster Home.

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.**
	(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217: **(e) A home for the aged resident may be transferred or discharged only for medical reasons, for his or her welfare or that of other residents, or for nonpayment of his or her stay, except as provided by title XVIII or title XIX. A nursing home patient may be transferred or discharged only as provided in sections 21773 to 21777. A nursing home patient or home for the aged resident is entitled to be given reasonable advance notice to ensure orderly transfer or discharge. Those actions shall be documented in the medical record.**
ANALYSIS:	Documentation revealed that Resident A's behaviors posed a risk of harm to others. The actions taken by the facility were consistent with the terms outlined in the residency agreement; therefore, a violation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A’s belongings were stolen.

INVESTIGATION:

On 9/23/2024, the Department received allegations forwarded from APS claiming that Resident A’s belongings were stolen.

Review of Resident A’s residency agreement read the resident was responsible for maintaining their personal property and “*strongly encouraged to obtain insurance with coverage for the Resident’s personal property and general liability as it relates to the Resident’s Unit*.” The agreement read “*Independent activities, responsibility*

for personal, financial, and health care decisions, and lifestyle and care preferences may involve risks or personal injury and/or property damage or loss."

Chart notes from August and September 2024 showed that Resident A entered other residents' rooms without permission and had a Gordon's shopping cart in his room. There were no indications in the notes that his belongings were stolen.

As of 10/10/2024, email correspondence with Ms. Ralph read Resident A remained at hospital and his family planned to remove his belongings from his apartment to an Adult Foster Care that day.

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:	Based on the residency agreement and chart notes, the allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's discharge letter did not include a statement informing the resident of the right to file a complaint with the department.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following: **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**

ANALYSIS:	Resident A's discharge letter was not consistent with this rule; therefore, a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/10/2024

Jessica Rogers Date
Licensing Staff

Approved By:

10/14/2024

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