GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Kory Feetham
Shields Comfort Care Assisted Living
9140 Gratiot
Saginaw, MI 48609

October 14, 2024

RE: License #: AH730412298
Investigation #: 2024A1022075
Shields Comfort Care Assisted Living

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 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 #:	AH730412298
Investigation #:	2024A1022075
Complaint Receipt Date:	08/08/2024
Investigation Initiation Date:	08/09/2024
Report Due Date:	10/07/2024
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
Administrator:	Ashley Mcloughlin
Authorized Representative:	Kory Feetham
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Female residents in the memory care unit have been sexually assaulted.	No
Residents in the memory care (MC) unit do not get adequate care.	Yes

III. METHODOLOGY

08/08/2024	Special Investigation Intake 2024A1022075
08/09/2024	Special Investigation Initiated - Telephone Complainant interviewed by phone.
08/20/2024	Inspection Completed On-site
10/14/2024	Exit Conference

ALLEGATION:

Female residents in the memory care unit have been sexually assaulted.

INVESTIGATION:

On 08/08/2024, the Bureau of Community and Health Systems (BCHS) received a complaint that read, “This is supposed to be a locked facility, but the staff and management do not feel like unlocking the doors all day for people, so they either leave these doors unlocked or leave the tap badges to get into the facility in the entryways! The final straw for me was a recent incident this past week. This facility has a dementia unit that is supposed to be LOCKED. But it wasn't, and a resident came from the long-term care side and while staff were completely absent and abandoned the dementia side patients, this resident put his penis in the mouths of the female dementia residents…”

On 08/09/2024, I interviewed the complainant by phone. According to the complainant, a male resident was able to gain access into the memory care (MC) unit at some point during the weekend of 08/03/2024 to 08/04/2024 because the unit had been left unsecured. While in the MC unit, the male resident sexually assaulted a female resident.

On 08/20/2024, at the time of the onsite visit, I interviewed the director of nursing (DON) and the director of operations, as the administrator was not in the building. Both the DON and the director of operations stated that they were not aware of a situation when a male resident entered the MC unit and sexually assaulted a female resident, but they both acknowledged there had been a sexual encounter that occurred between a male resident, Resident A and a female resident, Resident B. According to the director of operations, both of these residents lived in the AL section at the time of the incident. The DON stated that the facility's "hear-say" had been that Resident A and Resident B went into Resident B's room and locked the door. According to the director of operations, she had been present when Resident A had been interviewed by the administrator. Resident A told the administrator that Resident B had locked the door, turned to him, pulled his pants down and performed oral sex on him. Neither the DON nor the director of operations knew if the administrator had interviewed Resident B for her side of the story. Neither the DON nor the director of operations were able to produce an incident report. According to the DON, soon after this incident, Resident B moved into the MC unit.

At the time of the onsite visit, Resident A was unavailable for observation and interview. He was a PACE (Program of All-Inclusive Care for the Elderly) participant and had gone to the PACE location for the day.

Resident B, who was able to reliably answer questions, was observed in the MC unit common area. We went to Resident B's room, where I was able to interview her. According to Resident B, while she considered Resident A to be her "friend," he regularly "pressured" her to have sex. Resident B went on to say that Resident A exposed his penis and put it near her genitals. Resident B was not able to clearly articulate what had happened other than saying that she "sat down (on his penis) and got back up again." She did not acknowledge that oral sex had been any part of the encounter. Resident B went on to say that she was happy to be in the MC unit, apart from Resident A and any advances he might make toward her. She also acknowledged she tended to get into verbal altercations with other female residents in the AL section of the facility and she was glad to get away from that environment.

According to his service plan, Resident A needed only minimal assistance for activities of daily living (ADLs) and did not display any behavioral or cognitive deficits, although the service plan documented a past medical history of mental illness and impaired cognition. According to her service plan, Resident B also did not display any behavioral or cognitive deficits, although she had a documented past history of "mental illness… (bipolar) personality mood disorder, delusion…" Resident B needed moderate assistance and supervision to complete her ADLs and used a wheelchair for mobility.

Review of charting notes for both residents revealed that on 07/31/2024, at 4:53 am, Resident A was observed leaving another resident's room (Resident B). "Resident (Resident A) was asked prior not to go in others room." At 4:58 am, Resident B reported to the caregiver that at 4:15 am Resident A came into her room and

“showed their private area and asked resident (Resident B) to sit on them (Resident A). Also stated resident (Resident A) kissed them (Resident B) on mouth before leaving.”

On 08/03/2024, at 4:13 am, the caregiver documented that Resident B was awake and “went to another resident’s room (Resident A), knocking on his door screaming his name, waking him up…” Resident A was woken from sleep by Resident B “screaming his name and knocking on his door…” Resident A reported this to the caregiver.

According to the two incident reports (IRs) written for Resident A and Resident B respectively, on 08/06/2024, the administrator was “notified by staff at 9:10 pm of a report from (Resident B) that (Resident A) was in her room showing of his genital area… Adm (administrator) encouraged staff to keep them separated and increase monitoring until she (the administrator) could come in and do an investigation… Upon investigation it was confirmed by both residents that consensual sexual intercourse was had…” The IR for Resident A documented that his legal guardian requested that Resident A be separated from Resident B. On 08/08/2024, Resident B was moved into the memory care unit “due to agitation with peers, frequent wetting accidents and unsafe sexual behavior…”

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:	Regarding the sexual encounters between Resident A and Resident B, the facility handled the situation appropriately.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents in the memory care (MC) unit do not get adequate care.

INVESTIGATION:

According to the written complaint, “These patients (in the memory care unit) are not receiving care. They are essentially renting a room to die in. They are not groomed. Their rooms are not cleaned. They are not professionally administered medication…”

The complainant clarified that medications were left at residents’ bedsides.

At the time of the onsite visit, there were 7 residents living in the MC unit. I toured the MC unit, accompanied by both the DON and the director of operations.

Resident B was observed to have very poor oral care. According to the DON, Resident B would not need a caregiver to brush her teeth for her but would need promoting. According to her service plan, Resident B required “reminding and cueing for grooming and self-care tasks.” Otherwise, Resident B appeared to be adequately groomed. Her room was excessively cluttered, so it was difficult to determine whether it had been cleaned; however, bits of debris were observed on the floor.

Resident C was observed in the MC common area. She was adequately groomed. Observation of her room revealed that the furniture had a layer of dust on their upper surfaces and that there was debris on the floor of the bathroom and the inside of the shower. According to her service plan, Resident C was fully dependent on staff for all ADLs other than eating.

Resident D was observed in the MC common area. She was covered up with a blanket and I did not ask for it to be removed. Her face was clean and her hair in a bun, but there was black debris that may have been fecal matter underneath her fingernails. The DON acknowledged that the caregiver should have provided Resident D with nail care on the day of her shower. The room occupied by Resident D was tidy and appeared to be clean. According to her service plan, Resident D was fully dependent on caregivers to complete her ADLs. Under the heading “Grooming,” the service plan noted, “Staff will perform all grooming and personal hygiene tasks for the resident. Resident is unable to assist…”

Resident E was observed in the MC common area. Although she was adequately groomed, she was not wearing shoes. The room occupied by Resident E also was tidy and appeared to be clean. According to her service plan, Resident E needed a moderate amount of assistance primarily due to her cognitive deficits.

Resident F was observed in the MC common area. Resident F was adequately groomed, including his beard, which was quite lengthy. The toilet in the bathroom used by Resident F had what appeared to be crusted fecal matter on the toilet seat and around the rim of the bowl. There was dark debris on the floor of the shower, underneath the bath chair. According to the DON, the caregiver should clean the shower area as part of Resident F’s shower. According to his service plan, Resident F was unable to assist with his personal care and was fully dependent on a caregiver. The service plan went on to document that Resident F had a colostomy.

Resident G was observed in her room, asleep in her bed. Her room was excessively cluttered with Resident G’s belongings. According to her service plan, Resident G was fully dependent on a caregiver to complete her ADLs.

Resident H was also in her room, asleep in her bed. Resident H’s room also was cluttered, but the carpeting in the bedroom, just in front of her recliner had a mound of debris, that appeared to be cracker or cookie crumbs. In the bathroom, dark debris that appeared to be fecal matter was observed on the grab bar beside the toilet, on the toilet itself and on the emergency pull card next to the toilet. There was a discarded glove in the trash basket next to the toilet. According to the DON, the caregiver should clean the toilet as part of toileting. According to her service plan, Resident H needed physical assistance to complete her ADLs.

All resident service plans indicated they were to receive “Standard Housekeeping." At the time of the onsite visit, according to both the DON and the director of operations, housekeepers cleaned residents’ rooms according to a schedule and

caregivers were to keep rooms clean in between scheduled cleanings by the housekeeper. Review of job descriptions for both positions revealed that housekeepers were to clean resident rooms, toilets, sinks, and mirrors, according to their schedule. For caregivers, the expectation was for “cleaning of work areas and utensils,” but specific resident room cleaning was not addressed in the job description.

There was no evidence that medications had been left at the bedsides of any of these residents. According to the DON, should a family member or another visitor find medications left at a resident’s bedside, during business hours, they should inform the DON, the administrator, the director of operations. If medications are found during the evening or on the weekend, the shift supervisor should be notified. Medication should never be left at a resident’s bedside.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(2) 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 direct observation, residents living in the MC unit did not receive adequate care.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 10/14/2024. The AR was concerned that not all of the findings illustrated poor care, and he was assured that those findings were included in the report for the purpose of completeness and not because the facility was expected to correct them.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

10/14/2024

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Barbara Zabitz Date
Licensing Staff

Approved By:

10/08/2024

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