GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Alison VanRyckeghem
Shelby Comfort Care
51831 VanDyke Ave.
Shelby Township, MI 48315

November 7, 2024

RE: License #: AH500413843
Investigation #: 2024A1022078
Shelby 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 #:	AH500413843
Investigation #:	2024A1022078
Complaint Receipt Date:	08/16/2024
Investigation Initiation Date:	08/19/2024
Report Due Date:	10/15/2024
Licensee Name:	Shelby Comfort Care, LLC
Licensee Address:	2635 Lapeer Road Auburn Hills, MI 48326
Licensee Telephone #:	(989) 607-0001
Administrator:	Kassandra Thurlow
Authorized Representative:	Alison VanRyckeghem
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:**	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	77
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A sexually assaulted Resident B.	Yes

III. METHODOLOGY

08/16/2024	Special Investigation Intake 2024A1022078
08/19/2024	Special Investigation Initiated - Letter Arrangements made with facility for a remote videoconference interview.
09/04/2024	Contact - Telephone call made Investigation conducted remotely via videoconference.
11/07/2024	Exit Conference

ALLEGATION:

Resident A sexually assaulted Resident B.

INVESTIGATION:

On 08/16/2024, the Bureau of Community and Health Systems (BCHS) received a complaint that read, “(On 08/13/2024, staff at facility documented), “resident (referring to Resident A) combative since 9am. refusing care. Resident (A) was combative with visitors who left in and out of unit door. Resident attempted to elope all day. Resident raised hands to strike another resident, visitors/caregivers. PRN RX (as needed medication, likely to be antianxiety medication) given but no effect. Resident caught in room with another resident (referring to Resident B) performing inappropriate acts. Management was notified, and nurse (referring to wellness director) evaluated (Resident A). (On 8/15/24) NP (nurse practitioner) visited ALF (assisted living facility) today for rounds. Notified by staff aids patient [name of Resident A] "sexually assaulted" another resident 2 days ago…Staff reports she heard [name of Resident B] yelling in memory care (yelling out the words) "no" and "stop." Staff found [name of Resident B] on bed, [name of Resident A] holding her down, rubbing her breasts…”

On 08/16/2024, APS sent BCHS a referral that addressed the same incident as previously reported of the resident-to-resident sexual assault. According to the APS referral, “On 08/13/2024, [name of Resident B] was able to wander into another

resident's room. Staff walked in that room and observed that person (referring to Resident A) with his arm around [name of Resident B]'s neck and hand on her breast beneath her clothing. The male (Resident A) has been removed from the unit." The referral was marked, "Denied," signifying that APS had determined they would not be investigating the allegations.

On 09/04/2024, I interviewed the administrator and the authorized representative (AR) remotely, in a videoconference. The facility provided their incident report (IR), several witness statements, a police report, and the NP's visit note for Resident A.

The facility completed only one IR for this incident, naming both Resident A and Resident B in the report. The report was completed by caregiver #2. According to this IR, "…As I (caregiver #2) got closer I could hear [name of Resident A] … When I walked into the room, I witnessed him (Resident A), holding her (Resident B) down while rubbing her breast and attempting to make her stay… (Resident A stated) "Her (Resident B) no f*ck me (Resident A). Get her out." I (caregiver #2) removed [name of Resident B] and yelled for [name of caregiver #1] to call management… [Name of the business office manager] stated that she would remove [name of Resident A] from the environment for a while. Upon my leaving, it was my understanding that [names of the resident care director and the business office manager] was to notify the families of both parties." No measures to prevent a reoccurrence of this type of incident was indicated on the IR form.

According to the statement made by the resident care director (RCD), "On Tuesday, 08/13/2024, around 2:30 pm, [name of caregiver #1] could be heard over the walkie (walkie-talkie radio communication device) stating there was an emergency in memory care (MC)… I (the RCD) observed [name of caregiver #1] and [name of Resident B] in the med (medication) room. [Name of caregiver #1] explained that [name of caregiver #2] had observed [name of Resident A] touching [name of Resident B] inappropriately in his room. I (the RCD) assessed [name of Resident B] for any visible injuries. There were no obvious signs of physical trauma… [Name of caregiver #2] was visibly upset and explained that she had heard [name of Resident B] yelling. She (caregiver #2) observed [name of Resident B] on her knees in [name of Resident A]'s bed, with one (of Resident A's) arm around her neck, and his other hand up her shirt, groping her… [Name of caregiver #2] was instructed to complete an incident report as she was the only one to physically observe this altercation…"

According to the statement made by the business office manager (BOM), on 09/13/2024, at 2 pm, the BOM received a call to come to the memory care (MC) unit by caregiver #1. "[Names of caregiver #1 and caregiver #s] were both speaking and told me (the BOM) (that) [name of Resident A] had [name of Resident B] pinned down in his room with his hands down [name of Resident B]'s pants and hand up her shirt. I (the BOM) asked them did he (Resident A) penetrate her (Resident B). I (the BOM) asked them if they conducted a head-to-toe assessment and was told the assessment was completed. [Name of the resident care director (RCD) instructed the ladies (the caregivers) to complete an incident report…"

According to the statement made by caregiver #1, “I (caregiver #1) did not witness the assault happening, but I did mediate and called the resident (Resident B) and [name of caregiver #2] down…”

According to the NP’s visit note, dated 08/16/2024, “Report from bystander present in memory care on 08/13/2024: While I (bystander) was seeing hospice patients in memory care unit I heard a faint yell, and a female staff member went to investigate. Shortly after she (female staff member) returned with the female resident in question stating he (Resident A) was trying to rape her… The staff in memory care had expressed that the male resident has been inappropriate with them both sexually and physically aggressive…”

According to his service plan, Resident A displayed no behavioral-cognitive issues, although instructions to staff were to check on him on an hourly basis “to ensure safety.” He used a wheelchair for ambulation, used incontinence briefs, and needed a moderate amount of hands-on assistance to complete his activities of daily living.

According to her service plan, Resident B who was able to independently walk without any assistive device, was known to wander through the building and needed “eyes on every half hour to ensure safety and well-being.” She had a history of falls and needed mainly cuing and supervision to complete her activities of daily living.

When I asked the AR and the administrator about the current whereabouts of Resident A and Resident B, the AR stated that both residents continued to reside in the facility’s memory care (MC) unit. When asked about the appropriateness of this arrangement, the AR stated that she had no concerns about it. She described both residents as “easy to re-direct,” and the caregivers kept the two residents separated during the day. According to the AR, she could watch Resident A through the video surveillance camera that was stationed in the MC unit. She then acknowledged, “of course, they (the residents) are not monitored 24-7,” and the two residents could encounter each other at any time. When asked if Resident B had been evaluated for emotional trauma related to the assault, the AR replied, “well, she’s (on) hospice (care).”

According to the complainant, she had been told by caregivers that Resident A had previously been sexually aggressive with them. When I asked the AR and the administrator if Resident A was known to act out sexually, the administrator admitted that Resident A had tried to kiss both her and the female caregivers.

Review of the facility policy addressing Resident Rights and Abuse reveal that the policy consisted of how to complete an incident report if abuse occurred, but did not include any guidance on abuse prevention.

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**
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:	The facility did not protect Resident B from sexual abuse perpetrated upon her by Resident A and has not put intervention into place to protect Resident B, other female residents or female caregivers from Resident A's sexual aggressiveness.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 11/07/2024. 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.

11/07/2024

Barbara Zabitz Date
Licensing Staff

Approved By:

11/04/2024

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