GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 18, 2025

Ashley Mcloughlin
Shelby Comfort Care
51831 VanDyke Ave.
Shelby Township, MI 48315

RE: License #: AH500413843
Investigation #: 2025A1027068
Shelby 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

I. IDENTIFYING INFORMATION

License #:	AH500413843
Investigation #:	2025A1027068
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/08/2025
Report Due Date:	09/06/2025
Licensee Name:	Shelby Comfort Care, LLC
Licensee Address:	2635 Lapeer Road Auburn Hills, MI 48326
Licensee Telephone #:	(989) 607-0001
Authorized Representative:	Ashley Mcloughlin
Administrator:	Kassandra Thurlow
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	77
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Residents were neglected.	Yes
Opioids were missing from the medication cart.	Yes
Additional Findings	No

III. METHODOLOGY

07/07/2025	Special Investigation Intake 2025A1027068
07/08/2025	Special Investigation Initiated - Letter Email sent to AR and administrator requesting documentation
07/08/2025	Contact - Document Received Email received with requested documentation
07/18/2025	Contact - Document Sent Email sent to the complainant requesting additional information
07/18/2025	Contact - Document Received Email received from complainant with requested information
07/21/2025	Inspection Completed On-site
07/22/2025	Contact - Telephone call made Telephone interview conducted with Resident B's hospice team
07/24/2025	Contact - Telephone call made Telephone interview conducted with Relative B1
07/25/2025	Contact - Telephone call made Voicemail left with Resident B's hospice aide
07/25/2025	Inspection Completed-BCAL Sub. Compliance
08/18/2025	Exit Conference Conducted by email with Ashley Mcloughlin

ALLEGATION:

Residents were neglected.

INVESTIGATION:

On 7/8/2025, the Department received allegations forwarded from the Attorney General's (AG) office which read residents had bed sores, were left soaked in urine all day, and had open gashes on their heads and arms.

On 7/18/2025, email correspondence with the AG's complainant clarified Residents A and B were neglected.

On 7/21/2025, an on-site inspection was conducted, and staff were interviewed.

> Employee #1 stated that Resident A had a rash under her abdominal folds and groin area, which appeared to be a fungal condition, but denied any open sores or wounds. Employee #1 indicated that she was receiving hospice services from Harmony Hospice, with a nurse visiting twice a week and an aide five times per week. Employee #1 added that although Resident A had been sleeping exclusively in a recliner, she had recently agreed to use a hospital bed.
>
> Regarding Resident B, Employee #1 reported she did not have bed sores but did have bruises and a skin tear on her leg sustained during a transfer. She noted that hospice services were being provided by The Care Team, with regular visits from the nurse and aide. The hospice nurse was managing the wound care.
>
> Both residents were reportedly changed every two hours and received showers twice weekly in coordination with hospice support.
>
> Resident A confirmed staff changed her briefs regularly and expressed no concerns with her care. She denied having any open wounds or bruises.
>
> Resident B described staff as generally good but mentioned they were sometimes "rough" during transfers. She confirmed regular brief changes and assistance with showers. Upon observation, Resident B had bruising on both arms and legs and a dressing on her right lower leg. Resident B appeared to be dressed in clean clothing and her room lacked any odors.

On 7/22/2025, I conducted a telephone interview with Resident B's hospice nurse and their team. The hospice nurse stated that Resident B had not reported rough handling by staff, but she had informed him that she bruised easily. He confirmed that the bruising had been documented in his clinical notes, and he was dressing a wound on her lower right leg. Due to the difficulties staff encountered when transferring Resident B using a standard wheelchair, a Hoyer lift and Broda chair

were ordered and implemented. He also reported that staff were educated on Hoyer lift use but sometimes continued with stand-and-pivot transfers.

On 7/24/2025, I conducted a telephone interview Relative B1 who confirmed although Resident B bruised easily, staff would stand and pivot her instead of utilizing the Hoyer lift. She stated that showers were not consistently provided and were most recently performed by the hospice aide. The hospice aide reportedly found Resident B's briefs soaked in urine and noted that the bandage on her leg was not consistently changed.

On 7/25/2025, I attempted to contact Resident B’s hospice aide by telephone but did not receive a return call.

Resident B's face sheet indicated she moved into the home on 2/14/2025, with Relative B1 listed as her primary contact. She was receiving hospice services from The Care Team. Her service plan dated 2/14/2025, documented that she required one-person assistance with a gait belt for transfers and was considered a fall risk. It read she had no open wounds, her skin was intact, and she was to receive showers twice a week.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R 325.1901	**Definitions.**
	(p) "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.
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the 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:	Resident B reported that staff were "rough" with her during transfers. Observations confirmed bruising on her arms and legs, though the cause could not be conclusively determined. Interviews indicated Resident B should have been transferred using a Hoyer lift, but the service plan specified one-person assist with a gait belt. Additionally, the service plan indicated she had no open wounds, which contradicted observations and reports of a wound on her right lower leg. The service plan lacked clarity and failed to provide staff with adequate guidance on wound care responsibilities, including whether care was to be provided by facility staff or the hospice agency, and whom to contact in case of concerns. Based on the information gathered through interviews, observations, and record reviews, a violation was substantiated for lack of care consistent with Resident B's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Opioids were missing from the medication cart.

INVESTIGATION:

On 7/8/2025, the Department received allegations forwarded from the Attorney General's (AG) office which read opioids were "stolen" from the medication cart.

On 7/18/2025, email correspondence with the AG's complainant confirmed that the allegations specifically pertained to Residents A and B.

On 7/21/2025, an on-site inspection was conducted, and staff were interviewed.

Employee #1 stated that both Residents A and B had been prescribed morphine; however, neither resident was actively using the medication.

While on-site, I reviewed Residents A and B's July 2025 medication administration records (MARs). Residents A and B's July 2025 MARs revealed the following:

Resident A was prescribed Lorazepam and Morphine Sulfate on an as-needed basis. Documentation in the MAR was consistent with the Controlled Drug Receipt/Proof-of-Use/Disposition Forms in both the narcotic count book and the narcotic storage drawer.

Resident B was prescribed Hydromorphone and Lorazepam on an as-needed basis. While her MAR entries were consistent with the corresponding documentation in the narcotic count book, discrepancies were noted:

- The Controlled Drug Receipt/Proof-of-Use/Disposition form indicated there should have been 15 Hydromorphone syringes and 31 Lorazepam pills available.
- Hydromorphone syringes were missing and could not be located.
- Two Lorazepam pills were missing from the bubble pack and were also unaccounted for.

Review of the narcotic logbook covering the period July 16–21, 2025, revealed the following issues:

- Staff did not consistently sign off on narcotic counts.
- Documentation of the number of controlled substances present was often incomplete or omitted altogether.
- In several instances, there was no documentation of a narcotic count having been performed at shift change.

On 7/22/2025, a telephone interview was conducted with Resident B's hospice nurse and care team, who confirmed that the facility was to dispose of medications if they are expired, and Resident B's Hydromorphone prescription had expired on 5/18/2025.

A review of the facility's medication administration policy revealed that at each shift change, both the incoming and outgoing staff are required to verify the quantity of controlled medications by comparing the amount in each container with the quantity recorded on the "Proof of Use" sheet. The policy reads that each medication assistant is responsible for the medication cart upon receiving it, as confirmed by their signature in the narcotic logbook, and will be held accountable for its contents. In the event of a discrepancy in narcotic counts, staff are required to notify the administrator and the resident's physician, and to complete an incident report. The policy reads that outdated medications must not be stored or used in the facility and should be documented in the resident's clinical records. These medications must be destroyed by two or more staff members, with both individuals signing and dating the destruction record, which is to be maintained by the facility for a minimum of five years.

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:	Although it could not be determined if narcotics were stolen, the facility failed to comply with its own medication administration policy. Specifically, controlled substances (Hydromorphone and Lorazepam) were unaccounted for, documentation in the narcotic count log was incomplete and inconsistent, and staff failed to properly record medication counts or verify inventory. Although the Hydromorphone had expired, its disposal was not properly documented, and the missing Lorazepam was neither recorded nor explained. Based on this information, 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 remains unchanged.

08/04/2025

_____

Jessica Rogers Date
Licensing Staff

Approved By:

08/18/2025

_____

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