GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 5, 2025

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

RE: License #: AH730412298
Investigation #: 2026A1019010

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
[THIS REPORT CONTAINS GRAPHIC CONTENT]

I. IDENTIFYING INFORMATION

License #:	AH730412298
Investigation #:	2026A1019010
Complaint Receipt Date:	11/18/2025
Investigation Initiation Date:	11/21/2025
Report Due Date:	01/18/2026
LicenseeName:	Shields Comfort Care Assisted Living and Memory Care LLC
Licensee Address:	3061 Christy Way, Suite B Saginaw, MI 48603
Licensee Telephone #:	(989) 607-0001
Administrator:	Curtrice Farrow
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	65
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was sexually assaulted by Resident B.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/18/2025	Special Investigation Intake 2026A1019010
11/18/2025	Comment The complaint was forwarded to LARA from APS; APS is investigating the allegations.
11/21/2025	Special Investigation Initiated - Letter Emailed APS worker for additional information.
12/02/2025	Inspection Completed On-site
12/02/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Resident A was sexually assaulted by Resident B.

INVESTIGATION:

On 11/18/25, the department received a complaint forwarded from Adult Protective Services (APS) alleging that Resident A was sexually assaulted by Resident B on 11/8/25. The complaint alleges that Resident B went into Resident A's room and they were unattended for roughly 30 minutes until an employee walked in on the assault. The complaint alleges that the staff member failed to properly report the incident.

On 12/2/25, I conducted an onsite inspection. I interviewed [Employee 1]. Employee 1 confirmed that the event described in the complaint was accurate. Employee 1 reported that Resident B moved into the facility on 11/7/25. Employee 1 reported that she was not present when the incident happened and found out about it the following morning. Employee 1 reported that she came to the facility on Saturday 11/8/25 and received a text message from Employee 2, the text contained a screenshot of a text Employee 2 received from Employee 3, that read:

Hey [Employee 2], what y'all gonna do about [Resident B] I don't know if they told y'all or they are aware of that. He went in two of the resident room and he raped both of them. He went inside a share room and he was eating her coochie at that time I was on break. I got back and I just found out that he did that and then the other incident when I was in [Resident C] room he went into [Resident D] room and he was on top of her with her clothes where her bottoms off.

Employee 1 reported that no one had notified her of the incident, and this was the first time she heard about anything occurring. Employee 1 reported that she immediately began investigating to see what occurred. Employee 1 reported that Employee 3 worked third shift the previous evening, so she contacted those third shift staff who were working, which were Employees 3, 4, and 5, and had them all write statements. Employee 1 reported that she also watched surveillance footage and directly observed that Resident B went into three separate female resident apartments during that shift.

Employee 3 worked as a caregiver when the incident took place. Employee 3's statement read:

[Employee 4] and guy from late night (taken to mean Employee 5) come to let me go on break than when I come back from break in the guy from late night told me that [Resident B] was in [Resident A's] room while [Resident A] was laying in the bed [Resident B] decide to put his mouth inbetween her legs. When me and guy from late night we both was in [Resident C] room helping her to the bathroom once we got done with [Resident C] we was checking room once I realize [Resident B] wasn't in the room the guy from late night when to looking for [Resident B] he started check room than find him in [Resident D] room on top of her. She was laying down in shock and I just hurry up and got [Resident B] off of her and I basically tell him to get off and I have to report what he did.

Employee 4 worked as a shift supervisor when the incident took place. Employee 4's statement read in part:

When I came back from break around 1:30am [Employee 3] went to break right after me as I was sitting in the memory care [Employee 5] came in I ask him to sit in there to she get back from break while I do my checks and changes then he can go on break after she get back when I left memory care all the clients was in the living room looking at tv. After she came back from break I told [Employee 5] he can go on his break around 2:45am I came back to memory care she told me [Resident B] was in [Resident D] room trying to get on top of her and I told her to take him to his room help him to the restroom after that put him to bed and lock the room door and check on him every hour to make sure he okay…When I check on [Resident D] she had on a brief I could see it because her covers wasn't all the way on her I went over to make sure she was okay she was closing her eyes looked like she was going to bed. So I left out the room. [Employee 3] or

[Employee 5] never told me about [Resident B] on [Resident A] or about [Resident D] brief being off on the floor.

Employee 5 worked as a care giver when the incident took place. Employee 5's statement read:

I was sitting at the table doing my ADL's and out of nowhere I head [Resident A] either say "get off me" or "get out" so I get up to go check it out because she don't usually call out like that, and when I get to her room [Resident B] is kind of in between her legs with her brief pulled down. I go to get him off of her and her hair down there was wet, but her brief was dry and his face was all moist so I go to escort him back to his room after getting [Resident A] together (fixing her brief and making sure she isn't shaking up because she don't really speak).

I cant remember exactly what I was doing before I seen [Resident B] in [Resident D] room, I was either helping [Resident C] get up or helping clean (another resident) room, and after I was walking to [Resident D] room and when I made it there [Resident B] was on top of [Resident D] with her brief right next to the bed, and when he was on top of her it seems to be as if he was only kissing her. So I go to get him up off of her with the help of [Employee 3] and we go to escort him out of her room and check on [Resident D] to make sure she isn't all shook up, and after finding out she was ok we continued to get her up and get her all changed and dressed.

Employee 1 reported that she notified her direct supervisor of what occurred and was instructed not to call the police because due to being memory care residents, they were not reliable witnesses and couldn't testify to what occurred. Employee 1 reported that it didn't sit right with her, and she contacted the police on 11/10/25. Employee 1 reported that she also contacted the families of all affected residents. Employee 1 reported that Resident A's family moved her out of the facility a few days later and Resident B moved out effective 12/2/25. Employee 1 reported that on 11/8/25, she implemented 1:1 supervision of Resident B and moved his apartment to a different area. Employee 1 reported that Employee 5 has been terminated due to his conduct over this incident and Employees 3 and 4 have also since been terminated, but for other reasons.

While onsite, I obtained progress notes and incident report documentation. The progress note authored by Employee 1 read:

On November 8, 2025, during overnight hours, [Resident B] was observed on camera entering multiple female residents' rooms within the Memory Care Unit without authorization. At approximately 1:14am, he entered [Resident E's] room for about six minutes. At approximately 1:21am, he entered [Resident A's] room and remained there for approximately thirty minutes. At approximately 4:47am, he entered [Resident D's] room for approximately three minutes. Staff did not immediately intervene during these incidents, and management was not notified

until the following day (November 9, 2025). Upon learning of the situation, the Administrator initiated an immediate investigation and reviewed surveillance footage confirming [Resident B's] actions. When questioned by the Administrator, [Resident B] admitted to attempting to have sexual relations with one of the residents but was unable to identify which one.

Incident report documentation for Residents A, D and E was consistent with the events outlined in the progress note. The incident report for Resident A added that [Resident B] was "*engaging in inappropriate physical behavior*" with Resident A. The incident report for Resident D added "*Based on the short duration and observed behavior, staff do not believe inappropriate contact occurred".* The incident report for Resident E added "*Due to the short duration of the interaction and lack of direct observation, it is unclear whether any inappropriate contact occurred*".

While onsite, the authorized representative (AR) Kory Feetham provided the facility's incident reporting policy that read:

All employees will report orally and in writing to the administrator immediately if there is a suspected incident of abuse. Abuse is defined as an intentional sexual, physical, or mental action or omission that exposes a resident to serious risk of physical or emotional harm or the deliberate infliction of pain by any means.

In follow up correspondence, I spoke with the assigned APS worker. The APS worker reported that she is substantiating neglect on behalf of the facility because staff failed to follow proper protocol in reporting the incident and supervising Resident B.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(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, except those restraints authorized in writing by the attending physician, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, for**

	a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	On 11/8/25, staff believed to have observed Resident B performing oral sex on Resident A which appeared to be against her will. After further investigation, Resident B was observed going into two other female resident rooms that same morning; it is unknown if those encounters were inappropriate in nature as the residents could not recall what occurred due to cognitive limitations. Employee 4's documented statement outlined guidance to another staff member that would be a direct resident rights violation by restraining Resident B in his room. The investigation could not determine if Resident B was locked within his room or not after the incident, as suggested by the staff member.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	Facility staff failed to follow proper protocol of the incident reporting but not notifying management or the administrator of the events that took place. Additionally, staff failed to properly supervise Resident B, as he went into multiple resident rooms without being permitted to do so.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident B moved into the facility on 11/7/25 and moved out on 12/2/25. At the time of my onsite inspection on 12/2/25, the administrator and AR both could not locate a service plan for him and the AR reported that there must not be one in place.

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.
ANALYSIS:	The facility lacked a service plan for Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

12/04/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

12/04/2025

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