GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 25, 2026

Kory Feetham
Burton Comfort Care III
5340 Davison Road
Burton, MI 48509

RE: License #: AH250382918
Investigation #: 2026A0628037
Burton Comfort Care III

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 responsible party 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 (517) 335-5985.

Sincerely,

Rebekah Looney, Licensing Staff
Bureau of Community and Health Systems

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH250382918
Investigation #:	2026A0628037
Complaint Receipt Date:	04/29/2026
Investigation Initiation Date:	05/04/2026
Report Due Date:	06/29/2026
Licensee Name:	Burton Comfort Care LLC
Licensee Address:	5310 Davison Rd Burton, MI 48509
Licensee Telephone #:	(810) 228-3520
Authorized Representative/Administrator:	Kory Feetham
Name of Facility:	Burton Comfort Care III
Facility Address:	5340 Davison Road Burton, MI 48509
Facility Telephone #:	(810) 743-8520
Original Issuance Date:	10/05/2017
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	23
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The home doesn't allow Resident A to have visitors.	Yes
The home does not provide activities.	No
Additional Findings	No

III. METHODOLOGY

04/29/2026	Special Investigation Intake 2026A0628037
04/29/2026	Contact - Document Sent email sent to AR requesting documentation
04/30/2026	Contact - Document Received email received from AR
05/04/2026	Special Investigation Initiated - On Site
05/05/2026	Contact - Telephone call received voicemail from complainant forwarded to me from A. Clum
05/05/2026	Contact - Telephone call made telephone call made to complainant. No answer. Message left with name, job title, reason for call and phone number.
05/07/2026	Contact- Email received from administrator with requested documents.
05/08/2026	Contact- voicemail left from complainant #2
05/11/2026	Contact- Telephone call made to complainant #2. Voicemail message left.
05/11/2026	Contact -Voicemail message left from complainant #2.
05/12/2026	Contact – phone call with complainant #2
06/26/2026	Exit Conference conducted with Kory Feetham

ALLEGATION: The home doesn't allow Resident A to have visitors.

INVESTIGATION:

On 04/29/2026, the department received a complaint, from complainant #1, that alleged the home did not allow Resident A to have visitors. Additionally, the complainant alleged that the home does not allow Resident A to leave for outings including shopping and lunch with friends.

On 05/01/2026, the department received an additional complaint, from complainant #2, that alleged the home is not allowing Resident A to meet with her attorney. The complainant alleges that home threatened to call the police. The complainant additionally alleges that Resident A is not allowed any visitors.

On 05/04/2026, the department received an additional complaint, from complainant #3, that alleged Resident A is unable to have visitors. This complainant alleged they had visited Resident A in the past but have been told that Resident A is not allowed visitors.

On 05/05/2026, the department received a call from complainant #2. Additionally, that complainant submitted another complaint with information alleging that on 05/01/2026, while attempting to visit Resident A, the home called the local police, and the complainant was escorted out of the building by police officers and was told she was trespassing.

On 05/08/2026, the department received another complaint, from complainant #4, alleging that the home does not allow Resident A to have visitors.

Four separate complainants submitted a complaint that alleged Resident A was not allowed to have visitors. All those complaints are combined into this report.

On 05/04/2026, while onsite I spoke with the administrator and Employee #1. The administrator reported that Resident A had a DPOA. Additionally, he reported he had paperwork supporting Resident A's need for a DPOA. The administrator reported that Complainant #1 had come to the home during the evening, after management had left, and had Resident A sign attorney paperwork secretly. The administrator also reported that Complainant #1 had come to the home on 05/01/2026 and the police had been called to escort Complainant #1 off the property. When asked why Complainant #1 is not allowed to visit Resident A, the administrator and Employee #1 reported that Resident A's DPOA did not want her to visit. When asked how Complainant #1 knew Resident A or why Complainant #1 wanted to take on the role of Resident A's lawyer at this time, since she has been a resident of this home for three years, neither the administrator nor Employee #1 reported knowing the reason.

On 05/06/2026, I spoke with the administrator via telephone. The administrator reported that the home did not have a legal order or a physician's order to prohibit visitors from coming to see Resident A. Rather, he stated that the home was honoring the DPOA's request. Furthermore, the administrator reported that it is his building and he can kick anyone off the property that he wants.

On 05/07/2026, I reviewed the documents emailed to me by the administrator. The documents included documents by a physician that states, in their medical opinion, Resident A is not able to make medical or financial decisions for herself due to her cognitive impairment.

On 05/12/2026, I spoke with complainant #2 via telephone. Complainant #2 reiterated what she had written in her submitted complaints. She reported that she was Resident A's legal council and was not allowed to meet with Resident A. Additionally, she reported that she had been escorted off the property where Resident A resides, by local police, and told not to return or she would be considered trespassing. Complainant #2 also reported that the home had signs posted saying Resident A was not allowed to have visitors. She reported that she did not know where these signs were posted. Later, on 05/12/2026, Complainant #2 reported, via text message, that Resident A told her the signs were posted in the medication room. She also sent a photo of the alleged sign that was posted at the home.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting; 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: **(k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant with whom the physician has a practice agreement, with his or her advanced practice registered nurse, with his or her attorney, or with any other individual of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the**

	medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.
ANALYSIS:	Through review of documentation and interviews with staff, it was determined that Resident A has a DPOA to make medical and financial decisions for her. However, the home states they do prohibit Resident A from having visitors. This is in contradiction to the law and therefore, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: THE HOME DOES NOT PROVIDE ACTIVITIES.

INVESTIGATION:

On 04/29/2026, the department received a complaint that alleged the home did not provide any activities.

While onsite, on 05/04/2026, Employee #1 reported that the home does provide activities, but Resident A doesn't often participate. She reported that Resident A usually sleeps late and chooses not to participate in activities. Upon reviewing documents emailed to me from the home, including upcoming events/activities, it was noted that activities are offered. Additionally, upon review of the service plan for Resident A, it states that the home will offer activities/socialization to Resident A, but she will not often participate. It also states that Resident A does not wish to participate in religious activities, and she enjoys walking around the home.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	2(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:	Through interviewing staff and reviewing documents provided by the home, it appears that Resident A is offered the option to participate in available activities but usually declines. Therefore, this allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable plan of correction, I recommend that the status of this license remain unchanged.

05/26/2026

Rebekah Looney Date
Licensing Staff

Approved By:

06/25/2026

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