GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 3, 2023

Connie Clauson
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL240388304
Investigation #: 2023A0009017
Mallard Cove Assisted Living

Dear Ms. Clauson:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (231) 922-5309.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
701 S. Elmwood, Suite 11
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL240388304
Investigation #:	2023A0009017
Complaint Receipt Date:	02/05/2023
Investigation Initiation Date:	02/06/2023
Report Due Date:	03/07/2023
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	3196 Kraft Avenue SE, Suite 203 Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Michelle Horn
Licensee Designee:	Connie Clauson
Name of Facility:	Mallard Cove Assisted Living
Facility Address:	2801 Charlevoix Road Petoskey, MI 49770
Facility Telephone #:	(231) 347-2273
Original Issuance Date:	10/10/2017
License Status:	REGULAR
Effective Date:	04/10/2022
Expiration Date:	04/09/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
In the early morning on February 5, 2023, Resident A left the facility unbeknownst to staff. He wandered down the road and was not found until 7:20 a.m. He was taken to the hospital but, shortly thereafter, died of exposure. Resident A had previously wandered from the facility the week before but was followed by staff and led back in.	Yes

III. METHODOLOGY

02/05/2023	Special Investigation Intake 2023A0009017
02/06/2023	APS Referral
02/06/2023	Contact - Document Received from administrator Michelle Horn
02/06/2023	Special Investigation Initiated – Telephone call received from administrator Michelle Horn
02/06/2023	Inspection Completed On-site Interview with administrators Michelle Horn and Chris Milow
02/16/2023	Inspection Completed On-site Interview with administrator Michelle Horn
02/27/2023	Contact – Telephone call made to direct care worker Jodi Codner
02/27/2023	Contact – Telephone call made to administrator Michelle Horn
02/28/2023	Contact – Telephone call made to direct care worker Jodi Codner
02/28/2023	Contact – Telephone call made to administrator Michelle Horn
03/02/2023	Contact – Telephone call made to administrator Michelle Horn
03/03/2023	Exit Conference with licensee designee Connie Clauson

ALLEGATION: In the early morning on February 5, 2023, Resident A left the facility unbeknownst to staff. He wandered down the road and was not found until 7:20 a.m. He was taken to the hospital but, shortly thereafter, died of

exposure. Resident A had previously wandered from the facility the week before but was followed by staff and led back in.

INVESTIGATION: I received an AFC Licensing Division – Incident/Accident Report (BCAL-4607) from administrator Michelle Horn on February 6, 2023. It reported; *'Staff checked on resident at 6:00 a.m. and he was not in his room. Staff searched building and then called 911 at 6:23 a.m. Rescue workers found resident off grounds at 7:20 a.m. and took him to the emergency room. Resident died at the hospital. Authorities notified family.'*

I received a phone call from administrator Michelle Horn on February 6, 2023, to ensure I had received the incident report. That same day I conducted a site visit at the Mallard Cove Assisted Living facility and spoke directly with administrators Michelle Horn and Chris Milowe. Ms. Horn reported that Resident A had left at some time in the early morning hours of February 5, 2023, and staff did not discover he was missing until 6:00 a.m. when they checked his room and found him missing. Ms. Horn explained that direct care worker Jodi Codner was the one who first discovered Resident A was gone. Michelle Horn stated she was working in the other attached facility at the time Ms. Codner notified her that Resident A was missing. They each searched both facilities for Resident A and Ms. Horn called 911 when they determined he was not in either building. Emergency service workers searched the outside of the building and the surrounding area and finally found him down the road outside a nearby business. Ms. Horn said that Resident A's family was notified but that Resident A died shortly after he was transported to the hospital.

I asked Ms. Horn how Resident A could have exited the facility unbeknownst to staff. She explained that the doors leading to the outside are "alarmed". This alarm system makes the same sound and lights up the same as the call light that residents use when they need assistance. Ms. Horn stated that staff have to acknowledge the alert to get it to stop sounding. Ms. Horn admitted that they did not have an answer to whether the alarm had sounded or if the staff person on duty had acknowledged that alert as there was no record of it at that point.

Mr. Chris Milowe was also present at the time of the interview. Mr. Milowe is the regional operations director for the licensee. He was present at the facility after being notified of what had occurred. Mr. Milowe gave input during the interview and said that they were trying to determine when, and if, the alert to the outside door sounded that morning. They are supposed to receive an email of every call light or door exit alert but did not receive an email that morning for a door exit. They are working with Habitec, the security company they have a contract with, to try to determine when the outside door opened. They believe that Resident A exited through the north door of the facility since that exit to the outside is adjacent to Resident A's bedroom. Ms. Horn stated that they did open the north exit to the outside the day before to see if it would send an email notification, but it did not. They did not listen to hear if the alarm sounded at that time. They opened the exit door again today to test it and did hear an alert at that time.

Ms. Horn showed me the north exit of the building. She demonstrated that when one opens the door it causes an alarm/alert to sound which sounds exactly like the alert for when a resident uses their call button. She stated again that staff need to acknowledge the alert to get it to turn off. She showed me that the doorway to Resident A's room was directly adjacent to the exit to the outside. Ms. Horn stated they are trying to get a log from Habitec that might document specific alerts from that morning other than the email record. They will also be looking to put other safeguards in place including an exit alert that sounds differently than the call alerts. We also talked about the option of installing a delayed egress on the exits, which would need to be approved by the fire inspector.

I asked Ms. Horn and Mr. Milowe whether Resident A had a diagnosis of dementia. Mr. Milowe replied that it was his understanding that Resident A had "confusion" but not necessarily a diagnosis for dementia. Ms. Horn reported that Resident A's Family Member initially reported that Resident A experienced "ongoing confusion" but later turned in paperwork from the doctor documenting "dementia". I asked Ms. Horn for Resident A's written assessment plan. She provided that and I noted that it indicated that, '(Resident A) has occasional confusion and some difficulty recalling details. (He) needs occasional prompting or orientation.' I did not note any indication that he experienced "dementia". I asked them about the report I received that Resident A had also gotten out of the facility the week before this most recent incident, which was noted in the complaint that I received. Ms. Horn replied that Resident A did previously leave the facility through the exit door, but staff responded immediately, found him and brought him back in. I asked what they did in response to that incident. Ms. Horn stated that they did offer to the family to move Resident A to another room which would have been further from the exit. The family declined the offer saying that they did not wish to add to his confusion.

I made another site visit to the Mallard Cove Assisted Living facility on February 16, 2023. I spoke with administrator Michelle Horn at that time. She reported that they had installed "crash bars" on the exit doors of the facility. I observed these to be one-motion push bars which had been installed since my last visit. These made a much louder alert when opened than previously. It was also a different sound than the call alerts that sounded when a resident needed assistance. Ms. Horn said she believed that the louder and specific alert would allow staff to respond immediately when an exit door was opened. She showed me that the push bar had been installed on all the exit doors to the facility except the front door of the facility. She said that the front door needed a different size push bar and they were waiting for that to arrive. I asked Ms. Horn if there had been any clarification from the security company about the incident regarding Resident A. She said that Habitac reported that only 100 "events" are recorded at a given time. When an alert goes off and then the staff clears it is considered two separate events. Only the 100 events are recorded at any one time. It is possible that they had surpassed 100 events prior to Resident A exiting that morning. Ms. Horn stated that she is still trying to figure out whether the exit door opening would have sent an email like the call alerts do. One Habitac technician did come in to reprogram the system to ensure that it is working

properly. Another Habitac representative will be coming in to discuss what other options they can provide to ensure the safety of the residents. I told Ms. Horn that she should contact the fire inspector to ensure that the new push bars pass fire safety evacuation regulations.

I spoke with direct care worker Jodi Codner by phone on February 27, 2023. I asked her about the events on the morning of February 5, 2023, regarding Resident A. She reported that she was working the “night shift” at the facility and that she was the only one working from 11:00 a.m. until 7:00 a.m.. She said that she checked on Resident A at 1:00 a.m. and he was in his room. The door to his room had been closed. I asked her what then happened. Ms. Codner replied, “All the alarms sound the same and for some reason, I did not hear the alert.” She said that when she went to Resident A’s room at 5:00 a.m., his door was open and he was gone. She said that she searched his room and the surrounding area but could not find him. She contacted Ms. Horn, who was working in the attached facility, and told her that Resident A was missing. They both kept searching but then called 911 as soon as they determined he was not there. I asked Ms. Codner more specifically about the door alarm. She said that it hadn’t gone off or she would have heard it. They have to turn off each alert and she did not remember turning it off for an exit door. I asked her more about the alert system and how she would have known the exit door had been opened. Ms. Codner replied that the alert at the control panel tells you which room number the call is coming from or if an exit door is opened it says something like, “Front Fire Door”. I asked Ms. Codner what she had been doing during her shift after checking on Resident A. She said that she did give one resident medication around 1:00 a.m. and then the rest of the night it was just checking on residents and changing some of them. Ms. Codner said that she wanted me to know that they had offered to the family to move Resident A to another room after he wandered from the building the week before his death. She said that it was difficult to keep an eye on him where he was at the end of the hall.

I then spoke with Resident A’s Family Member by phone on February 27, 2023. He reported that his father had gone to live at the Mallard Cove Assisted Living facility on December 6, 2022. He had verbally told them of his father’s confusion at that time. In January of 2023, he took his father to his physician who did document that Resident A was experiencing “dementia”. Resident A’s Family Member provided the paperwork documenting the dementia to Mallard Cove Assisted Living. He said that he gave this paperwork directly to the nurse on duty when they returned from the physician’s visit. Resident A's Family Member stated that he was aware that his father had left the facility at the end of January of 2023, but that staff had found him and brought him back in. He acknowledged that the administrator at the facility had offered for his father to be moved to a room closer to the middle of the building. He said that they considered the offer, but did not want to add to his confusion. I asked him about the morning of February 5, 2023. Resident A’s Family Member said that the first he knew about it was when a 911 operator contacted him at 7:00 a.m. to tell him his father was missing. The 911 operator was checking to see if he was there. He then received a call at around 7:30 a.m. from a law enforcement officer informing

him that they had found his father but that it was “not good” and that he “better be ready”. He also received a call from Ms. Horn that morning, but he was sure that 911 personnel had called him initially. He checked his call log but did not have a record of the calls from that morning. Resident A’s Family Member stated that Ms. Horn had told him that they had video footage of his father wandering down to the cafeteria at the facility at 12:45 a.m. They also told him that they had footage of the staff person checking on him in his room at 1:00 a.m. Resident A’s Family Member said that he did not know if his father was sitting in a chair or was in his bed when staff checked on him. He said that he did not believe his father wandering in the middle of the night was typical behavior for him, and this was the first he knew that his father had wandered at night.

I spoke with administrator Ms. Horn by phone on February 27, 2023. She said that the security company, Habitec, had further clarified that their current system could only hold 100 events at a time. Having hit the limit of 100, there was no further log of what alerts went off that morning. Habitec did not have a log of the alerts themselves since it is a “localized” system and was not monitored by them. She said that she was still meeting with someone from their company to go over their options including someone from the company monitoring exit alerts. I asked Ms. Horn about the report that Resident A’s Family Member had disclosed that Resident A had been seen in the cafeteria at 12:45 a.m. on February 5, 2023. She said that it was “12:30ish” and that the camera footage only showed him in the hallway of the facility. It did not show him in the cafeteria. He is then seen entering his room. I asked Ms. Horn about Ms. Codner telling me she had discovered him missing at 5:00 a.m. She said that she believed that she meant 6:00 a.m. Ms. Codner notified her, Ms. Horn, shortly after 6:00 a.m. of him missing. They searched the facilities quickly and then she called 911.

I spoke again with direct care worker Ms. Codner by phone on February 28, 2023. I asked her again about the time discrepancy. She again indicated that it was 5:00 a.m. when she discovered Resident A missing. Ms. Codner stated that she checked an empty room that he sometimes goes to when he has been confused before. He was not there. She said that she almost immediately told Ms. Horn about him missing and then after about 10 to 15 minutes of searching, Ms. Horn called 911. I asked her about Resident A wandering in the hallway and/or cafeteria shortly before her reported room check at 1:00 a.m. Ms. Codner reported that she was unaware that he had been wandering. She had not seen him in the hallway or the cafeteria. I asked her if she actually did see him when she did the room check at 1:00 a.m. She replied that she did see Resident A and that he was sleeping in his bed at that time.

I spoke again with administrator Ms. Horn by phone on February 28, 2023. She clarified more specifically what the video footage of Resident A on February 5, 2023, had shown. The cameras are motion-activated so only gather footage when someone is in motion. Resident A was seen at around 12:30 a.m. in the hallway, turning the corner to the area that contains the dining room and kitchen. Ms. Codner was in the kitchen at the time preparing food for the residents. She did not see

Resident A. The footage shows Resident A going back down the hall to his room by himself. He is seen entering his room but leaves his door open. Ms. Horn stated that some of the residents sleep with their doors open. Ms. Codner is then observed looking into his room at around 1:00 a.m. She did not enter the room, but only looked into the room. Staff are supposed to lay eyes on the residents, and Ms. Horn stated she assumes that Ms. Codner did see him from the doorway. Resident A sometimes sleeps in his chair and she may also have seen him in bed from where she was. They do not have any policy about how many times staff need to check on residents during the night. They check as they are able during sleeping hours. There was no video footage of him leaving his room after that or exiting the building. I asked Ms. Horn about Ms. Codner again stating that she found Resident A missing at 5:00 a.m. She said that Ms. Codner reported Resident A missing right after 6:00 a.m. and told her, "I just checked on (Resident A) and he is not in his room." They searched the premises and Ms. Horn called 911 at around 6:20 a.m. She said that her only explanation for Ms. Codner's recollection of the time is that she is mistaken or not remembering correctly.

I reviewed Resident A's written assessment plan. The plan documented that Resident A, "Has occasional confusion and some difficulty recalling details. Needs occasional prompting or orientation." The plan indicated to the question, "Does the individual have self-stimulating wandering? No." There was no other documentation regarding dementia or wandering indicated in the assessment.

I spoke with administrator Michelle Horn by phone on March 2, 2023. She reported that she had not known of any previous wandering behavior by Resident A other than the one time he had gotten out of the building at the end of January 2023. She said that he would sometimes be confused about the direction of his room. From the dining area, he might turn left instead of right towards his room. If he did turn left, he might believe that the empty room on the end of that hallway was his room since it was also the last room on the right. She did not know of any other wandering behavior in the facility prior to February 5, 2023. Ms. Horn said that the written assessment plan had not been updated yet to include Resident A wandering from the building on January 28, 2023.

On March 3, 2023, I conducted an exit conference with licensee designee Connie Clauson. I told her of the findings of the investigation and gave her the opportunity to ask questions.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	It was reported to the facility that Resident A experienced confusion when he was admitted, and his physician further documented that he experienced dementia. Resident A wandered out of the facility a week before his death, but staff found him right away and brought him back into the facility. As a result of this incident, Resident A's family was given the option of having Resident A moved to a room farther away from the facility exits, but the family declined this offer. Staff reported checking on Resident A at 1:00 a.m. on February 5, 2023, and he was observed sleeping at that time. It was reported that video footage did confirm that staff looked into Resident A's room from the doorway at that time. It is unclear how Resident A got out of the building unbeknownst to staff. Alerts for exits sound the same as call alerts from residents and indicate the room number or exit that has been opened. The alerts need to be turned off by staff at the control panel. The staff person on duty denied hearing the alert for the exit doorway or turning it off. There was no documentation of the alert going off but also no indication that the system was malfunctioning. Resident A was not discovered missing until approximately 6:00 a.m. By then, he had wandered roughly a quarter of a mile away from the facility and was not dressed for winter weather. Resident A was found at around 7:20 a.m. by emergency personnel but died from exposure shortly thereafter in the hospital. It was confirmed through this investigation that Resident A's personal needs, including protection and safety, were not attended to on February 5, 2023, when he left the facility's premises unbeknownst to staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend a six-month provisional license for the above summarized quality of care violation.

03/03/2023

Adam Robarge — Date
Licensing Consultant

Approved By:

03/03/2023

Jerry Hendrick — Date
Area Manager