GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2024

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

RE: License #: AL240388304
Investigation #: 2024A0009017
Mallard Cove Assisted Living

Dear Mrs. Clauson:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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 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 (616) 356-0100.

Sincerely,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
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 #:	2024A0009017
Complaint Receipt Date:	03/19/2024
Investigation Initiation Date:	03/20/2024
Report Due Date:	04/18/2024
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Lauri Lee
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:	10/04/2023
Expiration Date:	10/03/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED & ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care worker Amie Graway pushed Resident A and shut her foot in a door causing injury.	Yes

III. METHODOLOGY

03/19/2024	Special Investigation Intake 2024A0009017
03/19/2024	Contact – Telephone call received from Chris Milowe, Regional Operations Director Baruch SLS, Inc.
03/19/2024	Contact – Document (email with attachments) received from Chris Milowe, Regional Operations Director Baruch SLS, Inc.
03/19/2024	APS Referral
03/19/2024	Contact - Telephone call received from adult protective services worker Lane Stopher
03/20/2024	Special Investigation Initiated - On site Interview with administrator Chris Milowe, direct care worker Angela Christie, Resident A and administrator Lauri Lee
03/20/2024	Contact - Telephone call made to direct care worker Amie Graway, left message
04/04/2024	Contact – Telephone call made to adult protective services worker Lane Stopher
04/04/2024	Contact - Telephone call made to direct care worker Amie Graway, left message
04/05/2024	Contact - Telephone call made to direct care worker Amie Graway
04/05/2024	Contact – Telephone call received from adult protective services worker Lane Stopher
04/08/2024	Contact – Face to face interview with Resident B
04/09/2024	Exit conference with licensee designee Connie Clauson

ALLEGATION: Direct care worker Amie Graway pushed Resident A and shut her foot in a door causing injury.

INVESTIGATION: I received a telephone call from Chris Milowe, regional operations director with Baruch SLS on March 19, 2024. He reported that Resident A had reported that she had been injured by a direct care worker at the Mallard Cove Assisted Living adult foster care home. Mr. Milowe reported that they are conducting their own internal investigation as well as reporting the matter to Licensing. He said that he would send me a copy of the Incident Report regarding the matter as well as photographic evidence they had collected regarding Resident A's injuries.

I received an email with attachments from Mr. Milowe later that day. The attachments included an Incident Report and photographic images. The Incident Report stated, *'Received phone call on March 15 (2024) that (Resident A) had bruising on her right arm and that her left ankle was swollen. (Resident A) indicated it was inflicted by an employee*.' I also reviewed the photographs. An ankle depicted in the photos was discolored and appeared to be swollen. The shoulder in the photos did not appear to have any obvious injury but was circled where Resident A indicated she was hurt.

I also spoke with adult protective services worker Lane Stopher by telephone on March 19, 2024. He reported that he was also investigating the matter and we agreed to meet at the facility the next day.

I conducted an unannounced site visit at the facility with Mr. Stopher on March 20, 2024. We spoke initially with Chris Milowe, regional operations director with Baruch SLS. The direct care worker involved, Amy Graway, has been suspended pending their investigation. Resident A had reported that problems between her and Ms. Graway had started on March 12, 2024. She said that she asked Ms. Graway why she didn't like her. Ms. Graway reportedly told Resident A that she believed Resident A is faking her physical disabilities. Then on March 13, 2024, Resident A said that she was in the doorway of Resident B's bedroom when Ms. Graway told her to get out, pushed her back and shut the door in on her ankle. When Ms. Graway opened the door again Resident A was still there with her arms on the doorframe. Ms. Graway reportedly grabbed her right arm and pulled it behind her when trying to get past. Mr. Milowe said that Resident A had not worked since that day because administration had heard that Ms. Graway had been verbally inappropriate with a resident but did not know about the injuries at that time. Mr. Milowe said that direct care worker Angela Christie was the first person to deal with Ms. Graway and Resident A after the alleged incident. She was present at the facility at that time.

We then spoke with direct care worker Angela Christie. She said that Resident A called the main office on March 13, 2024 and spoke with administrator Lauri Lee. Ms. Lee asked her, Ms. Christie, to go down and speak with her. Ms. Christie said

she did as asked, but met Ms. Graway on her way there who complained about Resident A. Ms. Christie said that she suggested to Ms. Graway that she write out a statement about what happened and have Resident B sign it. Ms. Christie went on to say that she then spoke with Resident A. Resident A told her that she had heard Ms. Graway yelling at Resident B so went to check on Resident B. Resident A was in the doorway of Resident B's room when Ms. Graway told her that she wasn't allowed to be in there and shut the door on her foot. When the door wouldn't shut, Ms. Graway pushed Resident A back and then closed the door. Resident A also reported that when Ms. Graway opened the door, Resident A was still there. Ms. Graway grabbed her arm and pushed her back out of the doorway to get around her. On that day, Resident A denied that she had any pain or injuries from the incident. Later in the week, on March 15, Resident A told her that she wanted to call the police. She also told Ms. Christie that she wanted her to look at her ankle which was discolored and swollen. Ms. Christie reported that she did look at her left ankle which was discolored and swollen at that time. Resident A also indicated that her right arm was hurt. Ms. Christie observed her arm which she indicated was red. Resident A also said that her right arm was tender to the touch. She told Ms. Christie that both injuries were from the altercation with Ms. Graway two days prior. We asked Ms. Christie if there had previously been any concerns with Ms. Graway. Ms. Christie stated that she had, at times, been surprised at how "gruff" Ms. Graway speaks with residents. Other staff have reported to her that they sometimes hear Ms. Graway yelling at residents. Family members of residents have also complained of Ms. Graway. Several residents "do not get along" with Ms. Graway. Ms. Graway has complained about needing to push Resident A in her wheelchair believing that she doesn't need a wheelchair.

We then spoke with Resident A. We asked her what she wanted to tell us regarding Ms. Graway. She said that the day before the incident, she had asked Ms. Graway why she didn't like her. Ms. Graway told her that she didn't think that she needed a wheelchair. She told her that she thought that she was faking her disability and that she didn't need to be living there. Ms. Graway told her that she didn't have time to push her around the facility. On March 13, 2024, Ms. Graway had pushed her down to the dining room but was upset about having to push her. Resident A said that Ms. Graway pushed her too hard into the table so that Resident A "banged into" the table. Later in the day, Ms. Graway saw that Resident A was in the hallway pushing her own wheelchair. Ms. Graway said, "Huh, you can't make it down to the dining room but you can just be out tooling around the hallway." Ms. Graway went into Resident B's room at that time and Resident A wanted to check on her. When Ms. Graway saw her in the doorway, she told her she wasn't allowed to be in there and to "get out". When Ms. Graway saw she wasn't moving she came over, pushed her back and tried to shut the door. Resident A said that her foot was in the way and that Ms. Graway shut her foot in the door. Resident A explained that her foot had been off the foot peddle of the wheelchair. Ms. Graway couldn't shut the door so kept opening it and closing it again and again. Each time, Resident A's foot was in the door preventing it from closing. Resident A said that she kept saying, "Oww, oww, oww". Resident A said that she finally shut the door, but that Resident A was

still there when Ms. Graway opened the door again. Resident A had her arms up on the doorframe and Ms. Graway yelled at her to get out of her way. Ms. Graway pushed her arm up and to the side so she could get around her. Resident A stated Ms. Graway was yelling at her at this time saying that she was "rude", "horrible" and shouldn't even be there. She also said that she was going to talk to administration to try to get her kicked out of the facility. Resident A said that she was injured from the incident. She showed us her left ankle which did appear swollen at that time. She said that her arm had also been injured and her neck had hurt after the incident. There were no obvious, observable injuries to her arm or neck at that time. We asked her if any staff or residents had observed the incident. She said no, that there were no staff around and that Resident B could not see what had happened from where she was sitting in her room at the time.

Chris Milowe spoke with me on my way to the administrator's office. Mr. Milowe informed me at that time the agency had decided to terminate Ms. Graway's employment effective that day. I then spoke with administrator Lauri Lee. Ms. Lee said that she had spoken with Resident A. Resident A initially told her that she had asked Ms. Graway why she didn't like her. She said that Ms. Graway had called her names and used foul language with her. Ms. Lee said that she had "written her up" for the language and name-calling at that time. Resident A later disclosed that Ms. Graway had pushed her and shut her foot in the door on March 13, 2024. Resident A had shown them her swollen ankle and talked about her arm being sore. That was when they suspended Ms. Graway and contacted Licensing. I asked for a copy of the written statement that Ms. Graway had created at the direction of direct care worker Angela Christie.

I reviewed the written statement from Ms. Graway. She wrote, '*I was in giving (Resident B) her meds and she had just got up not feeling well and I turned around and seen (Resident A) in the doorway. I had asked her to go back to her room. She told me 'No'. I told her (Resident B) didn't want anyone in her room, as (Resident A) opened the door and I told her again she can't come in and to shut the door. She just sat there and told me no she wanted to see (Resident B). As I was trying to leave (Resident A) wouldn't let me out of the room. She had one hand on the door and one hand on the frame of the door and wouldn't let me out. Once I got out I went right to Angela (Christie).*' I noted that Ms. Graway had signed the statement and had Resident B sign above her name.

I spoke with adult protective services worker Lane Stopher by telephone on April 4, 2024. He reported that law enforcement had been contacted and were looking into the matter. They had been trying to contact Ms. Graway by phone.

I spoke with former direct care worker Amie Graway by telephone on April 5, 2024. I asked her what had happened between her and Resident A on March 13, 2024. She said that it happened at around 9:30 a.m. Ms. Graway had been in Resident B's room giving her prescribed medication. Resident A came to the doorway of her room and she told her that she didn't need to be there. After some time, she turned

around and Resident A was still there in her wheelchair. She said that she asked her again to leave and when she didn't, she pushed her wheelchair out of the room and shut the door. Ms. Graway said that she finished administering Resident B's medication to her and opened the door to the room. Resident A was still there in her wheelchair with her arms up, one on the doorframe and one on the door handle. She said that Resident A wouldn't let her past. Ms. Graway admitted that she was angry at the time but said that she "didn't touch her". She said that she went under her arms. She said that she had a bunch of medication to administer to other residents and didn't have time for Resident A. I asked her again about her pushing Resident A out into the hallway. She said that she did do that but didn't hurt her. I asked her about Resident A's report that Ms. Graway had shut her foot in the door when she went to close the door. She replied that she "did not think she shut her foot in the door". I told her that Resident A did have injuries which she was reporting were from their interaction. Ms. Graway did not have any other explanation for the injuries. She did say that she wondered if they were self-inflicted. Ms. Graway said that it was possible that Resident A inflicted the injuries to herself to get Ms. Graway in trouble. She said that Resident A had been "pushing and pushing and pushing with tedious things since she moved in and she broke me". I asked her if anyone had witnessed the events. She said that she did not think that anyone else was around but that she thought that Resident B had seen from where she was sitting in her chair.

I made another unannounced site visit at the Mallard Cove Assisted Living adult foster care home on April 8, 2024. I spoke with Resident B at that time. She demonstrated that she was lucid at the time of my visit. I asked her about former direct care worker Amie Graway. Resident B said that she was very good to a lot of the people there but that she could "change just like that". Ms. Graway would get upset very easily. She spoke about the time that Resident A tried to come in her room. Resident A came into the entrance of her room in her wheelchair. As soon as Ms. Graway saw her she told her, "Just go back to your room." After a little while, she noticed that Resident A hadn't moved and told her, "Get out of here." Resident A still didn't move so Ms. Graway pushed her back. She said that she pushed her back at least three times. She then shut the door on her. I asked whether she had seen Resident A's foot get shut in the door. She said that she did not see that but that it could have happened. She mostly heard Ms. Graway saying, "Go, go, go" to her. I viewed Resident B's room at that time and noted that the chair in her room would have at least given her a partial view of the doorway if it was in the same position as that day.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:

	(b) Use any form of physical force other than physical restraint as defined in these rules.
ANALYSIS:	On March 13, 2024, direct care worker Amie Graway used physical force with Resident A. Ms. Graway pushed Resident A out of Resident B's room and shut the door. Resident A reported that Ms. Graway shut her foot, which was off her wheelchair peddle, in the door four times. Her ankle was discolored and swollen after the incident which Resident A stated was from the incident. Resident A also reported that Ms. Graway lifted her arm up and back to get past her in the doorway. Resident A stated that this hurt her arm and that it was tender to the touch. Ms. Graway is said to be "gruff" with residents and verbally inappropriate. Ms. Graway admitted that she was angry during the incident and pushed Resident A into the hallway because she needed to administer medication to other residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee Connie Clauson by telephone on April 9, 2024. I informed her of my findings in this investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the license status.

04/09/2024

Adam Robarge — Date
Licensing Consultant

Approved By:

04/09/2024

Jerry Hendrick — Date
Area Manager