GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 28, 2024

Rebecca Schlink-Wolfgram
Bavarian Comfort Care AL & MC LLC
5366 Rolling Hills Drive
Bridgeport, MI 48722

RE: License #: AH730412299
Investigation #: 2024A0784045
Bavarian Comfort Care AL & MC LLC

Dear Rebecca Schlink-Wolfgram:

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.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730412299
Investigation #:	2024A0784045
Complaint Receipt Date:	04/11/2024
Investigation Initiation Date:	04/12/2024
Report Due Date:	06/10/2024
Licensee Name:	Bavarian Comfort Care AL & MC LLC
Licensee Address:	Suite B 3061 Christy Way Saginaw, MI 48603
Licensee Telephone #:	(989) 607-0001
Administrator:	Shantelle Zarko
Authorized Representative:	Rebecca Schlink-Wolfgram
Name of Facility:	Bavarian Comfort Care AL & MC LLC
Facility Address:	5366 Rolling Hills Drive Bridgeport, MI 48722
Facility Telephone #:	(989) 777-7776
Original Issuance Date:	01/24/2023
License Status:	REGULAR
Effective Date:	07/24/2023
Expiration Date:	07/23/2024
Capacity:	65
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not seek necessary emergency medical care for Resident A	No
Additional Findings	Yes

III. METHODOLOGY

04/11/2024	Special Investigation Intake 2024A0784045
04/12/2024	Special Investigation Initiated - On Site
04/12/2024	Inspection Completed On-site
05/07/2024	Contact - Document Sent Email to complainant requesting video footage.
05/07/2024	Contact - Document Sent Email sent to authorized representative Rebecca Schlink-Wolfgram requesting hospital discharge papers for Resident A
05/07/2024	Contact - Document Received Requested documents received by email from Ms. Schlink-Wolfgram
05/28/2024	Exit – Email Report sent to Ms. Schlink-Wolfgram

ALLEGATION:

Staff did not seek necessary emergency medical care for Resident A

INVESTIGATION:

On 4/11/2024, the department received this complaint from adult protective services (APS) centralized intake. Information provided on the complaint indicated APS denied the allegations for investigation.

According to the complaint, on 4/09/2024, Resident A was reporting he was in pain since the morning and requested, several times, for staff to call 911. Staff refused to

contact 911 stating emergency medical services (EMS) would deny him. Resident A, who is a person with quadriplegia, was able to eventually call 911 on his own which is very difficult for him. EMS did transport Resident A to the hospital.

On 4/12/2024, I interviewed Associate 1 at the facility. Associate 1 stated she was familiar with Resident A but has not had a lot of interaction with him directly as she works in the memory care (MC) of the facility, and he is an assisted living (AL) resident. Associate 1 stated Resident A is currently still at the hospital. Associate 1 stated she was not aware of why he was sent to the hospital. Associate 1 stated Resident A is not quadriplegic as he does have the ability to use his upper body. Associate 1 stated Associates 2 and 3, currently working, would be more familiar with the care of Resident A.

On 4/12/2024, I interviewed Associate 2 at the facility. Associate 2 stated she has provided regular care for Resident A. Associate 2 stated she worked on 4/09/2024, the day that Resident A was taken to the hospital. Associate 2 stated that on 4/09/2024, she did recall Resident A reporting that he had some pain in his abdomen area. Associate 2 stated Resident A did not request emergency medical services (EMS) to her and that she is not aware of him requesting any staff to contact EMS. Associate 2 stated it can be difficult to communicate with Resident A as he often refuses to allow staff to assist him with his activities of daily living (ADLs). Associate 2 stated if Resident A would have requested medical services, she would have made sure to report it to a supervisor.

On 4/12/2024, I interviewed Associate 3 at the facility. Associate 3 stated she was familiar with Resident A. Associate 3 provided statements consistent with those of Associate 2. Associate 3 stated she has provided care for Resident A though she does not do so regularly as, of the two AL resident halls, she works in the “100 hall” and Resident A lives in the “300” hall. Associate 3 stated she was aware that Resident A was taken to the hospital on 4/09/2024, but she was not aware of why.

On 4/12/2024, I interviewed administrator Riley Moeggenberg at the facility. Ms. Moeggenberg stated Resident A is a person who is has Cerebral Palsy. Ms. Moeggenberg stated Resident A is unable to walk due to paralysis in his legs, but that he does have full use of his hands and arms. Ms. Moeggenberg stated Resident A has a personal cell phone and is able to use it without difficulty. Ms. Moeggenberg stated Resident A has contacted 911 almost weekly. Ms. Moeggenberg stated Resident A has never been denied appropriate medical assistance. Ms. Moeggenberg stated does get frequent stomach pain related to a diagnosis of Gastroesophageal Reflux Disease, but not always to the level at which he requests to go to the hospital. Ms. Moeggenberg stated Resident A takes a stool softener to assist with this issue. Ms. Moeggenberg stated she is not aware of any requests made to staff on 4/09/2024 by Resident A to go to the hospital. Ms. Moeggenberg stated Resident A did ultimately get taken to the hospital by EMS. Ms. Moeggenberg stated that the latest update from the hospital was that Resident A had a urinary tract infection (UTI). Ms. Moeggenberg stated it can be difficult for staff to care for

Resident A as he often refuses assistance with ADLs. Ms. Moeggenberg stated that Resident A requires extensive assistance due to his physical limitations such as staff assistance with bathing, transferring, dressing, toileting and grooming. Ms. Moeggenberg stated resident ADLs are tracked in the facilities computer system. Ms. Moeggenberg stated that for each ADL listed on Resident A's ADL log, there is data entry point for each day of the month and for the time of day each ADL is to be provided. Ms. Moeggenberg stated that when staff provide or offer care, they have to note this in the system and that the log will show the initials of the associate who provided care.

I reviewed Resident A's service plan, provided by Ms. Moeggenberg, which read consistently with her statements regarding his care needs.

I reviewed March and April 2024 *ADL logs* for Resident A, provided by Ms. Moeggenberg. The logs read consistently with Ms. Moeggenbergs statements indicating Resident A is provided assistance with dressing, laundry, ambulation, personal grooming, showers and toileting. Review of the log indicated that staff regularly offer assistance to Resident A and that he often refuses assistance.

I reviewed Resident A's hospital discharge papers, provided by authorized representative Rebecca Schlink-Wolfgram. Notes provided within the discharge papers indicated Resident A's was diagnosed with a "UTI", "asymptomatic COVID" and "some constipation".

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	The complaint alleged the facility did seek emergency medical attention for Resident A as needed. While Resident A did eventually go to the hospital, interviews with staff and documents reviewed do not suggest that Resident A was in imminent danger or that it was clear Resident A actually requested emergency medical care. Ultimately, Resident A did go to the hospital and received treatment for a UTI.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Upon arriving at the facility, the facility was secure and required the doorbell to be rung for someone to answer the front door which leads into the AL. After ringing the doorbell several times, I observed Associate 1 approaching the door talking to another person who appeared to be an outside provider.

When interviewed, Associate 1 stated she was currently scheduled to work in the MC and was talking to a provider about a resident. Associate 1 stated the administrative staff were not currently in the building as they were in an off-campus meeting. Associate 1 stated Associates 2 and 3 were currently scheduled to work in the AL and most likely did not answer the door because they were working with residents. During this time, I requested an interview with Associate 2 who Associate 1 stated was currently scheduled to work on the 100 hallway of the AL. Associate 1 left to find Associate 2 and after several minutes, Associate 1 came back and stated Associate 2 had just left to go on break. Associate 1 stated she was also unable to reach Ms. Moeggenberg. Associate 1 stated that when a staff member goes on break, the staff from the other hallway is supposed to cover both hallways. Associate 1 stated that the lunch break duration is 30 minutes, and that staff are permitted to leave the facility during that time. Associate 1 stated staffing is similar in the MC. Associate 1 stated breaks are staggered so that two staff are not permitted to be on break at the same time. Associate 1 stated Associate 3 is currently responsible to each of the residents in hall 100 and 300.

When interviewed, Associate 2 stated several residents in the Al require at least a one person assist with ADLs. Associate 2 stated that with only two staff on duty, and sometimes one for periods of time, it can be very difficult to provide care as needed for residents.

When interviewed, Ms. Moeggenberg stated there are currently 37 total residents in the facility with 13 in MC and 26 in AL. Ms. Moeggenberg stated the 26 residents in AL are evenly split between the two hallways. Ms. Moeggenberg stated the current staffing is consistent with expectations. Ms. Moeggenberg stated that for first and second shift, two staff are scheduled for AL and two for MC which at least one being able to administer medications. Ms. Moeggenberg stated that for third shift, one person is scheduled in AL and one in MC. Ms. Moeggenberg stated administrative staff can assist with cares when they are in the building.

I reviewed the *Facility Census*, provided by Ms. Moeggenberg, which was consistent with her statements regarding the number of residents living at the facility. In reviewing the census with Moeggenberg, she reported that of the 26 residents in AL, at least 18 residents required some kind of direct assistance from a staff member with ADLs with at least five of those residents requiring two staff for assistance. Ms.

Moeggenberg stated that up until a few months prior, she was allowed to schedule more staff during each shift but that for several weeks that has not been the case. Ms. Moeggenberg stated that with the reduction in staffing, it has been difficult for staff to keep up on duties and that family members of residents “have not been happy about the changes”.

I reviewed “as worked” staff schedules for March and April, provided by Ms. Moeggenberg, which read consistently with her statements.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	During the onsite on 4/12/2024, the facility was discovered to have two staff appointment to work in the AL with 26 residents, most of whom require at least a one person assist with ADLs. Staff interviewed reported that when someone takes a break, the one associate left working is responsible to all residents in the AL, leaving only one person to care for 26 residents which was the case at the time of the onsite. It should be noted that the AL consists of two hallways, hallway 100 and hallway 300, which are not closely located which would make it difficult and most likely impossible for the one remaining staff to hear a resident calling from one hallway to the next a situation was imminent and a call button or pull cord could not be reached. Based on the findings, it is reasonable to concluded that the current staffing, consistent with current staffing expectations, leaves the facility vulnerable to periods of time in which the residents are placed at an unacceptable level of risk to their safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable correction action plan, it is recommended that the status of the license remain the same.

5/09/2024

Aaron Clum — Date
Licensing Staff

Approved By:

05/28/2024

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