GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 3, 2024

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

RE: License #: AH730412299
Investigation #: 2024A1035032
Bavarian Comfort Care AL & MC LLC

Dear Rebecca,

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 authorized representative 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) 241-1970.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730412299
Investigation #:	2024A1035032
Complaint Receipt Date:	04/01/2024
Investigation Initiation Date:	04/01/2024
Report Due Date:	06/01/2024
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Unorganized Care Program	Yes
Food calendar not maintained, food served inappropriately, unsanitary conditions during dining experience.	Yes
Inappropriate Discharge	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

04/01/2024	Special Investigation Intake 2024A1035032
04/01/2024	Special Investigation Initiated - Letter email sent to AR.
05/03/2024	Contact - Face to Face
08/28/2024	Survey Completed BCAL Sub-Compliance
09/03/2024	Exit Conference Conducted by telephone with authorized representative

ALLEGATION:

Unorganized Care Program

INVESTIGATION:

On April 1, 2024, the department received a complaint through the online complaint system which read: “Resident A was hospitalized twice during his short stay at BCC. Both times were for extreme dehydration and complex UTI's. On both occasions the staff and nursing supervisor were notified by family that the resident appeared ill and to check resident. The first hospitalization occurred Dec 5th. He spent a week in the hospital and two weeks in a skilled nursing facility recovering. Second hospitalization

occurred on March 5. Staff Person (SP)1 and SP4 (administrator) were notified that resident was ill- cold and confused. An aide recognized his condition deteriorated significantly. Ambulance was called 4 days after notification. Hospitalized for a week, discharged to skilled nursing facility for two wks. He was admitted to hospital with healing fractured ribs and a bed sore. Staff were aware that resident had recurring UTI's and had been prescribed prophylactic antibiotics as a preventive. Pills were prescribed but were not administered by the staff.

Resident A care plan states that he needs assistance with ADL's. He is incontinent and to be checked and changed, if necessary, every two hours. On many occasions Resident A has been found with a bulging and soiled brief. He has been found in the morning with feces and urine outside of his brief. When the aides are sought for cleanup assistance, none have been found. After 3 months his mattress cover was so soiled and stained it had to be disposed of. Numerous occasions dirty brief left on the side of the bed, floor, bathroom floor and overflowing in trash receptacle. He has slept in his street clothes, been put to bed without washing up, brushing teeth or hair. He has been neglected. SP4 blamed his neglect on family being in the room. He went over 9 days without a shower Care plan= 2/week, with assistance. One morning he was found in his briefs and undershirt-no clean clothes. SP4 blamed his spouse for taking his laundry home. For months the facility had one washer. Clothes and bedding were not being washed.

Resident A was on a continuous glucose monitoring device (noted as Diabetes monitoring in his assessment/care plan). Monitor alarm would frequently go off. No staff responded. When staff assistance was sought, they stated they did not know what to do. No action was taken by the staff. Bed alarm would go off. Staff did not respond. When questioned as to bed alarm protocol family was told they have 2 hours to respond. Care plan stated he would get a shower/bath every other day. This never happened. MedTech dumped a handful of pills in Resident A's mouth. Did not offer water or snacks as prescribed. Resident A is able to take his own pills. Check and change every 2hrs is in care plan. Resident A was found multiple times with soiled briefs. During many visits staff was not seen."

On 5/5/2024 an onsite investigation was conducted, while onsite I interviewed Rebecca "Becky" Schlink-Wolfgram AR who has been newly appointed as the interim AR. Becky states she will assist in locating requested documents and policies.

While onsite I interviewed SP2 who states the facility has gone through a period where supplies were short, dining services had challenges, and staffing challenges. SP2 states Resident A was a pleasure to work with and got along with everyone. SP2 states it was difficult to work with Resident A's Family A who was not happy with care, food services nor the cleanliness of the facility. SP2 continues to state Family A would write on facility windows and car windows in the parking lot the word "dirty". According to SP2 Family A was informed not to write on windows and cars.

While onsite I interviewed SP3 who states Resident A liked to sleep in and rest throughout the day. SP3 states Family A did not want Resident A to sleep as much as he was. SP3 states Resident A was “easy” to care for. For the months of February and March there was a shortage of supplies with gloves, soap, and laundry detergent.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level. **(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.**

ANALYSIS:	Through record review Resident A was administered Metformin as ordered, glucose monitoring and recorded daily with discontinue date of 2/6/2024, snacks provided and recorded each shift with medications. There was no prophylactic antibiotic noted on MAR. Medical diagnosis of recurrent UTI's was document. No documentation provided to Resident A "ill – cold and confused" on March 5th. Progress notes recorded on March 5th states "Resident had a relaxing day had breakfast and lunch and been sleeping rest of day." No documentation related to injury or pressure ulcer noted. Resident A's weight was monitoring twice a week with daily blood pressure and pulse ox. Resident A's service plan states two showers per week. Twenty scheduled recorded showers with one refusal noted. Additional showers noted in progress notes. Residents observed on unit dressed appropriately, engaging in conversation and eating meals. Through direct observation linens and garbage noted on floor in community shower room. Glass separating nursing station and common areas noted to be soiled. No odor smelt during inspection. Through direct observation memory care unit had supply of hand soap, sanitizer, and linens. Based on information noted above this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Food calendar not maintained, food served inappropriately, unsanitary conditions during dining experience.

INVESTIGATION:

On April 1, 2024, the department received an additional complaint through the online complaint system which read: Resident A's food was served cold, food calendar was not kept current, food choices were not offered, food was served in an unsanitary method- ungloved hands, washing stations were not used by staff or residents

because they were not stocked with hand soap, towels or hand sanitizer. Drinks (when served) were delivered warm and by the aide cupping their ungloved, unwashed hand over the top of the cup at the point it touches the lips. Resident handbook states that assorted snack, drinks-including water and coffee will be available 24/7. During resident's stay nothing was available or presented. Food was served without appropriate cutlery for the meal- spaghetti with a spoon, pork chops with a spoon, no napkin Tables were eft dirty from meal to meal and residents' meals were delivered to dirty tables (i have pictures). The dining areas were not cleaned between meals- not the tables, floors, chairs, or service areas.

On 5/5/2024, an onsite investigation was conducted, while onsite I interviewed Rebecca "Becky" Schlink-Wolfgram AR who has been newly appointed as the interim AR. Becky states she will assist in locating requested documents and policies.

While onsite I interviewed SP2 who states the facility has gone through a period where supplies were short, dining services had challenges, and staffing challenges. SP2 states there were times months ago residents had been served inappropriately in dining area and supplies were very short. SP2 states the dining experience has changed significantly over the past few months.

While onsite I interviewed SP3 who states Resident A liked to sleep in and rest throughout the day. SP3 states Family A did not want Resident A to sleep as much as he was. SP3 states Resident A was "easy" to care for. For the months of February and March there was a shortage of supplies with gloves, soap, and laundry detergent.

Through direct observation approximately four residents observed in dining area. Food plated appealing drinks noted in front of residents. Floor noted to be soiled, garbage noted on the floor, glass separating nursing station and common area noted to be dirty. Posted menu was outdated from previous month.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular mealtimes. A home shall make snacks and beverages available to residents. **(2) A home shall work with residents when feasible to accommodate individual preferences.** **(3) A home shall assure that the temporary needs for meals delivered to a resident's room are met.** **(4) Medical nutrition therapy, as prescribed by a licensed health care professional and which may include therapeutic diets or special diets, supplemental nourishments or fluids to meet the resident's nutritional and hydration needs, shall be provided in accordance with the resident's service plan**

	unless waived in writing by a resident or a resident's authorized representative. **(5) A home shall prepare and serve meals in an appetizing manner.** **(6) A home shall provide a table or individual freestanding tray of table height for a resident who does not go to a dining room.**
ANALYSIS:	Through direct observation approximately four residents observed in dining area. Food plated appealing drinks noted in front of residents. Floor noted to be soiled, garbage noted on the floor, glass separating nursing station and common area noted to be dirty. Posted menu was outdated from previous month. Therefore, this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Inappropriate Discharge

INVESTIGATION:

Through record review a discharge notice was issued to Family A 3/1/2024 which notified the Bavarian Comfort Care has decided to terminate the admission contract discharging on 3/31/2024.

The reason for this discharge stated for “His or Her welfare or that of the other residents: EXAMPLE- The resident has demonstrated behaviors that pose a risk of serious harm to himself. There is substantial risk to the Resident due to the inability of the facility to meet the needs or due to the inability of the Facility to assure the safety and well- being of the Resident, other residents, visitors, or staff of the facility. There are medical reasons preventing the Company from supplying needed care and protection.”

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(13) A home shall provide a resident and his or her authorized representative, if any, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharge from the home. The written notice shall consist of all of the following:

	(a) The reasons for discharge. **(b) The effective date of the discharge.** **(c) A statement notifying the resident of the right to file a complaint with the department. The provisions of this subrule do not preclude a home from providing other legal notice as required by law.**
ANALYSIS:	Through record review a discharge notice was issued 3/1/2024, discharge notice stating "the resident is substantial risk to the resident due to the inability of the facility to meet the needs or due to the inability of the Facility to assure the safety and well- being of the Resident, other residents, visitors, or staff of the facility. There are medical reasons preventing the Company from supplying needed care and protection." Through record review there is no documentation to support involuntary discharge statement. There is no documentation that Resident A is a harm to self or others. No documentation to support medical reasons preventing company from supplying needed care and protection. Therefore, this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

05/30/3034

Jennifer Heim — Date
Licensing Staff

Approved By:

08/28/2024

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