



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 12, 2024

Zain Sikander
Bavarian Comfort Care AL & MC LLC
5366 Rolling Hills Drive
Bridgeport, MI 48722

RE: License #: AH730412299
Investigation #: 2025A0784014
Bavarian Comfort Care AL & MC LLC

Dear Zain Sikander:

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 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 #:	2025A0784014
Complaint Receipt Date:	11/27/2024
Investigation Initiation Date:	11/27/2024
Report Due Date:	01/26/2024
Licensee Name:	Bavarian Comfort Care AL & MC LLC
Licensee Address:	3061 Christy Way Suite B Saginaw, MI 48603
Licensee Telephone #:	(989) 607-0001
Administrator:	Zain Sikander
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	65
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was abused	No
Additional Findings	Yes

III. METHODOLOGY

11/27/2024	Special Investigation Intake 2025A0784014
11/27/2024	Special Investigation Initiated - On Site
11/27/2024	Inspection Completed On-site
12/12/2024	Exit - Email Report sent

ALLEGATION:

Resident A was abused

INVESTIGATION:

On 11/27/2024, the department received this complaint from adult protective services (APS).

According to the complaint, on 10/30/2024, Resident A sustained injuries to her forehead and cheek. There is concern that Resident A was assaulted by employee 1, her caregiver at the time. Resident A is a person with severe Dementia.

On 11/27/2024, I interviewed employee 2, a supervisor, at the facility. Employee 2 denied that Resident A had been harmed by any staff. Employee 2 stated that on 10/30/2024, Resident A did have a fall and, from what she could recall, sustained rug burns to her face. Employee 2 stated Resident A participates in the PACE program and that no one suspected the injuries were obtained from being harmed by staff as the marks were consistent with a fall. Employee 2 stated family member assumed Resident A had been harmed by employee 1. Employee 2 stated there was no evidence to suggest employee 1 had harmed Resident A in any way.

On 11/27/2024, I observed Resident A sitting in her wheelchair in the common area. Resident A appeared calm and well groomed. Resident A did not appear to have any injuries to her face. Resident A was non-responsive to an attempted interview.

I reviewed the facilities *INCIDENT/ACCIDENT REPROT*, for Resident A, provided by employee 2, regarding her fall on 10/30/2024. Under a section titled *Explain what happened/Describe Injury*, the report read, "Resident was observed on the floor bedside. Resident stated she slipped out of bed. Resident has a few rug burns on her face. Under a section titled *Action Taken by staff/Treatment Given*, the plan read, "contacted PACE, they are picking resident up this morning for a check up. Placed a cold compress on face per PACE request. Vitals taken. Contacted nurse and left voicemail to POA".

I reviewed facility *Charting Notes* for Resident, provided by employee 2. Notes dated 10/30/2024 read "This writer [employee 2] received P/C [phone call] that resident was observed on the floor bedside, stating she had slipped out of bed, staff states resident had rug burns to her face, advised staff to notify Pace of incident and further instruction".

APPLICABLE RULE	
MCL 333.20201	Policy describing rights and responsibilities of patients or residents
	(2)(I) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	The complaint alleged Resident A was physically abused by a staff member. The investigation did not uncover evidence to support the allegation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

When interviewed, employee 2 stated that the fall on 10/30/2024 was not Resident A's most recent fall. Employee 2 stated Resident A had another fall on 11/08/2024.

I reviewed an *INCIDENT/ACCIDENT REPORT* for Resident A, provided by employee 2, dated 11/08/2024. Under the section titled Explain What Happened/Describe the Injury, the report read "staff walked by resident room while delivering breakfast trays, observed resident sitting on side of bed, when staff walked about again minutes later, resident was laying on floor near bed". Under the section titled *Action Taken by Staff/Treatment Given*, the plan read "Resident assessed for injury – 0 apparent [no apparent injuries]. Resident assisted off floor into comfortable position in w/c [wheelchair]. Family (DPOA) notified". Under a section titled *Corrective Measures Taken to Remedy and/or Prevent Reoccurrence*, the plan read "Resident air mattress adjusted for increased flow/firmness of position. Will Notify pace & collaborate for safety measures".

I reviewed Charting Notes for Resident A, provided by employee 2. Notes dated 11/08/2024 read, in part, "this writer [employee 2] spoke with resident [Pace nurse] to discuss resident fall this AM and possible interventions for safety, [Pace nurse] discussed safety and fall issues with Pace PT when incident report was received this AM, Pace staff does not feel that bed/chair alarms are appropriate for resident by may benefit from floor mat, Pace to send mat to facility, [Pace nurse]".

I reviewed Resident A's Service Plan, provided by employee 2, dated 8/01/2024. Under a section titled *Fall Risk*, the plan read, in part, "History of falls: No". Under a section titled *Safety*, none of the additional measures noted within the incident/accident report or in the charting notes, as identified by the facility and the PACE program, were in the plan.

APPLICABLE RULE	
R 325.1922	Admission and retention of residents.
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	The investigation revealed Resident A had two relatively recent falls, one on 10/30/2024 and one on 11/08/2024. After the fall on 11/08/2024, it was determined, by review from the facility and PACE program that Resident A required additional measures for her safety. While Resident A had fallen twice in a matter of nine days and been determined to need additional measures for her safety, review of Resident A's service plan revealed that none of this information, Resident A's falls or additional safety measures, were updated within the plan. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receive of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.



12/11/2024

Aaron Clum
Licensing Staff

Date

Approved By:



12/12/2024

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

Date