



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 9, 2026

Brian Nitz
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL240388304
Investigation #: 2026A0009019
Mallard Cove Assisted Living

Dear Mr. Nitz:

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 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,

A handwritten signature in cursive script that reads "Adam Robarge".

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 #:	2026A0009019
Complaint Receipt Date:	03/18/2026
Investigation Initiation Date:	03/18/2026
Report Due Date:	04/17/2026
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 588-9131
Administrator:	Sara Smith
Licensee Designee:	Brian Nitz
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:	10/04/2025
Expiration Date:	10/03/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, ALZHEIMERS & AGED

II. ALLEGATION(S)

	Violation Established?
Resident A left the building in the night unbeknownst to staff.	Yes
Resident B has her “BM bag” stuffed with toilet paper because staff are too lazy to give her proper care.	No

III. METHODOLOGY

03/18/2026	Special Investigation Intake 2026A0009019
03/18/2026	Special Investigation Initiated – Telephone call received from administrator Sara Smith
03/20/2026	Inspection Completed On-site Interview with administrators Sara Smith and Amy Bye Face to face with Resident A and Resident B
04/03/2026	Contact – Telephone call made to administrators Amy Bye and Sara Smith
04/03/2026	Contact – Telephone call made to Resident B’s responsible person
04/06/2026	Contact – Face to face with administrator Sara Smith
04/07/2026	Exit conference with administrator Laura Whaley

ALLEGATION: Resident A left the building in the night unbeknownst to staff.

INVESTIGATION: Note: Other issues contained in this complaint included concerns about the care of a male resident which was previously investigated (SI2026A0009009) and a resident leaving the facility three years prior which was also previously investigated (SI2023A0009017).

I received a telephone call from administrator Sara Smith on March 18, 2026. She reported that Resident A had left the facility the night before. The door alarm sounded and staff did respond to the alert. They looked out the door and did not see anyone so they assumed that no one had left. They were supposed to do a bed check of all the residents to make sure they were all there but that did not happen. A passing motorist found Resident A and called law enforcement. The officer involved guessed that Resident A had come from their facility and contacted them.

Ms. Smith said she is continuing to look into the matter to ensure their policy will be followed in the future.

I conducted an unannounced site inspection at the Mallard Cove Assisted Living adult foster care home on March 20, 2026. I spoke with administrators Sara Smith and Amy Bye at that time. Ms. Smith told me that two direct care staff were working at the facility shortly after midnight when the door alarm sounded. They both responded to it but did not see anyone outside. One of the staff called Ms. Smith and the other was supposed to conduct thorough face-to-face bed checks of all the residents. The staff who was supposed to check on the residents did not finish doing the bed checks. She got distracted by a resident who was awoken by the alarm and went to care for her. She never checked into Resident A's bedroom. She said she saw Resident A's bathroom light on and assumed she was in the bathroom, but she never crossed the threshold of Resident A's room. Her employment was terminated as a result.

Resident A was found by a passing motorist who called the police. They brought her back to the facility. Resident A was gone for approximately 30 minutes and was not injured during the absence. Resident A believed that she was going home and thought it was the afternoon. She is currently receiving hospice services. Ms. Smith went on to say that Resident A has experienced memory loss but no diagnosis of dementia. She did not have any history of wandering before this incident. They have now placed a motion detector in her room that alerts staff when she crosses the threshold of the door leading out of her room.

I observed Resident B during my on-site inspection on March 20, 2026 and observed her to be in good spirits. She seemed well-cared for during my observation of her at that time. Resident B had visitors at that time.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

ANALYSIS:	<p>On March 18, 2026, Resident A left the facility unbeknownst to staff. One staff failed to conduct proper face-to-face bed checks to ensure all residents were present after a door alarm sounded. The resident had experienced confusion in the past but had not had wandering behavior prior to the incident.</p> <p>It was confirmed through this investigation that the resident was not kept protected and safe when she was allowed to leave the facility in the night unbeknownst to staff.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident B has her “BM bag” stuffed with toilet paper because staff are too lazy to give her proper care

INVESTIGATION: I asked about the report of a resident having her “BM bag” stuffed with toilet paper because some staff are too lazy to give her proper care. Both Ms. Smith and Ms. Bye explained that Resident B required an ileostomy procedure and requires an ostomy bag as a result. This collects waste from the small intestine and needs to be emptied. In response to the complaint, they both said that there would be no purpose to stuff it with toilet paper because this would only fill up the bag faster so that it would need to be emptied more often. Ms. Bye said that the fact that the person called it a “BM bag” reveals their lack of knowledge about it. There could be some leakage where the stoma on her body is attached to the bag. It is within possibility that someone might have put tissue around the opening of the bag if there was some leakage. Resident B may have even done this herself at some point. Staff are expected to check and empty the bag at least four times per day, more if needed.

I spoke with Resident B’s responsible person by telephone on April 3, 2026. She said that she “absolutely” feels that her mother is well-cared for at the Mallard Cove Assisted Living facility. She said that she just recently recommended the place to someone else. She went on to say that she lives close by and is frequently there visiting her mother. Resident B’s responsible person said that she sees first-hand what the staff are doing there and knows that they are taking good care of her mother and the other residents. She has even spent the night and surprised the staff at times when they have come into her mother’s room. I asked her about the complaint of her mother’s ostomy bag being stuffed with toilet paper because of staff being lazy. Resident B’s responsible person said that she saw that had been posted on social media from what looked like a disgruntled former employee. She said that she got on there to defend the facility and post that it wasn’t true because she suspected the person was referring to her own mother. Resident B’s responsible person agreed that there would be no reason at all to stuff the bag with toilet paper. The area where the stoma meets the hardware of the bag might leak a little bit which is not the fault of the staff. She has not seen that herself or ever seen toilet paper

around the stoma. From what she sees, she believes that they are caring for that area and emptying the ostomy bag on a regular basis. Resident B's responsible person said that her mother is always clean when she visits the facility.

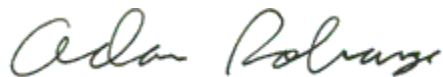
I reviewed Resident B's Assessment Plan for AFC Residents (BCAL-3265) dated October 1, 2025. I noted that it indicated that Resident B does require assistance with toileting. It indicated that her ostomy bag needs to be emptied throughout the day. There are scheduled times during first and second shift that staff are supposed to check the bag, as prompted through the electronic medication administration record. The assessment also indicated that staff are to check the bag whenever they are in the room with Resident B or help her use the toilet.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in the resident's assessment plan.
ANALYSIS:	<p>It was alleged that Resident B's ostomy bag was being stuffed with toilet paper. There did not seem to be any reason for this and it was suspected that possibly staff or Resident B had put tissue around the area because of some leakage. Resident B's responsible person was adamant that her mother was being well-cared for and that there was no truth to her mother not being given proper care. She was clear that this pertained to her general care as well as the specific care of her ostomy bag.</p> <p>In consideration of the above information, it is determined that the licensee has provided personal care as specified in Resident B's assessment plan.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

An exit conference was conducted by telephone with administrator Laura Whaley on April 07, 2026. I told her the findings of my 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.



04/07/2026

Adam Robarge
Licensing Consultant

Date

Approved By:



04/09/2026

Jerry Hendrick
Area Manager

Date