GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 25, 2026

Laura Whaley
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL240388305
Investigation #: 2026A0009035
Mallard Cove East

Dear Ms. Whaley:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (231) 922-5309.

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 #:	AL240388305
Investigation #:	2026A0009035
Complaint Receipt Date:	09/01/2026
Investigation Initiation Date:	09/02/2026
Report Due Date:	10/01/2026
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 719-5100
Administrator:	Sara Smith
Licensee Designee:	Laura Whaley
Name of Facility:	Mallard Cove East
Facility Address:	2801 Charlevoix Road Petoskey, MI 49770
Facility Telephone #:	(231) 347-2273
License Status:	REGULAR
Effective Date:	04/10/2026
Expiration Date:	04/09/2028
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED, & ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was admitted to the hospital after ten days living at the facility. His condition deteriorated after he moved in and he had two falls due to improper transfers. He was mostly isolated and left alone.	No

III. METHODOLOGY

09/01/2026	Special Investigation Intake 2026A0009035
09/02/2026	Special Investigation Initiated – Telephone call made to adult protective services worker Lane Stopher
09/02/2026	APS Referral – No former APS Referral made due to resident being deceased but contact made with APS worker
09/03/2026	Inspection Completed On-site Interview with administrator Sara Smith and assistant Swayne Forbes
09/24/2026	Contact – Telephone call made to nurse practitioner Juan Rhoades, Legacy Medical Group
09/24/2026	Contact – Telephone call made to Resident A's Family Member, left message
09/25/2026	Contact – Telephone call received from Resident A's Family Member
09/25/2026	Exit conference with licensee designee Laura Whaley

ALLEGATION: Resident A was admitted to the hospital after ten days living at the facility. His condition deteriorated after he moved in and he had two falls due to improper transfers. He was mostly isolated and left alone.

INVESTIGATION: I spoke with adult protective services worker Lane Stopher by telephone on September 2, 2026. He reported that there is no coordinating investigation at this time regarding the resident noted in the complaint.

I conducted an unannounced site visit at the Mallard Cove East adult foster care home on September 3, 2026. I spoke with administrator Sara Smith and her assistant, Swayne Forbes, at that time. I asked about the concern reported

regarding Resident A's time spent at the facility. Ms. Smith reported that Resident A was able to care for himself in some ways when he first arrived at the facility. Resident A was only at the facility for several days before being admitted to the hospital and never came back after he was admitted. She stated that his health took a turn for the worse after he came to live with them. On August 11, after they gave him his medication, he started throwing up. They called his son who came to get him and take him to the hospital. They had called him to ask him if he wanted to take his father in or if they should call an ambulance. I asked about the falls that had been reported. She stated that he did experience some falls. When he first arrived, he was walking with assistance but declined rapidly. Ms. Smith said that Resident A suffered from dementia and sometimes residents with that condition can deteriorate when they have a change in circumstances. The nurse practitioner who was working with him, Juan Rhoades, was the one who told them that Resident A was having "acute confusion" due to the relocation.

After they noted his decline, they provided him with a wheelchair. After he fell, they put a motion detector and bed alarm in his room. Resident A figured out how to turn his bed alarm off and did that a number of times. Staff were doing room checks as often as possible and they had "eyes on him" during the day. They were able to do this by bringing him to the common area where he would sit during the day. Family members were also often there with him during the day. Resident A did receive assistance with all his care needs. Staff got him up in the morning and assisted him with feeding, grooming and toileting. One staff would help him to the bathroom since he was able to walk with assistance. He could ambulate "75% of the time" otherwise they would provide him with a wheelchair. The assistance with his walking/mobility involved having a staff guide him by the arm. He could get in and out of bed by himself and only needed assistance guiding him.

I asked about the reported falls. Ms. Smith said that Resident A did have some falls. She provided me with the incident reports that showed that Resident A had been found on the floor when staff responded to the motion detector or bed alarm in his room. In one instance, he was found with a "small, red area above his right eye and small red area on the right side of his ribs". In another instance, he was found with a "small carpet burn on his right elbow. He had fallen after getting out of bed. The staff were performing "frequent checks" on Resident A, day and night, during his time there. I also asked about the report that he was "mostly isolated and left alone." Ms. Smith and Ms. Forbes said that all the residents are somewhat isolated when they are in their rooms although staff perform frequent checks. Resident A was getting more frequent checks than other residents as he declined. They also brought him out to the common area during the day when his family was not visiting. He was not "isolated" or "left alone" during those times since he was with other residents and staff.

Administrator Sara Smith provided me with Resident A's written assessment plan on September 3, 2026. The assessment plan, dated August 5, 2026, indicated that

Resident A required assistance with eating/feeding, toileting, bathing, grooming, dressing, personal hygiene and walking/mobility.

I spoke with nurse practitioner Juan Rhoades with the Legacy Medical Group by telephone on September 24, 2026. He said that he had been working with Resident A for some time and had worked with him when he lived at a previous care facility. The family had wanted a new home for him since they felt the other facility was having staffing issues. Resident A had a diagnosis of Parkinson's Disease and was experiencing dementia. He had fallen several times at the previous care facility and this was not new for him. After he moved, he did experience more confusion and even delirium which is common for someone with his condition experiencing a move. They tried to adjust his medication to help control the confusion and agitation. The administrator, Sara Smith, was in frequent contact with him about everything going on with Resident A. She would call him and the family after every incident or fall. He was talking to Ms. Smith every day about Resident A, sometimes several times a day. The family did not want Resident A going to the hospital unless he really needed to because of the belief this would add to his confusion. I asked Mr. Rhoades about the complaint against Mallard Cove that they had contributed to Resident A's decline. Mr. Rhoades said that he did not believe they were responsible in any way. He felt that they had done everything they could have given the situation. He does not believe they were neglectful. He stated that he believed Resident A declined because of his delirium. Resident A needed to be allowed to walk. It would not have been appropriate for them to restrain him. They would have had to have someone walking around behind him at all times to try to prevent a fall which is not possible in that setting. Resident A was prone to falling because of his Parkinson's Disease. After the falls, Resident A did not have any significant injuries that they were aware of. The staff contacted him after each fall and they assessed him at those times.

I spoke with Resident A's Family Member by telephone on September 25, 2026. He said that he felt that his father received very good care at the Mallard Cove adult foster care home. He was at the facility every day that his father was there and observed what he felt was "great" care from the staff to his father. He did not see anything during those times that concerned him. The administrator, Sara Smith, was in constant contact with them about his father and notified them after his father's falls. He agreed with what the nurse practitioner believes in regards to the fact that one cannot physically restrain a resident to keep them from falling. A facility like Mallard Cove also does not have someone who can follow someone around at all times. Resident A's Family Member said that his mother was having a hard time with his father's death and she sent him her concerns which he guessed were similar to what I had received. Resident A's Family Member told me that what she stated is not representative of what he and the other family members had experienced during their time working with Mallard Cove.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan.
ANALYSIS:	Resident A lived at the Mallard Cove East adult foster care home for approximately a week after coming from another care facility. He suffered from Parkinson's Disease and dementia. He experienced falls at the previous facility. His confusion increased upon moving to Mallard Cove and he experienced some delirium. His nurse practitioner was monitoring him between the homes and tried to ease the transition with medication. Resident A fell after getting out of bed during the night. The falls did not occur during "transfers". The facility had placed a motion detector in his room and a bed alarm on his bed although he had figured out how to turn off the bed alarm. The staff had found him after his falls after responding to the motion detector or alarm. The family and nurse practitioner were both notified after his falls. The nurse practitioner helped staff assess whether Resident A was injured at those times. The nurse practitioner does not believe the facility was responsible for Resident A's decline or his falls. He reported that it would not have been appropriate to restrain Resident A and knew it was not possible to have someone following Resident A around at all times. Resident A's Family Member believed that his father received very good care at Mallard Cove and that the administrator was in constant contact with them. It was confirmed through this investigation that the licensee did provide supervision, protection, and personal care as specified in Resident A's assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

An exit conference was conducted with licensee designee Laura Whaley by telephone on September 25, 2026. She was told of the findings of the investigation and given the opportunity to ask questions.

IV. RECOMMENDATION

I recommend no change in the license status.

09/25/2026

Adam Robarge — Date
Licensing Consultant

Approved By:

09/25/2026

Jerry Hendrick — Date
Area Manager