GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 5, 2022

Robert Ambler
Mulberry Hill Senior Living LLC
17332 11 Mile Road
Battle Creek, MI 49014

RE: License #: AS130410907
Investigation #: 2022A0578044
Mulberry Hill Senior Living LLC

Dear Mr. Ambler:

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 responsible party 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) 284-9727.

Sincerely,

Eli DeLeon, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 251-4091

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS130410907
Investigation #:	2022A0578044
Complaint Receipt Date:	08/10/2022
Investigation Initiation Date:	08/12/2022
Report Due Date:	10/09/2022
Licensee Name:	Mulberry Hill Senior Living LLC
Licensee Address:	17332 11 Mile Road Battle Creek, MI 49014
Licensee Telephone #:	(269) 966-6843
Administrator:	Robert Ambler
Licensee Designee:	Robert Ambler
Name of Facility:	Mulberry Hill Senior Living LLC
Facility Address:	17332 11 Mile Rd Battle Creek, MI 49014
Facility Telephone #:	(815) 717-8649
Original Issuance Date:	07/28/2022
License Status:	TEMPORARY
Effective Date:	07/28/2022
Expiration Date:	01/27/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There is not enough food for residents at this facility.	No

III. METHODOLOGY

08/10/2022	Special Investigation Intake 2022A0578044
08/10/2022	APS Referral
08/12/2022	Special Investigation Initiated - Telephone With Complainant.
08/12/2022	Special Investigation Completed On-site -Interview with staff member Ellen Grove. Interview with Resident A and Resident B.
08/12/2022	Contact-Documentation Reviewed -Menus for July 2022, August 2022.
08/12/2022	Contact-Telephone -Interview with Lori Ambler.
08/12/2022	Exit Conference -Message left for the licensee designee, Robert Ambler.

ALLEGATION:

There is not enough food for residents at this facility.

INVESTIGATION:

On 08/10/2022, I received this complaint through the BCHS On-line Complaint System. Complainant reported this facility is in the process of being sold to Joseph Rocha and Donna Bradley. Complainant reported that two weeks ago, a grocery list was provided to Mr. Rocha. Complainant reported that Mr. Rocha returned with laundry detergent, cat litter, dryer sheets, smoked sausage, frozen fruit and stir fry vegetables. Complainant alleged this was not enough food to feed residents for a week. Complainant added Ms. Bradley owns another facility and interested in

possibly moving residents from this facility to there, but it is unknown when this will occur.

On 08/12/2022, I interviewed Complainant regarding the allegations. Complainant reported Mr. Rocha ignored grocery lists and only obtained laundry detergent, cat litter and dryer sheets. Complainant reported Mr. Rocha stated that he would, “try to get the rest of the stuff” but several days had passed without Mr. Rocha making another delivery. Complainant reported the cupboards at this facility were empty and that residents needed food. Complainant reported stew meat, steaks, roasts, and bacon were available in the freezer located in the office but this office is now kept locked and staff do not have a key. Complainant reported they were aware of this meat being present in this freezer as Ms. Bradley had reported purchasing either half a cow and or a whole hog of meat for this facility.

Complainant denied residents had missed any meals due to food not being in the facility for any reason. Complainant reported staff made what they had but these meals did not follow any sort of menu and changes made to this menu were not documented by staff.

On 08/12/2022, I completed an unannounced investigation on-site at this facility and interviewed staff member Ellen Grove regarding the allegations. Ms. Grove reported she started working at this facility the day before but was previously employed at this facility for several years. Ms. Grove reported that she prepared residents in this facility an egg omelet with green peppers and onions and sausage in addition to applesauce, oranges and toast for breakfast. Ms. Grove reported that she prepared residents in this facility a tuna salad, crackers with cheese and beets and oranges for lunch. Ms. Grove reported that she currently has chicken boiling and was preparing a chicken stir fry for dinner later in the evening.

Ms. Grove denied being aware of any resident missing a meal for any reason. Ms. Grove clarified that one resident recently had a tooth pulled and had only eaten a light lunch earlier in the day.

Ms. Grove reported that frozen food was present in the office freezer in addition to the food supplies located in the kitchen and walk-in pantry. When asked why the allegations may have been made, Ms. Grove reported the two business owners of this facility had a “falling out” and one of the staff followed the business partner who had left. While at the facility, I inspected the kitchen and pantry and found an appropriate supply of shelf stable, fresh and frozen food. I reviewed menus posted in the kitchen and found them to be consistent with what Ms. Grove reported preparing for meals that day. I observed documented menu changes on this posted menu.

While at the facility, I interviewed Resident A and Resident B regarding the allegations. Resident A could not recall how long she had lived at this facility. Resident B reported living at this facility for over two years. Resident A and Resident B acknowledged having some type of egg casserole in addition to applesauce and

toast for breakfast earlier in the day. Resident A could not recall what she had for lunch. Resident B recalled eating a sandwich with cheese and crackers and oranges for lunch. Resident A and Resident B denied missing any meal for any reason. Resident A reported that she is well cared for at this facility. Resident A and Resident B denied having any additional concerns.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	During an unannounced investigation on-site at this facility, I observed an appropriate supply of shelf stable, fresh and frozen food in a walk-in pantry and kitchen. I interviewed Resident A and Resident B who denied ever missing a meal for any reason and identified eating meals previously in the day consistent with what was identified on the posted menu for the facility. In an interview, staff member Ellen Grove denied being aware of any resident missing any meal for any reason but clarified owners of the facility had recently split and suspected this was the cause of the allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 08/12/2022, Complainant reported that seven residents resided at this facility and identified them as Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G.

On 08/12/2022, I completed an unannounced investigation on-site and verified with staff member Ellen Grove that Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, and Resident G resided at this facility.

On 08/12/2022, I interviewed Lori Ambler, spouse of the licensee designee, Robert Ambler. Ms. Ambler operated a licensed adult foster care at this location prior to the current license being issued on 07/28/2022. Ms. Ambler acknowledged that seven residents resided at this facility but clarified that one resident did not receive adult foster care. I reviewed the licensing requirements related to licensed capacity with

Ms. Ambler and she acknowledged the need for discharging one resident at this facility.

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.
ANALYSIS:	During an unannounced investigation on-site, I confirmed seven residents resided at this facility as reported by Complainant and confirmed by Ms. Lori Ambler which is over the capacity of the license.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written plan of correction, it is recommended that this license continues on regular status.

09/22/2022

Eli DeLeon Date
Licensing Consultant

Approved By:

10/05/2022

Dawn N. Timm Date
Area Manager