GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 4, 2023

Connie Clauson
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AM490369296
Investigation #: 2023A0783006
Cedar Cove Assisted Living Specialized Care

Dear Mrs. Clauson:

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) 643-7960.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
234 W. Baraga Ave.
Marquette, MI 49855
(906) 250-9318

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM490369296
Investigation #:	2023A0783006
Complaint Receipt Date:	11/09/2022
Investigation Initiation Date:	11/10/2022
Report Due Date:	01/08/2023
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Connie Clauson
Licensee Designee:	Connie Clauson
Name of Facility:	Cedar Cove Assisted Living Specialized Care
Facility Address:	Bldg. #2 266 South Mary L Street Cedarville, MI 49719
Facility Telephone #:	(906) 484-1001
Original Issuance Date:	06/05/2015
License Status:	REGULAR
Effective Date:	12/05/2021
Expiration Date:	12/04/2023
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED

	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not seek immediate medical attention for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

11/09/2022	Special Investigation Intake 2023A0783006
11/10/2022	APS Referral Referral to APS
11/10/2022	Special Investigation Initiated - Telephone Referral to APS
11/17/2022	Inspection Completed On-site
11/17/2022	Contact - Face to Face Interview with Stephanie Leach, administrative assistant
11/17/2022	Contact - Document Received Medication Record
11/17/2022	Contact - Document Received Progress Notes
11/17/2022	Contact - Document Received Resident post-fall protocol
11/17/2022	Contact - Document Received medical history
11/17/2022	Contact - Document Received "My Michigan Health" skull fracture
12/20/2022	Contact - Telephone call made Interview with John Dubro
12/21/2022	Contact - Telephone call made Interview with Sandie Figiel, staff

12/22/2022	Contact – Telephone call made Interview with Dustin Tassier, got name of funeral home
12/22/2022	Contact – Telephone call made Spoke with staff at Galer Funeral Home, asked them to email me copy of Resident A's death certificate.
12/22/2022	Contact – Document Received Death Certificate – Intracranial hemorrhage
12/27/2022	Contact – Document Sent Email to admin to request more information
12/28/2022	Contact – Document Received Email from admin providing more information
12/28/2022	Contact – Document Sent Email to designee requesting exit conference
01/04/2023	Contact – Telephone call made Left voicemail for designee requesting exit conference
01/04/2023	Exit Conference Conducted with Dustin Tassier

ALLEGATION: The facility did not seek immediate medical attention for Resident A.

INVESTIGATION: On 11/9/2022, I received a series of three incident reports from Cedar Cove Assisted Living. The first incident report was dated 10/25/22 and reported that Resident A had fallen in her room and there was a large bump on her head. The incident report also indicated that staff asked that Resident A "pull her light when she needs something and that if she is going to move about, to use her walker. The incident report was signed by Ms. Figiel, as the lone staff member involved in the incident, and Dustin Tassier, the facility director.

The second incident report for Resident A was dated 10/26/2022 and reported that staff member Ms. Figiel had checked on Resident A at approximately 12pm and the bump on her head was gone. It also stated that at about 12pm, Resident A was not in her room and was found in another resident's room, very confused. Ms. Figiel called Resident A's doctor and were told to send the resident to get an MRI. The family was called, picked her up, and brought her to the hospital.

The third incident report for Resident A, dated 11/02/2022, states that Resident A had died. This incident report involved staff members Elizabeth Versluis and Julie Babcock and was signed by Ms. Versluis and Mr. Tassier. Resident A died while receiving hospice services at the facility and the cause of the death was not listed on the incident report. After Resident A had expired, staff called hospice at 6:20pm. Mr. Tassier called hospice two more times, at 7:30pm and 8:30pm as they had not yet arrived. Hospice arrived at the facility at 8:50 and noted the time of death as 8:55pm. Hospice then called the funeral home and Resident A was taken from the facility at 10pm.

On 11/17/2022 I conducted on unannounced, onsite inspection. I interviewed Stephanie Leach, administrative assistant. Ms. Leach told me that she believed that on the day of the fall the family made the determination to not take Resident A to seek medical attention. Ms. Leach went on to explain Resident A's general behavior, stating that some days Resident A wouldn't want to come out of her room and other days she'd be very social out in the common area with other residents.

Ms. Leach provided me Resident A's file. Resident A was 96 years old. In the file were several documents. The progress notes relating to Resident A document the fall taking place 10/25/2022 during 2nd shift, no exact time was noted. Staff member Ms. Figiel checked the resident's head and found a large bump shortly before the family showed up, unannounced, at an unspecified time, but before staff was able to call them to report the incident, and that ice was applied to the resident's head.

Also in the file was a form entitled: "Resident Post Fall Protocol" dated 06/09/2022. This document describes a fall Resident A had in the living room. Resident A's vitals were taken, and range of motion documented, both as normal. It detailed a small cut on the resident's head which bled for approximately 5 minutes. The cut was cleaned, ice applied, and Resident A's family was contacted. I asked Mr. Tassier about this incident and requested a copy of the incident report. The incident report details the fall as having involved two staff members, Ms. Versluis and Ms. Babcock, and is

signed by Mr. Tassier. The report explains that Resident A was sitting in the middle of two other residents on the couch. When Resident A was leaving, heading back to her room, she tried to squeeze between the resident and coffee table and lost her balance, falling on the way down, and hitting her head on a side table. Staff assessed Resident A and noticed a small cut on the back/top of her head. Staff cleaned the cut, assessed, and noted her blood pressure, pulse, temperature, and oxygen levels, gave Resident A an ice pack and contacted Family Member A. Mr. Tassier explained that they did not reach out to a medical provider after this specific fall. I was told that staff did reach out to Resident A's Family Member A and that Resident A's medical provider does monthly rounds at the facility as well as regularly communicates with Family Member A. The incident report regarding this fall did not have any notes regarding "Corrective Measures Taken to Remember and/or Prevent Recurrence."

On 12/27/2022, I asked Mr. Tassier whether the facility keeps records of physician contacts for residents and was told that they note any physician contacts for residents in their shift reports as well as any corresponding incident reports. I reviewed the shift report for the fall on 06/09/2022, there was reference made to the fall that day, but no contact made with a physician. I asked Mr. Tassier whether Resident A had any other falls at her time at the facility. I was told that Resident A moved into the facility prior to the COVID pandemic but that, at the start of the pandemic, Family Member A brought her back home to live with him until 05/16/2022. At that time Resident A moved back into the facility. I was told that Resident A required a lot of reminders to use her cane and walker but that the only falls since 05/16/2022 were the falls on 06/09/2022 and 10/25/2022 both of which were documented with incident reports.

Also in the file was a discharge report from MyMichigan Medical Center in Sault Ste. Marie. The paperwork is dated 10/26/2022 and reports a diagnosis of skull fracture.

On 12/20/2022, I interviewed Family Member A Family Member A, Resident A's son and guardian. Family Member A told me that Resident A had been living with him for some time, but her level of care became such that they decided to move Resident A into assisted living. Family Member A reported to me that on 10/25/2022 Resident A fell in her room and hit her head. He, along with other family, coincidentally happened to arrive at the facility soon after the incident. At that time Family Member A reported that he did not feel it necessary to seek medical attention for Resident A. The next day the facility called Family Member A with advice from Resident A's doctor. At that time Family Member A picked up Resident A and took her to the hospital. Family Member A reported he does not believe anyone at the facility did anything wrong and that he has nothing bad to say about the staff or the facility.

On 12/21/2022, I spoke with staff member Sandie Figiel. Ms. Figiel reported to me that on 10/25/22 Resident A fell and hit her head. It seemed Resident A had got up from her recliner, leaving her walker behind, and fell when she reached the counter in her bedroom. Ms. Figiel reported that she got Resident A up off the floor and sat

her down in her recliner. At that time, she noticed a bump on Resident A's head. Ms. Figiel told me that Resident A's family showed up right after the fall had occurred and that Resident A seemed okay, both physically and mentally. With input from the family, Resident A was not taken to seek medical attention.

On 12/21/2022, Ms. Figiel further reported to me that the next day, 10/26/2022, staff found Resident A in another resident's room, sitting in their recliner, and staring out the window. At this point staff called Resident A's primary physician and they were instructed to take her to the hospital. The family was called, picked up Resident A from the facility, and took her to the hospital. Ms. Figiel reported that if the family was not there the day of the fall, she would have sought medical attention for Resident A.

On 12/22/2022 I contacted Galer Funeral Home and received a copy of Resident A's death certificate. The cause of death is listed as "intracranial hemorrhage."

On 12/28/2022 I received and reviewed Resident A's assessment plan. The assessment plan indicates that staff are to "provide needed assistance if resident falls," and that staff are to "report all falls and any increase in falls or other safety concerns." The document notes Resident A does not move independently through the community and that she requires either a cane or a 4 wheeled walker. It also requires staff to remind Resident A that she is to use her cane and/or 4 wheeled walker if staff observe her not doing so.

On 01/04/2023 I conducted an exit conference with Dustin Tassier, who is currently in the process of completing paperwork to become the administrator of the facility. Mr. Tassier and I discussed the findings and the reason for substantiating a violation. Mr. Tassier reported that staff typically would have immediately contacted Resident A's primary care physician but that this incident occurred too late in the day. We further discussed instances in which medical attention may not be immediately required and instances, like this one, in which it would be. I also informed Mr. Tassier that regardless of the desires of the resident and/or their family to not seek medical attention, it is the facility's responsibility to seek immediate medical attention when incidents such as this occur. We further discussed the necessary contents of a corrective action plan and the time in which it must be completed.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	After speaking with staff and Resident A's family, as well as reviewing medical documentation and Resident A's death certificate, it appears that after Resident A fell and fractured her skull, the facility did not seek medical attention as required by licensing rules. In situations in which the family/guardian/resident refuse medical treatment, it is still the responsibility of the facility to obtain immediate care for a resident after an accident or other sudden change.
CONCLUSION:	**VIOLATION ESTABLISHED**

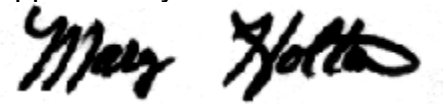
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

01/04/2023

Garrett Peters — Date
Licensing Consultant

Approved By:



01/04/2023

Mary E. Holton — Date
Area Manager