GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 22, 2023

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

RE: License #: AL240388304
Investigation #: 2023A0009033
Mallard Cove Assisted Living

Dear Connie Clauson:

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 for the 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 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 (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 #:	AL240388304
Investigation #:	2023A0009033
Complaint Receipt Date:	08/31/2023
Investigation Initiation Date:	08/31/2023
Report Due Date:	09/30/2023
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Lauri Lee
Licensee Designee:	Connie Clauson
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:	1ST PROVISIONAL
Expiration Date:	10/03/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED & ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell at the facility and does not have sufficient precautions in place to prevent falls.	No
Resident A has a bed sore as a result of staff not moving him frequently enough.	No
Resident B was given the wrong medication.	No
The administrator leaves resident medication in her office unlocked.	Yes

III. METHODOLOGY

08/31/2023	Special Investigation Intake 2023A0009033
08/31/2023	APS Referral
08/31/2023	Special Investigation Initiated – Telephone call received from adult protective services worker Louise Rohrer
09/05/2023	Inspection Completed On-site Interview with administrator Lauri Lee Interview with physical therapist Jason Barkley Face to face contact with Resident A and Resident B Interview with Resident A's Representative
09/08/2023	Contact – Telephone call received from adult protective services worker Louise Rohrer
09/11/2023	Contact – Document received (email with attachment) from administrator Lauri Lee
09/15/2023	Contact – Telephone call received from adult protective services worker Louise Rohrer, message left
09/19/2023	Contact – Telephone call made to Resident B's Representative
09/22/2023	Exit conference with licensee designee Connie Clauson

ALLEGATION: Resident A fell at the facility and does not have sufficient precautions in place to prevent falls.

INVESTIGATION: I received a telephone call from adult protective services worker Louise Rohrer on August 31, 2023. She reported that she had received a complaint

regarding two residents at the Mallard Cove Assisted Living adult foster care home. She said that she planned on investigating the matter and would forward her findings to me. She said that she planned on going to the facility that day to see the residents but would not be addressing the complaint with staff until later.

I conducted an unannounced site visit at the Mallard Cove Assisted Living adult foster care facility on September 5, 2023. I spoke with administrator Lauri Lee at that time. I asked her about Resident A falling. She said that she believed he fell shortly after being admitted on August 24, 2023. Ms. Lee said that another administrator, Aleena Hellebuyck, had handled the incident. Ms. Hellebuyck is no longer employed at the facility. Ms. Lee said that she would locate the incident report regarding the fall and provide that to me. Resident A is sometimes able to sit on the side of his bed but other times he is not able to do that. I asked for Resident A's written assessment. She provided that to me but said that this original assessment was completed by the previous administrator. Ms. Lee said that she has created another written assessment to more accurately address Resident A's current needs. The new copy is with Resident A's Representative who is looking it over and will give it back with any changes she wishes to see. Ms. Lee gave me a copy of the original written assessment. This was dated August 24, 2023, and stated that it was "Finalized by Aleena Hellebuyck". It indicated that Resident A only uses a wheelchair and that he receives daily assistance with dressing, grooming, bathing and special needs care. The assessment indicated that Resident A requires two-person assistance when transferring (from his wheelchair to bed or otherwise). It indicated that Resident A has a hospital bed. The assessment went on to say that Resident A had more than one fall in the last three months before coming to live at Mallard Cove.

Ms. Lee said that Resident A's physical therapist, Jason Barckley, was at the facility working with Resident A at the time of my visit. We invited him into the office to speak with us about Resident A. He said that Resident A is not ambulatory and uses a wheelchair. Resident A can sit up with assistance. They are not as concerned about him falling as they are with him lying in his bed without any movement. They are working with him to sit on the side of the bed with his feet on the floor. Mr. Barckley is working with staff at Mallard Cove to ensure that they help Resident A sit on the side of his bed with his feet on the floor. He will continue to work with Resident A there and educate staff to help him with his mobility. He was not aware of Resident A falling at Mallard Cove.

I observed Resident A at the time of my visit at Mallard Cove in a hospital bed. Resident A's Representative was present and agreed to speak with me. She said that Resident A has had falls before. Resident A's Representative said that he did fall once since coming to Mallard Cove and this fall was reported it to her. They told her that he fell out of bed but that he was not hurt. She agreed that he was not hurt by the fall. She said that they are working with a physical therapist to make him stronger so that he is less likely to have falls. Resident A's Representative said that she is at the facility several hours each day and feels the facility has adequate

safeguards in place to keep Resident A from falling. She would not want him restricted any more than he already is. Resident A's Representative said that the staff seem very attentive to Resident A and always lower his bed when she leaves so he is safe. She went on to say that she felt that her husband is safe at Mallard Cove and doesn't know what else they could do to make him safer.

I received a telephone call from adult protective services worker Louis Rohrer on September 8, 2023. She reported that she had spoken with staff at Mallard Cove and did not have any concerns regarding Resident A's care.

I received an email from administrator Lauri Lee on September 11, 2023. It contained an attachment of an incident report regarding Resident A dated August 24, 2023 at 9:30 p.m. The report indicated, *'Found (Resident A) on floor beside bed. Assisted him with getting into bed. Observed no skin tears or bruising. Lowered bed and repositioned resident.'*

I received a telephone message from adult protective services worker Louise Rohrer on September 15, 2023. She said that she has closed her case and has not substantiated any neglect or abuse in regards to Resident A.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A's written assessment plan indicated that Resident A needs assistance with care, two-person assistance when transferring (from his wheelchair to bed or otherwise). He has a wheelchair and a hospital bed. The current administrator is reportedly working on a new assessment to reflect his current needs which she initiated a week after Resident A arrived at the facility. Resident A and the staff are working with a physical therapist to assist him in gaining strength to prevent falls. Resident A did fall out of his bed the evening of his first day. There is no indication that he was hurt from the fall. Resident A's Representative states that the staff are attentive to Resident A and are doing everything they can to keep him safe. It was confirmed through this investigation that the licensee does provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A has a bed sore as a result of staff not moving him frequently enough.

INVESTIGATION: I spoke with administrator Lauri Lee during my site visit to Mallard Cove on September 5, 2023. I asked her about the report of Resident A having a bed sore as a result of staff not moving him frequently enough. Ms. Lee said that the new written assessment addresses them rotating Resident A every two hours because of the bed sore. She already entered this requirement in the medication administration record (MAR) under "medication passing and scheduled treatments" on August 31, 2023. It indicates that staff are to "check and change (Resident A) every 2 hours and rotate". She said that she put it directly into the system to ensure that it is done. This is being done and she is not aware of any worsening of the bed sore.

I spoke with Resident A's physical therapist, Jason Barckley, while at the facility on September 5, 2023. I asked him about Resident A's bed sore. Mr. Barckley confirmed that Resident A does currently have a bed sore but stated it did not occur at Mallard Cove. Mr. Barckley confirmed that Resident A had the bed sore before he was admitted to Mallard Cove.

I also spoke with Resident A's Representative at the facility on September 5, 2023. She is present with Resident A for several hours each day. She stated she notices what the staff do while she is there and confirmed the staff check on him and rotate him at least every two to three hours.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A had a bed sore when he was admitted to Mallard Cove. Administrator Lauri Lee entered the task into the MAR system for staff to reposition Resident A every 2 hours. She did this shortly after his arrival at the facility. The new written assessment will also address repositioning Resident A every 2 hours. His physical therapist confirmed that the bed sore was present before his arrival at Mallard Cove. It was confirmed through this investigation that the licensee does provide supervision, protection, and personal care as

	defined in the act and as specified in the resident's written assessment plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident B was given the wrong medication.

INVESTIGATION: I conducted an unannounced site visit at the Mallard Cove Assisted Living adult foster care facility on September 5, 2023 and spoke with administrator Lauri Lee at that time. I asked Ms. Lee about the allegation that Resident B was given the wrong medication. She replied that there was an incident regarding Resident B but it pertained to a probiotic that Resident B takes. Ms. Lee stated that Resident B's Representative is quite involved with Resident B's care including her medication and the supplements she takes. She said that Resident B's Representative has supplements sent directly to the facility. Ms. Lee stated that the company that supplies Resident B's probiotic sent the wrong one and that was what Resident B was given. Resident B's Representative called to let them know what had occurred and they discontinued it at that point.

I observed Resident B during my visit to the facility on September 5, 2023. She was alert and in good spirits during my visit. She seemed well-cared for and did not appear to have suffered any recent ill effects.

I received a telephone call from adult protective services worker Louis Rohrer on September 8, 2023. She reported that she had spoken with staff at Mallard Cove and did not have any concerns regarding Resident B's care.

I spoke with Resident B's Representative by telephone on September 19, 2023. She told me that she is a registered nurse and has been involved in Resident B's care for several years. This includes taking Resident B to her doctor's appointments and being involved in her medications and supplements. She is aware that supplements must also have a doctor's prescription before being administered in an adult foster care home and has obtained those prescriptions for the supplements that are given to Resident B. Resident B's Representative stated that she lives several hours away so she has some of the supplements sent directly to the facility. In August of 2023, the company sent Mallard Cove the wrong supplement and facility staff gave this supplement, a probiotic, to Resident B. Resident B's Representative stated that she has given Resident B a probiotic in the past and the facility has also given her a probiotic. She will often have Resident B take a probiotic after she is on an anti-biotic medication. The supplement that the company was supposed to send is called Vanali which is a combination of grape seed oil and vitamin C. Resident B did not have any adverse effects from the probiotic. She reiterated that Resident B has been on a probiotic before and that it would not have harmed her in any way.

I received a telephone message from adult protective services worker Louise Rohrer on September 15, 2023. She said that she has closed her case and has not substantiated any neglect or abuse in regard to Resident B.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Information was not discovered through this investigation which would indicate that Resident B was given the wrong medication. Resident B's Representative is directly involved with Resident B's medication and supplements and knows that all supplements require a doctor's prescription. She confirmed that it was her supplement supplier who sent the facility the wrong supplement. This was administered to Resident B for a short time before the error was caught. Resident B's Representative confirmed that her mother has been given the supplement many times before with no adverse effects and there were no adverse effects this time as well.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: The administrator leaves resident medication in her office unlocked.

INVESTIGATION: During my visit to the Mallard Cove Assisted Living on September 5, 2023, administrator Lauri Lee asked if I would speak to her in another office. I noted that employees signed in and out of work on a computer located in Ms. Lee's office. While in the other office, I asked Ms. Lee about the allegation that she left medication in her office unlocked. Ms. Lee acknowledged that she sometimes does and that there was medication in her office at this time. We went back to her office and she showed me that there was a resident's medication in a corner of her desk. She said that she sometimes has medication in her office when she is in the process of entering it into the medication administration record (MAR). She said that the pharmacy typically enters medication into the MAR and there is no

reason for the medication to be in her office but sometimes a hospice nurse or family member will drop something off to her directly. Ms. Lee said that there are times when she might leave her office and the medication would be in there, unlocked. I asked if her door was left unlocked because staff signed in and out in her office. She confirmed that is the case. Ms. Lee locked up the medication that had been left out at that time and said that she would always lock medication in a cabinet whenever she left her office.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	It was confirmed through this investigation that medication was occasionally left unlocked in an office while being processed. I observed one bottle of medication in this office unlocked at the time of my visit on September 5, 2023. The medication was hidden from view at that time.
CONCLUSION:	**VIOLATION ESTABLISHED**

On September 22, 2023, I conducted an exit conference with licensee Connie Clauson. I told her of 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.

Adam Robarge 09/22/2023

Adam Robarge Date
Licensing Consultant

Approved By:

09/22/2023

Jerry Hendrick Date
Area Manager