GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 28, 2024

Rebecca Schlink-Wolfgram
Bavarian Comfort Care AL & MC LLC
5366 Rolling Hills Drive
Bridgeport, MI 48722

RE: License #: AH730412299
Investigation #: 2024A1027069
Bavarian Comfort Care AL & MC LLC

Dear Licensee:

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 authorized representative 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH730412299 |
| | |
| **Investigation #:** | 2024A1027069 |
| | |
| **Complaint Receipt Date:** | 06/13/2024 |
| | |
| **Investigation Initiation Date:** | 06/13/2024 |
| | |
| **Report Due Date:** | 08/12/2024 |
| | |
| **Licensee Name:** | Bavarian Comfort Care AL & MC LLC |
| | |
| **Licensee Address:** | Suite B<br>3061 Christy Way<br>Saginaw, MI 48603 |
| | |
| **Licensee Telephone #:** | (989) 607-0001 |
| | |
| **Administrator:** | Shantelle Zarko |
| | |
| **Authorized Representative:** | Rebecca Schlink-Wolfgram |
| | |
| **Name of Facility:** | Bavarian Comfort Care AL & MC LLC |
| | |
| **Facility Address:** | 5366 Rolling Hills Drive<br>Bridgeport, MI 48722 |
| | |
| **Facility Telephone #:** | (989) 777-7776 |
| | |
| **Original Issuance Date:** | 01/24/2023 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/24/2023 |
| | |
| **Expiration Date:** | 07/31/2024 |
| | |
| **Capacity:** | 65 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A lacked protection.<br>Resident B's clothing was burned and replaced.<br>Staff do not stay in the building on 3rd shift. | No |
| Resident B was administered two narcotics. Medications were late on third shift. | No |
| Resident C did not receive his meals on his 2nd day at the facility. | Yes |
| There were many cleaning issues. | No |
| Additional Findings | No |

Complaint investigations are limited to allegations of law or rule violations based on events that have occurred, not events that could or may occur. Any hypothetical allegations contained in the complaint were not investigated.

## III. METHODOLOGY

| | |
|---|---|
| 06/13/2024 | Special Investigation Intake<br>2024A1027069 |
| 06/13/2024 | Special Investigation Initiated - Telephone<br>Telephone interview conducted with the complainant to obtain additional information |
| 06/17/2024 | Inspection Completed On-site |
| 06/25/2024 | Contact - Document Sent<br>Email sent to Ms. Zarko requesting additional documentation |
| 06/25/2024 | Contact - Document Received<br>Email received from Ms. Zarko with requested documentation |
| 06/25/2024 | Inspection Completed-BCAL Sub. Compliance |
| 06/28/2024 | Exit Conference<br>Conducted by email with Rebecca Schlink-Wolfgram and Shantelle Zarko |

**ALLEGATION:**

**Resident A lacked protection.**
**Resident B's clothing was burned and replaced.**
**Staff do not stay in the building on 3rd shift.**

**INVESTIGATION:**

On 6/13/2024, the Department received allegations by telephone which alleged on 6/6/2024, Employee #1 removed Resident A's teeth without consent which was reported to the administrator and no action was taken.

Additionally, the complaint alleged Resident B's clothing was burned in the dryer and the facility purchased new clothing; however, his family was not provided notification.

An interview with the complainant on the same day revealed her statements were consistent with allegations.

On 6/17/2024, an on-site interview was conducted, and staff were interviewed.

Interview with Shantelle Zarko revealed Resident A resided in the memory care and her family requested her dentures be removed while sleeping. Ms. Zarko stated initially Resident A declined to remove her teeth prior to bedtime; however, when Employee #1 attempted to remove her teeth again, she permitted her to remove them. Ms. Zarko stated the incident had been reported her in which she explained to staff that memory care residents required support and encouragement to participate in their activities of daily. Additionally, Ms. Zarko stated Employee #1 was terminated on 6/15/2024 for failure to notify and not show up to work.

While on-site, I reviewed Employee #1's file which read in part she hired on 2/7/2024, and her Workforce Background Check read she was eligible for employment. Employee #1's training records read in part she received training on but not limited to Resident's Rights and Responsibilities, abuse procedure and responsibilities, the employee handbook, and completed the facility's caregiver training checklist and observation.

Ms. Zarko stated the dryer malfunctioned and burned Resident B's clothing on 5/14/2024 in which new clothes were purchased for him. Ms. Zarko stated Resident B was his own decision maker and was informed of the incident involving his clothing in which he was amendable to the facility purchasing new clothing.

Interview with Employee #2 revealed Resident B was involved in the decisions regarding the purchase of his new clothing.

Regarding staffing, Ms. Zarko stated 12-hour shifts were implemented and staff received a 15-minute break and a half hour lunch. Ms. Zarko stated staff could leave the facility during their breaks; however, only one person was permitted to

leave at a time. Ms. Zarko stated breaks started at 10:00 AM and 10:00 PM, and lunch breaks started at 1:00 PM and 1:00 AM; however, the times may fluctuate pending resident care. Ms. Zarko stated staff were in-serviced on breaks during a recent meeting.

Employees #2 and #3 stated the supervisor communicated breaks with staff through the walkie talkie.

While on-site, I observed four staff members working the floor.

I reviewed Resident A's service plan updated on 2/16/2024 which read in part she had full dentures and required assistance with activities of daily living.

I reviewed Resident B's face sheet which read consistent with Ms. Zarko's interview. I reviewed Resident B's Residency Agreement dated 4/4/2023 and signed by him which read in part "*In no event shall the Company be liable for any damage to, loss of, lost, misplacement of, destroyed or theft of Resident's personal possessions and/or property for any reason*."

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1921** | **Governing bodies, administrators, and supervisors.** |
| | **(1) The owner, operator, and governing body of a home shall do all of the following:**<br><br>**(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |

| | |
|---|---|
| **ANALYSIS:** | The complaint alleged that Resident A lacked protection, Resident B's clothing was burned and replaced, and staff were not present in the building during the third shift.<br><br>According to staff statements, Employee #1 was accused of removing Resident A's teeth, but there was insufficient evidence to confirm whether this was done without consent. Reviewing Employee #1's file showed she met employment eligibility criteria and received training but was no longer employed by the facility.<br><br>Regarding Resident B's clothing, documentation review indicated that he was his own decision maker. Despite the facility not being liable per the terms of the admission contract, they replaced his clothing.<br><br>Staff statements also confirmed the implementation of an organized program to coordinate breaks.<br><br>In conclusion, based on the information provided, the allegations mentioned above were not substantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident B was administered two narcotics. Resident Medications were late on third shift.**

**INVESTIGATION:**

On 6/13/2024, the Department received allegations by telephone which alleged a resident was administered two narcotics. An interview with the complainant on the same day revealed the allegations regarding the narcotics being administered pertained to Resident B. Additionally, the complainant stated Resident D received the wrong insulin and it was expired, and Resident E received her medications late.

On 6/17/2024, an on-site interview was conducted, and staff were interviewed.

Employees #2 and #3 both stated Employee #4 administered the medication Gabapentin, to the wrong resident. Employee #2 stated she was notified immediately by Employee #4 that Resident F had received the wrong medication. Employee #2 stated Employee #4 was removed from the medication cart immediately, re-educated on medication administration policies and observed passing medications. Employee #2 stated Resident F’s physician was contacted,

his vital signs were obtained, and he was placed on hourly checks. Employee #2 stated Resident F's family was also contacted. Employee #2 stated Employee #4 received a corrective action in addition to her re-education. I reviewed the incident report for Resident F dated 6/8/2024 and Employee #4's corrective action which read consistent with staff statements.

Additionally, Employee #2 stated the facility's medication training program consisted of an individual review of the medication PowerPoint, then four days of training on the medication cart including, demonstration of medication administration on each hallway, as well as observation of the staff member prior to being signed off.

Employee #3 stated she ran a medication/chart exception variance report daily to review the reasons why medications or tasks were not completed as ordered. Employee #3 stated she communicated with the employee as well as the resident's physician if medications were not administered per the licensed healthcare professional.

Employee #2 stated Resident D was alert and orientated in which she would tell staff her insulin needs because she had been a diabetic for a long time. Employee #2 stated Resident D was concerned her insulin was expired due to its lack of effectiveness. Employee #2 stated she confirmed the insulin was not expired; however, ordered another insulin pen per Resident D's request.

On-site, I reviewed the medication/chart exception variance reports for June 2024. The report read in part the recorded exceptions included but were not limited to the resident refused, the medication was reordered, the resident was out of the facility, or held due to medication parameters. The report read in part Resident E refused one medication and her monthly weight, as well as one medication was reordered and another medication, she was physically unable to take.

On-site, I reviewed the medication/chart exception variance report for the past three days which lacked documentation that medications were administered late.

On-site, I observed Resident D's Novolog and Lantus pens located in the medication cart in which the expiration date was 7/31/2025 and 2/28/2026 consecutively. The insulin pens corresponded to Resident D's MAR.

I reviewed Resident B's June 2024 medication administration record (MAR) which lacked scheduled and as needed narcotics prescribed.

I reviewed Resident D's June 2024 MAR which read in part she received insulin medications Novolog and Lantus. The MAR read in part staff initialed the medications as administered.

| APPLICABLE RULE | |
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| **R 325.1932** | **Resident medications.** |
| | **(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.** |
| **ANALYSIS:** | The complaint alleged that Resident B received two narcotics and medications were administered late during the third shift. Additionally, in a telephone interview, the complainant alleged that Resident D received expired insulin and Resident E had her medications administered late.<br><br>Staff statements indicated that the facility adheres to an organized program for handling medication errors and regularly reviews medication exception reports to ensure compliance with medication administration policies.<br><br>Upon reviewing facility documentation, there was insufficient evidence to substantiate the allegations mentioned above, and no violations were found. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Resident C did not receive his meals on his 2nd day at the facility.**

**INVESTIGATION:**

On 6/13/2024, the Department received allegations by telephone which alleged Resident C did not receive his meals on the 2nd day he was there.

On 6/17/2024, an on-site interview was conducted, and staff were interviewed. Ms. Zarko affirmed that all residents, including those in memory care like Resident C, received three meals daily, all served simultaneously. She emphasized that the facility maintained a meal census to track meal delivery and ensure all residents were served.

Regarding Resident C specifically, Ms. Zarko confirmed that he moved into the facility on 6/5/2024. She reviewed chart notes indicating that on 6/6/2024, Resident C had reportedly consumed both breakfast and lunch. However, Ms. Zarko noted a discrepancy with the meal census for that date, mentioning it was incomplete, which was contrary to their policy.

While on-site, I reviewed the facility's weekly menu in which three meals and snacks were served.

| APPLICABLE RULE | |
|---|---|
| **R 325.1954** | **Meal and food records.** |
| | **The home shall maintain a record of the meal census, to include residents, personnel, and visitors, and a record of the kind and amount of food used for the preceding 3-month period.** |
| **ANALYSIS:** | The allegations read Resident C did not receive his meals.<br><br>Upon reviewing facility records, it was found that Resident C did receive his breakfast and lunch, however, due to incomplete meal census records, therefore dinner consumption could not be confirmed. This violation was confirmed through failure to document the meal census. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**There were many cleaning issues.**

**INVESTIGATION:**

On 6/13/2024, the Department received allegations by telephone which alleged there were many cleaning issues present. An interview with the complainant on the same day revealed concerns about inadequate cleaning, including claims of stool in trash cans and dirty floors.

On 6/17/2024, an on-site interview was conducted, and staff were interviewed.

Ms. Zarko stated she recently hired two housekeepers to work weekdays from 9:00 AM to 5:00 PM, who responsible for both housekeeping and laundry. No resident complaints about cleanliness were reported to Ms. Zarko.

Employee #3's statements corroborated Ms. Zarko's interview, adding plans to replace facility carpeting and residents' rooms with laminate flooring instead of carpeting.

During the visit, observations showed some carpet stains in resident rooms but generally clean floors and bathrooms in both assisted living and memory care.

Resident D, interviewed separately, expressed no issues with room or facility cleanliness.

| APPLICABLE RULE | |
|---|---|
| **R 325.1979** | **General maintenance and storage.** |
| | **(1) The building, equipment, and furniture shall be kept clean and in good repair.** |
| **ANALYSIS:** | The complaint raised concerns about cleanliness.<br><br>Staff statements addressed the recent hiring of new housekeeping staff following the resignation of previous employees, along with plans for renovations.<br><br>Although there were sporadic carpet stains observed, there was not enough evidence to substantiate claims that the facility lacked cleanliness. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

Jessica Rogers 06/26/2024

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L. Moore 06/28/2024

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section