GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 25, 2024

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

RE: License #: AL240388304
Investigation #: 2024A0009033
Mallard Cove Assisted Living

Dear Ms. Clauson:

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
701 S. Elmwood, Suite 11
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 #:	2024A0009033
Complaint Receipt Date:	09/05/2024
Investigation Initiation Date:	09/06/2024
Report Due Date:	10/05/2024
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Sara Smith
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:	REGULAR
Effective Date:	10/04/2023
Expiration Date:	10/03/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED & ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A has fallen several times prompting Emergency Medical Services to be called. On September 5, 2024, there was only one staff on-duty.	Yes

III. METHODOLOGY

09/05/2024	Special Investigation Intake 2024A0009033
09/05/2024	APS Referral
09/06/2024	Special Investigation Initiated – Telephone call made to adult protective services worker Lane Stopher
09/09/2024	Inspection Completed On-site Interview with administrator Sara Smith and face to face contact with Resident A
09/12/2024	Contact – Document (email) received from administrator Sara Smith
09/23/2024	Contact – Telephone call made to administrator Sara Smith
09/23/2024	Contact – Telephone call made to direct care worker Justine Bowser
09/24/2024	Contact – Document (email with attachment) received from administrator Sara Smith
09/25/2024	Contact – Telephone call made to administrator Sara Smith
09/25/2024	Exit conference with licensee designee Connie Clauson

ALLEGATION: Resident A has fallen several times prompting Emergency Medical Services to be called. On September 5, 2024, there was only one staff on-duty.

INVESTIGATION: I spoke with Adult Protective Services worker Lane Stopher by telephone on September 6, 2024. Mr. Stopher reported that he had only been to the Mallard Cove assisted living home on one occasion recently. The case he was there

for did not have to do with the care of a resident but rather that a resident was unable to pay the facility.

I conducted an unannounced site visit at the Mallard Cove assisted living home on September 9, 2024. I spoke with administrator Sara Smith at that time. Ms. Smith reported that she had already spoken to the family and guardian about the fact that they were no longer able to continue to have Resident A living there. Resident A requires more personal care than they can provide. Ms. Smith said that they have attempted to meet her needs but are unable. After Resident A is put to bed, she often will swing her legs over the side of the bed and fall down after being unable to stand. She will not use her call button during those times to ask for assistance. When Resident A has fallen, she is too heavy for them to pick up. It doesn't matter if they have one or two staff on duty at those times. The staff are just physically unable to do that. She has instructed them not to try to lift her themselves or use the mechanical patient lift for their safety as well as Resident A's safety. Resident A is obese and they are unable to get her off the floor safely. She has instructed staff to call Emergency Medical Services (EMS) during those times because she felt they did not have any other safe option. Ms. Smith reiterated that the family has been looking for a more appropriate placement for Resident A and she is scheduled to leave the following week. The family has agreed to sit with Resident A during some of the time and have also hired a patient service to sit with her when they are not present to ensure she does not fall again. Ms. Smith did not anticipate any further falls or that EMS would need to be called. I requested a copy of Resident A's written assessment at that time.

I received and email from administrator Sara Smith on September 12, 2024. She reported in the email that Resident A had moved from their facility on that day to an appropriate facility.

I reviewed Resident A's written assessment with a "Started Date" of January 22, 2024. It documented that Resident A has occasional confusion and disorientation. She has, *'severe orientation deficits with past history of poor judgement creating potential unsafe behaviors to self or others.'* It also reported, *'(Resident A) is a fall risk and continuously tries to get up and walk around without ringing her call light for assistance. We remind her constantly to use her call light for assistance and it is disregarded.'* The written assessment indicated that Resident A, *'Requires two employees to assist with bathroom assistance.'* It noted, *'Mechanical lift required*' and, *'(Resident A) uses a Hoyer Lift for all transfers. Remind resident to wait for transfer assistance. Ensure that two persons are available to assist with the transfer. Assist resident to transfer using good technique to protect resident and staff. Report increasing difficulty with transfer or other safety concerns*.'

I spoke with administrator Sara Smith by telephone on September 23, 2024. I asked her about Resident A's written assessment indicating that Resident A requires a two-person assist with all transfers. She agreed that was true. She explained that Resident A's hospice physician had ordered a mechanical lift for her and that one

had been provided by medical equipment company. The mechanical lift requires two staff to operate properly. There was a second staff person available on the morning of September 5, 2024. Ms. Smith explained that each of the attached facilities has one staff assigned during the midnight shift with a third person who "floats" between facilities to assist with any eventuality. I asked her why EMS did not see a second staff person when they responded to the call on the morning of September 5, 2024. Ms. Smith replied that she did not know why. She said that it is possible that the second staff was involved in assisting another resident at the time and was not available right at that time. I asked Ms. Smith to provide me with a copy of the work schedule which would show the staffing around the time of September 5, 2024.

I spoke with direct care worker Justine Bowser by telephone on September 23, 2024. I asked her about Resident A falling. She said that Resident A did fall a lot. Ms. Bowser reported that in those instances she called the administrator, and the administrator asked her to call EMS. I asked her about staffing at the facility. She said that there was always one staff for each side during the midnight shift. We talked about how each side is its own licensed facility. Ms. Bowser reported that she understood that. She said that there is always one person for each side during the midnight shift and sometimes a third person who she called a "floater". I asked her if there was a floater or if she was alone, on her side, the last time that Resident A fell. I told her this was reported to have happened on September 5, 2024. She said that she could not remember specifically. She said that she thought that she was alone but was not sure. She knew she was alone on that side of the building during some of the times that Resident A fell.

I received an email with the requested work schedule attached from administrator Sara Smith on September 24, 2024. The work schedule provided covered the time-period of August 30 to September 13, 2024. Ms. Smith previously reported to me that Resident A moved from the facility on September 12, 2024. The schedule covered both sides of the building and only differentiated some staff with a E or W after their shift to designate which side they worked on. During the midnight shift, it appeared that there were some nights that there was only one staff working on the West side where Resident A lived. This included August 30, August 31, September 6 and September 7, 2024.

I spoke with administrator Sara Smith by telephone on September 25, 2024. She acknowledged that there were some days that there would have been only one direct care staff working on the West side of the building which is where Resident A resided. She said that she lost a midnight worker and is already in the process of hiring new staff which will include that shift.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**

	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Resident A's written assessment indicated that she required assistance from two direct care staff when in the bathroom and when being transferred. The complainant reported that on the morning of September 5, 2024, there was only one direct care worker on-duty. Both the direct care worker on-duty that morning as well as the administrator acknowledged that there were times during the midnight shift when there was only one direct care worker on-duty. The printed work schedule indicated that there were some midnight shifts when only one direct care staff was on-duty. In consideration of the above information, it is determined that the licensee did not have sufficient staff on-duty to provide services as specified in the resident's written assessment.
CONCLUSION:	**VIOLATION ESTABLISHED**

I conducted an exit conference with licensee designee Connie Clauson by telephone on 9/25/2024. I told her of the findings of my investigation and gave her the opportunity to ask questions.

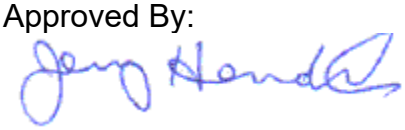
IV. RECOMMENDATION

I recommend no change in the license status.

09/25/2024

Adam Robarge Date
Licensing Consultant

Approved By:



09/25/2024

Jerry Hendrick Date
Area Manager