GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2026

Jeanette Sanders
Bavarian Comfort Care AL & MC LLC
5366 Rolling Hills Drive
Bridgeport, MI 48722

RE: License #: AH730412299
Investigation #: 2026A1035035
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 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) 335-5985.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH730412299
Investigation #:	2026A1035035
Complaint Receipt Date:	04/16/2026
Investigation Initiation Date:	04/16/2026
Report Due Date:	06/16/2026
Licensee Name:	Bavarian Comfort Care AL & MC LLC
Licensee Address:	Suite B 3061 Christy Way Saginaw, MI 48603
Licensee Telephone #:	(989) 607-0001
Administrator:	Kory Feetham
Authorized Representative:	Christine Wade
Name of Facility:	Bavarian Comfort Care AL & MC LLC
Facility Address:	5366 Rolling Hills Drive Bridgeport, MI 48722
Facility Telephone #:	(989) 777-7776
Original Issuance Date:	01/24/2023
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	65
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had not received care in accordance with his service plan and electronic medical record. The facility has poor staffing.	Yes
Additional Findings	No

III. METHODOLOGY

04/16/2026	Special Investigation Intake 2026A1035035
04/16/2026	Special Investigation Initiated - Letter
05/12/2026	Contact - Face to Face
07/30/2026	Inspection Complete. BCAL Sub Compliance.
07/30/2026	Exit Conference.

ALLEGATION:

Resident A had not received care in accordance with his service plan and electronic medical record. The facility has poor staffing.

INVESTIGATION:

On April 16, 2026, the Department received a complaint through the online complaint system which read:

> "As a result of a pattern of neglect (repeated ER visits for dehydration, soiled clothing and furniture, insufficient staffing, complete absence of supervisory role after hours and weekends, etc.), Resident A was rushed to the ER at Saginaw Covenant Hospital after one of the memory care staff reported a bedsore on Resident A's sacrum. I received a call late in the morning of November 22, 2025, asking if they should send Resident A to the ER to be checked out. I had them show me via phone video Resident A's sore in order to gather more information about the situation. It was a severe open bed sore, clearly infected and draining. I was horrified and nauseated. I gave permission to send him and when the EMT's showed up, they asked to speak with me on the phone. He told me he was "shocked at my Resident A's condition". Later in the ER the EMT also talked to my brother as well, about Resident A's state of health upon his arrival at the Bavarian Comfort Care. My brother and I had been visiting Resident A on a

regular basis and had never been told he was showing symptoms of a bedsore or potential bedsore. Resident A had regular visits with the NP at the facility and had just had a visit from her 2 days prior on the 20th of November. No one notified us or shared any concerns with us regarding any aspect of his health or changes in his health, even when repeated phone calls and requests to speak to the NP were made. In the ER, Resident A was in a great deal of pain - it was traumatizing to witness. After debriding the wound and supported by lab reports, the doctors determined his bedsore was infected/septic unstageable and severe. My brother and I both requested the hospital staff to make a report but, we never received a call from APS, so we assume a report was never filed even though hospital staff are mandated reporters. I had also asked the managing social worker about reporting the neglect and was told "bedsores just happen to the elderly". I now know that all bedsores are preventable. We had been so disgusted with the care Resident A received that we were in the process of moving him to a new facility. His scheduled transport date to the new facility was November 25, 2025. Just a month later Resident A passed away. The bedsore that was a direct result of neglect, took Resident A's life. Please investigate this facility with utmost diligence."

On April 16, 2026, an email was sent to the facility Administrator requesting Resident A's face sheet, service plan, progress notes, incident reports, and staffing goals, and staffing schedule.

On May 11, 2026, the facility provided the requested documentation. Through record review, Resident A was admitted to Bavarian Comfort Care May 21, 2025. Resident A's service plan effective date 5/23/2025 indicates Resident A has a pressure ulcer. The service plan does not provide location, severity, treatment plan, or preventative measures implemented. No documentation noted related to pressure ulcers within Resident A's progress notes.

Through record review of the electronic medication administration record (eMAR) for the month of November 2025 Resident A had three missed doses of Divalproex 250mg on 11/2/25,11/9/25, and 11/15/25 at 2:00p.m. Multiple area of missed documentation related to activities of daily living noted.

- ADL: Eating missed documentation 11/1, 11/14 x 2, 11/16, 11/17, and 11/20/2025
- Locomotion: Ambulation missed documentation 11/1 x 2, 11/14, 11/16, 11/17, and 11/20/2026.
- Meals: 8 PM snacks missed documentation 11/1, 11/16, 11/17, and 11/20/2025.
- Meals: Meals missed documentation 11/1, 11/9, 11/14, 11/16, 11/17, and 11/20/2025.
- Personal Care: 1 Assist missed documentation 11/1, 11/14, 11/16, and 11/17/2026.
- Safety – Safety Checks 24hr missed documentation 11/1, 11/14, 11/16, 11/17 and 11/20/2026.
- Toileting: Bladder – Toileting Program missed documentation 11/1 x 2, 11/14, 11/16, 11/17, and 11/20/2026.

The facility states they staff with four care staff on day and afternoon shift and three care staff on midnight shift. Employee schedule reviewed for the timeframe of November 16, 2025, through November 29, 2025. The facility staffed as stated.

Multiple attempts to interview the complainant have gone without success.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan. **(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.**
ANALYSIS:	Through record review Resident A did not consistently receive care in accordance with his service plan and electronic record. There were multiple missed documentations noted in the month of November. The facility was unable to provide documentation related to the pressure ulcer noted on the service plan. There was no documentation of the pressure ulcer location, severity, responsible care partner taking care of pressure wound, and preventative measures implemented to improve or maintain pressure area. Through record review, the facility staffed in accordance with their staffing goals. The facility utilizes an on-call system and mandates to meet the staffing goals. Based on missed documentation related to care being provided this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/27/2026

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

07/30/2026

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