GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 28, 2022

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

RE: License #: AL250381015
Investigation #: Amended 2022A0580020
Hyde Park AL II

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

This report was amended to address some formatting issues. No wording on this report was changed.

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 (906) 226-4171.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250381015
Investigation #:	2022A0580020
Complaint Receipt Date:	12/03/2021
Investigation Initiation Date:	12/09/2022
Report Due Date:	01/02/2022
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Stacy Bohn
Licensee Designee:	Connie Clauson
Name of Facility:	Hyde Park AL II
Facility Address:	3200 Wyndham Flushing, MI 48433
Facility Telephone #:	(810) 659-3000
Original Issuance Date:	05/19/2016
License Status:	REGULAR
Effective Date:	11/19/2020
Expiration Date:	11/18/2022
Capacity:	20

Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is short-staffed, having only 2 staff for 20 residents.	Yes
Resident A died with no dignity. Resident A was observed dead in a diaper while on the floor.	No
There was a change in Resident A's condition, requiring medical care.	No
Resident A's medication was being dispensed incorrectly.	No

III. METHODOLOGY

12/03/2021	Special Investigation Intake 2022A0580020
12/07/2021	Contact - Document Received An email was received assigning the case due to the assigned consultants absence.
12/09/2022	Special Investigation Initiated - Telephone A call was made to the complainant.
12/17/2022	Inspection Completed On-site An onsite inspection was conducted. Contact made with the manager Ms. Heather and Ms. Daisy Moore.
12/17/2022	Contact - Document Received A copy of the FC Assessment Plan, Care Agreement, Health Care Appraisal, November Medication Logs, and November staff schedules were received.
12/17/2021	Contact - Face to Face An interview was conducted with Resident B.

12/17/2021	Contact - Telephone call made A call was made to Relative Guardian A.
12/20/2021	Contact – Document Received An email from Relative Guardian A was received.
01/24/2022	Contact - Telephone call made A call was made to Ms. Juanita Robinson, Staff.
01/24/2022	Contact - Telephone call made A call was made to Ms. Summer Bobb, Staff.
01/24/2022	Contact - Telephone call made A call was made to Ms. Lou Ann Brandt, of Ascension Living PACE, case manager assigned to Resident A.
01/25/2022	Contact - Telephone call made A call was made to Ms. Michelle Rossie and Ms. Stephanie Thomas, Nurse Practitioners at Ascension Living PACE, assigned to Resident A.
01/26/2022	Exit Conference An exit conference was held with the license administrator, Ms. Stacy Bohn.

ALLEGATION:

The facility is short-staffed, having only 2 staff for 20 residents.

INVESTIGATION:

On 12/07/2021, I received an email assignment of this complaint, due to the assigned consultant's absence.

On 12/09/2021, I made a call to the complainant. A message was left requesting a return call.

On 12/17/2021, I conducted an onsite inspection at Hyde Park AL II. Contact was made with the manager, Ms. Heather Atkins, and Ms. Daisy Moore. They denied the allegations that they are short staffed. There were 18 residents in the facility as the time Resident A passed. This facility is considered a memory care unit in which most of the residents require assistance, however, there is only one resident who requires a 2-person assist. Bed checks for residents are conducted every 15-20 minutes.

On 12/17/2021, I received a copy of staff schedules for the month of November, fire drill records for the last quarter and a copy of the A copy of the AFC Care Agreement and Assessment Plan for Resident A.

November staff schedules were received Staff schedules for the month of November 2021 was observed. The schedule reflects 3 shifts. First shift, which begins at 8am-4pm reflects that there were at least 3 staff working 1st shift at all times. Second shift, which begins at 4pm-12am consists of 2 staff, with a 3rd staff present during the hours of There are only 2 staff working during the hours of 10pm-6am. Third shift begins at 12am until 8am. The schedule reflects 2 staff working 3rd shift during the month of November.

Fire Drills reviewed reflect a 3rd shift drill, conducted in September of 2021, which included 3 staff and 18 residents. This drill took 4 minutes in total. The October 2021 fire drill took place on 1st shift, and consisted of 3 staff, 8 residents, lasting a total of 3 minutes and 51 seconds. The drill that took place in November of 2021 occurred on 2nd shift. It consisted of 3 staff, 18 resident, and lasted a total of 4 minutes. These drills occurred with 3 staff. If the fire drills are conducted with 2 staff, then they would be slower.

Resident A's care agreement was signed and dated for 10/01/2021. The assessment plan indicates that Resident A is fully ambulatory and does not require assistance with walking or mobility. Resident A requires assistance with toileting. The plan indicates that staff will assist and direct as needed.

On 12/17/2021, I conducted an in-person interview with Resident B. Resident B recalled that he was sleeping with his TV on when all of a sudden, Resident A burst in his room in his shirt and underwear and began running around. While running he bumped into Resident B's walker and collapsed on his bed. Two staff came and tried to get him off the floor, however, they could not. A third staff from the other side of the building came and all 3 tried to get Resident A in a wheelchair. He was then asked to leave the room. Resident B denied that he has to wait long periods of time for assistance.

On 12/17/2021, I spoke with Relative Guardian A. She expressed concern that the facility is charging 7k a month for memory care, but only have 2 staff working at night for 20 people. She indicated that the staff is underpaid and the facility is understaffed.

On 12/20/2021, I received an email from Relative Guardian A verifying that she was granted Durable Power of Attorney and Heath Care Power of Attorney by Resident A. This document was notarized September 2, 2015.

On 01/24/2022, I spoke with staff, Ms. Juanita Robinson, direct staff. She recalled that on the date of Resident A's passing, staff, Ms. Summer Bobb requested her assistance in getting Resident A out of another resident's room. Upon entering the room, Resident A was observed ½ was on the bed, slumped over as if he were about to fall on the floor.

Upon calling his name, Resident A did not answer, however, he began to feel heavy. As Ms. Bobb went to retrieve a wheelchair to assist, Ms. Robinson indicated that she lowered Resident A to the floor because she could no longer support his weight and he was about to fall. She and Ms. Bobb could not pick Resident A up and get him in the chair so they called for a staff from Hyde Park AL I to assist. She denied the allegations that they are short staffed. She shared that staff work as a team.

On 01/24/2022, I spoke with Ms. Summer Bobb, direct staff. Ms. Bobb indicated that she does not recall if she or Ms. Juanita Robinson was assigned to work with Resident A that evening because they work as a team and assist throughout the facility. She denied the allegations that the home is short staffed. Ms. Bobb recalled that she received a buzzer call from Resident B on 11/29/21. Upon arriving to his room, Resident B indicated that Resident A was trying to get in his bed. Ms. Bob then called for staff, Ms. Juanita Robinson to assist. They were unsuccessful at getting Resident A out of the bed so she went to retrieve a wheelchair. They could not get him in the wheelchair so they lowered him to the floor. They realized they needed additional help and called for assistance from the facility next door.

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:	It was alleged that the facility is short-staffed, having only 2 staff for 20 residents. Relative Guardian A expressed concern that the facility only has 2 staff working at night for 20 people. Manager, Ms. Heather Atkins, and Ms. Daisy Moore deny the allegations that they are short staffed. There were 18 residents in the facility as the time Resident A passed. Bed checks for residents are conducted every 15-20 minutes. One resident who requires a 2-person assist. On 1/24/21, two staff could not meet the needs of the residents and a staff person from another licensed facility next door had to assist. This left the other licensed facility short staffed as well. November staff schedules were reviewed. The staff schedule confirms two staff persons are supervising the residents at

	different times of the 24-hour shift, and specifically midnight to 6 am. The AFC assessment plan indicates that Resident A is fully ambulatory and does not require assistance with walking or mobility. Resident A requires assistance with toileting. The plan indicates that staff will assist and direct as needed. Resident B denied that he has to wait long periods of time for assistance. Fire Drills records were reviewed and conducted with three staff working. This is a concern as the facility is only staffing two staff during the sleeping hours when a fire is most likely to occur. Ms. Juanita Robinson stated that two staff could not lift Resident A on 11/29/21. A staff person from another licensed facility was called to assist her and another staff person. Ms. Bobb, direct staff, further confirmed that two staff were not able to meet the needs of the residents. Based on the information gathered in the course of this investigation, there is substantial evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A died with no dignity. Resident A was observed dead in a diaper while on the floor.

INVESTIGATION:

On 12/17/2021, I conducted an onsite inspection at Hyde Park AL II. Contact was made with the manager, Ms. Heather Atkins, and Ms. Daisy Moore. They shared that Resident A was a receiving hospice services and medical care via Ascension Living PACE located in Genesee County. Staff contacted Pace upon Resident A's passing.

On 12/17/2021, Ms. Atkins recalled that direct staff, Ms. Juanita Robinson, and Ms. Summer Bobb were working on the evening of Resident A's passing. Ms. Atkins shared that before departing the day, she assisted Resident A in his pajamas and to his bed that evening. Resident A had pajama pants on when she left. She is unsure of how his pants got off and assumes that he must have taken them off himself.

On 12/17/2021, I received a copy of the incident report dated 11/29/2021. The incident report indicates that staff went to check on Resident A and found him in another resident's room. Staff found Resident A on another resident's bed. It appeared the resident collapsed. Staff attempted to take vital signs. The resident was talking but having a hard time breathing. Staff attempted to get Resident A back to his room via wheelchair so that he could get his oxygen back on. As the resident was being transported back to his room, he stopped breathing. Staff lowered Resident A to the floor. Staff notified PACE Hospice staff and the POA to notify them of the change in condition.

On 12/17/2021, I spoke with Relative Guardian A. She indicated that when she arrived at the facility on the date of Resident A's passing, Resident A was laying on the floor, in another resident's room. His head and body were in the doorway. Resident A had a waist, lift belt around his waist. A diaper, t-shirt, and no teeth in his mouth. She does not believe that Resident A passed away from natural causes and something terrible happened that night. She shared that the official cause of death listed on the death certificate is listed as Alzheimer's.

On 01/24/2022, I spoke with staff, Ms. Juanita Robinson, direct staff. She recalled that on the date of Resident A's passing, staff, Ms. Summer Bobb requested her assistance in getting Resident A out of another resident's room. Upon entering the room, Resident A was observed ½ was on the bed, slumped over as if he were about to fall on the floor. Upon calling his name, Resident A did not answer, however, he began to feel heavy. As Ms. Bobb went to retrieve a wheelchair to assist, Ms. Robinson indicated that she lowered Resident A to the floor because she could no longer support his weight and he was about to fall. She and Ms. Bobb could not pick Resident A up and get him in the chair so they called for a staff from Hyde Park AL I to assist. Upon that staff arriving, she noticed Resident A was not breathing and informed Ms. Robinson and Ms. Bobb that Resident A was deceased. They then determined that Resident A should not be moved. Ms. Robinson indicated that she put a pillow under Resident A's head, so he wouldn't be lying on the floor, and covered him with a sheet while Resident B was ushered out of the room. She contacted MMR, who assisted in lifting Resident A's body off the floor.

On 01/24/2022, I spoke with Ms. Summer Bobb, direct staff. Ms. Bobb recalled that she received a buzzer call from Resident B. Upon arriving to his room, he indicated that Resident A was trying to get in his bed. She then called for staff, Ms. Juanita Robinson to assist. They were unsuccessful at getting Resident A out of the bed so she went to retrieve a wheelchair. They could not get him in the wheelchair so they lowered him to the floor. They realized they needed additional help and called for assistance from the facility next door. She did not know that Resident A had passed away.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	It was alleged that Resident A died with no dignity, on the floor, in a t-shirt and a diaper. Manager, Ms. Heather Atkins recalled that she assisted Resident A in his pajamas and to his bed that evening. Resident A had pajama pants on when she left. She is unsure of how his pants got off and assumes that he must have taken them off himself. The incident report dated 11/29/2021 was reviewed. Resident B recalled that he was sleeping with his TV on when all of a sudden, Resident A burst in his room in his shirt and underwear and began running around. Resident A collapsed on his bed. Two staff came and tried to get him off the floor, however, they could not. A third staff from the other side of the building came and all 3 tried to get Resident A in a wheelchair. He was then asked to leave the room. Relative Guardian A indicated that when she arrived at the facility on the date of Resident A's passing, Resident A was laying on the floor, in another resident's room. His head and body were in the doorway, he had on a waist lift belt around his waist, a diaper, a t-shirt, and no teeth in his mouth. She does not believe that Resident A passed away from natural causes and something terrible happened that night. Direct staff, Ms. Juanita Robinson recalled that on the date of Resident A's passing, she received a request to assist in getting Resident A out of another resident's room. Upon entering the room, Resident A was observed ½ was on the bed, slumped over as if he were about to fall on the floor. Upon calling his name, Resident A did not answer. Ms. Robinson indicated that she lowered Resident A to the floor because she could no longer support his weight and he was about to fall. Upon determining Resident A was deceased, she put a pillow under Resident A's head, so he wouldn't be lying on the floor, and covered him with a sheet. MMR assisted in lifting Resident A's body off the floor.

	Direct staff, Ms. Summer Bobb, direct staff. Ms. Bobb recalled that she received a buzzer call from Resident B indicating that Resident A was trying to get in his bed. She then called for staff, Ms. Juanita Robinson to assist. They were unsuccessful at getting Resident A out of the bed so she went to retrieve a wheelchair. They could not get him in the wheelchair so they lowered him to the floor. Based on the information gathered in the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There was a change in Resident A's condition, requiring medical care.

INVESTIGATION:

On 12/17/2021, I conducted an onsite inspection at Hyde Park AL II. Contact was made with the manager, Ms. Heather Atkins, and Ms. Daisy Moore. They shared that Resident A was a receiving hospice services and medical care via Ascension Living PACE located in Genesee County. Staff contacted Pace upon Resident A's passing.

On 01/24/2022, I spoke with Ms. Juanita Robinson, direct staff. She indicated that she contacted PACE staff, her manager, Ms. Heather Atkins, and Relative Guardian A upon Resident A's passing.

On 01/24/2022, I spoke with Ms. Lou Ann Brandt, of Ascension Living PACE, case manager assigned to Resident A. Ms. Brandt shared that she had worked with Resident A for several years while he resided in his own apartment, before he transitioned to living with a family member, to Hyde Park AL II. She shared that Resident A had been placed on Hospice for an estimated 2 weeks prior to his passing. She visited with him at least every 2 weeks, with the exception of once a month during the height of Covid 19. She indicated that she and the Nurse Practitioner, Ms. Michelle Rossie, had several discussions with Guardian A regarding Resident A's declining health. She confirmed that staff were required to contact PACE before contacting any ambulance or other medical staff. Pace RN, Ms. Gabrielle Wells arrived at the facility on the date of his passing to confirm the time of death.

On 01/25/2022, I spoke with both Ms. Michelle Rossie, and Ms. Stephanie Thomas, Nurse Practitioners at Ascension Living PACE, located in Genesee County. Ms. Rossi indicated that she has worked with Resident A and his guardian for 2 years prior to his death. She indicated that on 11/18/2021, Relative Guardian A decided that she no

longer wanted Resident A to do any other hospital testing. Palliative (Hospice) care became effective on 11/19/2021. Ms. Rossie indicated that Resident A was diagnosed with advanced stage Dementia.

APPLICABLE RULE	
R 400.15310	**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:	It was alleged that there was a change in Resident A's condition, requiring medical care. Ms. Heather Atkins and Ms. Daisy Moore shared that Resident A was a receiving hospice services and medical care via Ascension Living PACE located in Genesee County. Staff contacted Pace upon Resident A's passing. Direct staff, Ms. Juanita Robinson indicated that she contacted PACE staff, her manager, Ms. Heather Atkins, and Relative Guardian A upon Resident A's passing. Ms. Lou Ann Brandt, of Ascension Living PACE, case manager assigned to Resident A, shared that Resident A had been placed on Hospice for an estimated 2 weeks prior to his passing. She confirmed that staff were required to contact PACE before contacting any ambulance or other medical staff. Pace RN, Ms. Gabrielle Wells arrived at the facility on the date of his passing to confirm the time of death. Ms. Michelle Rossie, and Ms. Stephanie Thomas, Nurse Practitioners at Ascension Living PACE, located in Genesee County, confirmed that Resident A began receiving Palliative (Hospice) care became effective on 11/19/2021. Ms. Rossie indicated that Resident A was diagnosed with advanced stage Dementia. Based on the information gathered in the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medication was being dispensed incorrectly.

INVESTIGATION:

On 12/17/2021, I conducted an onsite inspection at Hyde Park AL II. Contact was made with the manager, Ms. Heather Atkins, and Ms. Daisy Moore. They denied the allegations that Resident A's medicine was being dispensed incorrectly. A copy off the November MARS medication log for Resident A and the Physician Order changes during the month of November were requested.

On 12/17/2021, I received a copy of Resident A's November MARS medication log and Physician Order changes during the month of November. The medication log reflects that Resident A was given his medication as prescribed, with the exception of medications refused on 11/19/2021 and 11/23/2021.

On 01/24/2022, I spoke with Ms. Lou Ann Brandt of Ascension Living PACE, case manager assigned to Resident A. She shared that when a resident receives any prescription changes, the orders are faxed to the pharmacy. She has no information about any medication wrongfully dispensed. The Nurse Practitioner assigned to Resident A wrote the prescriptions and should be able to share more information.

On 01/25/2022, I spoke with both Ms. Michelle Rossi and Ms. Stephanie Thomas of Ascension Living PACE, Nurse Practitioners, assigned to work with Resident A. Ms. Rossie indicated that Resident A was being prescribed Zantax for anxiety, however it was discontinued by the physician, at the request of the family. Ms. Stephanie Thomas indicated that she began working with Resident A effective 11/19 when he became a hospice patient. She shared that she prescribed Morphine as a PRN, however, it was discontinued by the physician, at the family's request.

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 alleged that Resident A's medication was being dispensed incorrectly. Manager, Ms. Heather Atkins and Ms. Daisy Moore. They deny the allegations that Resident A's medicine was being dispensed incorrectly. Resident A's November MARS medication log and Physician Order changes during the month of November were reviewed. The medication log reflects that Resident A was given his medication as prescribed, with the exception of medications refused on 11/19/2021 and 11/23/2021. Ms. Lou Ann Brandt of Ascension Living PACE shared that when a resident receives any prescription changes, the orders are faxed to the pharmacy. She has no information about any medication wrongfully dispensed. Ms. Michelle Rossi and Ms. Stephanie Thomas of Ascension Living PACE, Nurse Practitioners, assigned to work with Resident A, indicated that Resident A was being prescribed Zantax for anxiety, however it was discontinued by the physician, at the request of the family. Ms. Stephanie Thomas indicated that she prescribed Morphine as a PRN, however, it was discontinued by the physician, at the family's request. Based on the information gathered in the course of this investigation, there is insufficient evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 01/26/2022, I conducted an exit conference with the license administrator, Ms. Stacy Bohn. Ms. Bohn was informed that a violation of licensing rule R206(2) was found. A corrective action plan was requested in 15 days.

IV. RECOMMENDATION

Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.

January 26, 2022

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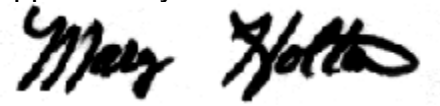
Sabrina McGowan — Date
Licensing Consultant

Approved By:



January 28, 2022

_____

Mary E Holton — Date
Area Manager