GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2022

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

RE: License #: AL700289601
Investigation #: 2023A0583001
Georgetown Manor - West

Dear Mrs. Clauson:

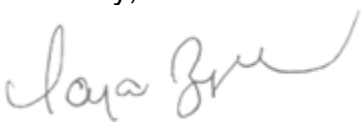
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (616) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700289601
Investigation #:	2023A0583001
Complaint Receipt Date:	09/26/2022
Investigation Initiation Date:	09/27/2022
Report Due Date:	10/26/2022
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Connie Clauson
Licensee Designee:	Connie Clauson
Name of Facility:	Georgetown Manor - West
Facility Address:	141 Port Sheldon Road Grandville, MI 49418
Facility Telephone #:	(616) 457-3050
Original Issuance Date:	02/21/2013
License Status:	REGULAR
Effective Date:	08/15/2021
Expiration Date:	08/14/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
The facility is insufficiently staffed to meet the residents' needs.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/26/2022	Special Investigation Intake 2023A0583001
09/27/2022	Inspection Completed On-site Staff Robin Rogers, Business Office Manager Ann Hoelsema
09/27/2022	Contact - Telephone call made Staff Maranda Maulson
09/28/2022	Inspection Completed On-site Regional Director Amanda Beacham, Resident A, Resident B
09/29/2022	Contact – Document received Staff Rebecca Jiggens
10/03/2022	Contact – Document received Staff Rebecca Jiggens
10/11/2022	Contact – Telephone call made Staff Jenica Linburg
10/11/2022	Contact – Telephone call made Staff Da'Kyra McGhee-Monk
10/11/2022	Contact – Telephone call made Staff Diamond Navarro
10/12/2022	Contact – Telephone call made Staff Diamond Navarro
10/13/2022	Contact – Telephone call made Staff Diamond Navarro
10/13/2022	Contact – Document received Staff Rebecca Jiggens
10/14/2022	Contact - Telephone call made

	Staff Rebecca Jiggens
10/14/2022	APS Referral
10/19/2022	Contact - Telephone call made Staff Da'Kyra McGhee-Monk
10/19/2022	Contact - Telephone call made Staff Rebecca Jiggens
10/21/2022	Contact - Telephone call made Staff Da'Kyra McGhee-Monk
10/25/2022	Exit Conference Licensee Designee Connie Clauson

ALLEGATION: The facility is insufficiently staffed to meet the residents' needs.

INVESTIGATION: On 09/26/2022 a complaint was received from an anonymous complainant alleging that the facility is "understaffed".

On 09/28/2022 I completed an unannounced onsite investigation at the facility and interviewed Regional Director Amanda Beacham. Licensing Consultant Megan Aukerman was present during the inspection.

Regional Director Amanda Beacham acknowledged that the facility has been struggling with a lack of staff however she stated the facility is adequately staffed to provide for residents' needs. Ms. Beacham stated administrative staff have been filling in shifts to assist with resident care. Ms. Beacham stated there have been dates in which administrative staff have assisted with resident care however the facility staff schedule was not updated to reflect this. Ms. Beacham stated the facility currently houses seventeen residents.

Resident B stated the facility doesn't have enough staff. She stated the facility is typically staffed with "one staff" for third shift and "two staff" for first and second shifts. Resident B stated that there have been occasions in which only one staff worked at the facility during the day. She stated she had to wait "up to 30 minutes or sometimes staff never came at all" after she used her call button to request staff assistance.

Resident C stated he has had to "remind staff" to administer his medications. Resident C stated he typically waits "half an hour" for staff assistance when he uses his call light.

On 09/27/2022 I interviewed staff Maranda Maulson via telephone. Ms. Maulson stated she heard from other staff that the facility operated with no staff on 09/11/2022 from 3:00 AM until 7:00 AM. She stated that on this date the facility was covered by staff who were assigned to work in the adjacent separately licensed AFC program.

On 09/30/2022 I completed a licensing file review. I observed that special investigation 2022A0583038 indicates that on 08/5/2022 the facility was cited for violating licensing rule 401.15206 (1) due to inadequate staffing levels. The special investigation report documented that regional director Amanda Beecham acknowledged the facility operated with no staff on 05/17/2022 from 11:00 PM until 11:15 PM and operated with no staff on 06/24/2022 from 11:00 PM until 06/25/2022 7:00 AM. The file contained the LARA approved Corrective Action Plan signed by Licensee Designee Connie Clauson on 08/30/2022.

On 10/03/2022 I received an email from staff Rebecca Jiggens which included the staff schedule for September 2022. The staff schedule was poorly constructed and difficult to decipher. It also was not updated and did not document when all staff started and ended their shifts.

On 10/11/2022 licensing consultant, Megan Aukerman interviewed staff, Jenica Linburg by telephone. Ms. Linburg stated she did not work at the facility on 09/10/2022. Ms. Linburg stated there were a few rare occasions when one staff person covered two separately licensed facilities during third shift. She stated this was due to staff not showing up and administration not being able to find a replacement. Ms. Linburg could not recall actual dates this occurred.

On 10/11/2022, Licensing consultant, Megan Aukerman contacted former staff Diamond Navarro. Ms. Navarro stated she would call right back, then promptly hung up the phone.

On 10/12/2022 I telephoned former staff Diamond Navarro however she did not answer the telephone call and her voicemail was full.

On 10/12/2022 I once again telephoned former staff Diamond Navarro however she did not answer the telephone call and her voicemail was full.

On 10/12/2022 I text messaged former staff Diamond Navarro however she did not respond to my text message.

On 10/13/2022 I telephoned former staff Diamond Navarro once again however she did not answer the telephone call and her voicemail was full.

On 10/13/2022 I received and reviewed an email from staff Rebecca Jiggens. The email contained Resident A’s Medication Administration Record MAR). Resident A’s Medication Administration Record states Resident A is prescribed nitroGLYCERIN

(NITROSTAT) 0.4 MG sublingual tablet “Place 1 tablet under the tongue every 5 minutes as needed for Chest pain” and Morphine 100 MG/5ML solution every three hours as need “comfort pack”. Resident A’s MAR indicated he was administered one dose of Morphine on 09/10/2022 at an unknown time and was not administered the medication on 09/11/2022. I observed Resident A was not administered nitroGlycerin on 09/10/2022 or 09/11/2022. The observation notes indicated staff Da’Kyra McGhee-Monk observed Resident A “was complaining of chest pains” and “hospice was notified and instructed RCS to give PRN morphine .25mL”.

On 10/14/2022 I emailed the complaint allegation to Centralized Intake.

On 10/14/2022 I interviewed staff Rebecca Jiggens via telephone. Staff Rebecca Jiggens stated that the facility staff schedule indicates that staff Diamond Navarro worked at the facility from 09/10/2022 11:00 PM until 09/11/2022 07:00 AM. Ms. Jiggens stated she observed the staff schedule appears, “hard to read and doesn’t make sense”.

On 10/19/2022 I telephoned former staff Diamond Navarro however she did not answer the telephone call and her voicemail was full.

On 10/19/2022 I interviewed staff Da’Kyra McGhee- Monk via telephone. Ms. Monk stated she worked at the facility on 09/11/2022 at 07:00 AM. Ms. Monk stated staff Diamond Navarro did not work at the facility on 09/10/2022 11:00 PM from 09/11/2022 07:00 AM as Ms. Navarro was, “scheduled on another unit”. Ms. McGhee-Monk stated staff Tricia VanKoevering gave Ms. McGhee-Monk the facility keys on 09/11/2022 07:00 AM. Ms. McGhee-Monk stated Ms. Navarro was not the unit on 09/11/2022 at 07:00 AM.

On 10/19/2022 I telephoned staff Tricia VanKoevering however she did not answer, and a voicemail message was left requesting a call back.

On 10/19/2022 staff Rebecca Jiggens confirmed that the staff schedule has not been updated “in real time” and is difficult to understand. Ms. Jiggens stated that the facility’s timecards indicated “five staff” worked between the four facilities on campus on 09/10/2022 11:00 PM to 09/11/2022 7:00 AM however the timecards do not identify which specific facilities each of the staff worked at. Ms. Jiggens stated that staff Tricia VanKoevering was on vacation out of state for the week.

On 10/21/2022 I interviewed Staff Da’Kyra McGhee-Monk via telephone. Ms. McGhee-Monk stated on multiple dates in September 2022 she has entered the facility first shift and observed that staff were not assigned to work specifically at the facility. She stated that on these occasions staff from one of the other three licensed facilities on the campus would have been required to check on residents and provide care as needed.

On 10/25/2022 I completed an Exit Conference with Licensee Designee Connie Clauson and informed her of the Special Investigation findings. Ms. Clauson stated she did not disagree with the findings but would request time to examine the Special Investigation Report for further information that may dispute the violations. She stated she would submit an acceptable Corrective Action Plan but would like time to decide whether she would be accepting the issuance of a Provisional License.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	Resident B stated the facility doesn't have enough staff. She stated the facility is typically staffed with one staff for third shift and two staff for first and second shifts. Resident B stated that there have been occasions in which only one staff worked at the facility during the day. She stated she had to wait, "up to 30 minutes or sometimes staff never came at all" after she has used her call button to request staff assistance. Resident C stated he has had to "remind staff" to administer his medications. Resident C stated he typically waits "half an hour" for staff assistance when he uses his call light. Staff Jenica Linburg stated there were a few occasions when one staff person covered two separately licensed facilities during third shift. She stated this was due to staff not showing up and administration not being able to find a replacement. Staff Da'Kyra McGhee-Monk stated on multiple dates in September 2022 she has entered the facility first shift and observed that staff were no staff assigned to work specifically at the facility. She stated that on these occasions staff from one of the other three licensed facilities on the campus would have been required to check on residents and provide care as needed. The facility staff schedule for the September 2022 was poorly constructed and difficult to decipher. The staff schedule was not updated and did not document when all staff started and ended their shifts.

	There is a preponderance of evidence to substance violation of R 400.15206 (1). The Special Investigation findings indicate that the facility has operated third shift with no scheduled staff during the month of September 2022.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED 2022A0583038 (08/5/2022)**

ADDITIONAL FINDINGS: The facility staff schedule lacks required information.

INVESTIGATION: On 09/28/2022 I completed an unannounced onsite investigation at the facility and interviewed Regional Director Amanda Beacham. Licensing Consultant Megan Aukerman was present during the inspection.

Regional Director Amanda Beacham acknowledged the facility has been struggling with a lack of staff however the facility is adequately staffed to provide for residents' needs. Ms. Beacham stated administrative staff have been filling in shifts to assist with resident care. Ms. Beacham stated there have been dates in which administrative staff have assisted with resident care however the facility staff schedule was not updated to reflect this.

On 10/03/2022 I received an email from staff Rebecca Jiggens which contained a staff schedule for September 2022. The staff schedule was poorly constructed, difficult to decipher, was not updated and did not document when all staff started and ended their shifts.

On 10/14/2022 I interviewed staff Rebecca Jiggens via telephone. Ms. Jiggens stated she observed the facility staff schedule appears, "hard to read and doesn't make sense".

On 10/25/2022 I completed an Exit Conference with Licensee Designee Connie Clauson and informed her of the Special Investigation findings. Ms. Clauson stated she did not disagree with the findings but would request time to examine the Special Investigation Report for further information that may dispute the violations. She stated she would submit an acceptable Corrective Action Plan but would like time to decide whether she would be accepting the issuance of a Provisional License.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.**

	(b) Job titles. **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**
ANALYSIS:	Regional Director Amanda Beacham stated administrative staff have been filling in shifts to assist with resident care. Ms. Beacham stated there have been dates in which administrative staff have assisted with resident care however the facility staff schedule was not updated to reflect this. The staff schedule for the September 2022 was poorly constructed and difficult to decipher, was not updated and did not document when all staff started and ended their shifts. Staff Rebecca Jiggens stated she observed the facility staff schedule appears, “hard to read and doesn’t make sense”. There is a preponderance of evidence to substance violation of R 400.15208 (3).
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident A’s Assessment Plan was not completed annually.

INVESTIGATION: On 09/29/2022 I received an email from staff Rebecca Jiggens. The email contained Resident A’s Resident Evaluation form, which was signed by his legal decision maker on 05/16/2022 but lacks the signature of the Licensee Designee or administrator.

On 09/30/2022 I completed a licensing file review and observed that special investigation 2022A0583038 indicates that on 08/5/2022 the facility violated licensing rule 400.1430 (4). The file contained the LARA approved Corrective Action Plan signed by Licensee Designee Connie Clauson on 08/30/2022.

On 10/25/2022 I completed an Exit Conference with Licensee Designee Connie Clauson and informed her of the Special Investigation findings. Ms. Clauson stated she did not disagree with the findings but would request time to examine the Special Investigation Report for further information that may dispute the violations. She stated she would submit an acceptable Corrective Action Plan but would like time to decide whether she would be accepting the issuance of a Provisional License.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Resident A's Resident Evaluation form was signed by his legal decision maker on 05/16/2022 but lacks the signature of the Licensee Designee or administrator. There is a preponderance of evidence to substance violation of R 400.14301 (4).
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED 2022A0583038 (08/5/2022)**

ADDITIONAL FINDINGS: Facility staff did not notify LARA after a resident death.

INVESTIGATION: On 09/27/2022 I completed an unannounced onsite investigation at the facility and privately interviewed staff Robin Rogers and business office manager Ann Hoelsema.

Ms. Rogers stated Resident A died at the facility on 09/11/2022 and hospice was promptly notified of his passing. Ms. Rogers stated she could not locate an incident report regarding Resident A's death and was unsure if another staff had completed the required document.

Ms. Hoelsema stated an incident report regarding Resident A's 09/11/2022 death was "missing", and she did not know if an incident report was completed by any staff.

On 09/28/2022 I completed an unannounced onsite investigation at the facility and interviewed Regional Director Amanda Beacham. Licensing Consultant Megan Aukerman was present during the inspection.

Ms. Beacham stated that Resident A died at the facility and was discovered deceased by facility staff on 09/11/2022. Ms. Beacham stated an Incident Report "was completed, but not sent" to Adult Foster Care Licensing.

On 09/29/2022 I received an email from staff Rebecca Jiggens which contained an Incident Report signed by Licensee Designee Connie Clauson on 09/29/2022. The Incident Report stated, “resident was observed on the floor of his room” on 09/11/2022 at 9:00 am. The Incident Report further stated, “staff observed no respirations, no pulse” and “resident was assisted into bed, hospice + family were notified”.

On 10/25/2022 I completed an Exit Conference with Licensee Designee Connie Clauson and informed her of the Special Investigation findings. Ms. Clauson stated she did not disagree with the findings but would request time to examine the Special Investigation Report for further information that may dispute the violations. She stated she would submit an acceptable Corrective Action Plan but would like time to decide whether she would be accepting the issuance of a Provisional License.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	On 09/28/2022 Regional Director Amanda Beacham stated that Resident A was discovered deceased by facility staff on 09/11/2022. Ms. Beacham stated an Incident Report was completed, but not sent to Adult Foster Care Licensing. There is a preponderance of evidence to substance violation of R 400.15311 (1).

CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS: Resident A did not receive his medications as prescribed.

INVESTIGATION: On 10/11/2022, licensing consultant, Megan Aukerman interviewed staff, Da'Kyra McGhee-Monk by telephone. Ms. McGhee-Monk stated she worked first shift and often provided care to Resident A. She confirmed Resident A was also receiving services through hospice. Ms. McGhee-Monk stated that on 09/10/2022, Resident A was complaining of chest pains and as a result was moved to "high alert" status, meaning staff had to check on him more frequently. Ms. McGhee-Monk contacted his hospice nurse to make them aware. The hospice nurse instructed staff to administer Resident A his morphine every three hours. She also stated she was calling in a prescription for Nitroglycerine. Ms. McGhee-Monk stated she kept the nurse informed on Resident A as well as administration. Ms. McGhee-Monk stated her shift ended at 6:00 pm. Prior to leaving, Ms. McGhee-Monk administered Resident A his morphine at 5:35 pm. Ms. McGhee-Monk also stated she spoke with the manager, informing her of Resident A's next dose and what the hospice nurse said. Ms. McGhee-Monk stated the following morning, when she started her shift, she went to Resident A's room around 8:00 am to get him ready for breakfast. Upon entering his room, she saw that he looked like he had been deceased for several hours, his skin was cold and blue. Ms. McGhee-Monk later learned staff did not work in the facility or check on Resident A during the night. Ms. McGhee-Monk stated Resident A did not get any of his medications he was supposed to.

On 10/13/2022 I received and reviewed an email from staff Rebecca Jiggens. The email contained Resident A's Medication Administration Record and observation notes. Resident A's Medication Administration Record states Resident A is prescribed nitroGLYCERIN (NITROSTAT) 0.4 MG sublingual tablet "Place 1 tablet under the tongue every 5 minutes as needed for Chest pain" and Morphine 100 MG/5ML solution every three hours as need "comfort pack". I observed Resident A was administered one dose of Morphine on 09/10/2022 at an unknown time and was not administered the medication on 09/11/2022. I observed Resident A was not administered nitroGlycerin on 09/10/2022 or 09/11/2022. I reviewed the observation notes indicated Staff Da'Kyra McGhee-Monk observed Residnet A, "was complaining of chest pains and hospice was notified and instructed RCS to give PRN morphine .25mL".

On 10/25/2022 I completed an Exit Conference with Licensee Designee Connie Clauson and informed her of the Special Investigation findings. Ms. Clauson stated she did not disagree with the findings but would request time to examine the Special Investigation Report for further information that may dispute the violations. She stated she would submit an acceptable Corrective Action Plan but would like time to decide whether she would be accepting the issuance of a Provisional License.

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 S333.1101 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:	Staff Da'Kyra McGhee-Monk stated that on 09/10/2022, Resident A was complaining of chest pains and Ms. McGhee-Monk contacted his hospice nurse to make them aware. Ms. McGhee-Monk stated the hospice nurse instructed staff to administer Resident A his morphine every three hours and the hospice nurse stated she was calling in a prescription for Nitroglycerine. Ms. McGhee-Monk stated she administered Resident A his morphine at 5:35 pm. Ms. McGhee-Monk also stated she spoke with the manager, informing her of Resident A's next dose and what the hospice nurse said. Resident A's Medication Administration Record states Resident A is prescribed nitroGLYCERIN (NITROSTAT) 0.4 MG sublingual tablet "Place 1 tablet under the tongue every 5 minutes as needed for Chest pain" and Morphine 100 MG/5ML solution every three hours as need "comfort pack". I observed Resident A was administered one dose of Morphine on 09/10/2022 at an unknown time and was not administered the medication on 09/11/2022. I observed Resident A was not administered nitroGlycerin on 09/10/2022 or 09/11/2022. There is a preponderance of evidence to substance violation of R 400.15312 (1).
CONCLUSION:	**VIOLATION ESTABLISHED**

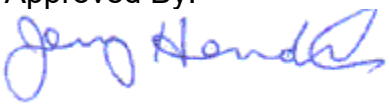
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license be modified to Provisional for the above-cited quality of care violations.

10/25/2022

Toya Zylstra Date
Licensing Consultant

Approved By:



10/25/2022

Jerry Hendrick Date
Area Manager