GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 6, 2023

Paul Wyman
Retirement Living Management of Standale, LLC
1845 Birmingham S.E.
Lowell, MI 49331

RE: License #:	AL700355094
Investigation #:	2023A0356006
	Green Acres of Standale

Dear Mr. Wyman:

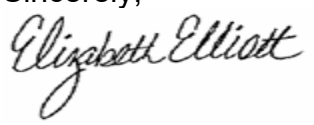
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700355094
Investigation #:	2023A0356006
Complaint Receipt Date:	11/22/2022
Investigation Initiation Date:	11/22/2022
Report Due Date:	01/21/2023
Licensee Name:	Retirement Living Management of Standale, LLC
Licensee Address:	1845 Birmingham S.E. Lowell, MI 49331
Licensee Telephone #:	(616) 897-8000
Administrator:	Liam MacRitchie
Licensee Designee:	Paul Wyman
Name of Facility:	Green Acres of Standale
Facility Address:	11276 - 1st Ave. N.W. Grand Rapids, MI 49534
Facility Telephone #:	(616) 431-3021
Original Issuance Date:	07/28/2014
License Status:	REGULAR
Effective Date:	01/28/2021
Expiration Date:	01/27/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff Kelli Baltrusaitis was rough in her treatment of residents at the facility.	Yes

III. METHODOLOGY

11/22/2022	Special Investigation Intake 2023A0356006
11/22/2022	Special Investigation Initiated - Telephone Liam MacRitchie, administrator, and regional consultant, Kelly Nelson.
11/22/2022	Contact-Document received
11/22/2022	APS Referral Denied for investigation.
12/06/2022	Contact - Face to Face Resident A, Relative #1.
12/06/2022	Contact - Face to Face Liam MacRitchie & Kelly Nelson.
12/13/2022	Contact - Telephone call made DCW Ce'Ericka Chriss.
12/20/2022	Contact - Telephone call made DCW Kelli Baltrusaitis.
01/12/2023	Contact-Face to Face Liam MacRitchie & Kelly Nelson
01/12/2023	Contact-Face to Face DCW interviews
01/13/2023	Contact-Face to Face Resident interviews
01/16/2023	Contact-Document received Skin assessments, IR
01/19/2023	Contact-Telephone call made

	Centralized Intake re: new allegations
01/19/2023	Contact-Telephone call made DCW Mary Rogers.
02/01/2023	Contact-Telephone call received DCW Stacy Newcomb.
02/06/2023	Exit Conference-Kelly Nelson, Regional Consultant as approved by LD, Paul Wyman.

ALLEGATION: Staff Kelli Baltrusaitis was rough in her treatment of residents at the facility.

INVESTIGATION: On 11/22/2022, I received a BCAL (Bureau of Children and Adult Licensing) online complaint. The complainant reported on 11/11/2022, Resident A asked DCW (direct care worker) Ce'Erica Chriss, day shift worker, to be gentle with her while assisting Resident A with going to and from the bathroom. The complainant reported the evening shift worker on 11/10/2022, Kelli was rough in an unknown manner while providing care to Resident A. The complainant reported that Resident A requires a one-person assist and hands-on assistance with lifting her legs up and being moved to the bed. Adult Protective Services denied this allegation for investigation.

On 11/22/2022, I interviewed Liam MacRitchie, Administrator and Kelly Nelson, Regional Consultant via telephone. Mr. MacRitchie stated he was informed by staff at the facility that Resident A had complained that staff on the evening shift on 11/10/2022, was rough with her. Mr. MacRitchie stated an Incident Report was written and he conducted an internal investigation that resulted in staff, Kelli Baltrusaitis being suspended for three working days because of interactions with co-workers and due to the concern reported in this complaint.

On 11/22/2022, I reviewed the Incident Report (IR) dated 11/11/2022, signed by Mr. MacRitchie. The IR documented the following information, *'Employee Ce'Erica Chriss stated to writer (DCW Pilar Kent) (Resident A's) husband (Relative #1) told me that Kelli on second shift has been rough with (Resident A) and was crying. (Relative #1) said he has said something about Kelli before. Administrator was notified. Employee suspended for 3 working days.'*

On 12/06/2022, I conducted an unannounced inspection at the facility and interviewed Resident A in her room. Present during the interview was Relative #1 and Relative #2. Resident A stated she does not remember any staff including Ms. Baltrusaitis who may have treated her roughly while providing care. Relative #1 stated, "someone tossed her around" on 2nd shift but is not willing or able to state staff by name. Relative #1 stated he encountered issues with Ms. Baltrusaitis when it

came to food and pills for Resident A and that, “Kelli insisted she was going to do it her way.” Relative #1 explained that Ms. Baltrusaitis insisted on giving Resident A her medications at certain times when Relative #1 wanted them administered at a different time. Relative #1 stated he gave Resident A her medications a certain way and at specific times at home when he cared for her, and Ms. Baltrusaitis was not doing that. Relative #1 stated he spoke to the administrator about his concerns at the time he had them. Relative #2 stated she has no information to add.

On 12/13/2022, I interviewed Ms. Chriss via telephone. Ms. Chriss stated she was assisting Resident A on first shift and Resident A asked her not to be rough with her. Resident A reportedly told Ms. Chriss that the girls last night (11/10/22) were very rough with her, specifically Kelli and that she plops her on the toilet, plops her in her chair, leaves her alone to get in her chair, jerks her up and is not patient with her. Ms. Chriss stated Resident A said the same thing to Relative #1 which made him concerned so he told her (Ms. Chriss) about it. Ms. Chriss stated Relative #1 was teary eyed and concerned. Ms. Chriss stated Resident A reported that Ms. Baltrusaitis talks mean to her, and that Resident A said she would have her husband “pop her in the mouth” if she keeps talking to her like that. Ms. Chriss stated she has seen and heard of Ms. Baltrusaitis being rough with other residents. Ms. Chriss suggested interviewing other residents of the facility because several of them have had issues with Ms. Baltrusaitis.

On 12/20/2022, I interviewed Ms. Baltrusaitis via telephone. Ms. Baltrusaitis stated she has worked at this facility since 2017 and works 2nd shift, 3:00p.m.-11:00p.m. Ms. Baltrusaitis stated she is a “med passer” and the DCW’s (direct care workers) put Resident A to bed that she does not put Resident A to bed. Ms. Baltrusaitis stated she tries not to do any of the direct cares of residents because she passes the medications, so she only interacts with Resident A at 3:00p.m. and 8:00p.m. when it is medication time. Ms. Baltrusaitis stated she does assist the DCW’s if it is minor, no heavy lifting and never has been rough with any of the residents including Resident A. Ms. Baltrusaitis stated she was not rough with Resident A on the evening of 11/10/2022 because she did not assist with putting her to bed.

On 01/12/2023, After conducting the renewal inspection at the facility, I was interviewing other residents for this complaint investigation. While at the facility, I received a written statement from DCW Bryan Haarsma with the following complaint information regarding Ms. Baltrusaitis and Resident B: *‘At approximately 8:15p.m.-8:30p.m. on 01/10/2023, DCW (*Bryan Haarsma*) was finishing passing med and a resident was having an anxiety episode in the activity room. DCW (*Haarsma*) went and told the resident that someone will be right with her and DCW (*Haarsma*) put a movie on for the resident which seemed to help calm her down for a little bit. DCW went back and started passing meds again and resident started having another anxiety episode and before this DCW (*Haarsma*) could go back into the activity room another DCW* (Kelli Baltrusaitis) *went storming into the activity room and grabbed the resident by her right arm and pulled the resident up and said let’s go you’re going to bed. Resident kept yelling, “STOP THAT HURTS.” DCW* (Baltrusaitis) *kept*

*dragging the resident by her arm to the point the resident almost fell while dragging her cane along with. DCW (Haarsma) told the DCW (*Baltrusaitis) *that we don't do it that way and DCW (*Baltrusaitis) *said I do. Resident was eventually put to bed and did not fall asleep until after we ended our shift at 11:00p.m. due to her anxiety being out of control.*'

On 01/12/2023, I interviewed Mr. Haarsma at the facility. Present in the office during this interview were Mr. MacRitchie and Ms. Nelson. Mr. Haarsma and I reviewed his statement, and he stated that the information documented in the written statement is accurate, that he wrote and signed the statement. Mr. Haarsma stated Ms. Baltrusaitis is verbally and physically rough with the residents. Mr. Haarsma stated Ms. Baltrusaitis picks who she will care for and who she will not take care of. She has called residents "lucifer" and "pain in the butt" to the residents so they can hear her say that about them. Mr. Haarsma stated Resident B was in the activity room with Resident C when this incident dated 01/10/2023 occurred and while Resident B will not be able to recall any of the details due to cognitive deficits, Resident C was present and should be able to. Mr. Haarsma stated he did not see any bruises on Resident B after the incident on 01/10/2023 but Ms. Nelson stated she saw a "purple-ish" bruise on the back of Resident B's upper right arm. In addition, Mr. Haarsma stated he responded to a pulled cord call from Resident D and upon entering the resident's room, the resident said, "oh, thank God it's not her, she's so rough with me, I can't stand it." Mr. Haarsma questioned Resident D about what staff she was talking about, and the resident described Ms. Baltrusaitis. Mr. Haarsma reported Resident E is nonverbal and refuses to take her medications, so Ms. Baltrusaitis will force Resident E to take her medications by putting them on her finger and putting them into Resident E's mouth. Mr. Haarsma stated Ms. Baltrusaitis will not check or change Resident E's brief and even though Resident E is a two person assist, she (Ms. Baltrusaitis) will move her using a Hoyer, all by herself.

On 01/12/2023, I interviewed DCW Brittanee Vantuinen at the facility. Present during this interview was Mr. MacRitchie and Ms. Nelson. Ms. Vantuinen stated she has worked at the facility since March 2022 and works with Ms. Baltrusaitis often. Ms. Vantuinen stated Ms. Baltrusaitis is verbally "mean" to the residents and has heard Ms. Baltrusaitis say to Resident F, "You can do it" in a mean tone when he needed her help getting into his wheelchair, and instead of assisting him, she told him he can do it himself. Ms. Vantuinen stated Ms. Baltrusaitis made a resident put her legs up and applied lotion to the resident's legs after the resident told Ms. Baltrusaitis not to touch her. Ms. Vantuinen stated residents have told her (Ms. Vantuinen) they are afraid of Ms. Baltrusaitis. Ms. Vantuinen did not witness or have any information regarding the 1/10/2023 incident Mr. Haarsma reported.

On 01/12/2023, I interviewed DCW Julian Gonzalez via telephone. Mr. Gonzalez stated he has worked at the facility for one month. Mr. Gonzalez stated he was assisting Resident G with standing, and the resident was struggling so he (Mr. Gonzalez) asked Ms. Baltrusaitis for help with getting Resident G up. Mr. Gonzalez stated Ms. Baltrusaitis began to yell at Resident G to "stand up, do it on your own"

and when Ms. Baltrusaitis left the room, Mr. Gonzalez stated to Resident G, “you looked scared” and Resident G said to Mr. Gonzalez, “eh, that’s just how she is.”

On 01/12/2023, After conducting interviews in the office with Mr. MacRitchie and Ms. Nelson, Ms. Nelson stated she was glad staff were coming forward with their concerns but troubled because she had not been made aware by staff of the number of concerns they had. Ms. Nelson stated on 01/11/2023, she looked at the bruise on Resident B’s arm and noted a bruise that was long and thin, purple in color and to her (Ms. Nelson), appeared fresh on the back of Resident B’s right tricep. Ms. Nelson stated DCW Mary Rogers was present in the room when she was looking at the bruise, and Ms. Rogers told Ms. Nelson she thought the bruise was old and had been on Resident B’s arm prior to the reported incident on 01/10/2023.

On 01/13/2023, I received and reviewed a picture of the bruise on Resident B’s right arm. I also interviewed Resident B at the facility and inspected her arm. Resident B stated she does not know who Ms. Baltrusaitis is and she has no idea how she got the bruise on her arm and stated possibly she got it by “bumping it.” The bruise was long in shape in the middle, up and down on the back of Resident A’s right arm and dark purple in color. I observed bruising around the outside of the purple bruise that was circular in shape and a very light, yellow color resembling a healing bruise.

On 01/13/2023, I reviewed an Incident Report (IR) dated 12/17/2022, written by DCW Deondre Wilson and signed by Mr. MacRitchie. The incident occurred on 12/16/2022 at 1:20a.m. and documented the following events, ‘*Resident (*B*) was in bathroom area yelling for assists, she stated she fell and hit her head and arm. She kept saying she “was fine but her head hurts.” Contacted 911, sent resident to Spectrum hospital for complete care. Fall from ground level.’*

On 01/13/2023, I interviewed DCW Bonnie King at the facility. Ms. King stated Ms. Baltrusaitis is “gruff” with residents and Ms. Baltrusaitis has taken Resident F’s wheelchair from him so he could not get up.

On 01/13/2023, I interviewed other Residents at the facility. The following documents information gathered from the interviews regarding staff at the facility and more specifically, Ms. Baltrusaitis’ treatment and care of each resident.

- Resident C stated she does not remember an incident in the activity room involving Resident B and Ms. Baltrusaitis. Resident C stated she did not see or witness Ms. Baltrusaitis lead Resident B to her room by holding or grabbing her arm. Resident C stated she did not hear Resident B say, “stop, you’re hurting me” and does not recall anything about an incident such as that. Resident C stated the staff at the facility are “great” and she has no concerns about any of the staff including Ms. Baltrusaitis. Resident C added “Ms. Baltrusaitis, she’s rough and too verbal with Liam (administrator).”
- Resident D stated she has had “a couple” staff that were rough in their care of her, but she would “rather not blame people” and she would “rather not be a

part of this" interview. Resident D stated she does not want to get any one in trouble, but that Ms. Baltrusaitis thought she was encouraging her (Resident D) to be more independent when she would tell her to get dressed, to obey what she was telling her and that she could do it herself but Resident D stated, Ms. Baltrusaitis was not helping, she was just telling "how to do things myself, when all I needed was help, not to learn how to do it." Resident D stated she was not afraid of Ms. Baltrusaitis. Resident D stated she thought Ms. Baltrusaitis thought she was doing the right thing. Resident D stated "she thinks she is helping, she's not mean spirited, she just got annoyed easily." Resident D stated, "I thought she (Ms. Baltrusaitis) was trying to help me, but I prefer someone else over her."

- Resident E is nonverbal and unable to participate in an interview.
- Resident F stated staff are ok including Ms. Baltrusaitis. Resident F said "no" when asked if Ms. Baltrusaitis took his wheelchair so he could not get up.
- Resident G was not interviewed.
- Resident H stated all staff are "pretty good, even Kelli, we joke around a lot." Resident H stated he has never gotten poor care or rough care from any of the staff at the facility including from Ms. Baltrusaitis.
- Resident I stated Ms. Baltrusaitis is a "pretty nice person." Resident I stated it is possible that Ms. Baltrusaitis is rough with other residents but, "not with me." Resident I stated she treats him well and is always nice to him.
- Resident J stated she has never had one mean staff, but there is one staff that is "a little short" but she is "not going to say" what staff it is because she "doesn't want to get anyone in trouble." Resident J then stated, "staff Kelli (Baltrusaitis), out of all of them is iffy, but I'm fine with her, she's ok." Resident J stated everyone has good days and bad days, so she is fine with all staff at the facility.

On 01/16/2023, I reviewed an IR dated 01/04/2023 at 9:00p.m., written by DCW, Juana Hernandez. The IR documented the following information, '*While staff was assisting the resident in the shower, staff observed a bruise on their right arm. Filled out a skin assessment, an IR and notified on call.*'

On 01/16/2023, I reviewed an IR dated 01/10/2023, written by Brian Haarsma detailing the events reported to me on 01/12/2023 by Mr. Haarsma. The IR is signed by Mr. MacRitchie and on the IR is documented that Ms. Baltrusaitis was terminated from employment on 01/13/2023.

On 01/16/2023, I received and reviewed skin assessments for Resident B. The skin assessment dated 12/16/2022 documented, '*red skin irritation on right forearm, possible bruise developing from fall.'* Skin assessments dated 12/17/22, 01/03/2023, 01/07/23, 01/11/23, 01/14/23 and 01/18/23 do not document a bruise on the back of Resident B's arm.

On 01/19/2023, I interviewed Ms. Baltrusaitis via telephone regarding the latest allegations. Ms. Baltrusaitis stated she is "old school" and that caused friction with

the younger staff at the facility. Ms. Baltrusaitis stated she believes when you come to work, you are not on your phone, you are not doing homework and you are not under the influence of substances so she would say things to staff and that caused issues. Ms. Baltrusaitis stated she knew nothing about the reported incident with Resident B and stated the way the incident was reported is not how it happened at all. Ms. Baltrusaitis stated Resident B was “having a meltdown” with anxiety in the activity room, Resident B was sitting on the couch and Ms. Baltrusaitis stated she held her hand out and said “here, I’ll help you up.” Ms. Baltrusaitis stated that she never grabbed Resident B by her arm but rather assisted her to her room by holding Resident B’s left hand with her right hand so Resident B could use her cane to walk down the hall. Ms. Baltrusaitis stated Resident B said at one point, “you’re walking a little too fast,” so she slowed down and never did Resident B say “stop, you’re hurting me.” Ms. Baltrusaitis stated she proceeded to assist Resident B with getting ready for bed, showed her how to brush her teeth, and got her into bed. Ms. Baltrusaitis stated she never grabbed Resident B by the upper arm and did not leave that bruise on her. Ms. Baltrusaitis stated the bruise on Resident B’s arm was there, it was an old bruise from a fall she had and hit her arm. Ms. Baltrusaitis stated Resident C often helps by taking Resident B walking up and down the hallways to calm her down. Ms. Baltrusaitis stated Resident C and DCW Stacy Newcomb was present in the activity room and witnessed what occurred and knows she did not harm Resident B. Ms. Baltrusaitis stated she was not verbally or physically aggressive with any of the residents at this facility including Resident’s A or B. Ms. Baltrusaitis stated it does not matter anymore because she is no longer working at this facility.

On 01/19/2023, I interviewed DCW Mary Rogers via telephone. Ms. Rogers stated Resident B had a bruise from a month or two ago on the back of her right upper arm, definitely prior to the latest incident reported with Resident B and Ms. Baltrusaitis. Ms. Rogers stated the bruise was large and in the yellow/brown stage of healing and the bruise reported on the latest incident could be the bruise from that time. Ms. Rogers stated she was in the room when Ms. Nelson came in and looked at Resident B’s bruise and she thought it was the same bruise from when Resident B fell but there is always a possibility that it could be a new bruise too. Ms. Rogers stated she has never heard Ms. Baltrusaitis call residents names, but she has witnessed mostly “aggression and lack of patience with the residents.” Ms. Rogers stated Ms. Baltrusaitis does not have a “soft hand.” Ms. Rogers stated Ms. Baltrusaitis yelled at the residents to stand up even when they couldn’t and intimidated staff verbally.

On 02/01/2023, I interviewed DCW Stacy Newcomb via telephone. Ms. Newcomb stated she did not see or hear anything happening on 01/10/2023 in the activity room involving Resident B and Ms. Baltrusaitis. Ms. Newcomb stated she heard staff talking about it but was not a witness to anything that may or may not have occurred. Ms. Newcomb stated Resident C is “very keen” and if anything went wrong on the night of 01/10/2023 with Resident B and Ms. Baltrusaitis, Resident C would have told someone and if she does not remember anything happening, then she was not

a witness to it or it did not occur. Ms. Newcomb stated she enjoyed working with Ms. Baltrusaitis, that Ms. Baltrusaitis went the extra mile to provide kind care to the residents and took the time to talk to them.
On 02/06/2023, An exit conference was conducted with Ms. Nelson via telephone. Ms. Nelson stated she accepts the information, analysis, and conclusion of the applicable rule.

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:	The complainant reported Ms. Baltrusaitis had been rough in her treatment of residents in the facility. Several staff reported observing Ms. Baltrusaitis being rough in her treatment of residents in the facility. Ms. Baltrusaitis denied being rough in her treatment of the residents. Three residents stated Ms. Baltrusaitis' care was fine and they did not want to get anyone in trouble while two residents reported Ms. Baltrusaitis had been rough in her treatment of them. Based on investigative findings, there is a preponderance of evidence to show that Ms. Baltrusaitis did not treat the residents with dignity and respect while caring for them and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

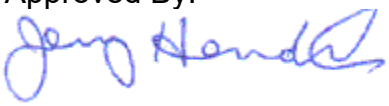
Elizabeth Elliott

02/06/2023

Elizabeth Elliott Date

Licensing Consultant

Approved By:



02/06/2023

_____

Jerry Hendrick Date
Area Manager