GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 12, 2023

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

RE: License #: AL410289606
Investigation #: 2023A0464035
Yorkshire Manor - East

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,

Megan Aukerman, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410289606
Investigation #:	2023A0464035
Complaint Receipt Date:	04/10/2023
Investigation Initiation Date:	04/10/2023
Report Due Date:	06/09/2023
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:	Yorkshire Manor - East
Facility Address:	3511 Leonard St. NW Walker, MI 49534
Facility Telephone #:	(616) 791-9090
Original Issuance Date:	10/31/2012
License Status:	REGULAR
Effective Date:	04/30/2021
Expiration Date:	04/29/2023
Capacity:	20
~~**Program**~~ **Type:**	PHYSICALLY HANDICAPPED AGED/ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility does not have sufficient staff to meet resident needs. On more than one occasion, the facility did not have any staff working from 11:00 pm to 7:00 am.	Yes
Residents are left in bed for several hours per day, sitting in soiled clothes and linens.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/10/2023	Special Investigation Intake 2023A0464035
04/10/2023	APS Referral
04/10/2023	Special Investigation Initiated - Telephone Emily Graves, Kent County APS
04/14/2023	Contact-Document received Stephen Conrad, Kent County APS
04/14/2023	Inspection Completed On-site Emily Graves (Kent County APS), Stephen Conrad (Kent County APS), Julie Treakle (Manager), Kelly Smith (Regional Director), Val Katona (Staff), and Resident A
04/14/2023	Contact-Document received Facility Records
04/21/2023	Contact - Telephone call made Relative B
04/28/2023	Inspection Completed-Onsite Drew Blackall (Kent County APS), Connie Clauson (licensee Designee), Julie Treakle (Administrator), Belinda Pettis (Staff), Brajama Richardson (Staff) and Resident C
04/28/2023	Contact-Telephone call received Emily Graves, Kent County APS
05/01/2023	Contact-Document received Additional Information

05/01/2023	Contact-Telephone call received Relative B
05/08/2023	Contact-Document sent Julie Treakle, Administrator
05/10/2023	Inspection Completed-Onsite Julie Treakle, Administrator
05/11/2023	Contact-Document received Records
05/12/2023	Exit Conference Connie Clauson, Licensee Designee

ALLEGATION: The facility does not have sufficient staff to meet resident needs. On more than one occasion, the facility did not have any staff working from 11:00 pm to 7:00 am.

INVESTIGATION: On 04/10/2023, I received an online BCAL complaint which alleged the facility does not have sufficient staff. As a result, residents have been left with no one to care for them. The facility reportedly "shares" staff with the neighboring AFC facility (Yorkshire Manor-West). When facility staff are present, there are not enough to meet the resident's needs. Residents are left lying in soiled clothes and linens for up to eighteen hours a day. Residents are not being bathed or showered.

On 04/10/2023, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 04/10/2023, I spoke with Kent County APS worker, Emily Graves to coordinate the investigation.

On 04/14/2023, I received a new complaint from Kent County APS worker, Stephen Conrad. The complaint alleged Resident A is not receiving staff assistance for wound cleaning and catheter changing. A separate investigation was initiated under SIR 2023A0464039.

On 04/14/2023, Mrs. Graves, Mr. Conrad and I completed an unannounced, onsite inspection at the facility. We interviewed newly appointed business manager, Julie Treakle. Ms. Treakle stated she just started working at the facility four days prior; however, her mother resides in the facility. Ms. Treakle stated the facility (Yorkshire Manor-East) is one of four facilities on campus (Stonebridge Manor-North, Stonebridge Manor-South, Yorkshire Manor-East, and Yorkshire Manor-West). Ms.

Treakle stated fifteen residents currently reside in Yorkshire Manor-East. She stated residents in Yorkshire Manor-East require the more staff assistance than the other facilities. The residents may be difficult to interview as most suffer from Alzheimer's Disease and other debilitating conditions. Ms. Treakle stated she has noticed there appears to be issues with staffing and was informed there have been occasions when the facility did not have any staff and staff from adjoining buildings had to come and care for the residents. Mrs. Treakle stated she is currently working on developing a new scheduling system.

Ms. Graves, Mr. Conrad, and I then interviewed Baruch regional director, Kelly Smith. Ms. Smith stated she is working at the facility to address the current staffing concerns. Ms. Smith stated she is aware of recent incidents when the facility did not have any staff to fill a shift at Yorkshire Manor-East. Ms. Smith stated to rectify the issue, she has staff coming from other Baruch locations to fill needed shifts. She has also signed contracts with two outside staffing companies, Clipboard and Interim.

We then interviewed facility staff Val Katona. Ms. Katona stated she primarily works in Yorkshire Manor-West but has worked in all four facilities. Mrs. Katona stated the facility is struggling to find staff. Ms. Katona stated she has worked several shifts alone and has had to work in Yorkshire Manor-East and Yorkshire Manor-West simultaneously. Ms. Katona stated when she had to "run over" to Yorkshire Manor-East, she had to leave the phone on speaker and take her cell phone with her so that she could hear if anyone needed assistance in West, while she was caring for residents in East. She stated the residents who reside in Yorkshire Manor-East require a lot of care. Ms. Katona stated there was one weekend where she was the only staff person for East and West; therefore, she called her husband in to sit with the residents in West, while she provided care to residents in East. Mrs. Katona confirmed her husband is not a Baruch Employee and has not completed training.

Mr. Conrad then interviewed Resident A privately. Resident A reported staffing is a "big issue". She stated when she calls for staff assistance, she is often left waiting for long periods of time.

On 04/14/2023, I received and reviewed the staff schedules for March and April 2023. The schedule reflects the facility is consistently staffed with two resident care aids from 7:00 am to 11:00 pm. The schedule reflects there were no staff working on 03/24/2023, 03/30/2023, 03/31/2023 and 04/02/2023 from 11:00 pm to 7:00 am. On these occasions, the facility used a "floater" staff person who simultaneously worked between Yorkshire Manor-West and Yorkshire Manor-East.

On 04/21/2023, I spoke with Relative B, by telephone. She stated her brother went to visit Resident B on 03/30/2023 and called Relative B because there was no staff in the facility. Relative B stated she called the administrator at the time to inform her.

On 04/28/2023, I completed an unannounced, onsite inspection at the facility. I met with licensee designee, Connie Clauson, and Ms. Treakle. Ms. Clauson stated Ms. Treakle will be the newly appointed facility administrator. Ms. Clauson stated the facility and surrounding units are currently infected with Covid-19. Ms. Clauson acknowledged the facility is experiencing a staff crisis and as a result Ms. Clauson has been working out of the facility. Ms. Clauson has reportedly been working with Ms. Treakle on the new scheduling system. She reports they are making "radical" changes from previous scheduling systems. She stated they have begun to schedule a few "back-up" staff each shift, in case there is a staff person who calls in.

I then interviewed facility staff, Belinda Pettis and Brajama Richardson. Both staff stated they have worked at the facility for a few months. Ms. Pettis and Ms. Richardson both stated there was a period of time where the facility did not have enough staff to meet all of the resident's needs; however, they said it "seems to be getting better".

On 04/28/2023, I received a phone call from on-call APS worker, Emily Graves. Ms. Graves stated she received a new complaint, alleging there were no staff scheduled to come in for the night shift. Ms. Graves stated she would provide further information when received.

On 05/01/2023, additional information was received through BCAL Online Complaints, under intake #194908. The complaint alleged there were numerous shifts over the past few months when staff called in to work and there was no staff to care for the residents. On 04/29/2023, Relative C was reportedly told by the administrator that none of the scheduled staff showed up to work their shift and there was only one staff person working on both Yorkshire Manor-East and Yorkshire Manor-West. As of 10:00 pm, none of the residents were ready for bed or administered their evening medications. The complaint was dismissed, as allegations related to inadequate staffing are being addressed under SIR 2023A0464035.

On 05/01/2023, I spoke with Relative B. She stated she was at the facility both Saturday (04/29/2023) and Sunday (04/30/2023). Relative B stated when she arrived at the facility both mornings, around 8:00 am, residents had not yet been taken out of bed or given breakfast. Relative B stated there was not enough staff working to care for the residents. Relative B stated she and other relatives of residents were helping staff get residents out of bed, dressed and fed. Relative B stated some of the residents require a Hoyer lift and the staff working did not know how to operate the lift. Relative B expressed concern regarding resident safety due to lack of staffing.

On 05/10/2023, I completed an unannounced, onsite inspection at the facility. I met with Ms. Treakle. She stated she would gather all of the residents' Assessment Plans. Ms. Treakle expressed excitement because she hired new staff to work at the facility.

On 05/11/2023, I received and reviewed resident Assessment Plans for all twelve residents. The Assessment Plans reflected there are only two residents in the facility that are able to move independently and do not require staff assistance with ADL's. The plans reflect ten residents require a minimum of a one person staff assist with ADL's.

The Assessment Plans further reflect that Residents A, B, C, D, E, F and G all require a two-person assist with transfers and assistance with ADL's. The plans for Residents D, E, F and G state a two-person assist, with a Hoyer lift is required for transfers.

On 05/12/2023, I completed an exit conference with Ms. Clauson. She was informed of the investigation findings and recommendations. Ms. Clauson stated since staff issues were brought to her attention, she has implemented several positive changes at the facility. Ms. Clauson stated individuals have expressed noticing the changes for the good. Ms. Clauson provided an understanding of the rule violations and stated a corrective action plan would be submitted. Ms. Clauson stated she would also provide documentation on whether or not Baruch would accept the recommendation 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:	On 04/10/2023, a complaint was received alleging there were occasions when the facility did not have any staff. Staff Julie Treakle and Val Katona stated the facility does not have enough staff. They reported there have been occasions when there have been no staff working in the facility; therefore, staff from the neighboring facility (Yorkshire Manor-West) had to be pulled over; working both Yorkshire Manor-West and Yorkshire Manor-East simultaneously. Facility schedules for March and April 2023 reflected there were several evening shifts when there was only a "floater staff "scheduled to simultaneously work at both the East and West facilities.

	Resident A disclosed the facility does not have enough staff. Relatives B and C reported they have provided care to residents while visiting the facility, due to lack of staff. Based on the investigative findings, there is sufficient evidence to support a rule violation that the facility is not sufficiently staffed.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On 04/10/2023, a complaint was received, alleging the facility does not have sufficient staff to meet residents' needs. Staff Val Katona, Belinda Pettis and Brajama Richardson all reported the facility has not had enough staff to meet the needs of the residents. Resident Assessment plans were reviewed and reflected seven of the twelve residents require a two-person staff assist with Activities of Daily Living (ADL's). Four of the seven residents require a two-person assist with the use of a Hoyer lift for transfers. Based on the investigative findings, there is sufficient evidence to support a rule violation that the facility is not adequately staff to meet the care needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are left in bed for several hours per day, sitting in soiled clothes and linens.

INVESTIGATION: On 04/14/2023, Ms. Graves, Mr. Conrad and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Treakle and Ms. Smith. Ms. Treakle stated she has only worked at the facility for four days. Ms.

Treakle stated there are currently fifteen residents residing in the facility, and all require staff assistance. She and Ms. Smith acknowledged there has not been enough staff to provide adequate care for the residents. Ms. Smith stated they are actively taking measures to obtain more staff.

Ms. Graves, Mr. Conrad, and I then interviewed Ms. Katona. Ms. Katona stated she primarily works in Yorkshire Manor-West but has covered both Yorkshire Manor-West and Yorkshire Manor-East by herself. Ms. Katona stated most of the residents in the East building have been diagnosed with dementia and are unable to care for themselves. In addition, most of the residents are in wheelchairs and require staff assistance with transfers. Ms. Katona stated when there are not enough staff, the residents do not get the care they need.

Mr. Conrad interviewed Resident A, privately. Resident A reportedly informed Mr. Conrad that she requires staff assistance with wound and catheter care. Resident A informed Mr. Conrad she has to remind staff what they need to do and has waited for long periods of time to receive any staff assistance. Additional interview content is documented in SIR 2023A0464039.

On 04/21/2023, I spoke with Relative B by telephone. Relative B expressed concerns regarding a lack of care residents receive. Relative B stated she has visited the facility on numerous occasions to spend time with Resident B. While visiting, Relative B has reportedly witnessed several residents lying in bed for several hours a day. Relative B stated the residents are not being bathed or dressed and she has washed hair for residents and helped them get out of their beds. Relative B stated she even started doing activities with other residents in the facility, so that they could get out of their rooms. Relative B stated that due to the lack of care Resident B has received, she has obtained Hospice services for her mother so that additional professionals in the facility can care for Resident B. Relative B stated Resident B receives showers from Hospice staff because the facility staff do not give Resident B showers.

On 04/28/2023, I completed an unannounced, onsite inspection at the facility. Ms. Treakle and Ms. Clauson stated several residents have recently tested positive for Covid-19. They stated Resident D has completed the recommended CDC quarantine guidelines. I then made face-to-face contact with Resident D. Attempts were made to interview Resident D; however, she would not speak. Resident D was observed to be laying in her chair. She was clean and appropriately dressed. Her bedroom was observed to be clean and appropriately furnished. No concerns were observed.

I then observed other resident bedrooms, the dining room and kitchen. All living spaces were observed to be clean and appropriately furnished. Clean linens were observed on resident beds. There were no concerns observed.

I then interviewed staff Belinda Pettis and Brajama Richardson. Both staff stated they have worked at the facility for approximately six months. Both stated the residents in the facility require at least a “one person assist” for personal care and transfers. Some require use of a Hoyer when transferring. Ms. Pettis and Ms. Richardson stated there were weeks where “it was really bad”, meaning the facility did not have enough staff to meet all of the residents needs. Residents were waiting longer to receive care. Both staff stated it appears to be getting better as more staff are being hired.

On 04/30/2023, Relative C stated Resident C currently has Covid-19. Resident C also suffers from Dementia, is hard of hearing, has poor vision and is incontinent. Resident C requires staff assistance with ambulating, toileting, and other activities of daily living (ADL). Relative C visited the facility on 04/29/2023. Relative C stated there were no staff to care for the residents. There was only one staff person working between Yorkshire Manor-East and Yorkshire Manor-West. As a result, Resident C, including other residents were left in bed. When Relative C left the facility around 10:00 pm, residents had not yet received assistance with getting ready for bed.

On 04/01/2023, I spoke with Relative B by telephone. Relative B stated there were not enough staff over the weekend and as a result residents were not being dressed, toileted, or groomed. Relative B stated she, along with other relatives, provided assistance to other residents, helping them with dressing, transferring and other ADLs.

On 05/12/2023, I completed an exit conference with Ms. Clauson. She was informed of the investigation findings and recommendations. Ms. Clauson provided an understanding of the rule violations and stated a corrective action plan would be submitted.

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:	On 04/10/2023, a complaint was received alleging residents are left in bed for several hours per day. They are left in soiled linens and clothing. Facility staff Julie Treakle, Val Katona, Belinda Pettis and Brajama Richardson all reported the residents all require staff assistance with Activities of Daily Living (ADL). Due to a lack of

	facility staff, residents have had to wait long period of time, before receiving staff assistance. Resident A was interviewed and reported she requires assistance with ADLs, specifically wound and catheter care. Resident A stated she frequently waits for long periods of time to receive staff assistance. Relative B and Relative C stated they have witnessed several residents confined to their bed due to lack of staff assistance. Both relatives stated they have provided resident care while visiting the facility. Based on the investigative findings, there is sufficient evidence to support a rule violation that resident care needs are not being met.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Untrained individuals provided resident care.

INVESTIGATION: On 04/14/2023, Ms. Graves, Mr. Conrad and I completed an unannounced onsite inspection at the facility. We interviewed Ms. Katona privately. Ms. Katona stated there was a weekend recently when she was working Yorkshire Manor-East and Yorkshire Manor-West alone. Ms. Katona stated there are around fifteen residents in each facility. She stated the residents in East require more staff assistance than West. Ms. Katona stated during her weekend shift, no other staff showed up for work. As a result, she was running back and forth between units. Ms. Katona stated she ended up having her spouse, who is not a facility employee come in during her shift. She had him sit with the residents in Yorkshire Manor- West, while she provided care to residents in Yorkshire Manor-East.

On 04/21/2023 and 05/01/2023, I spoke to Relative B by telephone. Relative B stated while visiting Resident B at the facility, she has witnessed several residents in need of care. There were not enough staff to provide care to the residents; therefore, she and other relatives assisted with dressing and transferring other residents.

On 05/12/2023, I completed an exit conference with Ms. Clauson. She was informed of the investigation findings and recommendations. Ms. Clauson provided an understanding of the rule violations and stated a corrective action plan would be submitted.

APPLICABLE RULE	
400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(a) Reporting requirements.** **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	During the investigation, it was discovered individuals who are not considered to be facility employees, were providing resident care, due to lack of staffing. Staff Val Katona reported she recently worked weekend shifts where she was the only staff between Yorkshire Manor-East and Yorkshire Manor-West. She reported having her husband come to the facility during her shift to monitor residents, while she cared for others. Relative B was interviewed and reported on more than one occasions she assisted residents with transfers, grooming and dressing. Based on the investigative findings, there is sufficient evidence to support a rule violation that the facility did not have trained staff performing resident care.
CONCLUSION:	**VIOLATION ESTABLISHED**

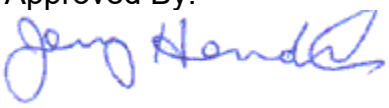
IV. RECOMMENDATION

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

05/12/2023

Megan Aukerman Date
Licensing Consultant

Approved By:



05/12/2023

Jerry Hendrick — Date
Area Manager