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 #: 2023A0464039
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 #:** | 2023A0464039 |
| | |
| **Complaint Receipt Date:** | 04/14/2023 |
| | |
| **Investigation Initiation Date:** | 04/14/2023 |
| | |
| **Report Due Date:** | 06/13/2023 |
| | |
| **Licensee Name:** | Baruch SLS, Inc. |
| | |
| **Licensee Address:** | Suite 203<br>3196 Kraft Avenue SE<br>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<br>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<br>AGED/ALZHEIMERS |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| Facility staff leave Resident A laying in her bed with soiled clothes and linens. | Yes |
| Facility staff are not cleaning and dressing Resident A's pressure ulcer. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 04/14/2023 | Special Investigation Intake<br>2023A0464039 |
| 04/14/2023 | APS Referral |
| 04/14/2023 | Special Investigation Initiated - Face to Face<br>Stephen Conrad, Kent County APS |
| 04/14/2023 | Inspection Completed On-site<br>Stephen Conrad (Kent APS), Julie Treakle (Administrator), Kelly Smith (Regional Director), Val Katona (Staff), and Resident A |
| 04/14/2023 | Contact-Document received<br>Facility Records |
| 04/28/2023 | Inspection Completed-Onsite<br>Belinda Pettis (Staff) and Brajama Richardson (Staff) |
| 05/12/2023 | Exit Conference<br>Connie Clauson, Licensee Designee |

**ALLEGATION: Facility staff leave Resident A laying in her bed with soiled clothes and linens.**

**INVESTIGATION:** On 04/14/2023, I received a complaint from Adult Protective Services (APS), which alleged Resident A has been diagnosed with Multiple Sclerosis and is paralyzed from the waste down. Resident A requires staff assistance with all activities of daily living (ADL) and has to wait for long periods of time before she receives assistance from staff. Resident A has to ask for help from staff and they do not routinely check on her. Resident A has a pressure ulcer and is supposed to receive wound care, but staff do not assist. Resident A also has a suprapubic catheter that needs to be changed daily, but staff only change it when Resident A tells them to.

On 04/14/2023, I completed a file review. A concurrent investigation exits at the facility under SIR 2023A0464035. Due to the nature and severity of the cited quality care violations, a provisional license was recommended.

On 04/14/2023, I made face-to-face contact with Kent County Adult Protective Services (APS) worker, Stephen Conrad to coordinate the investigation.

On 04/14/2023, Mr. Conrad and I completed an unannounced, onsite inspection at the facility. We interviewed facility administrator, Julie Treakle. Mrs. Treakle stated she has only worked at the facility for four days and could not attest to the care Resident A has received. Regional manager, Kelly Smith was also present. Ms. Smith does not work out of the facility; therefore, she did not have any firsthand knowledge of Resident A. Ms. Treakle and Ms. Smith provided Resident A's facility records.

Mr. Conrad then interviewed Resident A, privately. Resident A reported staffing has been a huge issue at the facility. She has to wait for long periods of time after she calls for staff assistance. Resident A explained that since she is paralyzed from the waist down, she wears adult briefs and requires facility staff to change her briefs. Resident A stated staff do not routinely check on her to see if she needs to be changed. She stated she has to call for them to come and then is left sitting in a soiled brief for long periods of time. According to Resident A, there have been occasions when she has waited for an hour. Resident A stated she has a pressure ulcer on her buttocks and it is important that the area is kept clean and dry. This is not being done, as staff do not change her briefs as often as they should. Resident A stated she also has a catheter that is required to be changed daily, but often times she has to remind staff to come and change it.

I interviewed facility staff Val Katona. She stated she does not primarily work in Yorkshire Manor-East but has covered both Yorkshire Manor-East and Yorkshire Manor-West, simultaneously, because there were no staff on East. Ms. Katona confirmed that due to this lack of staffing, Resident A has had to wait long periods of time to receive assistance with ADLs.

On 04/14/2023, I received and reviewed Resident A's facility records, specifically Resident A's Activities of Daily Living (ADL) logs. The ADL reflects Resident A did not receive any personal care, including the changing of her adult briefs, on 04/02/2023, 4/04/2023, and 04/12/2023.

On 04/28/2023, I completed an unannounced, onsite inspection at the facility. Due to several residents testing positive for Covid-19, I did not speak with Resident A. I did however, interview facility staff, Belinda Pettis and Brajama Richardson. Both staff stated they have worked at the facility for approximately six months. Both stated they routinely assist Resident A with her ADLs. Ms. Pettis and Ms. Richardson stated the facility has been experiencing staffing issues and

acknowledged Resident A may have been required to wait for long periods of time before receiving assistance from staff on other shifts.

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

| **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 04/14/2023, a complaint was received alleging Resident A is not receiving assistance with Activities of Daily Living (ADL's).<br><br>Resident A disclosed she has to wait for long periods of time before receiving assistance from staff with ADL's. Resident A stated she often has to remind staff to provide her assistance with changing her catheter and her adult briefs.<br><br>Facility staff Val Katona, Belinda Pettis and Brajama Richardson each reported that due to a staffing shortage, residents have had to wait for long periods of time before receiving staff assistance.<br><br>Resident A's facility Activities of Daily Living (ADL) logs reflect Resident A did not receive assistance with personal care on 04/02/2023, 4/04/2023, and 04/12/2023.<br><br>Based on the investigative findings, there is sufficient evidence to support a rule violation that staff are not providing timely assistance to Resident A. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: Facility staff are not cleaning and dressing Resident A's pressure ulcer.**

**INVESTIGATION:** On 04/14/2023, Mr. Conrad and I completed an unannounced, onsite inspection at the facility. We met with Ms. Treakle, who stated she is fairly new and did not have information regarding Resident A's wound care. Ms. Treakle provided a copy of Resident A's facility records.

Mr. Conrad interviewed Resident A privately. Resident A stated she has a pressure ulcer on her buttocks and requires staff to clean change the dressing on the wound on a daily basis. Resident A stated often times, staff do not change the dressing. Resident A reported that she wears adult briefs and reported that she gets soiled from time to time. Resident A stated it is important for staff to change her right away; otherwise, she risks infection to the pressure ulcer. Resident A stated due to the pressure ulcer, staff are also supposed to assist with regular body position change, and this is not occurring.

On 04/14/2023, I received and reviewed Resident A's facility records, specifically Resident A's Medication Administration Record (MAR). The MAR reflected that on 03/01/2023, Resident A's physician, visiting nurse practitioner Carole Lenzo, ordered wound care. Staff are to wash the wound with soap and water, then cover the area with a clean bandage. This was ordered to be completed on a daily basis. The MAR has no staff initials during the month of March 2023 and during the beginning of April 2023, documenting the wound care had been completed.

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

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15310** | **Resident health care.** |
| | **(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following:**<br>**(a) Medications.**<br>**(b) Special diets.**<br>**(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.**<br>**(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.** |
| **ANALYSIS:** | On 04/14/2023, a complaint was received alleging facility staff are not providing wound cleaning to Resident A.<br><br>Resident A reported she has a pressure ulcer on her buttocks. As a result, her physician ordered for the wound be routinely cleaned and for Resident A to be frequently be repositioned. Resident A stated she is unable to perform these tasks independently due to her paralysis. Resident A stated often |

| | times she is left in soiled briefs and staff do not come to reposition her.<br><br>Resident A's Medication Administration Record MAR) reflected Resident A's physician ordered daily wound care. The MAR reflects staff did not provide wound care to Resident A.<br><br>Based on the investigative findings, there is sufficient evidence to support a rule violation that facility staff are not following physician orders regarding Resident A's pressure ulcer. |
|---|---|
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

On 05/03/2023, special investigation (SIR 2023A0464035) was completed and resulted in a recommendation of a provisional license for quality-of-care violations. This investigation has resulted in additional quality of care violations being cited and the recommendation for the issuance of a provisional license continues. A separate acceptable Corrective Action Plan addressing the violations cited in this report must be submitted by the licensee.

Megan Aukerman, MSW 05/12/2023

Megan Aukerman Date
Licensing Consultant

Approved By:

05/12/2023

Jerry Hendrick Date
Area Manager