GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 17, 2023

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

RE: License #: AL410289606
Investigation #: 2023A0464057
Yorkshire Manor - East

Dear Mrs. Clauson:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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, MSW

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 #:	2023A0464057
Complaint Receipt Date:	07/26/2023
Investigation Initiation Date:	07/26/2023
Report Due Date:	09/24/2023
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:	1ST PROVISIONAL
Effective Date:	06/23/2023
Expiration Date:	12/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS/AGED

II. ALLEGATION(S)

	Violation Established?
Staff failed to secure Resident A in her Broda chair. As a result, Resident A fell and broke her tibia.	Yes

III. METHODOLOGY

07/26/2023	Special Investigation Intake 2023A0464057
07/26/2023	APS Referral
07/26/2023	Special Investigation Initiated - Telephone Drew Blackall, Kent County APS
08/01/2023	Inspection Completed On-site Julie Treakle (Administrator), Hope Smith (interim Administrator), Christine Cybulskis (Resident A's daughter) and Resident A
08/01/2023	Contact – Document received Facility Records
08/03/2023	Contact-Document received Kristin Campbell, Case Manager
08/08/2023	Contact-Telephone call made Drew Blackall, Kent County APS
08/09/2023	Contact-Telephone call made Colleen Perkins, Staff
08/14/2023	Exit Conference Connie Clauson, Licensee Designee

ALLEGATION: Staff failed to secure Resident A in her Broda chair. As a result, Resident A fell and broke her tibia.

INVESTIGATION: On 07/26/2023, an online BCAL complaint was received from Adult Protective Services (APS). The complaint alleged that on 07/23/2023, Resident A fell out of her Broda chair and sustained bruises and skin tears on her elbows. It was additionally reported that staff failed to notify Resident A's daughter and Resident A is now "bedbound" with hospice administering morphine for her pain. On 07/26/2023, hospice ordered x-rays and it was discovered Resident A

fractured her tibia.

On 07/26/2023, I conducted a review of the facility file. Facility records indicated that on 06/22/2023 an investigation was completed at the facility (SIR #2023A0464035) and licensing rule quality-of-care violations were established regarding facility staffing, resident care and protection. A corrective action plan was approved and submitted on 06/22/2023. As a result, a provisional license was issued on 06/22/2023.

On 07/26/2023, I spoke with Kent County APS worker, Drew Blackall to coordinate the investigation. Mr. Blackall stated he went to the facility earlier today and made face-to-face contact with Resident A. Mr. Blackall stated an interview was not completed due to Resident A's condition however, she was observed sleeping in her bed.

Mr. Blackall stated he interviewed staff, Rickiya Garner. Ms. Garner reportedly informed Mr. Blackall that Resident A is very easy to care for and they have specific protocol (alarms, chair recline, slip pad, regular checks) required to ensure she is not falling out of her Broda chair or harming herself unintentionally. Ms. Garner reported to Mr. Blackall that she is aware that had Resident A had a "fall" on 07/23/2023 (Monday) and sustained numerous injuries from the incident. Ms. Garner reported Resident A has bruising on her feet, shins, biceps, and eyebrow, along with skin tears on both elbows. Ms. Garner reportedly told Mr. Blackall that she was not working immediately prior to Resident A's fall or when the fall occurred. Ms. Garner stated another staff was caring for Resident A and did not follow the protocols for Resident A's chair or alarms.

Mr. Blackall informed me that he also interviewed licensee designee, Connie Clauson and interim administrator, Hope Smith. Mrs. Clauson reported that things have been "going well" at the facility and "much improvement" has been made as far as staffing. She reportedly informed Mr. Blackall that they have been able to adequately staff the facility with "direct hires" and are no longer utilizing staff from an outside agency. She reported the employee sick calls/no shows have gone way down and things are "better."

Mr. Blackall stated that Ms. Smith informed him that she became aware of Resident A's fall and staff, Colleen Perkins was caring for Resident A on 07/23/2023. Ms. Smith stated Resident A's Broda chair was not reclined as it should have been and her chair alarm was not plugged in. Ms. Smith reportedly informed Mr. Blackall she believes Resident A fell out of her Broda chair, causing her to sustain injuries.

Mr. Blackall informed me that Ms. Smith and Mrs. Clauson expressed their continued effort to make and keep residents safe. They reported they continue "on the spot" education regarding specific resident needs such as alarms, chair recline, slip pad, and regular checks. They also reported they are having staff complete all incident reports before shift end. Both administrator roles have been filled, one role

including detailed trained administrator in Dementia. This additional Dementia training and knowledge will be utilized by staff. The facility continues to work on worker retention offering ongoing training. In addition, the facility will be completing “write-ups” when necessary to hold staff accountable. Specifically, regarding Resident A’s situation, administration will be adding “Chair Recline” and “Slip pad” into the electronic care plan, which is a form that is checked by staff throughout their shift.

On 08/01/2023, I completed an unannounced, onsite inspection at the facility. I interviewed facility administrator, Julie Treakle and Ms. Smith. Both stated they were made aware of Resident A’s fall on 07/23/2023. Mrs. Treakle and Ms. Smith stated an x-ray was completed on 07/26/2023, due to the swelling of Resident A’s leg. It was discovered that Resident A had a fractured tibia. Mrs. Treakle and Ms. Smith stated during their internal investigation, they discovered staff did not properly recline Resident A’s Broda chair. Mrs. Treakle and Ms. Smith stated that since then, they have provided staff with additional training on the Broda chair and alarms.

I then made face-to-face contact with Resident A. Resident A was observed laying in her bed with her eyes closed. Relative A was also present at her bedside. Relative A stated she was informed by hospice that Resident A does not have much longer before she passes. Relative A stated since Resident A fell out of her chair, breaking her leg, Resident A’s health has quickly declined. Relative A expressed frustration and stated she feels if staff would have followed Resident A’s orders regarding her chair and alarms, this would have been prevented. Relative A stated hospice ordered that Resident A’s Broda chair always be reclined, with Resident A’s slip pad underneath her body. Resident A’s alarm is also supposed to be plugged in at all times to prevent falls and notify staff immediately if something happens. Relative A stated there were numerous times she has come to visit Resident A, and found her sitting up in her chair, without the slip pad and her alarm not attached. Relative A stated on 07/23/2023, staff failed to recline Resident A’s chair and as a result Resident A fell out of the chair, getting her leg caught in the leg of the chair. Relative A stated she is not sure how long Resident A was lying on the floor until staff discovered her. Relative A stated Resident A sustained several bruises and marks. Relative A stated she and the hospice nurse noticed Resident A’s lower leg was swelling, therefore X-rays were ordered, and it was discovered Resident A had a broken tibia. Relative A stated Resident A has been unable to get out of bed since the incident.

On 08/01/2023, I received and reviewed Resident A’s facility records, specifically her Assessment Plan and Health Care Appraisal. Resident A was born on 09/03/1928, was diagnosed with Basal Cell Carcinoma, Hypothyroidism, Diabetic Mellitus, Hypercholesterolemia, Anxiety, Insomnia and Osteoarthritis. Resident A began receiving hospice services through Spectrum Health Hospice on 001/04/2022 due to her diagnosis of Lewy Body Dementia and Cerebrovascular Disease. Resident A’s Assessment Plan was completed and signed on 06/26/2023. Under the resident needs section of the plan it states, “(Resident A) will try to get out of her chair and

bed at times. (Resident A) requires the use of alarms, fall mat, anti-slide mat and soft rail to prevent falls. Under the assistive devices section of the plan, it states, (Resident A) utilizes a Broda chair, pressure alarm, fall mat, anti-slide mats and soft rail for the bed. The assessment plan also states staff are to ensure the pressure mat alarm is used and the call light is within reach.

On 08/03/2023, I received an email from Resident A's case manager, Kristin Campbell, stating Resident A passed away during the night of 08/02/2023.

On 08/08/2023, I spoke to Mr. Blackall. Mr. Blackall stated he interviewed Resident A's Spectrum Hospice nurse, The nurse reportedly informed Mr. Blackall she is aware of the situation involving Resident A. She informed Mr. Blackall that on 07/26/2023, Hospice requested X-rays and would monitor the results. On 07/29/2023, results from the X-rays showed a mild spiral fracture in Resident A's tibia. The nurse reportedly told Mr. Blackall that facility staff would often forget to recline Resident A's Broda chair and chair alarm. The nurse also reportedly informed Mr. Blackall she has had ongoing concerns about the facility's staffing, communication, and documentation. Mr. Blackall informed me that he has substantiated his investigation and his case is now closed due to the recent passing of Resident A.

On 08/09/2023, I interviewed staff, Colleen Perkins by telephone. Ms. Perkins stated that on 07/23/2023, she was scheduled to work third shift, but was asked to come into work early. She arrived at the facility around 4:30 pm. Ms. Perkins stated she was in another resident's room providing care when she thought she heard someone yell for help. Ms. Perkins opened the door so she could hear better. Ms. Perkins stated a few minutes later she heard someone yell for help again and went running out to see where it was coming from. Ms. Perkins stated she observed Resident A lying face down in the living area. Ms. Perkins stated Resident A had apparently slipped out of her Broda chair and was lying on the ground, with her left foot caught in the chair. Ms. Perkins stated she yelled for the other staff to come assist her with getting Resident A back in her chair. Ms. Perkins stated when she found Resident A, she noticed that her Broda chair was not in the reclined position as it should have been, and her alarm was not connected. Once they got Resident A back in the chair, she reclined Resident A into the proper position and assessed her for injury. She noticed Resident A had sustained marks on her face and leg and had skinned her elbow. Ms. Perkins applied first aid and put ice on Resident A's ankle. Ms. Perkins stated she completed an incident report the following morning when her shift was ending.

On 08/14/2023, I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation findings and recommendations. Mrs. Clauson inquired about the process for the recommendation and indicated she would provide documentation of the facility's progress at the compliance conference.

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:	A complaint was received alleging that Resident A fell out of her Broda Chair and sustained injuries due to staff neglect. Facility staff, Julie Treakle, Hope Smith, Rickiya Garner, and Colleen Perkins all confirmed that Resident A was supposed to be in a reclined position with slip pads and pressure alarms while in her Broda chair. On 07/23/2023, Resident A was sitting in her Broda chair in an upright position and her alarm was not attached. As a result, Resident A fell out of her chair, sustaining injuries. Resident A's Assessment Plan documents that she requires the use of a Broda chair, anti-slip mats, and pressure mat alarms. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff failed to adequately attend to Resident A's personal needs, including her protection and safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Due to a repeated quality of care rule violation, I recommend revocation of the license.

Megan Aukerman, MSW
08/14/2023

Megan Aukerman, Licensing Consultant Date

Approved By:

08/14/2023

Jerry Hendrick, Area Manager Date