GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 20, 2023

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

RE: License #: AL410289606
Investigation #: 2023A0464065
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 #:	2023A0464065
Complaint Receipt Date:	09/27/2023
Investigation Initiation Date:	09/27/2023
Report Due Date:	11/26/2023
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 AGED/ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B is supposed to have her heart monitor plugged-in at all times. The heart monitor was found to be unplugged and the cord missing.	Yes
Resident A had a stroke and facility staff failed to seek medical attention.	No

III. METHODOLOGY

09/27/2023	Special Investigation Intake 2023A0464065
09/27/2023	Special Investigation Initiated - Telephone RS
09/27/2023	APS Referral
10/10/2023	Inspection Completed-Onsite Jerry Hendrick (Area Manager), Joseph Dionise (AG Investigator), Tracey Jones (AG Investigator), Julie Treakle (Administrator), Amanda Beecham (Regional Director), Aliesha Rivera (Staff), Rosie Velez (Staff)
10/10/2023	Contact-Documents received Resident A Facility Records
11/14/2023	Contact-Telephone call made Melissa, Corewell Health
11/20/2023	Exit Conference- Connie Clauson, Licensee Designee

ALLEGATION: Resident B is supposed to have her heart monitor plugged-in at all times. The heart monitor was found to be unplugged and the cord missing.

INVESTIGATION: On 09/27/2023, I received an online BCAL complaint which alleged Resident A had a pacemaker implanted. The pacemaker connects to a heart monitoring machine which is located in Resident A's bedroom and must be plugged-in at all times. On 09/19/2023, the machine was found unplugged. It was also reported Resident A suffered from a stroke and staff were unaware.

On 09/27/2023, I spoke with the referral source (RS) by telephone. The RS stated Resident A has a pacemaker. The RS explained Resident A receives hospice services through Corewell Health Hospice for her medical issues. The pacemaker sends results to a heart monitor, which is located in Resident A's bedroom. The monitor is supposed to be plugged-in at all times. The RS stated she visited the facility on 09/19/2023 and found the monitor unplugged with the cord missing. The RS reported this was not the first time the heart monitor was found unplugged.

On 09/27/2023, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 09/27/2023, I completed a file review. I noted that a on 08/14/2023, a previous special investigation was completed (SIR#2023A0464057) that resulted in several quality-of-care rule violations being cited. As a result, revocation of the facility's license was recommended. Since then, there have been five additional investigations, three of which resulted in additional quality of care rule violation citations.

On 10/10/2023, Area Manager, Jerry Hendrick, Attorney General investigators, Joseph Dionise, and Tracey Jones, and I completed an unannounced, onsite inspection at the facility. We interviewed facility manager, Julie Treakle and regional director, Amanda Beecham. Mrs. Treakle and Ms. Beecham reported all of the residents have been moved out of the facility. Resident A now residents at a different facility. Mrs. Treakle confirmed Resident A has a pacemaker implant and requires the use of a heart monitoring device. Mrs. Treakle stated she was not aware that Resident A's heart monitor had ever been unplugged until Resident A's relative reported the heart monitor plug missing. Staff never reported the monitor being unplugged.

We then interviewed staff, Aliesha Rivera. Ms. Rivera stated Resident A has a heart monitor in her bedroom, which is supposed to be plugged-in at all times. Ms. Rivera stated there was one day when Resident A's relative came and found the monitor unplugged and the cord missing. Prior to the relative noticing the machine was unplugged, Ms. Rivera was not aware it wasn't plugged-in.

We then interviewed staff, Rosie Velez. Ms. Velez stated she does not typically work in the facility, but there was one day when she was asked to work in Yorkshire Manor-East. Ms. Velez stated she was aware Resident A had a pacemaker that sends data to a heart monitor. Ms. Velez stated staff are required to always check to make sure the monitor is plugged-in, and the green light is on. Ms. Velez denied observing the heart monitor to be unplugged.

On 10/10/2023, I received and reviewed Resident A's facility records, specifically Resident A's Spectrum Health Cardiovascular letter. On 06/15/2021, Resident A had a medical procedure performed by Dr. Andre Gauri to implant a pacemaker.

The medical records reflect Resident A was sent home with a heart monitor after the procedure. The purpose of the heart monitor is to monitor Resident A's pacemaker.

On 10/10/2023, I received and reviewed Resident A's Assessment Plan which was completed on 10/19/2022. Under the assistive device section of the assessment plan, it states Resident A has a wheelchair and bed-side commode. The Assessment Plan made no mention of a heart monitor machine for Resident A's pacemaker implant.

On 11/14/2023, I spoke to Corewell Health Hospice Nurse Manager, Melissa Ryske. Ms. Ryske stated the heart monitor typically just transmits a weekly report on how the pacemaker is functioning. Ms. Ryske stated typically when a resident is receiving hospice services, it is not necessary for the monitor to be plugged-in. Some families chose to have the heart monitor plugged in and hospice will honor their request.

On 11/20/2023. I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation findings and recommendations.

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: **(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 09/27/2023, a complaint was received alleging Resident A has a heart monitor that is supposed to be plugged-in at all times. There have been occasions when the monitor was observed to be unplugged. Facility staff, Julie Treakle, Aliesha Rivera, and Rosie Velez all confirmed Resident A requires the use of a heart monitoring device, which is supposed to be plugged-in at all times. Ms. Rivera reported she observed Resident A's heart monitor to be unplugged. Resident A's medical records reflected Resident A had a medical procedure for a pacemaker implant on 06/15/2021. Resident A was discharged with a heart monitoring device.

	Resident A's Assessment Plan states Resident A utilizes a wheelchair and bed side commode. The assessment plan made no mention of the heart monitor. Based on the investigative findings, there is sufficient evidence to support a rule violation that the facility did not ensure Resident A's heart monitor was always plugged-in.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A had a stroke and facility staff failed to seek medical attention.

INVESTIGATION: On 09/26/2023, I spoke to the RS by telephone. The RS stated she went to the facility on 09/19/2023 to visit Resident A. Resident A was in bed. The RS proceeded to wake Resident A up and recognized Resident A was suffering from a stroke. Another resident reportedly informed the RS that Resident A was "slumped over" during lunch and the resident informed the staff. According to the RS, the staff did not do anything and put Resident A in bed. The RS stated she contacted Resident A's hospice nurse who came to the facility and confirmed Resident A was having a stroke. The RS reported Resident A is being moved to a new facility at the end of the week.

On 10/10/2023, Mr. Hendrick, Mr. Dionise, Mr. Jones, and I completed an unannounced, onsite inspection at the facility. We interviewed Mrs. Treakle. Mrs. Treakle stated she was working on 09/19/2023. Mrs. Treakle stated she did not observe and was not made aware that Resident A was experiencing a stroke.

We then interviewed Ms. Rivera. Ms. Rivera stated she was working on 09/19/2023 and provided care to Resident A. According to Ms. Rivera, Resident A was acting as she usually does. She did not notice any concerns or abnormalities that would indicate Resident A was suffering from a stroke.

On 11/14/2023, I spoke to Ms. Ryske. She stated the facility notified the evening nurse during the night of 09/19/2023 around 7:00 pm to report Resident A was possibly experiencing stroke-like symptoms. The on-call nurse came to the facility that evening (09/19/2023) and noted some neurological changes for Resident A. The following day, Resident A's regular nurse visited her at the facility. The nurse noted Resident A had increased difficulty raising her head and lifting her arms. The nurse noted Resident A's speech had also slowed down. Ms. Ryske stated hospice does not provide diagnostics and could not say Resident A suffered from a stroke or mini stroke. Ms. Ryske stated Resident A was not sent to the hospital as she was receiving hospice services. Ms. Ryske stated Resident A was relocated to a different facility and has since been discharged from hospice services due to improving health and no longer meeting hospice criteria.

On 11/17/2023. I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation findings and recommendations.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	On 09/26/2023, a complaint was received alleging Resident A had a stroke and staff failed to seek medical treatment. Facility staff Julie Treakle and Aliesha Rivera both denied Resident A demonstrated any unusual symptoms to indicate she was having a stroke. Corewell Health Hospice nurse manager reported Resident A's hospice nurse visited Resident A on 09/20/2023 and documented neurological changes in Resident A. However, the nurse could not confirm a stroke diagnosis. Based on the investigative findings, there is insufficient evidence to support a rule violation that the facility failed to seek medical treatment for Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

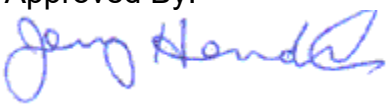
IV. RECOMMENDATION

On 08/14/2023 a recommendation for revocation was made as a result of SIR 2023A0464057. I continue to recommend revocation of the facility's license.

11/20/2023

Megan Aukerman, Licensing Consultant Date

Approved By:



11/20/2023

Jerry Hendrick, Area Manager Date