GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2024

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

RE: License #: AL540398499
Investigation #: 2024A1029053
Evergreen Terrace Assisted Living

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.

If you desire technical assistance in addressing these issues, please feel free to 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL540398499 |
| | |
| **Investigation #:** | 2024A1029053 |
| | |
| **Complaint Receipt Date:** | 06/07/2024 |
| | |
| **Investigation Initiation Date:** | 06/11/2024 |
| | |
| **Report Due Date:** | 08/06/2024 |
| | |
| **Licensee Name:** | Baruch SLS, Inc. |
| | |
| **Licensee Address:** | 3196 Kraft Avenue SE, Suite 203<br>Grand Rapids, MI 49512 |
| | |
| **Licensee Telephone #:** | (616) 285-0573 |
| | |
| **Administrator:** | Laura Hawley |
| | |
| **Licensee Designee:** | Connie Clauson |
| | |
| **Name of Facility:** | Evergreen Terrace Assisted Living |
| | |
| **Facility Address:** | 801 Fuller, Big Rapids, MI 49307 |
| | |
| **Facility Telephone #:** | (231) 527-1050 |
| | |
| **Original Issuance Date:** | 04/28/2020 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 10/28/2022 |
| | |
| **Expiration Date:** | 10/27/2024 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Direct care staff members are under 18 years of age. | No |
| Direct care staff members are taking breaks leaving the residents without care while they are gone. | No |
| Direct care staff members are setting up the medications in cups before administering them and leaving them on the dining room table for the residents. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 06/07/2024 | Special Investigation Intake 2024A1029053 |
| 06/11/2024 | Special Investigation Initiated – Email to Jana Lipps, AFC Licensing consultant |
| 06/18/2024 | Contact - Telephone call made to Sam Talaske APS and sent email to APS worker Andrew Hawkins |
| 06/20/2024 | Contact - Document Received Email from Adam Hawkins APS |
| 06/22/2024 | Inspection Completed On-site - Face to Face with Kayleigh Hawkins activities director, Resident A, Resident B, Resident C, Resident D, kitchen manager, Dawn Gould with APS Adam Hawkins |
| 07/18/2024 | Contact - Telephone call made to Jana Lipps AFC Licensing consultant |
| 07/19/2024 | Inspection Completed On-site - Met with administrator, Laura Whaley, direct care staff members Hayley Johnson, Alayna Heiler, and Resident E at Evergreen Terrace Assisted Living. |
| 07/25/2024 | Contact – Telephone call to licensee designee Connie Clauson, left message. Telephone call and email to Administrator, Laura Whaley |
| 07/26/2024 | Contact – Telephone call made to licensee designee Connie Clauson, left message, and sent email to her. |
| 07/26/2024 | Contact – Telephone call made to Relative D1, left message |

| | |
|---|---|
| 07/30/2024 | Contact – Telephone call to licensee designee Connie Clauson. Left message for her. Telephone call to administer, Laura Whaley. |
| 07/30/2024 | Exit conference with administrator Laura Whaley and left message for licensee designee Connie Clauson |

**ALLEGATION: Direct care staff members are under 18 years of age.**

**INVESTIGATION:**

On June 7, 2024, a complaint was received via Bureau of Community and Health Systems online complaint system with concerns the direct care staff members are not 18 years of age and they are providing direct care to residents at Evergreen Terrace Assisted Living.

On June 23, 2024, I completed an unannounced on-site investigation at Evergreen Terrace Assisted Living with Adult Protective Services (APS) specialist, Mr. Hawkins. Mr. Hawkins and I interviewed Resident A, Resident B, Resident C, and Resident D. None of these residents had concerns there were staff members under 18 years of age.

On June 23, 2024, APS Mr. Hawkins and I interviewed kitchen manager, Dawn Gould. Ms. Gould stated there were no direct care staff members working under the age of 18 years providing direct care to residents. Ms. Gould stated they do have kitchen staff who are 16 and 17 years of age but they are not able to provide direct care to residents until they turn 18 years of age. Ms. Gould stated the youngest kitchen staff members working now are Autum Thompson and Hayden Brown who both just turned 18 years of age but they do not work on the floor providing care yet. Ms. Gould stated the youngest direct care staff members who are currently providing resident care are Morgan Livermore and Sara DeBruyne. Ms. Gould stated Ms. Livermore and Ms. DeBruyne both moved from the kitchen to providing resident care once they turned 18 years of age.

On July 18, 2024, I interviewed direct care staff member Morgan Livermore. Ms. Livermore stated she has worked there for just over two years. Ms. Livermore stated she turned 18 on February 3, 2024. Ms. Livermore stated she did have her CNA license and she had someone with her while she was shadowing so she was doing work-based learning for her CNA license from Mecosta County Career Center and once she was able to turn 18 she was able to be on her own. Ms. Livermore stated she has never observed any of the other direct care staff members provide direct care before they turned 18 years of age. Ms. Livermore stated Ms. DeBruyne is also 18 and she turned 18 on April 15, 2024 so she recently moved over to providing resident care.

On July 18, 2024, I interviewed direct care staff member Alexis Andrews. Ms. Andrews stated there are some in the kitchen staff that are under 18 but they are not supposed to provide any care to the direct care staff members unless they are over 18.

On July 19, 2024, I completed an unannounced on-site investigation and interviewed administrator, Laura Whaley. Ms. Whaley stated there were no direct care staff members who were under the age of 18 years of age but sometimes they do hire kitchen staff who are at least 16 years of age. Ms. Whaley stated the kitchen staff do not provide direct care to residents. Ms. Whaley stated Ms. Livermore was 16 years old when she started however she was completing work-based learning through her CNA program so she was always shadowing another direct care staff member until she was on her own when she turned 18 years old. Ms. Whaley was able to show documentation Ms. Livermore completed all required licensing trainings and I was able to confirm that she did not start on the schedule as an assigned direct care staff member until she turned 18 years old and was not listed as a direct care staff member before she turned 18 years old.

During the on-site inspection, I reviewed Ms. Livermore's employee record which included the following documentation showing she was not employed as a direct care staff member before she turned 18:

- I confirmed she turned 18 on February 3, 2024 by reviewing her drivers license.
- I reviewed documentation from the Mecosta Osceola Career Center Work Based Learning and Training program showing Ms. Livermore was supervised by Ms. Whaley in this program. There were also evaluations completed by Ms. Whaley for March and May 2024 regarding her shadowing experience.
- I also reviewed the schedule for the two-week period starting in February 2024 and confirmed Ms. Livermore was not on the schedule as a direct care staff member until February 10, 2024.
- Ms. Livermore's original application was dated March 20, 2022 and she was applying for a position in the kitchen.

Ms. Whaley provided listing with all direct care staff members listing their date of birth and length of service at Evergreen Terrace Assisted Living as well as Ms. Livermore and Ms. DeBruyne's dates of service from their employment record. I was able to confirm none of the direct care staff members working were employed to provide direct care before they turned 18 years old.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15204** | **Direct care staff; qualifications and training.** |
| | **(1) Direct care staff shall not be less than 18 years of age and shall be able to complete required reports and follow written and oral instructions that are related to the care and supervision of residents.** |

| | |
|---|---|
| **ANALYSIS:** | There is no indication any of the direct care staff members are working before they turn 18 years old unless they are working in the kitchen. Ms. Whaley was able to show confirmation of all direct care staff members and their date of birth to confirm they were all at least 18 years of age. Ms. Livermore was the only direct care staff member who was in the process of training through her CNA work-based learning program before she turned 18 years old but I confirmed she was not on the schedule as a direct care staff member before she turned 18 years old. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION: Direct care staff members are taking breaks leaving the residents without care while they are gone.**

**INVESTIGATION:**

On June 7, 2024 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns the direct care staff members were taking breaks leaving residents without adequate direct care staff members.

On June 22, 2024 I completed an unannounced on-site investigation with APS Mr. Hawkins at Evergreen Assisted Living and interviewed Resident A. Resident A stated sometimes direct care staff members will take breaks while they have him in the bathroom but he does not think they are short staffed because he can always get his needs met.

On June 22, 2024 APS Mr. Hawkins and I interviewed Resident B, Resident C, and Resident D who all stated they did not think they were short staffed because they have never noticed direct care staff members taking a break and leaving residents without care.

On June 22, 2024, APS Mr. Hawkins and I interviewed direct care staff member whose current role was kitchen manager, Ms. Gould. Ms. Gould stated the direct care staff members do go outside during their breaks because they typically do not take lunch breaks because they are eating with the residents. Ms. Gould stated she has never noticed a time where someone was taking a break and there were not enough direct care staff members to provide care. Ms. Gould stated there are currently nineteen residents and two direct care staff members working per shift. Ms. Gould stated in the morning the administrator, Laura Whaley as well as the office manager and Activities director, Kayleigh Carpenter are also present and they are also trained as direct care staff members.

On July 18, 2024, I interviewed direct care staff member Ms. Livermore. Ms. Livermore stated she believes they are allowed to take breaks but they do not take them because they eat meals with the residents. Ms. Livermore stated they are allowed to go outside

for smoke breaks. Ms. Livermore stated does not know how long it would be because she does not smoke but she knows other direct care staff members are not outside long. Ms. Livermore stated she has never noticed anyone going without care because people were out smoking.

On July 18, 2024, I interviewed direct care staff member Ms. Andrews. Ms. Andrews stated she has no concerns regarding residents not receiving care because the direct care staff members were taking breaks. Ms. Andrews stated a couple times when she worked the morning shift when Ms. Johnson was taking her break but she came back in shortly and there were no residents who did not receive care as a result. Ms. Andrews stated there was an incident when Resident E fell in the bathroom and was bleeding on the floor. Ms. Andrews stated she does not know how long Resident E was on the floor before being attended to by direct care staff member Ms. Johnson. Resident E was not on 1:1 supervision at the time of this fall.

On July 19, 2024, I interviewed direct care staff member Ms. Johnson. Ms. Johnston stated she does not know of any breaks that she gets because it is an 8-hour shift. Ms. Johnson stated sometimes direct care staff members step outside for a few minutes however, there is another direct care staff member providing care to residents. Ms. Johnson stated she does not recall a time when a resident needed care and did not receive it because direct care staff members were taking a break.

Ms. Johnson stated there was an incident where Resident E fell however, she was declining and very weak that day. Ms. Johnson stated Resident E was assisted to the bathroom and afterward she assisted her to sit in the chair in her room. Ms. Johnson stated after she left the room to answer another resident alarm, Resident E managed to get up and she had the fall. Ms. Johnson stated when she was walking down the hallway she noticed she was not in her chair but was in the bathroom. Ms. Johnson stated she assisted Resident A right away. Ms. Johnson stated she was not outside taking a break but assisting another resident when this fall occurred. Ms. Johnson stated no direct care staff member has ever told her she could not be located during her shift.

On July 19, 2024, I interviewed direct care staff member Ms. Heiler. Ms. Heiler stated direct care staff members do not take scheduled breaks. Ms. Heiler stated direct care staff members typically take a 10 minute or less break if any break at all. Ms. Heiler stated she has never noticed anyone being out on smoke breaks and residents going without care. Ms. Heiler stated there are always at least two direct care staff members working at one time. Ms. Heiler stated there was an incident that Resident E fell but it was not due to lack of direct care staff member care. Ms. Heiler stated after Resident E's fall Ms. Snyder and Ms. Johnson responded appropriately by completing an *AFC Incident / Accident Report* and contacting Hospice. Ms. Heiler stated she is always able to find other direct care staff members when she needs assistance.

On July 19, 2024 I interviewed administrator Ms. Whaley. Ms. Whaley stated she did not have concerns that direct care staff members were taking breaks resulting in

residents not receiving care. Ms. Whaley stated direct care staff members can take breaks as long as they inform their coworkers. Ms. Whaley stated there are always at least two direct care staff members on per shift. Ms. Whaley stated there was an incident where Resident E fell on April 24, 2024 but this was not a result of direct care staff members taking breaks or not providing adequate supervision. Ms. Whaley did not have concerns about how Ms. Johnson handled that situation. Ms. Whaley stated she arrived at the facility shortly after the fall and Hospice had been called and an *AFC Incident / Accident Report* had been completed which I was able to review during my on-site inspection.

Ms. Whaley provided the following statement for review from the Employee Handbook:

*"Baruch Senior Ministries is not required to provide rest period or meal periods, except for those covered under Michigan Youth Employment Standards. Because an employee's presence in the facility is required throughout their shift meal and break periods during the scheduled shift are considered hours worked for purposes of calculating wages and overtime since the employee is not completely relieved of duty. In this case an employee may be asked to perform certain job functions during the break period."*

| **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:** | Based on the interviews with Ms. Gould, Ms. Andrews, Ms. Johnson, and administrator Ms. Whaley there does not appear to be a time where there was not adequate staffing as a result of the direct care staff members taking breaks. All direct care staff members interviewed stated direct care staff members do not take scheduled breaks but when they do, the break lasts less than five minutes and they check in with their shift partner before going outside. None of the residents interviewed stated there were concerns regarding them not receiving care. Ms. Andrews reported an incident where Resident E fell on April 24, 2024 but I was able to review the *AFC Incident / Accident Report* for that incident and Ms. Johnson responded appropriately to the fall. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION: Direct care staff members are setting up the medications in cups before administering them and leaving them on the dining room table for the residents.**

**INVESTIGATION:**

On June 7, 2024 a complaint was received via Bureau of Community and Health Systems online complaint system with concerns direct care staff members were presetting the medications from the medication cart and leaving them on the table before meals.

On June 22, 2024 I completed an unannounced on-site investigation with APS Mr. Hawkins at Evergreen Terrace Assisted Living and interviewed Resident A. Resident A stated he likes it there and does not have any complaints. Resident A stated he receives plenty of food here and has no concerns. Resident A stated his medications are administered in a cup and their room number is written on the cup. Resident A stated most of the time he receives his medication in the dining room and the direct care staff member is there to administer this to him and denied the cups are left out on the table.

On June 22, 2024 APS Mr. Hawkins and I interviewed Resident B who stated her medications are given in a cup but she did not recall if they were left out on the table or not.

On June 22, 2024 APS Mr. Hawkins and I interviewed Resident C. Resident C stated she enjoyed living there and has been there for 12 years. Resident C stated the only problem is that she is “getting old.” Resident C stated direct care staff members give her medications that are set up ahead of time and placed on the dining room table. Resident C stated she was not sure if direct care staff members watch her take the medications or if anyone ever took the wrong medications.

On June 22, 2024, APS Mr. Hawkins and I interviewed direct care staff member whose current role was kitchen manager, Ms. Gould. Ms. Gould stated she primarily works in the kitchen now but she used to be a direct care staff member. Ms. Gould stated they are able to administer medications one hour before or after their scheduled medication time. Resident A stated they are prepped on the medication cart but she did not know how far in advance the medications are prepped. Ms. Gould denied the medications are left on the dining room table for the residents.

On July 18, 2024, I interviewed direct care staff member Ms. Livermore. Ms. Livermore stated the doctors order the medications and she administers to the residents according to the Medication Administration Record (MAR). Ms. Livermore stated she does not set medication up ahead of time. Ms. Livermore stated she hands the medications to the residents directly and does not put them out at the place settings. Ms. Livermore stated she has seen medications sitting at the place settings at breakfast when they are waiting for the residents and she has also observed the medications to be sitting under

their drinking cup so when they go to pour their drinks they get the medications at that time. Ms. Livermore stated no one has taken the wrong medications with this system.

On July 18, 2024, I interviewed direct care staff member Ms. Andrews. Ms. Andrews stated she was trained to administer medications and stated in her opinion she was the last round of direct care staff members to be trained correctly to administer resident medications. Ms. Andrews stated direct care staff members are trained to wash their hands, selecting the resident, and getting the medication in the cart and matching the computer to the cart, triple checking the information, and then administering the medication into a medication cup. Ms. Andrews stated after they do this, they will take it to the resident. Ms. Andrews stated some of the medications were given at different times so sometimes they are in their rooms and sometimes it's at the table. Ms. Andrews stated eye drops and blood sugar will always be done in a private setting like their office or resident bedroom. Ms. Andrews stated she takes medication directly to the resident but she knows others on first shift set up the breakfast medications at their table placement but she "is not a fan of that". Ms. Andrews stated this is done on 1st shift and sometimes 2nd shift. Ms. Andrews stated it is a regular occurrence that the medications are put on table without the resident being present to take the medications.

On July 19, 2024 I interviewed administrator Ms. Whaley at Evergreen Terrace Assisted Living. Ms. Whaley stated there was an incident in the last couple months when Resident F almost ate Resident E's applesauce which had her medications in it. Ms. Whaley stated this occurred because the medications were preset and were sitting on the dining room table unsupervised. Ms. Whaley stated Resident F has a history of stealing food from other residents. Ms. Whaley stated she did not ingest it but almost took the applesauce and could have ingested it. Ms. Whaley stated there was also an aide present from Hartland Hospice (Misty unknown last name) when this incident occurred.

Ms. Whaley stated there are several medications that are taken during lunch time in the dining room but insulin, inhalers, or eye drops are all done in the resident bedroom. Ms. Whaley stated if there are medications in a cup in the dining room, then the direct care staff members are trained to watch residents take medications. Ms. Whaley stated former manager, Tracy Snyder was setting the medication cups up ahead of time and she was terminated for this practice. Ms. Whaley stated she was also training the other first shift staff members to do the same so Ms. Whaley stated she plans to retrain direct care staff members on this policy in August 2024 at their staff meeting.

Ms. Whaley stated she has never observed any direct care staff member administer medications in this manner but believes direct care staff will not do this in front of her. Ms. Whaley stated she observes Ms. Snyder doing this in the past and she told her she could not do this. Ms. Whaley stated she was there for breakfast today and did not see any medication cups out on the table. Ms. Snyder provided me with documentation of the disciplinary notice showing Ms. Snyder's termination and last day worked as May 22, 2024. Ms. Whaley also confirmed there were no *AFC Incident / Accident Reports* written regarding residents receiving the wrong medications. I reviewed the *AFC*

*Incident / Accident Report* book during my on-site inspection and also did not see any written *AFC Incident / Accident Reports* regarding medication errors.

On July 19, 2024, I interviewed direct care staff member Ms. Johnson. Ms. Johnson stated she was trained to administer medications an hour before or after with a 2-hour window. Ms. Johnson stated direct care staff are trained to prepare one resident's medications at a time including checking the dosages, right person, right route, and right time. Ms. Johnson stated she takes resident medications to the specific resident's room to administer it, however if the resident is at breakfast she stated sometimes prepares medications them by putting the medications in cups and taking them to the table for the residents. Ms. Johnson stated sometimes she will tell residents their medications are in front of them but does not always watch them take them. Ms. Johnson stated Resident G is more independent so she knows she will not leave breakfast until she takes them so she does not always watch her.

On July 19, 2024, I interviewed direct care staff member Ms. Heiler. Ms. Heiler stated in the morning they start with the 7 AM medications because she gets here at 6 AM so she has an hour to prepare them. Ms. Heiler stated depending on the resident she is getting up first she sets up their medications by checking the screens, confirms the name, dosage, and puts them into the cup and initial and date the log. Ms. Heiler stated she takes resident medication to the resident to administer. Ms. Heiler stated she always watches residents take the medications because otherwise they would drop them or forget to take them. Ms. Heiler stated some of the residents who come to breakfast already have had their medications because they take them at 7 AM but some prefer to take them at the table. Ms. Heiler stated she does not leave medications sitting at the resident's table setting. Ms. Heiler stated she has observed other direct care staff members leave medications out at the table setting but she does not do this because she is worried the wrong resident will take them. Ms. Heiler stated Ms. Whaley has instructed direct care staff members not to preset the medications and leave them on the dining room table.

After completing my interviews, I informed Ms. Whaley that a new policy update should be sent out immediately regarding not setting up the medications instead of waiting until the August 2024 staff meeting because several direct care staff members thought it was permitted to prepare the medications and set them out on the dining room table without watching residents take the medication. On July 19, 2024, I received the following notice from Ms. Whaley which was signed by direct care staff members Ms. Johnson, Ms. Gould, Ms. Carpenter, and Ms. Heiler.

*"Effective immediately:*
*Medications **cannot** be left unattended in the dining room. Under no circumstances are you allowed to prep medications and place them on the tables and leave them unattended. You must hand the resident their medications and observe them taking it. Please sign below that you have read and understood this memo. Please see Laura if you have any questions."*

The exit conference for this investigation was completed with administrator, Laura Whaley. Despite calling and sending an email, I was unable to reach licensee designee Ms. Clauson. Ms. Whaley stated a *Corrective Action Plan* would be sent within 15 days and she was aware of the violation found for medications being prepared and left at the dining room table.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | **(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.** |
| **ANALYSIS:** | Based on the interviews with Ms. Livermore, Ms. Andrews, and Ms. Johnson and administrator Ms. Whaley, direct care staff members are not taking precautions when administering resident medications to assure there are no medication errors. Direct care staff members are leaving residents medications unattended at the resident's table place setting. Ms. Whaley stated the former manager, Tracy Snyder trained the direct care staff members how to prepare the medication cups up ahead of time and instructed them to leave them at their place setting at the dining room table. Ms. Whaley stated she will be retraining direct care staff members on this policy in August 2024 at their staff meeting but after realizing that many of the direct care staff members may still be following this practice she sent out a memo against this procedure that was effective immediately. Ms. Snyder is also no longer an employee at Evergreen Terrace Assisted Living. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

_____07/26/2024_____

Jennifer Browning
Licensing Consultant

Date

Approved By:

07/29/2024

_____

Dawn N. Timm
Area Manager

Date