GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 30, 2021

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

RE: License #: AL410289605
Investigation #: 2022A0464005
Yorkshire Manor - West

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 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 (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 #:	AL410289605
Investigation #:	2022A0464005
Complaint Receipt Date:	11/08/2021
Investigation Initiation Date:	11/08/2021
Report Due Date:	01/07/2022
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 - West
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 ALZHEIMERS/AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff administered Resident A too much medication, causing her to be sent to the emergency room.	Yes

III. METHODOLOGY

11/08/2021	Special Investigation Intake 2022A0464005
11/08/2021	APS Referral Referral came from APS
11/08/2021	Special Investigation Initiated - Telephone Marques McLemore, Kent County APS
11/10/2021	Inspection Completed On-site Epiphany Donat (Associate Administrator) Resident A
11/23/2021	Exit Conference Connie Clauson, Licensee Designee

ALLEGATION: Facility staff administered Resident A too much medication, causing her to be sent to the emergency room.

INVESTIGATION: On 11/08/2021, I received an online BCAL complaint from Adult Protective Services (APS). The complaint stated Resident A's physician lowered her Amitriptyline dose from 30mg (3 pills) to 25mg (1 pill). Staff administered Resident A 90mg (3-25mg pills). As a result, Resident A was transported to the emergency room.

On 11/08/2021, I spoke with Kent County APS worker, Marques McLemore. He stated he visited Resident A at the facility on 11/08/2021. Mr. McLemore stated he was unable to interview Resident A. He attempted, however due to Resident A's diagnosis of Dementia, she was very confused.

On 11/10/2021, I completed an unannounced, onsite inspection at the facility. I interviewed Associate Administrator, Epiphany Donat. Mrs. Donat stated Resident A utilizes a different pharmacy than the one the facility uses. She stated Resident A's daughter, typically brings in Resident A's written prescriptions and medications. Mrs. Donat stated Resident A was prescribed 30 mg of Amitriptyline. She was administered three, 10mg Amitriptyline pills. Mrs. Donat stated on 11/04/2021, Resident A's physician changed Resident A's prescription to one 25mg pill. Resident

A's daughter brought in the new medication; however, they did not receive the new written order, therefore Resident A's electronic Medication Administration Record (MAR) had not yet been updated. During the evening of 11/04/2021, staff, Nalini Poelman went to administer Resident A's Amitriptyline. Ms. Poelman did not read the new Amitriptyline bottle and only looked at Resident A's MAR. Ms. Poelman administered Resident A three 30mg of Amitriptyline totaling 90mg. Shortly after, Resident A was acting unusual and lethargic and was transported to the emergency room. The error was not discovered until after Resident A arrived at the emergency room. Resident A was treated and released back to the facility the same day. An incident report was completed.

On 11/10/2021, I received and reviewed Resident A's facility records, specifically Resident A's MAR. Resident A's MAR for November 2021, states Resident A is prescribed Amitriptyline 10 mg (three pills at bedtime). Amitriptyline 25 mg was also listed. The MAR reflected Ms. Poelman administered Resident A 90mg of Amitriptyline on 11/04/2021. The MAR reflected Resident A's other medications were administered as prescribed.

I then reviewed the incident report (IR) completed on 11/04/2021. The IR stated that on 11/04/2021, around 11:00 pm, staff Tarina Garcia found Resident A on the floor. Resident A informed Ms. Garcia she felt weak and could not walk to the bathroom. Ms. Garcia contacted emergency medical services who arrived and transported her to the emergency room. Ms. Garcia also notified Resident A's daughter. The medication error was discovered at the emergency room. Resident A was discharged and released to the facility a few hours later.

On 11/23/2021, I completed an exit conference with licensee, Connie Clauson. She was informed of the investigating findings and recommendations. A corrective action plan will be completed.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 11/04/2021, Resident A's physician changed Resident A's prescription of Amitriptyline from 30mg to 25mg. During the evening of 11/04/2021, staff, Nalini Poelman accidentally administered Resident A 90mg of Amitriptyline. Later that evening, Resident A was experiencing negative symptoms and was transported to the emergency room, where the medication error was discovered.

	Resident A's Medication Administration Record confirmed the medication error on 11/04/2021. Resident A's other medications were administered as prescribed. Based on the investigative findings, there is sufficient evidence to support the rule violation that staff administered Resident A the wrong dosage of Amitriptyline.
CONCLUSION:	**VIOLATION ESTABLISHED**

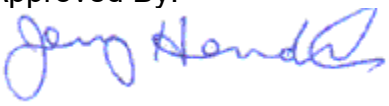
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the licensing status remain unchanged.

11/30/2021

Megan Aukerman Date
Licensing Consultant

Approved By:



11/302021

Jerry Hendrick Date
Area Manager