GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 10, 2021

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

RE: License #: AL700289600
Investigation #: 2022A0579004
Georgetown 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.
- 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,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW, 7th Floor-Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700289600
Investigation #:	2022A0579004
Complaint Receipt Date:	10/22/2021
Investigation Initiation Date:	10/22/2021
Report Due Date:	12/21/2021
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Steven Bunce
Licensee Designee:	Connie Clauson
Name of Facility:	Georgetown Manor - East
Facility Address:	141 Port Sheldon Road Grandville, MI 49418
Facility Telephone #:	(616) 457-3050
Original Issuance Date:	02/21/2013
License Status:	REGULAR
Effective Date:	08/23/2021
Expiration Date:	08/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED/ AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff withheld Resident A's boxers, pants, and lunch.	Yes
Resident A did not receive his medications as instructed by his physician.	Yes

III. METHODOLOGY

10/22/2021	Special Investigation Intake 2022A0579004
10/22/2021	Special Investigation Initiated - Face to Face Resident A, Latecia Turner (Direct Care Worker), Ebony Harris (Direct Care Worker), Rachel Rynbrandt (Direct Care Worker), and Steve Bunce (Administrator).
11/09/2021	Exit Conference Connie Clauson, Licensee Designee Steve Bunce, Administrator.

ALLEGATION: Staff withheld Resident A's boxers, pants, and lunch.

INVESTIGATION: On 10/22/2021, I received this referral through the Bureau of Health Systems online complaint system. The complaint alleged on 10/21/2021 staff took Resident A's underwear away from him stating that they stunk, and he just urinates in them anyway. Resident A was told he had to wear incontinence briefs and he refused. He remained naked from the waist down, stayed in his room, and did not go to the dining area. Staff did not bring him his lunch.

On 10/22/2021, I completed an onsite investigation at the facility. Interviews were completed with Latecia Turner (Direct Care Worker), Ebony Harris (Direct Care Worker), Rachel Rynbrandt (Direct Care Worker), and Steve Bunce (Administrator).

I observed Resident A, who I had spoken to in September 2021 and who I knew had challenges with managing his incontinence in a sanitary way. Resident A presented as more agitated and less engaged than when I last spoke to him. The pants he was wearing were stained with urine from his groin to his ankle on one leg. Resident A could not engage in interviewing. I observed several unused incontinence briefs on his closet floor. I observed one pair of boxers in a nightstand in his room.

Ms. Turner denied direct knowledge of what occurred on 10/21/2021. She stated Resident A does get agitated when even prompted for toileting assistance now. She expressed that she has already attempted to address his urine-stained pants and

toileting needs multiple times today. She stated he is resistant to any care but especially refuses any assistance relating to toileting.

Ms. Harris stated she was working on 10/21/2021. She stated it was decided, by the "Med Tech" (who she stated she did not want to name) that she was working with, that since Resident A will only urinate in his boxers and pants and then will not change out of his urine-stained clothing, that Resident A's boxers would be removed from his room, and he would only be provided incontinence briefs. She stated this upset Resident A, he threw the briefs out of his room and remained naked from the waist down. She stated she was then directed by the Med Tech to not bring Resident A his lunch and to allow him time to put on a brief and come down to communal dining. She stated they became busy and realized later in the afternoon that Resident A never came down to lunch and lunch was never brought to him. She stated she and her coworker were spoken to about how those actions were not appropriate. She stated Resident A's boxers were returned to him. She stated they did not intend to withhold Resident A's lunch, they just missed serving him since he did not come down to lunch, but that taking away his boxers was intentional.

Mr. Bunce and Ms. Rynbrandt stated they learned yesterday that staff withheld Resident A's boxers to attempt to force him into wearing incontinence briefs. Mr. Bunce stated Resident A's incontinence, refusing toileting assistance, refusing to change his soiled clothes, and combativeness have increased drastically over the last few weeks. He stated he could typically talk to Resident A and at least get him to change into clean pants. He stated previously staff relied on when Resident A was sleeping to wash his soiled pants to ensure they were washed daily, but that has become a challenge. He stated he is regularly discussing options, with staff and Resident A's family, for managing Resident A's incontinence, and it has come to the point where the discussion is whether Resident A needs to be moved to a skilled facility. He stated he does not feel that staff intentionally withheld food from Resident A but rather, when Resident A did not put on briefs to come to lunch and remained in his room, staff became busy, and forgot that he did not receive his meal until hours after mealtime. He stated Resident A's boxers were returned to his room and staff were advised they were not to withhold items to manage Resident A's incontinence.

Ms. Rynbrandt confirmed she was also made aware yesterday and spoke to staff about withholding items from Resident A to attempt to manage his incontinence. She expressed that she does not feel that staff intentionally withheld food from Resident A, that they got busy after lunch and forgot to bring the food to Resident A's room since he was not dressed appropriately to go into communal areas. She agreed Resident A's incontinence and challenges associated with it have drastically increased over the last few weeks. She stated in addition to discussing whether a new placement is needed, she has also been discussing medication to help with his combativeness and incontinence with his supports and his doctor.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(e) Withhold food, water, clothing, rest, or toilet use.**
ANALYSIS:	Ms. Harris confirmed she was present on 10/21/2021 when Resident A's boxers were removed from his room to force him to wear incontinence briefs due to Resident A's severe incontinence. Ms. Harris reported Resident A refused the briefs, remained naked from the waist down, and did not come to communal dining. She stated staff got busy and forgot that Resident A did not come to communal dining and forgot to bring him his lunch, so he did not eat lunch. Ms. Rynbrandt and Mr. Bunce confirmed they learned on 10/21/2021 what occurred with Resident A's boxers being withheld and then Resident A not receiving lunch. Both confirmed they spoke to the staff involved about how that was not appropriate and Resident A's boxers were returned to him. Resident A was observed but could not engage interviewing. I observed unused briefs on Resident A's closet floor and a pair of boxers in a nightstand in his room. Based on the interviews completed and observations made, there is sufficient evidence to support the allegation that direct care staff withheld food and clothing from Resident A in an attempt to force him in wear incontinence briefs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A did not receive his medications as instructed by his physician.

INVESTIGATION: On 10/22/2021, I reviewed the complaint that alleged Resident A also did not receive his afternoon medication at mealtime on 10/21/2021.

On 10/22/2021, Ms. Turner allowed me to observe the electronic medication tracking system she was using, and it showed Resident A did not receive his Divalproex and Furosemide on 10/21/2021 which he is prescribed to receive at lunch time.

Ms. Harris stated Resident A receives his afternoon medication mixed into his food so when his lunch was held, so where his medications. She stated by the time they realized he had not eaten; it was outside of the appropriate timeframe for him to receive his medication, so he did not receive it.

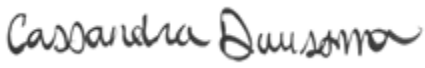
Ms. Rynbrandt reported Resident A's afternoon medications are sprinkled onto his lunch. She stated by the time staff realized Resident A had not received lunch, it was outside of an acceptable timeframe to give Resident A his afternoon medication, therefore his medication was not received.

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: **(a) Medications.**
ANALYSIS:	The facility medication tracking system showed Resident A did not receive his Divalproex or Furosemide as instructed by his physician on 10/21/2021. Ms. Harris reported Resident A's afternoon medications are mixed with his food so when his lunch was not served on 10/21/2021, he also did not receive his medication as instructed by his physician. Ms. Rynbrandt confirmed Resident A's afternoon medications are sprinkled onto his meal so when his meal was missed on 10/21/2021, his medications were missed as well. Based on the interviews completed and documentation observed, there is sufficient evidence to support the allegation that Resident A did not receive his medication as instructed by his physician when they were not given with his lunch on 10/21/2021.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/09/2021, I completed an exit conference with Ms. Clauson and Mr. Bunce who did not dispute my findings or recommendations.

IV. RECOMMENDATION

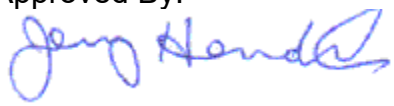
Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of this license remain the same.



11/10/2021

Cassandra Duursma — Date
Licensing Consultant

Approved By:



11/10/2021

Jerry Hendrick — Date
Area Manager