GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2022

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

RE: License #: AL830309607
Investigation #: 2022A0870026
Sunnyside Senior 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 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,

Bruce A. Messer, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 342-4939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL830309607
Investigation #:	2022A0870026
Complaint Receipt Date:	05/04/2022
Investigation Initiation Date:	05/04/2022
Report Due Date:	07/03/2022
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	3196 Kraft Avenue SE, Suite 203 Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Jackie Kibbe
Licensee Designee:	Connie Clauson
Name of Facility:	Sunnyside Senior Living
Facility Address:	108 Wildwood Drive Cadillac, MI 49601
Facility Telephone #:	(231) 775-7750
Original Issuance Date:	10/23/2012
License Status:	REGULAR
Effective Date:	04/23/2021
Expiration Date:	04/22/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell from her bed and was found by staff on the floor of her bedroom. Staff did not provide appropriate follow-up medical care and assistance following the fall.	No
Additional Findings	Yes

III. METHODOLOGY

05/04/2022	Special Investigation Intake 2022A0870026
05/04/2022	APS Referral This referral was made to AFC Licensing by the Michigan Department of Health and Human Services, Protective Services Centralized Intake unit, who declined to investigate.
05/04/2022	Special Investigation Initiated - Telephone Telephone interview with Family Member -1.
05/05/2022	Inspection Completed On-site Interview conducted with facility Administrator Jackie Kibbe.
05/06/2022	Contact - Telephone call made Telephone interview with staff member Julie Poole.
05/06/2022	Contact - Telephone call made Telephone interview with staff member Hillary Hogberg.
05/13/2022	Contact - Telephone call made Telephone call to Hospice of Michigan-Cadillac.
05/19/2022	Contact - Document Received Clinical Notes for Resident A received from Hospice of Michigan.
06/10/2022	Contact - Telephone call made Telephone call to Jackie Kibbe and Connie Clauson. V/M left for both.
06/10/2022	Inspection Completed-BCAL Sub. Compliance
06/13/2022	Exit Conference Completed with facility Administrator Jackie Kibbe.

ALLEGATION: Resident A fell from her bed and was found by staff on the floor of her bedroom. Staff did not provide appropriate follow-up medical care and assistance following the fall.

INVESTIGATION: On May 4, 2022, I spoke with Family Member-1, who stated she is the guardian of Resident A. Family Member-1 explained that she has concerns with the circumstances related to Resident A's arm injuries, allegedly from a fall on or about March 18, 2022, and the actions of the facility staff following her mother's fall. She further noted that Resident A had dementia and was unable to explain the arm injuries nor any details concerning the fall itself. She also noted that Resident A is now deceased, having died on March 25, 2022.

Family Member-1 stated Resident A fell and broke her hip "about two years ago", had surgery, and upon her return to Sunnyside AFC, was placed on hospice services. Family Member-1 noted that a "bed alarm" was purchased and used at that time "for a while" but "it later disappeared." She also noted that the facility uses "call buttons" for the residents and Resident A lost her button shortly before the March 18, 2022, fall and thus did not have it with her on that date. Family member-1 also noted she felt the care provided to Resident A "had been deteriorating recently" and that she "doesn't think (Resident A) fell."

Family Member-1 provided a narrative of communication between herself, the AFC home, and Hospice of Michigan (HOM) beginning March 18, 2022. She stated she received a call from HOM on March 18, 2022, informing her that Resident A had fallen and that they asked her if she wanted Resident A to be taken to the hospital. Family Member-1 noted that she was told that "none of the staff felt additional medical attention was necessary." She declined to have Resident A taken to the hospital at that time based on information received from HOM. Family Member-1 stated she went to the facility later that morning and was met by HOM nurse Dan (Finley). She noted Resident A was sitting in a wheelchair and Mr. Finley stated that Resident A "seemed fine" but was sore with some bruising, but there was no indication of a broken arm. Family Member-1 also noted that Resident A had a "split lip", was crying, saying "my arms hurt" and had bruising from her upper arm to shoulder. She also noted that if you touched Resident A's arm, she would cry out. Family Member-1 stated she assisted in feeding Resident A her breakfast and left shortly thereafter. Family Member-1 stated she called the facility later that evening and asked if Resident A was "ok." She stated she was told by a facility staff member "no, she didn't want to eat."

Family Member-1 stated she received a call the next morning, March 19, 2022, from HOM nurse Kim (Beasley) who stated, "your mom is in pain, she needs an X-Ray, and we will schedule it for tomorrow." She stated X-Rays were taken on March 2, 2022, but "it took three days to get the X-Rays back." Family Member-1 noted that when the results of the X-Ray were received, they showed that both of Resident A's upper arms were broken. She noted that she had previously asked Resident A how she hurt her arm, but Resident A had "no idea how she hurt herself, as she had

dementia." Family Member-1 also noted that at one time during the week following the injury, Resident A had told "one of the aides" that "you're just going to fling me" when the aide was attempting to toilet her. Family member-1 also noted that Resident A "did not have any bruises on her knees."

Family Member-1 stated the funeral director, Adam Hilt, of Holdship funeral home, stated to her that he had concerns about the bruising on Resident A's arms and called the county medical examiner to conduct an exam. Family Member-1 stated Medical Examiner Paul Waggoner told her that he "didn't see how her arms could have those injuries from a fall." Family Member-1 stated she had a copy of the death certificate issued for Resident A. She stated the certificate noted the classification of death was listed as "accident", and the cause was listed as "mechanical fall" and "complications of bilateral arm fracture."

On May 5, 2022, I conducted an unannounced on-site special investigation at the Sunnyside Senior Living AFC home. I met with facility Administrator Jackie Kibbe and informed her of the above stated allegation. Ms. Kibbe explained that Resident A was admitted to the facility in April 2015 and has had a slow decline in her abilities and cognition since. She stated Resident A went on hospice services in October 2019 following a fall and broken hip, noting that Resident A "would always forget to use her walker."

Ms. Kibbe stated that she received a call from facility staff member Julie Poole at approximately 4:00 a.m. on March 18, 2022, informing her that she had heard Resident A call for help, and upon responding to Resident A's bedroom, found her on the floor. Ms. Kibbe stated that Ms. Poole told her that she called another staff member, Hillary Hogberg, for help getting Resident A up, but because Resident A stated she was in pain, Ms. Poole called 911 for a "lift assist" from EMS. Ms. Kibbe further noted that Ms. Poole informed her that she had also called HOM. She went on to explain that EMS arrived at the facility, assessed Resident A's condition, assisted her back into her bed and instructed facility staff to put ice on Resident A's shoulder. Ms. Kibbe also noted that HOM nurse Kristi (Keeder) also responded to the facility at that time and conducted a further assessment of Resident A. Ms. Kibbe stated that later in the morning that same day, March 18, 2022, at approximately 9:00 a.m. HOM nurse Dan (Finley) came to the facility, assessed Resident A, and consulted with HOM physician Dr. Zook. Ms. Kibbe noted that throughout the day of March 18, facility staff, including herself, checked on Resident A. She noted various family members of Resident A were also present throughout the day. Ms. Kibbe noted that Resident A did not complain of pain unless you moved her. Ms. Kibbe acknowledged that Resident A did have a bed sensor alarm but "it was lost" and she "does not know when or how" it was lost. She also noted that Resident A did lose her call button for a day or two, but it was replaced, and Resident A did have one prior to March 18, 2022.

On May 6, 2022, I conducted a telephone interview with facility staff member Julie Poole. Ms. Poole explained that she worked the overnight shift on March 18, 2022,

and was working with Hillary Hogberg. Ms. Poole stated staff conduct two-hour bed checks throughout the night and noted she “had the hallway” where Resident A resided. She noted that Resident A was sleeping in her recliner, as is typical, when she last looked in on her that night. Ms. Poole stated shortly after she looked in on Resident A, she heard someone say, “somebody help me.” She stated she “ran” to Resident A’s bedroom and found her on the floor by the end of her bed. Ms. Poole stated she called for Ms. Hogberg, did a quick assessment of Resident A, who stated her arms hurt and she just wanted to lay on the floor. Ms. Poole stated she then called 911, Ms. Kibbe and HOM. She stated EMS arrived shortly after, did an evaluation of Resident A “to see if she needed to be taken in” to the hospital. Ms. Poole stated EMS personnel “did not believe her arm was broken” and it was decided she did not need to go to the hospital. She noted the EMS workers sat Resident A upright, she complained of her arm hurting, they lifted her from the floor to a standing position and she walked with assistance the few steps to her bed. Ms. Poole stated that after Resident A was in her bed she did not complain of any more pain. She stated she does not remember if she dispensed any pain medications at that moment. Ms. Poole stated she “checked her all over” and did not note any bruising at that time but did see “a little bleeding” on one elbow. She stated Resident A fell back asleep shortly after. Ms. Poole stated she next checked on Resident A “just before shift change”, which she noted was 7:00 a.m., changed her “depends”, noting that Resident A walked to the bathroom for this, and returned her to her bed. She did note that Resident A mentioned that she had pain in one arm. Ms. Poole stated she worked the following night, March 19, 2022, noting that HOM had been overseeing her care at this point. She stated Resident A stayed in her bed that night and “started complaining more of pain.” Ms. Poole also stated she noticed Resident A had “bruising” on the side of her body where she had fallen. She stated she conducted her two-hour checks on Resident A throughout the night and “Resident A seemed to be getting worse as time went on.” Ms. Poole noted that HOM was informed of this. Ms. Poole stated she “had heard of a bed pressure alarm” for Resident A but had never seen it in the two years she has worked at this facility. She stated that Resident A slept in her recliner and her bed, did “some wandering” at night and was confused, looking for her granddaughter and the school bus.

On May 6, 2022, I conducted a telephone interview with staff member Hillary Hogberg. Ms. Hogberg stated she was working, along with Ms. Poole, the overnight shift of March 18, 2022. She stated that at one point during the night she and Ms. Poole heard “crying” and went to investigate, finding Resident A on the floor of her bedroom near the foot of her bed. Ms. Hogberg stated that she and Ms. Poole started to lift Resident A up to her bed but Resident A “was scared” and said that it hurt too much (to be lifted). Ms. Hogberg stated that she and Ms. Poole assessed Resident A for injury, noting that she had bitten her lip, placed a blanket over her and Ms. Poole called 911 and HOM. She stated EMS arrived shortly after, as did a nurse from HOM. Ms. Hogberg stated EMS and the HOM nurse “checked over” Resident A and lifted her into her bed. She stated Resident A appeared to have some pain. Ms. Hogberg stated she then left Resident A’s bedroom as she needed

to attend to other facility residents as they were starting to get up. She noted Ms. Poole continued to attend to and monitor Resident A until the end of the shift. Ms. Hogberg stated she did have interactions with Resident A after that first night of the fall but did not "recall any significant details." Ms. Hogberg stated she has worked at this facility for the past two and a half years and does not recall Resident A having a bed alarm system.

On May 13, 2022, I spoke with Hospice of Michigan manager in charge April Sieinovski. Ms. Sieinovski confirmed from HOM records that HOM nursing staff responded to a call from Sunnyside AFC at approximately 4:00 a.m. the morning of March 18, 2022, regarding Resident A.

I requested from Ms. Sieinovski, and obtained from her on May 19, 2022, a copy of Resident A's HOM "clinical notes." Excerpts from these clinical notes are as follows:

Entry dated March 18, 2022, by Lois Abbot-White, RN – Received call, 3/18/22 @4:25 from Julia to report fall with possible injury. Julie states patient (Resident A) is complaining of both her arms hurting, does not want to be touched. Julia stated she also has a fat lip. Will cover her to keep her warm and at ease.

Entry dated March 18, 2022, by Kristi Keeder, RN – On call unscheduled visit 3/18/22 @0445. Upon arrival EMTs present and working with patient (Resident A) to get her to sit and then stand. Patient complained of bilateral arm pain. Patient able to move her arms. Skin tear to left elbow noted and patient did bite her left upper lip. EMS checked patient for further injuries, and none were noted. When the EMT was massaging patients right arm, patient would say it felt good but then would state after that she could not move it. Noted patient moving right arm/hand when distracted. EMT's were able to get patient to a standing position and sat her on her bed. Ice applied to right arm and patient stated this felt better. Call placed to patient's daughter Lisa. Lisa was in agreement with plan to monitor patient at this time. RN to follow up later today. Patient was given Norco and reassessed. Patient was in recliner chair resting at the end of visit, smiling and thankful for the visit.

Entry dated March 18, 2022, by Daniel Finley – Routine visit 3/18/22 @ 0900. Patient has BUE pain. Especially with movement of extremity. SN obtained orders to increase Norco dosage. Patient was sitting in dining room with breakfast. Patient has no non-verbal indications of pain by end of visit.

Entry dated March 19, 2022, by Brenda Sweeney, RN – 3/19/22 1148, Call received from Brenda, patient's daughter reporting patient fell x2 yesterday. She was assessed by RN and he did not feel there were any injuries at that time. However, later in the afternoon patient was unable to use her arms due to pain now she is unable to bear weight. Caller feels patient may need X-Rays to see if she has fractures. Writer will request on call RN assess patient and see if this is an appropriate request.

Entry dated March 19, 2022, by Tiwanna Boyland RN – 3/19/22, 1426, Received call from Kim reporting that x-Rays have been ordered by NP Pamela Smith under Dr. Zook to rule out fractures.

The clinical notes further record additional nursing visits, and communication with the facility or Resident A's family, by HOM nursing staff on March 19, 2022, March 21, 2022 (with an additional note that X-Rays were taken on March 20, 2022), March 24, 2022, and March 25, 2022.

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:	Facility staff, along with the Nursing Clinical Notes from HOM, indicate that the Sunnyside AFC staff called 911 and the HOM on-call nurse upon discovering Resident A had fallen from her bed and appeared to have pain/injuries. EMS and HOM responded following notification from the facility, assessed potential injuries to Resident A, and HOM conducted follow up assessments and care daily thereafter. The group home did obtain needed care immediately, following the discovery of Resident A on the floor of her bedroom with a possible injury.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

During this special investigation, I requested a copy of Resident A's assessment plan. Ms. Kibbe was unable to locate an assessment for the current year and provided a copy of the most recently completed assessment, which indicated a completion date of December 15, 2020. This assessment does not indicate the name of the person who completed the assessment, nor does it have the signature of Resident A or her designated representative/guardian.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**

	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	The Licensee failed to complete a written assessment plan, on an annual basis, for Resident A. The Licensee failed to complete a written assessment plan with Resident A or her designated representative.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

The Assessment Plan, dated December 15, 2020, which was provided to me by Ms. Kibbe notes:

- Behaviors: Wanders with no regard of personal items and space of others. Possible exit seeking behaviors.

- Use wander guard or other warning device…

Family Member – states that a "bed alarm" was purchased and used "for a while but it later disappeared."

Facility Administrator Jackie Kibbe acknowledged that Resident A did have a "bed sensor" and it was lost. She could not say when the bed sensor was lost or why it was missing.

Staff members Julie Poole, who has worked at the facility for two years stated she had heard of Resident A having a bed pressure alarm but had never seen it.

Staff member Hillary Hogberg, who has worked at the facility for two and a half years stated she does not recall Resident A having a bed alarm.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	The Licensee did not utilize a wander guard or other warning device for Resident A as specified in her assessment. The Licensee did not provide protection to Resident A when it did not provide or use a “wander guard or other warning device” for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On June 13, 2022, I conducted an exit conference with facility Administrator Jackie Kibbe. I explained my findings as noted above. Ms. Kibbe stated she understood and would submit a corrective action plan addressing the cited rules. Ms. Kibbe stated she would call Licensee Designee Connie Clauson to brief her on the findings of this investigation.

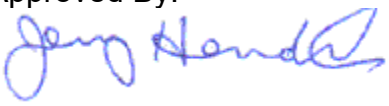
IV. RECOMMENDATION

I recommend, contingent upon the submission of an acceptable corrective action plan, that the status of the license remain unchanged.

June 13, 2022

Bruce A. Messer — Date
Licensing Consultant

Approved By:



June 13, 2022

Jerry Hendrick — Date
Area Manager