STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

May 12, 2023

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

RE: License #: AL410289602
Investigation #: 2023A0464037
Stonebridge Manor - North

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 #:	AL410289602
Investigation #:	2023A0464037
Complaint Receipt Date:	04/10/2023
Investigation Initiation Date:	04/11/2023
Report Due Date:	06/09/2023
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:	Stonebridge Manor - North
Facility Address:	3515 Leonard NW Walker, MI 49534
Facility Telephone #:	(616) 791-9090
Original Issuance Date:	10/22/2012
License Status:	REGULAR
Effective Date:	08/27/2021
Expiration Date:	08/26/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED/ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility does not have sufficient staff to meet resident needs. On more than one occasion, the facility did not have any staff working from 11:00 pm to 7:00 am.	Yes
Facility staff are not administering Resident A's prescribed medications.	Yes
Resident A has dirty skin and a bad body odor. Facility staff are not showering Resident A or brushing her teeth.	Yes
Additional Finding	Yes

III. METHODOLOGY

04/10/2023	Special Investigation Intake 2023A0464037
04/11/2023	Special Investigation Initiated - Telephone RS
04/11/2023	APS Referral Emily Graves, Kent County APS
04/14/2023	Inspection Completed On-site Emily Graves (Kent County APS), Stephen Conrad (Kent County APS), Julie Treakle (Manager), Kelly Smith (Regional Director), Val Katona (Staff), Lindsay Fromm (Staff), and Resident A
04/14/2023	Contact-Document received Facility Records
04/24/2023	Contact-Telephone call received Emily Graves, Kent County APS
04/28/2023	Inspection Completed-Onsite Connie Clauson (licensee Designee) and Julie Treakle (Administrator)
05/11/2023	Contact-Document received Records
05/12/2023	Exit Conference Connie Clauson, Licensee Designee

ALLEGATION: The facility does not have sufficient staff to meet resident needs. On more than one occasion, the facility did not have any staff working from 11:00 pm to 7:00 am.

INVESTIGATION: On 04/10/2023, I received an online BCAL complaint which alleged the facility is experiencing a staffing crisis and as a result there have been incidents when there were no staff scheduled and residents were left alone. The complaint also alleged Resident A is not receiving proper care from staff. Staff have not showered or bathed Resident A. Staff have neglected to provide Resident A with oral hygiene. The facility was supposed to obtain dental services for Resident A but has failed to do so. Resident A was not administered her prescribed medication.

On 04/10/2023, I spoke with the referral source (RS) by telephone. RS stated Resident A was admitted into the facility in August 2022. She stated Resident A suffers from dementia and cannot care for herself. RS stated the facility has gone through several different administrators since Resident A was admitted and does not have enough staff to care for the residents.

On 04/10/2023, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 04/10/2023, I spoke with Kent County APS worker, Emily Graves to coordinate the investigation.

On 04/14/2023, Ms. Graves and I completed an unannounced, onsite inspection at the facility. We interviewed newly appointed business manager, Julie Treakle. Mrs. Treakle stated she just started working at the facility; however, her mother is a resident of the facility. Mrs. Treakle stated the facility (Stonebridge Manor-North) is one of four facilities on campus (Stonebridge Manor-North, Stonebridge-South, Yorkshire Manor-East, and Yorkshire Manor-West). Mrs. Treakle stated twelve residents currently resident in Stonebridge Manor-North. Mrs. Treakle stated she has noticed there appears to be issues with staffing. Mrs. Treakle stated she was informed there have been occasions when Stonebridge Manor-North did not have any staff assigned to work during the night and staff from adjoining buildings had to come and care for the residents as there were no staff present. Mrs. Treakle stated she is currently working on developing a new scheduling system.

Ms. Graves and I then interviewed Baruch regional director, Kelly Smith. Ms. Smith stated she is working at the facility to address the current staffing concerns. Ms. Smith stated she is aware of recent incidents when Stonebridge Manor-North did not have any staff to fill a shift. Ms. Smith stated to rectify the issue, she has staff coming from other Baruch locations to fill needed shifts. She stated that she has also signed contracts with two outside staffing companies, Clipboard and Interim to help address the staffing shortage.

Ms. Graves then attempted to interview Resident A. Ms. Graves stated Resident A appeared to be confused and was unable to answer specific questions that were asked. Ms. Graves stated Resident A was clean and appropriately dressed. There were no observable concerns.

I then interviewed facility staff, Lindsay Fromm. Ms. Fromm stated the facility does not have enough staff. Ms. Fromm stated she primarily works in Stonebridge Manor North and South. Ms. Fromm stated there have been incidents when there has been only one staff person working in both Stonebridge Manor-North and Stonebridge Manor-South. She stated this has occurred between the hours of 11:00 pm and 7:00 am. Ms. Fromm stated the administration is trying to get more staff and is using outside sources.

On 04/14/2023, I received and reviewed the staff schedules for March and April 2023. The schedules reflect that on 03/19/2023, 03/25/2023, 03/26/2023, 03/28/2023, 03/31/2023, 04/02/2023, 04/03/2023, 04/04/2023, 04/05/2023, 04/06/2023, 04/07/2023 and 04/08/2023 there were no staff scheduled to work in Stonebridge Manor-North from 11:00 pm to 7:00 am. On these occasions, the facility used a “floater” staff person who worked between Stonebridge Manor-North and Stonebridge Manor-South simultaneously. During these incidents, the “floater” staff was the only person working both Stonebridge Manor-North and Stonebridge Manor-South simultaneously. The schedule reflects there were no other staff present.

On 04/14/2023, I received and reviewed Resident A’s Assessment Plan, which was signed and completed on 08/03/2022. The Assessment Plan reflects Resident A requires staff assistance with dressing, hygiene care and bathing. Under the Ambulation section of the plan, it reflects Resident A has a walker she uses to ambulate.

On 04/28/2023, I completed an unannounced, onsite inspection at the facility and met with licensee designee, Connie Clauson and Ms. Treakle. Mrs. Clauson stated Ms. Treakle will be the newly appointed facility administrator. Mrs. Clauson stated Stonebridge Manor-North as well as the surrounding units are currently infected with Covid-19. Mrs. Clauson acknowledged Stonebridge Manor-North is currently experiencing a staffing crisis and as a result Mrs. Clauson has been working out of the facility. Mrs. Clauson has been working with Ms. Treakle on the new scheduling system. She reports they are making “radical” changes from the previous scheduling system. She stated they have begun to schedule a few “back-up” staff each shift, in case there is a staff person who calls-in.

On 05/11/2023, I received and reviewed the Assessment Plans for all twelve residents. A review of the plans reflected four residents function independently and do not require staff assistance with ADL’s. The plans reflected that Residents A, B, C, D, E, F, G, H and I all require a one-person staff assist with all ADL’s.

On 05/12/2023, I completed an exit conference with Ms. Clauson. She was informed of the investigation findings and recommendations. Ms. Clauson provided an understanding of the rule violations and stated a corrective action plan would be submitted. Ms. Clauson stated she would provide documentation, stating whether or not Baruch intends to accept the recommendation of a Provisional license.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	On 04/10/2023, a complaint was received alleging there have been several occasions when Stonebridge Manor-North did not have any staff working. Staff Julie Treakle, Kelly Smith and Lindsay Fromm all stated the facility does not have enough staff. All three staff reported there have been occasions when there have been no staff working in Stonebridge Manor-North and as a result, staff from the neighboring facility had to be pulled over and work both Stonebridge Manor-North and Stonebridge Manor-South simultaneously. Facility schedules were reviewed for March and April 2023. The schedules reflected there were multiple evening shifts when there was only a single “floater staff “scheduled to simultaneously work at both the North and South facilities. Based on the investigative findings, there is sufficient evidence to support a rule violation that the facility is not sufficiently staffed.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On 04/10/2023, a complaint was received alleging the facility has insufficient staff to care for the residents. Unannounced, onsite inspections were completed on 04/14/2023 and 04/28/2023. Facility staff Lindsay Fromm was interviewed and reported the facility does not have enough staff to meet residents' care needs. Resident Assessment Plans were reviewed and reflected eight of the ten residents require a one-person staff assist with Activities of Daily Living. Based on the investigative findings, there is sufficient evidence to support a rule violation that the facility is not adequately staffed to meet the needs of the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility staff are not administering Resident A's prescribed medications.

INVESTIGATION: On 04/10/2023, I spoke with the RS. She stated Resident A was prescribed an antibiotic for an abscessed tooth. Resident A had reportedly been complaining of tooth pain. RS stated the facility was given the antibiotic prescribed by the dentist however staff never administered the medication to Resident A.

On 04/14/2023, Mrs. Graves and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Treakle and Ms. Smith. Both stated they have not been at the facility long enough to attest to whether or not Resident A received her antibiotic. Ms. Treakle stated she would provide Resident A's records.

Ms. Graves then attempted to interview Resident A. Ms. Graves stated Resident A appeared to be confused and was unable to answer specific questions that were asked. Ms. Graves stated Resident A could not recall what medications she is prescribed or if anyone administers her medications.

I then interviewed Ms. Fromm. Ms. Fromm stated she could not recall whether or not Resident A was administered her antibiotic as she does not work as a medication technician. Ms. Fromm stated there have been occasions when there has only been one med tech between all four facilities, so it is possible staff did not administer Resident A's antibiotic.

On 04/14/2023, I received and reviewed Resident A's Medication Administration Record (MAR). The MAR reflects that on 03/18/2023 Resident A was prescribed Amoxicillin 875 mg. Resident A was to be administered two tablets, every twelve hours until gone. The MAR reflects facility staff did not begin administering the medication to Resident A until the evening of 03/23/2023, six days after the prescription date. Staff then administered the medication from 03/24/2023 through 04/05/2023.

On 04/14/2023, a progress note was completed by visit physician, Dr. Jessica Sneller. The note stated Resident A was prescribed Amoxicillin 875 mg on 03/18/2023. Dr. Sneller expressed concern that the facility staff did not administer the antibiotic until 03/24/2023.

On 05/12/2023, I completed an exit conference with Ms. Clauson. She was informed of the investigation findings and recommendations. Ms. Clauson provided an understanding of the rule violations and stated a corrective action plan would be submitted.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 04/10/2023, a complaint was received alleging Resident A was not administered prescribed medication. The referral source reported Resident A was prescribed an antibiotic by the dentist for an abscessed tooth, however, facility staff never administered the antibiotic to Resident A. Facility staff Lindsay Fromm reported there have been occasions when there was only one "med tech" covering all four facilities and therefore it is possible staff did not administer all of Resident A's prescribed medications. Resident A's Medication Administration Record (MAR) reflected Resident A was prescribed Amoxicillin 875 mg, every twelve hours on 03/18/2023. However, facility staff did not administer the medication until 03/23/2023. Based on the investigative findings, there is sufficient evidence to support a rule violation that Resident A did not receive her Amoxicillin in a timely manner. The medication was prescribed

	on 03/18/2023; however, staff waited six days before administering the medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A has dirty skin and a bad body odor. Facility staff are not showering Resident A or brushing her teeth.

INVESTIGATION: On 04/10/2023, I spoke with the RS who stated facility staff are not showering Resident A or brushing her teeth. RS stated staff claim Resident A refuses to shower; however Resident A suffers from dementia and cannot recall if she needs a shower or has already had one. RS feels staff are not actively prompting Resident A to get in the shower and stated there have been multiple occasions when she has gone to the facility and gave Resident A a shower and brushed her teeth because her skin was so dirty, and she had body odor. RS stated she recently took Resident A to the dentist and the dentist informed RS that Resident A has not had her teeth brushed or cared for in a long time. The dentist reportedly informed RS that Resident A needs to have all of her teeth removed.

On 04/14/2023, Ms. Graves and I completed an unannounced, onsite inspection at the facility. We interviewed Ms. Treakle. She stated she has only worked at the facility for four days; therefore, she could not attest to staff's failure to provide Resident A with showering or brushing her teeth. Mrs. Treakle stated she has spoke with Resident A's family and is going to ensure that Resident A is regularly showered and provided oral care.

Ms. Graves then attempted to interview Resident A. Ms. Graves stated Resident A appeared to be confused and was unable to answer specific questions that were asked. Ms. Graves stated Resident A could not recall if she showers or brushes her teeth and was unable to recall if staff give her showers and brush her teeth. Resident A was also unable to recall the last time she had a shower or oral care.

I then interviewed Ms. Fromm, privately. Ms. Fromm stated she has provided care to Resident A. Ms. Fromm stated Resident A has always refused showers when she has tried to give her one. Ms. Fromm stated she has never brushed Resident A's teeth. She stated that would have been the early morning shift persons responsibility. Ms. Fromm stated she was recently informed by administration, that she as well as other staff have to make more attempts to give Resident A a shower.

On 04/14/2023, I received and reviewed Resident A's facility records, specifically Resident A's Activities of Daily Living (ADL) logs. The logs reflect that for the month of April 2023, the only days that showers were given were on 04/04/2023 and 04/07/2023. During the month of March 2023, Resident A was showered on 03/03/2023, 03/14/2023, 03/17/2023, 03/24/2023 and 03/29/2023. The log reflects Resident A was provided oral care by staff every day. This documentation is not

consistent with the concern reportedly expressed by Resident A's dentist regarding the condition of her teeth.

On 04/24/2023, I received a phone call from Ms. Graves. She reported she was informed Resident A had oral surgery to remove all of her teeth. Ms. Graves stated RS informed her staff are supposed to routinely change Resident A's gauze in her mouth but have failed to do so.

On 04/28/2023, I completed an unannounced, onsite inspection at the facility. I met with Ms. Treakle and Ms. Clauson. Mrs. Treakle stated she met with Resident A's family recently and someone from the Ombudsman's office. Ms. Treakle stated she is ensuring staff on each shift are providing oral care to Resident A.

On 05/12/2023, I completed an exit conference with Ms. Clauson. She was informed of the investigation findings and recommendations. Ms. Clauson provided an understanding of the rule violations and stated a corrective action plan would be submitted.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions, when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	On 04/10/2023 a complaint was received alleging facility staff are not showering Resident A or brushing her teeth. The referral source reported she has visited Resident A at the facility multiple times and has given Resident A a shower, as well as brushed her teeth, because staff had not done so. The referral source also reported the dentist commented on the poor condition of Resident A's teeth due to neglect. Facility staff Lindsay Fromm reported she has never given Resident A a shower, as Resident A would often "refuse" the shower. Ms. Fromm also denied providing oral care to Resident A. Resident A's Activities of Daily Living (ADL) logs reflected Resident A only received two showers during the month of April 2023.

	Based on the investigative findings, there is sufficient evidence to support a rule violation that staff did not shower Resident A or brush her teeth.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident A was supposed to be on a special, soft food diet after her teeth were pulled however facility staff are not following the diet.

INVESTIGATION: On 04/24/2023, I received a phone call from Ms. Graves. She reported Resident A had oral surgery to remove all of her teeth and was supposed to be on a soft food diet for six weeks, until her mouth was healed. Ms. Graves stated she was informed by RS that the day after surgery, RS saw staff provide Resident A with a small bag of Fritos chips.

On 04/28/2023, I completed an unannounced, onsite inspection at the facility and met with Ms. Treakle and Ms. Clauson. Both stated the facility has several positive cases for Covid-19. Ms. Treakle confirmed Resident A was supposed to be on a soft food diet following her oral surgery. Ms. Treakle stated the family was very concerned because they found Resident A with Frito chips. Ms. Treakle stated she did not witness this; however, she met with staff afterwards to ensure Resident A receives a soft food diet.

On 04/28/2023, I received and reviewed a progress note completed by D. Jessica Sneller, DDS. The note stated My Community Dental will be removing all of Resident A's teeth. Once surgery is complete, Resident A is to receive a soft food diet for six weeks.

On 05/12/2023, I completed an exit conference with Ms. Clauson. She was informed of the investigation findings and recommendations. Ms. Clauson provided an understanding of the rule violations and stated a corrective action plan would be submitted.

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.** **(b) Special diets.** **(c) Susceptibility to hyperthermia and hypothermia and related limitations for physical activity, as appropriate.**

	(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 04/24/2023, it was reported Resident A had oral surgery to remove all of her teeth and was prescribed a soft food diet for six weeks following surgery. On 04/23/2023, Resident A was found with a bag of Fritos chips, given to her from staff. On 04/28/2023, an unannounced, onsite inspection was completed at the facility. Facility administrator, Julie Treakle stated Resident A did have Fritos, but she did not witness staff give them to Resident A. Based on the investigative findings, there is sufficient evidence to support a rule violation that facility staff did not follow the order for Resident A to receive a soft food diet.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license be modified to Provisional for the above-cited quality of care violations.

Megan Aukerman, MSW 05/12/2023

Megan Aukerman Date
Licensing Consultant

Approved By:

05/12/2023

Jerry Hendrick Date
Area Manager