GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 15, 2023

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

RE: License #: AL410289605
Investigation #: 2023A0464050
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.
- 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 #:	AL410289605
Investigation #:	2023A0464050
Complaint Receipt Date:	07/10/2023
Investigation Initiation Date:	07/10/2023
Report Due Date:	09/08/2023
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:	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:	04/30/2023
Expiration Date:	04/29/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED/ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's Assessment Plan has not been updated to reflect Resident A's increased care needs.	No
Facility staff are not addressing Resident A's frequent falls.	No
Residents are not being administered their prescribed medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/10/2023	Special Investigation Intake 2023A0464050
07/10/2023	APS Referral
07/10/2023	Special Investigation Initiated - Telephone RS
07/20/2023	Contact-Telephone call made Relative A
08/01/2023	Inspection Completed-Onsite Hope Smith (Interim Administrator), Julie Treakle (Administrator), & Resident A
08/01/2023	Contact-Document received Facility Records
08/30/2023	Contact-Document received Relative A
09/06/2023	Inspection Completed-Onsite Julie Treakle (Administrator), Julie Adelberg (Associate Administrator), and Teresa Perez (Staff), Aleisha Rivera (Staff), and Val Katona (Staff)
09/06/2023	Contact-Document received Facility Records
09/11/2023	Contact-Telephone call made Molly Nixon, Faith Hospice

09/13/2023	Contact-Telephone call made Bathsheba Bordeaux, Staff
09/13/2023	Contact-Telephone call made Barbara Kamasinski, Staff
09/13/2023	Contact-Telephone call made Stennesha Jones, Staff
09/13/2023	Contact-Telephone call made Kaila Willemstein, Staff
09/15/2023	Exit Conference Connie Clauson, Licensee Desigee

ALLEGATION: Resident A's Assessment Plan has not been updated to reflect Resident A's increased care needs.

INVESTIGATION: On 07/10/2023, I received an online BCAL complaint from Adult Protective Services (APS), which alleged Resident A has been diagnosed with cerebral vascular disease, vascular dementia, abnormal weight loss, essential hypertension, gastro-esophagi reflux disease, irritable bowel syndrome and constipation. Resident A requires use of a walker to ambulate. Resident A had multiple falls and has waited long periods of time for staff assistance. The facility has not updated Resident A's Assessment Plan to reference Resident A's increased fall risk. Adult Protective Services did not assign the complaint for investigation.

On 07/10/2023, I spoke with the referral source (RS). The RS expressed concerns regarding the facility's ability to prevent Resident A from falling.

On 07/20/2023, I spoke to Relative A by telephone. Relative A stated the facility managers did not accurately complete Resident A's Assessment Plan. Relative A stated Resident A utilizes a walker to ambulate and has become an increased fall risk. Resident A's Assessment Plan does not reflect Resident A's increase in the number of falls and that additional support is needed from staff. Relative A stated Resident A's Assessment Plan that was updated on 07/12/2023 stated Resident A has not had any falls, which is inaccurate. Resident A had reported falls on 04/26/2023, 05/02/2023 and 07/02/2023. Relative A stated she met with facility administrator, Julie Treakle and reviewed the Assessment Plan. Relative A was informed the Assessment Plan would be updated to reflect Resident A's increased fall risk.

On 08/01/2023, I completed an unannounced, onsite inspection at the facility. I met with administrators, Hope Smith, and Julie Treakle. Both stated resident Assessment Plans are routinely updated. Ms. Smith and Ms. Treakle stated they had a meeting

with Relative A last week to update Resident A's Assessment Plan. The plan reflects Resident A had an increase in falls and reflects Resident A utilizes a walker to ambulate. To prevent future falls, Ms. Treakle stated motion sensors were placed in Resident A's room to help alert staff if there is any movement in the room. Ms. Treakle provided me with a copy of Resident A's updated Assessment Plan.

I then made face-to-face contact with Resident A. I was unable to conduct an interview of Resident A as Resident A appeared to be confused and was unable to answer questions. I did observe Resident A to be clean and appropriately dressed. There were no observable marks or bruises.

On 08/01/2023, I received and reviewed Resident A's facility records; specifically Resident A's Assessment Plan which was signed and completed on 07/12/2023. Under the Resident Needs section of the assessment plan, it is documented that Resident A requires staff assistance with bathing, grooming, dressing, hygiene practices and toileting. Under the Assistive Devices section of the Assessment Plan, it states Resident A utilizes a walker to ambulate. Under the Incident section of the plan, it states that Resident A has had more than one fall in the past three months. It also states staff are to ensure Resident A's call light is within reach and to report any increase in unsteadiness or falls.

On 09/15/2023, I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation findings and recommendations.

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:	On 07/10/2023, a complaint was received alleging the facility has not updated Resident A's Assessment Plan. Resident A was admitted to the facility on 10/09/2018. An Assessment Plan was completed upon admission to reflect Resident A's care needs at the time of admission. Records reflect Resident A's Assessment Plan was updated annually. Based on the investigative findings, there is insufficient evidence to support a rule violation that the facility did not complete an

	updated Assessment Plan for Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.** **(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.**
ANALYSIS:	Resident A was admitted to the facility on 10/09/2018. An Assessment Plan was completed upon admission to reflect Resident A's care needs at the time of admission. Records reflect Resident A's Assessment Plan was updated annually. Resident A's mobility and stability began to decline; therefore, Resident A's Assessment Plan was updated on 07/12/2023. The Assessment Plan documents that Resident A had more than one fall within the past three months. The plan documented that Resident A utilizes a walker and that staff should make sure Resident A's call light is easily accessible. Facility staff Hope Smith and Julie Treakle both stated Resident A's Assessment Plan has been updated to reflect her increase in care needs. Ms. Treakle stated motion sensors have also been placed in Resident A's room. Based on the investigative findings, there is insufficient evidence to support a rule violation that the facility did not adequately update Resident A's Assessment Plan.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff are not addressing Resident A's frequent falls.

INVESTIGATION: On 07/20/2023, I spoke to Relative A by telephone. Relative A stated Resident A has been falling more recently. Relative A stated Resident A informed her she fell on 07/02/2023 and that she sat on the floor for hours before staff finally came to check on her. Resident A stated she yelled for staff to help when she fell, but her bedroom door was closed, and she did not think staff heard her. Relative A stated she was informed staff check on Resident A every one to two hours; however Resident A reported she was on the floor longer than two hours.

On 08/01/2023, I completed an unannounced onsite inspection at the facility. I interviewed Ms. Smith and Ms. Treakle. Ms. Smith and Ms. Treakle reported they were made aware of Resident A's fall on 07/02/2023 from staff. They denied being aware of other recent falls. Ms. Treakle stated that on 07/12/2023 motion sensors were placed in Resident A's room and when they go off, it alerts staff, who then check on Resident A. Ms. Treakle stated Resident A's call light was also made more accessible to Resident A. Ms. Treakle stated Resident A has not had a fall since 07/02/2023.

I then made face-to-face contact with Resident A. I was unable to conduct an interview of Resident A as Resident A appeared to be confused and was unable to answer questions. I did observe Resident A to be clean and appropriately dressed. There were no observable marks or bruises.

On 08/01/2023, I received and reviewed Resident A's facility records**;** specifically Resident A's Assessment Plan which was signed and completed on 07/12/2023. Under the Resident Needs section of the assessment plan, it reflects Resident A requires staff assistance with bathing, grooming, dressing, hygiene practices and toileting. Under the Assistive Devices section of the Assessment Plan, it states Resident A utilizes a walker to ambulate. Under the Incident section of the Assessment Plan, it states that Resident A has had more than one fall in the past three months. It also states staff are to ensure Resident A's call light is within reach and report any increase in unsteadiness or falls.

On 08/30/2023, I received an email from Relative A. Relative A stated Resident A fell again on 08/28/2023. Relative A reported staff informed her of the incident and Resident A did not sustain any injuries. Relative A stated when she visited the facility, she saw that Resident A's motion sensor alarm was unplugged. Relative A expressed concern regarding facility staff failing to protect Resident A. Relative A stated hospice ordered that facility staff are to check on Resident A every hour, but she does not believe staff are doing so. Relative A stated Resident A will be moving out of the facility.

On 09/06/2023, I completed an unannounced, onsite inspection at the facility. I interviewed facility staff Val Katona. Ms. Katona stated Resident A has been falling more frequently and is now required to have checks every hour. Ms. Katona denied witnessing Resident A fall, but stated Resident A has told her in the past she fell and had to wait long periods of time for staff to respond.

On 09/11/2023, I spoke to Faith Hospice nurse, Molly Nixon by phone. Ms. Nixon stated she has not heard of Resident A having any recent falls. Ms. Nixon stated she visited Resident A recently and did not have any concerns regarding staff failing to check on Resident A.

On 09/13/2023, I interviewed facility staff, Bathsheba Bordeaux, Barbara Kamasinski, Stennesha Jones and Kaila Willemstein individually, by telephone. All four staff stated they provide care to Resident A. They all stated routine checks are completed to make sure Resident A has not fallen. Ms. Bordeaux, Ms. Kamasinski, Ms. Jones, and Ms. Willenstein denied witnessing Resident A fall or finding her on her bedroom floor. All four reported Resident A has a motion sensor in her room that alerts staff if she is up moving during the night. All four staff denied having any direct knowledge of Resident A's motion sensor being unplugged.

On 09/15/2023, I completed an exit conference with Mrs. Clauson. She was informed of the investigation findings and recommendations.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 07/10/2023, a complaint was received alleging Resident A has frequent falls and facility staff are not adequately protecting her from falling. Relative A reported Resident A has become an increased fall risk and had to wait for hours for staff assistance after a recent fall. Relative A stated she observed Resident A's motion sensor was unplugged when she recently visited the facility. Facility staff Hope Smith and Julie Treakle both stated they were aware Resident A fell on 07/02/2023. Ms. Smith and Ms. Treakle stated Resident A's Assessment Plan was updated to reflect Resident A's need for an increased level of care. Ms. Treakle stated motion sensors were placed in Resident A's room to better alert staff if Resident A falls.

	Facility staff, Val Katona, Bathsheba Bordeaux, Barbara Kamasinski, Stennesha Jones, and Kaila Willemstein all denied witnessing Resident A fall. They also denied any knowledge of Resident A having to wait for several hours after falling, for staff to assist. Staff reported a motion sensor was placed in Resident A's bedroom to assist with alerting staff when Resident A gets out of bed. Resident A's Faith Hospice Nurse, Molly Nixon denied having any concerns regarding Resident A falling and staff failing to respond appropriately. Based on the investigative findings, there is insufficient evidence to determine facility staff are not adequately addressing Resident A's falls.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents are not being administered their prescribed medications.

INVESTIGATION: On 08/30/2023, I received an email from Relative A. Relative A stated while she was visiting the facility, there was not a scheduled medication technician for the morning shift. As a result, residents were not administered their medications.

On 09/06/2023, I completed an unannounced, onsite inspection at the facility. I interviewed facility staff, Theresa Perez, Aliesha Rivera, and Val Katona. All three staff reported that on more than one occasion there was not a medication technician in Yorkshire-East and Yorkshire-West; therefore, residents were not administered their prescribed medications. All three staff reported the most recent incident was the morning of 09/05/2023. All three staff stated they do not believe resident physicians were contacted each time a resident was not administered a prescribed medication.

I then interviewed Ms. Treakle. Ms. Treakle acknowledged there have been incidents when there was not a med tech on duty and as a result, facility residents did not receive their prescribed medications. Ms. Treakle stated often times there is a med tech scheduled, but they will not show up or call in sick.

I then reviewed the electronic medication administration record for all residents during the month of September 2023. The MAR reflected that on 09/05/2023, residents did not receive their morning medications. I then printed resident MAR's from previous months.

On 09/06/2023, I received and reviewed resident Medication Administration Records (MAR) for Residents A, B, C, D and E for the month of August 2023. The MAR reflected Residents B administers her own medications. The MAR's reflected Residents A, C and E did not receive their prescribed evening medications on 08/29/2023. For example, Resident A is prescribed Melatonin 3 mg at night. On 08/29/2023, the MAR reflected Resident A was not administered her Melatonin.

On 09/15/2023, I completed an exit conference with Mrs. Clauson. She was informed of the investigation findings and recommendations. Mrs. Clauson stated she was only recently informed of the extent of the medication issues. Mrs. Clauson stated she is taking immediate action to rectify the issue.

APPLICABLE RULE	
R 400.15312	**Resident medication.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 08/30/2023, a complaint was received reporting that residents are not being administered prescribed medications. Facility staff, Julie Treakle, Val Katona, Theresa Perez, and Aliesha Rivera each reported there have been incidents when, due to a lack of a medication technician, residents were not administered their prescribed medications. Facility staff, Bathsheba Bordeaux, Barbara Kamasinski, Stennesha Jones, and Kaila Willemstein each reported there have been occasions when due to a lack of a scheduled medication technician, residents were not administered their prescribed medications. The resident Medication Administration Records (MAR) reflected residents did not receive prescribed medications on 08/29/2023 and 09/05/2023. Based on the investigative findings, there is sufficient evidence to support a rule violation that residents were not administered prescribed medications on 08/29/2023 and 09/05/2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: Facility staff are not adequately completing resident Medication Administration Records (MARs).

INVESTIGATION: On 09/06/2023, I completed an unannounced, onsite inspection at the facility. I printed and reviewed August 2023 MARs for Residents A, B, C, D, and E. During the month of August 2023 there were several spaces on each resident's MAR that were left blank, indicating the residents were not administered their prescribed medications. The MARs also reflected there were several dates when the resident was not administered their prescribed medication and staff selected "other" as the reason. There was no explanation of why the medication was not administered. For example, Resident A is prescribed Melatonin 3 mg at bedtime. The MAR reflected Resident A was not administered her Melatonin during the evening of 08/29/2023, as the box was left blank with no staff initials. Resident C's MAR reflected she is prescribed Donepezil 10 mg, Melatonin 3 mg, Famotidine 20 mg, Minerin cream, Triamcinolone ointment, Preseversion soft gels and Latanoprost eye drops at bedtime. The MAR reflects that during the evening of 08/29/2023, Resident C was not administered her bedtime medications. The boxes were blank with no staff initials. Resident C's MAR also reflected Resident A was not administered her morning medications on 08/28/2023. Staff selected "other" as the reason, with no explanation provided.

On 09/13/2023, I interviewed facility staff, Bathsheba Bordeaux, Barbara Kamasinski, Stennesha Jones, and Kaila Willemstein individually by telephone. All four staff reported when residents are not administered prescribed medications, the medication pass is not documented in the MAR.

On 09/15/2023, I completed an exit conference with Mrs. Clauson. She was informed of the investigation findings and recommendations. Mrs. Clauson stated she was only recently informed of the extent of the medication issues. Mrs. Clauson stated she is taking immediate action to rectify the issue.

APPLICABLE RULE	
400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**

ANALYSIS:	During an unannounced, onsite inspection it was discovered staff were not adequately completing resident Medication Administration Records (MARs). On 09/06/2023, August 2023 MARs were reviewed for Residents A, B, C, D, and E. The MARs showed several blank spaces where staff initials should have been. There were also several "other" reasons listed, with no explanation, for when residents were not administered prescribed medications. Facility staff, Bathsheba Bordeaux, Barbara Kamasinski, Stennesha Jones, and Kaila Willemstein were interviewed individually. All four staff reported when residents are not administered medications, the MAR is left blank. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff are not adequately completing resident MARs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: The facility did not notify resident physicians each time a prescribed medication was not administered.

INVESTIGATION: On 09/06/2023, I completed an unannounced, onsite inspection at the facility. I printed and reviewed August 2023 MARs for Residents A, B, C, D, and E. During the month of August 2023 there were several spaces on each resident's MAR that were left blank, indicating the residents were not administered their prescribed medications. The MARs also reflected there were several dates when the resident was not administered their prescribed medications and staff selected "other" as the reason. There was no explanation of why the medication was not administered. The MAR also failed to reflect that resident physicians were contacted each time a resident was not administered a prescribed medication.

On 09/13/2023, I interviewed Bathsheba Bordeaux, Barbara Kamasinski, Stennesha Jones, and Kaila Willemstein individually by telephone. All four staff reported there have been incidents when residents were not administered their prescribed medications. All four staff denied that the residents' physicians were contacted each time a resident was not administered a prescribed medication.

On 09/15/2023, I completed an exit conference with Mrs. Clauson. She was informed of the investigation findings and recommendations. Mrs. Clauson stated she was only recently informed of the medication issues. Mrs. Clauson stated she is taking immediate action to rectify the issue.

APPLICABLE RULE	
400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (f) Contact the appropriate health care professional if a medication error occurs or when a resident refuse prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	The MARS indicated there was more than one occasion when residents were not administered their prescribed medications. The MAR also lacked documentation indicating that the residents' physicians were contacted with each medication error. Bathsheba Bordeaux, Barbara Kamasinski, Stennesha Jones, and Kaila Willemstein all acknowledged that the residents' physicians were not contacted when a resident was not administered a prescribed medication. Based on the investigative findings, there is sufficient evidence to support a rule violation that resident physicians were not contacted with each medication error.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the license be modified to a provisional as a result of the above-cited quality of care violations.

Megan Aukerman, MSW 09/15/2023

Megan Aukerman, Licensing Consultant Date

Approved By:

09/15/2023

Jerry Hendrick, Area Manager Date