GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 22, 2023

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

RE: License #: AL410289606
Investigation #: 2023A0464058
Yorkshire Manor - East

Dear Mrs. Clauson:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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, MSW

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 #:	AL410289606
Investigation #:	2023A0464058
Complaint Receipt Date:	08/01/2023
Investigation Initiation Date:	08/01/2023
Report Due Date:	09/30/2023
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 - East
Facility Address:	3511 Leonard St. NW Walker, MI 49534
Facility Telephone #:	(616) 791-9090
Original Issuance Date:	10/31/2012
License Status:	1ST PROVISIONAL
Effective Date:	06/23/2023
Expiration Date:	12/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS/AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff are not administering Resident A's prescribed medications.	Yes

III. METHODOLOGY

08/01/2023	Special Investigation Intake 2023A0464058
08/01/2023	APS Referral Centralized Intake, DHHS
08/01/2023	Special Investigation Initiated - Telephone Relative B
08/01/2023	Inspection Completed On-site Hope Smith (Interim Administrator), Julie Treakle (Administrator), Resident A
08/01/2023	Contact - Document Received Facility Records
08/14/2023	Exit Conference Connie Clauson, Licensee Designee

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

INVESTIGATION: On 08/01/2023, I received a complaint alleging facility staff are not administering Resident A's prescribed medication.

On 08/01/2023, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 08/01/2023, I spoke to Relative B by telephone. Relative B stated he was at the facility visiting Resident B and staff were administering his prescribed medications. Relative B stated the facility ran out of Resident B's prescribed Carbidopa 25/100 mg; therefore, they were unable to administer the medication to Resident B. In addition, Relative B stated Resident B has been out of his Lexapro 20 mg for two weeks. Staff reportedly told Relative B the medication was requested, but the pharmacy did not refill it. Relative B expressed concern regarding the lack of follow

through to have the prescribed medication refilled. Relative B stated he got involved and the hospice nurse sent a new prescription for the Lexapro to be filled. Relative B stated he was unsure if the facility has yet received the medication and if it is being given to Resident B.

On 08/01/2023, I completed an unannounced, onsite inspection at the facility. I interviewed facility managers, Hope Smith, and Julie Treakle. Both stated Resident B is administered his Carbidopa as prescribed. Ms. Treakle stated a few weeks ago she met with Relative B to explain how the medication was administered, as there seemed to be confusion. Mrs. Treakle denied Resident B had run out of his Carbidopa. Mrs. Treakle acknowledged that Resident B recently ran out of his prescription for Lexapro 20 mg. She stated a refill request was submitted to the pharmacy, and they are just waiting for the pharmacy to deliver the medication.

I then made face-to-face contact with Resident B. An interviewed was not completed as Resident B was observed asleep in his bed. Resident B appeared to be clean and appropriately dressed. No concerns were observed.

I then reviewed and counted Resident B's prescribed medications as well as his electronic Medication Administration Record (MAR). Resident B is prescribed the following medications:

Medication	Dosage	Frequency
Carb-Levo ER (Carbidopa)	50-200 mg	Once Daily
Carb-Levo (Carbidopa)	25-100 mg	Twice Daily
Levothyroxine	100 mg	Once Daily
Lexapro	20 mg	Once Daily
Metoprolol	25 mg	Twice Daily
Galantamine	12 mg	Twice Daily
Xanax	.25 mg	Three Times Daily

All of Resident B's prescribed medications were accounted for in the medication cart, except for his prescribed Lexapro 20 mg. The MAR reflected Resident B was not administered his Lexapro 20 mg from 07/01/2023 to 08/01/2023. The MAR reflected Resident B ran out of the medication on 07/01/2023 and a refill request was submitted to Hometown Pharmacy. On 07/25/2023, a note was placed in the MAR stating the medication was not yet available and it was on back order. The medication has been yet to be received. The MAR reflected Resident A was administered both Carbidopa medications as prescribed.

On 08/14/2023, a file reviewed was conducted as a part of a separate investigation (SIR #2023A046457) that was completed on 08/14/2023. That investigation resulted in substantiated repeat quality of care rule violations and revocation of the facility's license was recommended.

On 08/14/2023, I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation and recommendations.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 08/01/2023, a complaint was received alleging facility staff were not administering Resident A's medications. On 08/01/2023, an unannounced, onsite inspection was completed at the facility. Facility staff Hope Smith and Julie Treakle stated Resident B ran out of his prescribed Lexapro 20 mg; however, a refill request was submitted to the pharmacy. Resident B's prescribed medication and Electronic Medication Administration Record (MAR) indicated Resident B did not have any Lexapro 20 mg in the medication cart. The MAR reflected Resident B ran out of the medication on 07/01/2023 and it was not provided to Resident B from 07/01/2023 through 08/01/2023. A refill request was submitted to the pharmacy; however, no documentation existed regarding any follow-up on the part of facility personnel to acquire Resident B's Lexapro. Based on the investigation findings, there is sufficient evidence to support a rule violation that staff did not ensure Resident B was administered his prescribed medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

The previous recommendation for revocation in SIR # 2023A0464057 remains unchanged.

08/22/2023

Megan Aukerman Date
Licensing Consultant

Approved By:

08/22/2023

Jerry Hendrick Date
Area Manager