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 #: AL410289606
Investigation #: 2023A0464062
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 #:	2023A0464062
Complaint Receipt Date:	09/05/2023
Investigation Initiation Date:	09/05/2023
Report Due Date:	11/04/2023
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?
Due to lack of supervision, Resident A spilled hot chocolate on himself, causing a large burn.	Yes
Residents are not being administered their prescribed medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/05/2023	Special Investigation Intake 2023A0464062
09/05/2023	Special Investigation Initiated - Telephone Referral Source
09/06/2023	APS Referral Centralized Intake, DHHS
09/06/2023	Inspection Completed On-site Alisha Rivera (Staff), Julie Treakle (Administrator), Julie Adelberg (Associate Administrator), Theresa Perez (Staff), Resident A and Resident B
09/06/2023	Contact-Document received Facility Records
09/11/2023	Contact-Telephone call made Belinda Pettis, Staff
09/11/2023	Contact-Telephone call made Brajama Richardson, Staff
09/13/2023	Contact-Document received Julie Adelberg, Associate Administrator
09/13/2023	Contact-Telephone call made Belinda Pettis, Staff
09/13/2023	Contact-Telephone call made Brajama Richardson, Staff
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 Designee

ALLEGATION: Due to lack of supervision, Resident A spilled hot chocolate on himself, causing a large burn.

INVESTIGATION: On 09/05/2023, I received an online BCAL complaint which alleged during the morning of 09/01/2023, facility staff gave Resident A a cup of hot chocolate without a lid and straw. Resident A subsequently spilled the drink on himself, causing a large burn on his left thigh.

On 09/05/2023, I exchanged emails with the referral source (RS). The RS sent a photograph of Resident A's burn. The photograph showed a significant burn on Resident A's left thigh, that appeared to be in the blistering phase. The RS confirmed hospice was notified and treated Resident A at the facility on 09/01/2023.

On 09/05/2023, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services referral per policy.

On 09/06/2023, I completed an unannounced, onsite inspection at the facility. I interviewed facility staff, Theresa Perez. Ms. Perez stated Resident A struggles with eating and drinking. Resident A requires staff supervision with each meal. Resident A's hands shake badly; therefore, staff have to assist with meals. Ms. Perez stated Resident A is supposed to be given all of his drinks with a lid and straw, due to unsteady hands. Ms. Perez believes the third shift staff failed to supervise Resident A the morning of 09/01/2023 during breakfast, when they gave Resident A a hot drink. Ms. Perez stated staff also failed to give Resident A is drink with a lid and straw. Ms. Perez stated that she came in the morning of 09/01/2023, to relieve the third shift staff. When Ms. Perez went to change Resident A, she noticed a large burn on his left thigh. Ms. Perez stated she immediately informed administration, who contacted Resident A's hospice nurse and family. Ms. Perez stated she worked the day before and Resident A did not have the burn. Ms. Perez stated she knew Resident A had spilled something on himself because his pants were wet, with a brown spot that smelled like chocolate.

I then interviewed facility administrators, Julie Treakle and Julie Adelberg. Mrs. Treakle stated Resident A requires staff supervision during meals as well as all drinks being served with a lid and straw. Both Mrs. Treakle and Ms. Adelberg stated as soon as they learned of Resident A's burn, the hospice nurse and Resident A's family were contacted. Mrs. Treakle and Ms. Adelberg stated they are completing an internal investigation on the issue as well. They stated they have narrowed it down to two staff who could have given Resident A access to the cup of hot chocolate during breakfast. The staff working the morning of 09/01/2023 were Brajama Richardson and Belinda Pettis. Mrs. Treakle stated they have not yet heard back from either staff person. Mrs. Treakle reported that both staff have a history of calling in sick to work. Mrs. Treakle and Ms. Adelberg stated since the incident, staff have been retrained on burn protocols and each building is supplied with a burn emergency kit.

Face-to-face contact was made with Resident A while at the facility on 09/06/2023. An interviewed was not completed as Resident A has a diagnosis of Dementia and does not speak. Ms. Perez showed me the burn on Resident A's left leg. The burn was covered in medication and a large bandage. The area surrounding the covered burn was observed to be clean. Resident A did not appear to be in pain.

On 09/06/2023, I received and reviewed Resident A's facility records, specifically Resident A's Assessment Plan, which was signed and completed on 05/11/2023. Under the diet section of the Assessment Plan, it states Resident A is unable to eat meals independently and requires constant staff monitoring. Staff are to assist with prompts and cutting food. Resident A is to have all meat ground into tiny pieces. The Assessment Plan does not specifically state that Resident A is to have a lid and straw with each drink.

On 09/11/2023, I attempted to contact staff, Belinda Pettis and left a voice message requesting a return phone call.

On 09/11/2023, I attempted to contact staff, Brajama Richardson; however, there was no answer, and the mailbox was full. Therefore, I was unable to leave a voice message.

On 09/11/2023, I spoke with staff, Will Benson by telephone. Mr. Benson stated he was working in the early morning on 09/01/2023. Mr. Benson stated he got Resident A up and wheeled him to breakfast. Mr. Benson stated he left his shift before Resident A received the injury. Mr. Benson stated Resident A shakes a lot and requires a lid and straw for his drinks. Mr. Benson stated he only brought Resident A to the table the morning of 09/01/2023. At that time Resident A had not yet received a drink or food. Mr. Benson believes someone must have given Resident A a hot drink without a lid and he spilled on himself.

On 09/13/2023, I exchanged emails with Ms. Adelberg. She stated after the incident Ms. Pettis did not show up for her scheduled shift on 09/12/2023. Ms. Adelberg

stated she spoke with Ms. Richardson who denied giving Resident A a cup of hot coco and leaving Resident A unsupervised during breakfast.

On 09/13/2023, I left a message for Ms. Pettis requesting a return phone call.

On 09/13/2023, I interviewed Ms. Richardson by telephone. Ms. Richardson stated she was working the morning of 09/01/2023. Ms. Richardson stated the shift was ending; therefore, she did not supervise Resident A during breakfast. Ms. Richardson did not see staff with Resident A during breakfast or serve him a hot beverage without a lid.

On 09/15/2023, I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation findings and recommendations. Mrs. Clauson demonstrated an understanding regarding the recommendation. Mrs. Clauson stated she was informed of the incident by the staff and informed me that actions are being taken to prevent further incidents.

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 09/05/2023, a complaint was received alleging Resident A spilled a hot drink, causing a large burn on his left thigh. Facility staff Theresa Perez, Brajama Richardson, Julie Treakle, and Julie Adelberg each reported Resident A requires staff assistance with each meal. Each staff also reported Resident A is to have all beverages served with a lid and straw. Ms. Treakle, Ms. Adelberg, Ms. Perez, and Ms. Richardson reported they believe a staff person left Resident A unsupervised during breakfast the morning of 09/01/2023. Someone had given Resident A a hot beverage with no lid. Due to lack of staff supervision, Resident A spilled the hot drink, causing a burn on his left leg. Resident A's Assessment Plan was reviewed. Under the diet section of the Assessment Plan, it states Resident A requires constant staff supervision during each meal. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff did not supervise Resident A appropriately during breakfast the morning of 09/01/2023.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Residents are not being administered their prescribed medications.

INVESTIGATION: On 09/05/2023, I received a complaint alleging there have been incidents when residents were not administered their prescribed medications.

On 09/06/2023, I completed an unannounced, onsite inspection at the facility and interviewed facility staff Alisha Rivera, and Theresa Perez. Both staff stated there have been incidents when a scheduled medication technician did not come in for a scheduled shift; therefore, residents were not administered their prescribed medications. Ms. Rivera and Ms. Perez stated the resident's physicians were not notified. Ms. Rivera and Ms. Perez stated the most recent incident was during the morning of 09/05/2023. A medication technician did not come in during the morning shift and none of the residents were administered their morning medications. Ms. Rivera and Ms. Perez stated this has occurred other times as well but were unable to recall the dates.

I then interviewed Mrs. Treakle and Ms. Adelberg. Both confirmed there have been occasions when residents were not administered their medications due to a medication technician not showing up for their scheduled shift.

I interviewed Resident B privately. Resident B stated she is aware of all her prescribed medications. Resident B stated there have been incidents when she has not been administered her medications. Resident B stated this has occurred on more than one occasion; however, she was unable to recall the exact dates.

On 09/06/2023, I received and reviewed resident Medication Administration Records (MAR) for all ten residents (Resident A, B, C, D, E, F, G, H, I, and J). The MARs were difficult to decipher which dates during the month of August 2023 residents did not receive their prescribed medications. The MARs for all ten residents had various boxes that were left blank or only stated "other" listed as reasons a resident was not administered medication. The MARs also reflected there were several resident refusals of medications. There was no documentation in the MAR, stating resident physicians were contacted each time a prescribed medication was not administered.

Resident A's August 2023 MAR was reviewed. The MAR reflected Resident A was not administered his Carb-Levo 25-100 mg and Xanax .25 mg on 8/21/2023 or on 8/22/2023. The boxes were left blank and did not contain any staff initials.

The MAR for August 2023 was reviewed for Resident B. Resident B is prescribed milk of magnesia 30 ml, Senna 8.6 mg, multivitamin and zinc 220 mg. The MAR was left blank on 08/31/2023, indicating Resident A was not administered the prescribed medications.

On 09/11/2023, I interviewed Mr. Benson by telephone. Mr. Benson stated he was aware of incidents when residents were not administered prescribed medications but was unable to recall the exact dates. Mr. Benson stated in the past, staff would leave their shift even before the other medication technician arrived. Mr. Benson stated now, the assigned med tech is not allowed to leave their shift until the next one comes on the floor.

On 09/13/2023, I interviewed Ms. Richardson by telephone. Ms. Richardson stated there have been incidents, when a medication technician was not scheduled or they were running behind; therefore, residents were not administered their prescribed medications. Ms. Richardson was unable to provide exact dates when this occurred. Ms. Richardson stated she was not aware of the staff calling the resident's physicians to report when residents were not administered their medications.

On 09/13/2023, I interviewed staff, Bathsheba Bordeaux, by telephone. Ms. Bordeaux stated there have been occasions that she knows residents were not administered their prescribed medications due to a lack of a trained medication technician on duty. Ms. Bordeaux stated these incidents have typically occurred on weekends. Ms. Bordeaux stated she has not contacted the residents' physicians to inform them when residents do not get prescribed medications.

On 09/13/2023, I interviewed staff, Kaila Willemstein, by telephone. Ms. Willenstein stated she is not a med tech, but she has worked shifts when residents were not administered their prescribed medications. She was not aware of any staff contacting the resident's physicians to report the resident did not get their prescribed medication.

On 09/13/2023, 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 explained she is meeting with staff to address the issues immediately.

APPLICABLE RULE	
400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 09/05/2023, a complaint was received alleging there were incidents when residents were not administered their prescribed medications. Facility staff Alisha Rivera, Theresa Perez, Brajama Richardson, Kaila Willemstein, Bathsheba Bordeaux, Julie Treakle, and Julie

	Adelberg stated there have been incidents when residents were not administered their prescribed medications. Resident B was also interviewed and reported there have been incidents when she was not administered her prescribed medications. Resident Medication Administration Records (MAR) were reviewed for Resident A, B, C, D, E, F, G, H, I and J and included several blank boxes, indicating residents did not receive those prescribed medications. Based on the investigative findings, there is sufficient evidence to support the rule violation that residents were not administered their prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: Facility staff are not adequately completing resident Medication Administration Record (MAR).

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, E, F, G, H, I and J. During the month of August 2023 there were several spaces on each resident's MAR that were left blank, indicating the resident was 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 C's MAR reflected that on 08/02/2023 and 08/03/2023, Resident C was not administered his prescribed Melatonin 5 mg and Docusate Sod 100 mg. Staff selected "other" as the reason; providing no explanation of why the medication was not administered. Resident C's MAR also reflected that on 08/25/2023, Resident C was not administered his prescribed Losartan 100 mg, Furosemide 40 mg, Lipitor 40 mg, Vitamin D3, Vitamin C, Aspirin 81 mg, and Carvedilol 6.25 mg. The boxes were left blank, with no staff initials.

On 09/13/2023, 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 explained she is meeting with staff to address the issues immediately.

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 (MAR). On 09/06/2023, August 2023 MARs were reviewed for all ten residents, Residents A, B, C, D, E, F, G, H, I and J. 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. 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, E, F, G, H, I and J. During the month of August 2023 there were several spaces on each resident’s MAR that were left blank, indicating the resident was 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 or documentation stating facility staff contacted the residents’ physician’s each time a prescribed medication was not administered.

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

On 09/13/2023, 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 explained she is meeting with staff to address the issues immediately.

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. Facility staff Brajama Richardson, Kaila Willemstein, and Bathsheba Bordeaux 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

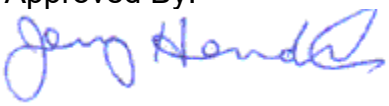
On 05/12/2023 special investigation (SIR# 2023A0464035) was completed and quality of care rule violations were established. As a result, the facility was placed on a provisional license. On 08/22/2023 a subsequent special investigation was completed (SIR# 2023A0464058) and repeated quality of care rule violations were

established. As a result, revocation of the license was recommended. That previous recommendation for revocation of the license remains as a result of the above-cited quality of care violations.

09/15/2023

Megan Aukerman Date
Licensing Consultant

Approved By:



09/15/2023

Jerry Hendrick Date
Area Manager