GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 31, 2023

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

RE: License #: AL410289602
Investigation #: 2023A0464063
Stonebridge Manor - North

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 #:	AL410289602
Investigation #:	2023A0464063
Complaint Receipt Date:	09/06/2023
Investigation Initiation Date:	09/06/2023
Report Due Date:	11/05/2023
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:	06/23/2023
Expiration Date:	12/22/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS/AGED

II. ALLEGATION(S)

	Violation Established?
The facility is insufficiently staffed to meet resident care needs.	Yes
Residents are not being administered their prescribed medications.	Yes
Physicians are not being notified when residents are not administered their medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/06/2023	Special Investigation Intake 2023A0464063
09/06/2023	APS Referral Centralized Intake, DHHS
09/06/2023	Contact-Document received File Review
09/06/2023	Special Investigation Initiated - On Site Julie Treakle (Administrator), Julie Adelburg (Assistance Administrator)
09/06/2023	Contact-Document received Police Reports, Walker Police Department
09/26/2023	Contact-Telephone call made Referral Source
09/26/2023	Contact-Telephone call received Joseph Dionise, AG Investigator
10/10/2023	Inspection Completed-Onsite Joseph Dionise (AG Investigator), Tracey Jones (AG Investigator), Jerry Hendry (Area Manager) Julie Treakle (Administrator), Amanda Beecham (Regional Director), Aliesha Rivera (Staff), Valarie Katona (Staff), Rosie Velez (Staff), Residents A
10/20/2023	Contact-Document received Facility Records
10/30/2023	Exit Conference Connie Clauson, Licensee Designee

ALLEGATION: The facility is insufficiently staffed to meet resident care needs.

INVESTIGATION: On 09/06/2023, I received an online BCAL complaint. The complaint alleged the facility does not have sufficient staff to care for the residents; residents are not being administered their prescribed medications; and medications were left out, sitting on top of the medication cart.

On 09/06/2023, I contacted the Department of Health and Human Services (DHHS), Centralized Intake to complete an Adult Protective Services (APS) referral per policy.

On 09/06/2023, I completed a file review. As a result of special investigation 2023A0464037, the facility was issued a provisional license on 06/23/2023 due to repeat quality of care rule violations.

On 09/06/2023, I completed an unannounced, onsite inspection at the facility. I interviewed facility administrator, Julie Treakle and assistant administrator, Julie Adelburg. Both denied having current concerns regarding staffing at the facility. Both stated there are few residents residing in the facility that require a two-person staff assist.

On 09/06/2023, I received and reviewed police reports from the Walker Police Department. Police report #23-008241 states that on 08/15/2023, police officers responded to a domestic dispute regarding three recently terminated employees who were threatening physical violence. The situation was deescalated, the terminated staff were banned from the property, and the case was closed.

I then reviewed police report #23-008542. On 08/22/2023, police officers responded to a call regarding two employees fighting outside the facility. When officers arrived, the dispute appeared to be only a verbal argument. Both employees were terminated and banned from the facility. The case was closed.

I then reviewed police reports 23-009462, 23-008987, 23-004352, and 23-004198. All four reports reflect officers responded to a complaint concerning resident safety and well-being. It was reported lack of staffing has been an ongoing issue causing problems withing the facility and concern for resident safety. A complaint was made to APS and the cases were closed.

On 09/26/2023, I spoke to the referral source (RS) by telephone. The RS expressed concerns regarding lack of staff at the facility. She stated she has witnessed it taking more than fifteen minutes for staff to assist residents who require staff assistance. The RS stated this occurs frequently. The RS reported due to the ongoing issues at the facility, she is relocating Resident R to another facility.

On 09/26/2023, I spoke with Joseph Dionise, an investigator with the Attorney General's Office to coordinate the investigation.

On 10/10/2023, Mr. Dionise, AG investigator Tracey Jones, area manager Jerry Hendrick, and I completed an onsite inspection at the facility. We interviewed Ms. Treakle and regional director, Amanda Beecham. Both explained the facility functions as their memory care unit. A majority of the residents have a diagnosis of Alzheimer's Disease or Dementia. There are currently seventeen residents residing in the facility. Ms. Treakle reported only one resident requires a two-person staff assist with a Hoyer lift. Ms. Treakle stated there are typically two staff scheduled per shift, along with one medication technician. Ms. Treakle acknowledged the facility has been struggling with staffing shortages. She explained that staff will call in sick for their scheduled shift, and there may not be available staff to cover their shift. There have also been times where staff will simply not show up for a scheduled shift.

We then interviewed staff, Aliesha Rivera. Ms. Rivera stated there have been many times when there has been insufficient staff to care for the residents. Ms. Rivera stated just this past weekend, she worked her scheduled shift by herself. Ms. Rivera expressed concerns as there are two residents in the facility who require a two-person assist, along with a Hoyer lift. Ms. Rivera stated Ms. Treakle was trying to find staff to come in and assist; however, was unsuccessful. Ms. Rivera stated Ms. Treakle then informed Ms. Rivera she was going to come in and help, but she never showed up. Ms. Rivera stated this is not the first time she worked a shift alone in the facility.

We then interviewed staff, Valarie Katona and Rosie Velez, individually. Both staff stated the facility struggles with staffing. Often times there are not enough staff on each shift. Many staff call in or don't show up for their scheduled shifts. Both expressed concerns regarding the facility's ability to find "good" staff that are able to meet resident care needs.

I then interviewed Resident A privately. Resident A stated she is moving to a different facility, where staff are able to better meet her care needs. Resident A stated the facility lacks sufficient staff. Resident A stated often times there is only one staff person to cover the entire facility. Resident A stated residents have to wait for long periods of time to receive staff assistance.

On 10/20/2023, I received and reviewed resident assessment plans for all seventeen residents including Residents A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P and Q. The assessment plans reflect that Residents D, C, F, H, I, G, N, O and Q all have a diagnosis of Alzheimer's Disease or Dementia. A review of the assessment plans reflect that Residents B, C, D, E, F, I, K, L, M and O complete most activities of daily living (ADL) independently. They require minimal staff assistance and prompts. Residents G, H, N, P and Q require a one-person staff assist with ADL's. Resident J requires a two-person staff assist with ADL's along with use of a Hoyer lift.

On 10/30/2023, I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation findings and recommendations.

The revocation process was explained, and Mrs. Clauson was informed of her options.

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 09/06/2023, a complaint was received alleging the facility does not have sufficient staff to care for the residents. Onsite inspections were completed on 09/06/2023 and 10/10/2023. Facility staff Julie Treakle, Valarie Katona, Aliesha Rivera, and Rosie Velez were all interviewed. All four staff acknowledged the facility does not have sufficient staffing to meet resident care needs. Resident assessment plans were reviewed and indicated nine of the seventeen residents have a diagnosis of Alzheimer's Disease or Dementia. The assessment plans also indicated Resident J requires a two-person staff assist with ADL's, along with the use of a Hoyer lift. Based on the investigation findings, there is sufficient evidence to support a rule violation that the facility does not have sufficient staff to meet resident care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are not being administered their medications.

INVESTIGATION: On 09/26/2023, I spoke to the referral source (RS) by telephone. The RS stated she believes residents are not being administered prescribed medications. The RS stated she has noticed the residents appear to be more agitated, which could be a sign that they are not receiving certain medications.

On 10/10/2023, Mr. Dionise, Mr. Jones, Mr. Hendrick, and I completed an onsite inspection at the facility. We interviewed Ms. Treakle and Ms. Beecham. Both acknowledged there were incidents when residents did not receive prescribed medications. Ms. Beecham explained she is working out of the facility more frequently to address medication errors and ensure residents receive medications as

prescribed. Ms. Beecham also explained a nurse has been hired to oversee all resident medications as well.
We then interviewed Ms. Katona and Ms. Rivera, individually. Both staff reported that due to a lack of staffing, there have been incidents when there was no med tech on shift to administer resident medications. Residents have either waited for long periods of time to receive their medications or were not administered their prescribed medications.

We then interviewed Ms. Velez. She stated she only provides resident care and does not administer resident medication. Ms. Velez denied having information regarding residents not being administered their prescribed medications.

I then interviewed Resident A privately. Resident A stated the facility is struggling with having staff that are trained to administer medications. Resident A stated there have been times, especially on the weekends, when she was not administered prescribed medications, which she is supposed to take on a daily basis.

On 10/20/2023, I received the medication administration records (MAR) for Residents B, C, D, E, F, G, H, I, J, K, L, M, N, O, P and Q. The MAR's reflected several medication errors for the months of September 2023 and October 2023. Examples of the medication errors are provided below:

On 10/03/2023, Resident B was not administered Melatonin 3mg and Risperidone .25 mg. On 09/23/2023, Resident P was not administered Hydrochlorothiazide 25mg, Sertraline 50mg, eye drops, Flonase nasal spray, Risperidone .25mg, and Sertraline 25 mg. Resident O was not administered prescribed Famotidine 20mg on 09/04/2023, 09/09/2023, 09/17/2023, 09/19/2023, 09/26/2023, 09/28/2023, 10/10/2023, 10/11/2023 and 10/14/2023. On 09/23/2023, Resident O was not administered prescribed Venlafaxine HCL 25 and Acetaminophen 500mg. On 09/23/2023, Resident Q was not administered Acetaminophen 500mg, Aspirin 81mg, Furosemide 20mg, multivitamin Vitamin D3 and Zinc Gluconate 50mg. On 10/02/2023 and 10/06/2023, Resident Q was not administered her 2:00 pm dose of Glucosamine 500/400 capsule.

On 10/30/2023, I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation findings and recommendations. The revocation process was explained, and Mrs. Clauson was informed of her options.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On 09/06/2023, a complaint was received alleging residents are

	not being administered prescribed medications. Onsite inspections were completed on 09/06/2023 and 10/10/2023. Facility staff Julie Treakle, Valarie Katona, Aliesha Rivera, and Rosie Velez were all interviewed. All four staff reported there have been incidents when residents have not been administered prescribed medications. The medication administration records (MAR) were reviewed for all seventeen residents, specifically the months of September 2023 and October 2023. The MAR's reflected several medication errors, indicating residents were not administered prescribed medications. Based on the investigative findings, there is sufficient evidence to support a rule violation that residents were not administered prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Physicians are not being notified when residents are not administered their medications.

INVESTIGATION: On 10/10/2023, Mr. Dionise, Mr. Jones, Mr. Hendrick, and I completed an onsite inspection at the facility. We interviewed Ms. Treakle and Ms. Beecham. Both Ms. Treakle and Ms. Beecham acknowledged staff are not contacting resident physicians when residents are not administered prescribed medications. Ms. Beecham stated she is now implementing a new medication administration training program and staff will be taught that physicians must be contacted when a medication is not administered.

We then interviewed Ms. Katona and Ms. Rivera, separately. Both staff stated there have been incidents when residents were not administered their prescribed medications. Both staff acknowledged that they did not contact resident physicians when these incidents occurred. Both Ms. Katona and Ms. Rivera denied any knowledge regarding whether or not other staff contacted resident physicians.

On 10/20/2023, I received and reviewed the medication administration records for Residents B, C, D, E, F, G, H, I, J, K, L, M, N, O, P and Q. The MARs for September 2023 and October 2023 reflect medication errors when residents were not administered their prescribed medications. There was no documentation to indicate that staff had contacted resident physicians to inform them of the errors.

On 10/30/2023, I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation findings and recommendations.

The revocation process was explained, and Mrs. Clauson was informed of her options.

APPLICABLE RULE	
R 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 refuses prescribed medication or procedures and follow and record the instructions given.
ANALYSIS:	On 09/06/2023, a complaint was received alleging facility staff are failing to contact resident physicians when residents are not administered a prescribed medication. Facility staff Julie Treakle, Valarie Katona, and Aliesha Rivera each reported there have been incidents when residents were not administered their prescribed information. All three staff denied resident physicians were informed of the medication errors. Resident Medication Administration Records (MAR) were reviewed for all seventeen residents. The MARs reflected several instances when residents were not administered their prescribed medications. The MARs did not provide documentation to indicate resident physicians were notified of each medication error. Based on the investigation findings, there is sufficient evidence to support a rule violation that resident physicians are not being contacted when a medication error occurs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: Resident Assessment Plans are not being completed and signed annually.

INVESTIGATION: On 10/23/2023, I received and reviewed resident assessment plans for Residents B, C, D, E, F, G, H, I, J, K, L, M, N, O, P and Q. The assessment plans for Residents C, G, K and P reflect they were updated electronically; however, the responsible party signatures were not updated annually. The assessment plan for Resident C reflects it was updated on 05/10/2023;

however, it was last signed by the responsible party on 03/17/2022. The Assessment plan for Resident G reflects it was updated electronically on 05/24/2023; however, it was last signed on 05/19/2022. The Assessment plan for Resident K reflects it was electronically updated on 08/21/2023; however, it was last signed on 06/21/2021. Lastly, the assessment plan for Resident P was electronically updated and signed on 08/08/2022. A review of the assessment plans also reflected the assessment plan for Resident I was not updated or signed since 08/08/2022. The assessment plans received for Residents F, L and O were current; however, they did not have any responsible party signatures.

On 10/30/2023, I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation findings and recommendations. The revocation process was explained, and Mrs. Clauson was informed of her options.

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:	Resident Assessment Plans for Residents C, G, K and P were updated annually; however, they lacked annual responsible person signatures. The Assessment plan for Resident I had not been updated or signed annually. Lastly, the assessment plans for Residents F, L and O lacked responsible person signatures. Based on the investigative findings, there is sufficient evidence to support a rule violation that the facility did not update and sign assessment plans annually.
CONCLUSION:	**VIOLATION ESTABLISHED**

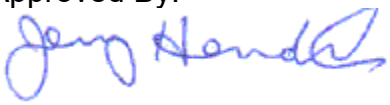
IV. RECOMMENDATION

Due to repeated quality of care rule violations, I recommend revocation of the license.

10/31/2023

Megan Aukerman Date
Licensing Consultant

Approved By:



10/31/2023

Jerry Hendrick Date
Area Manager