GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 17, 2025

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

RE: License #: AL410289605
Investigation #: 2025A0583041
Yorkshire Manor - West

Dear Mrs. Clauson:

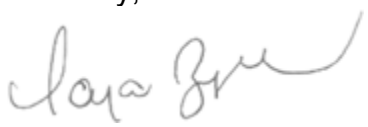
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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) 356-0100.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL410289605
Investigation #:	2025A0583041
Complaint Receipt Date:	05/21/2025
Investigation Initiation Date:	05/22/2025
Report Due Date:	06/20/2025
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:	04/23/2024
Expiration Date:	04/22/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility staff force Resident A to pivot during transfers which causes her pain.	No
Facility staff lifted Resident A's blouse and looked at her breast.	No
Resident A does not receive her medication as prescribed.	Yes
Facility staff restrict Resident A's food portions.	No
Additional Findings	Yes

III. METHODOLOGY

05/21/2025	Special Investigation Intake 2025A0583041
05/21/2025	APS Referral
05/22/2025	Special Investigation Initiated - Letter APS Sheena McBride
05/29/2025	Inspection Completed On-site
06/17/2025	Exit Conference Licensee Designee Connie Clauson

ALLEGATION: Facility staff force Resident A to pivot during transfers which causes her pain.

INVESTIGATION: On 05/21/2025 a complaint was received from Adult Protective Services via the LARA-BCHS-Complaints online system. The complaint alleged the following, "Staff force (Resident A) to pivot and transfer in ways that cause her back and leg pain".

On 05/22/2025 I received an email from Adult Protective Services staff Sheena McBride. Ms. McBride confirmed that she is assigned to investigate the complaint allegations.

On 05/22/2025 I completed an unannounced onsite investigation at the facility and privately interviewed administrator Jennifer Marckini and Resident A.

Ms. Marckini stated that Resident A utilizes a wheelchair and has a history of leg pain prior to entering the facility. Ms. Marckini stated that staff assist residents with transfers however Resident A can complete transfers on her own when she chooses. Ms. Marckini stated that staff are adequately trained to assist Resident A with transfers and there has been no indication that staff are forcing Resident A to pivot in a manner that causes her pain.

Resident A utilizes a wheelchair. She stated that she can transfer from her wheelchair independently when she chooses. Resident A stated that staff have not forced her to pivot while transferring and staff have not caused her pain while assisting with transfers. Resident A stated that she is happy with the care she receives.

On 06/02/2025 I received and reviewed a fax from Administrator Jennifer Marckini. The fax contained Resident A's Assessment Plan signed 04/10/2025. Resident A requires the assistance of a wheelchair. Resident A requires the assistance of one staff member for "toileting" but "may do it on her own when able".

On 06/16/2025 I interviewed staff Seth Dagen via telephone. Mr. Dagen stated that he provides hands-on care to Resident A in the form of transfer assistance. He stated that he has "never forced" Resident A to pivot during transfers and has never observed other staff force Resident A to do so. Mr. Dagen stated that Resident A typically transfers herself, but Mr. Dagen will physically assist her when she requests help.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A stated that she can transfer from her wheelchair independently when she chooses. Resident A stated that staff have not forced her to pivot while transferring and staff have not caused her pain while assisting with transfers. Resident A stated that she is happy with the care she receives. Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, a violation of the applicable rule has not been established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff lifted Resident A's blouse and looked at her breast.

INVESTIGATION: On 05/21/2025 a complaint was received from Adult Protective Services via the LARA-BCHS-Complaints online system. The complaint alleged that staff Jake Wellman "lifted" Resident A's "blouse and looked at her breast".

On 05/22/2025 I received an email from Adult Protective Services staff Sheena McBride. Ms. McBride stated that she interviewed Resident A and Resident A "denied anyone lifting up her shirt to look at her breast".

While onsite on 05/22/2025 Ms. Marckini stated that she had no knowledge of the incident. She stated that to her knowledge Mr. Wellman provides appropriate care.

Resident A denied Mr. Wellman lifted her blouse and denied he observed her breast. Resident A stated that the allegation was false.

On 06/16/2025 I interviewed staff Jake Wellman via telephone. Mr. Wellman stated that he does provide hands on care for Resident A but stated that he has never lifted her shirt and looked at her breasts. He stated that the allegation was false.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Resident A denied staff Jake Wellman lifted her blouse and denied he observed her breast. Resident A stated that the allegation was false. Staff Jake Wellman stated that he has never lifted Resident A's shirt and looked at her breasts. Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has not been established that facility staff mistreated Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A does not receive her medication as prescribed.

INVESTIGATION: On 05/21/2025 a complaint was received from Adult Protective Services via the LARA-BCHS-Complaints online system. The complaint alleged that facility "staff at the facility are not giving Resident A her medication". The complaint

further alleged that “when asked if (Resident A) got her pain medication, the nurse aid (Jasmine) at the assistant living said she does not give (Resident A) her pain medication anymore because it does not work” and “Staff Seth also gave Mary an anal suppository in her vagina”.

On 05/22/2025 I received an email from Adult Protective Services staff Sheena McBride. Ms. McBride stated that she “met with the client and she stated that she does get her medications as prescribed” and “stated that the gentleman did try to stick the enema in the wrong place however, he was there with a nurse, and she showed him the correct way”.

While onsite on 05/22/2025 Ms. Marckini stated that staff are providing Resident A with her pain medications as prescribed.

Resident A stated that facility staff regularly administer her pain medications. She stated she could not recall an incident in which a staff member administered an anal suppository into her vagina. She stated that she is happy with the level of care provided and stated that staff administer her medications as prescribed.

On 06/02/2025 I received and reviewed a facsimile from Administrator Jennifer Marckini. The facsimile contained Resident A’s Medication Administration Record. I observed that on 05/16/2025 and 05/26/2025 Resident A did not receive her prescribed Advil 250 MG due to the medication not being in the medication cart.

On 06/09/2025 I received an email from Administrator Jennifer Marckini. Ms. Marckini stated that she spoke with staff Seth Dagen on 06/06/2025 and he acknowledged that he did not administer Resident A’s Advil 250 MG on 05/16/2025 and 05/26/2025 due to the medication not being cart. Mr. Dagen stated that he did not contact an appropriate health care provider regarding the missed doses of Advil.

On 06/16/2025 I interviewed staff Seth Dagen via telephone. Mr. Dagen stated that on 05/16/2025 and 05/26/2025 the facility ran out of Resident A’s Advil and therefore she did not receive the medication. He denied staff withhold Resident A’s pain medications. He further stated that on one occasion he administered a PRN anal suppository into Resident A’s rectum. He stated that on that occasion the “suppository slipped” into Resident A’s lower vaginal area however Mr. Dagen did replace the suppository into the correct location.

On 06/16/2025 I interviewed staff Jasmine Gonzalez via telephone. Ms. Gonzalez stated that Resident A receives her pain medications as prescribed. She stated that she administers Resident A’s pain medications according to label instructions.

APPLICABLE RULE	
R 400.15312	**Resident medications.**

	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A MAR indicates that on 05/16/2025 and 05/26/2025, Resident A did not receive her prescribed Advil 250 MG due to the medication not being in the medication cart. Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has been established that facility staff did not administer Resident A's Advil as prescribed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation 2025A0464011 01/09/2025** **01/16/2025 Corrective Action Plan approved**

ALLEGATION: Facility staff restrict Resident A's food portions.

INVESTIGATION: On 05/21/2025 a complaint was received from Adult Protective Services via the LARA-BCHS-Complaints online system. The complaint alleged that facility staff "have also cut down (Resident A's) food portions without talking to doctor or family".

On 05/22/2025 I received an email from Adult Protective Services staff Sheena McBride. Ms. McBride stated that she interviewed Resident A and Resident A stated that she requested smaller portions in food as "she is a 200lb older woman".

While onsite on 05/22/2025 Ms. Marckini stated that to her knowledge, Resident A's food portions have never been reduced or restricted.

Resident A stated that she is provided three nutritious meals plus snack daily. She stated that staff have never reduced her portion sizes, and she is happy with the food quality.

On 06/16/2025 I interviewed staff Seth Dagen via telephone. Mr. Dagen stated that he has never restricted Resident A's food portions, and he has never observed other staff do so.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.

ANALYSIS:	Resident A stated that staff do not restrict her food portions, and she is happy with the food quality. Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has not been established that facility staff restrict Resident A's food portions.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING: Facility staff did not contact an appropriate medical provider.

INVESTIGATION: On 06/02/2025 I received and reviewed a facsimile from Administrator Jennifer Marckini. The facsimile contained Resident A's Medication Administration Record. I observed that on 05/16/2025 and 05/26/2025 staff Seth Dagen documented in her MAR that Resident A did not receive her prescribed Advil 250 MG due to the medication not being in the medication cart.

On 06/09/2025 I received an email from Administrator Jennifer Marckini. Ms. Marckini stated that she spoke with staff Seth Dagen on 06/06/2025 and he acknowledged that he did not administer Resident A's Advil 250 MG on 05/16/2025 and 05/26/2025 due to the medication not being cart. Mr. Dagen stated that he did not contact an appropriate health care provider regarding the missed doses of Advil.

On 06/16/2025 I interviewed staff Seth Dagen via telephone. Mr. Dagen stated that on 05/16/2025 and 05/26/2025 the facility ran out of Resident A's Advil and therefore she did not receive the medication. Mr. Dagen stated that he did not contact a medical provider to report the medication error because he "didn't know" he "was supposed to".

APPLICABLE RULE	
	Resident Medications.
R 400.14312	**(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:	Resident A's MAR indicates that on 05/16/2025 and 05/26/2025, Resident A did not receive her prescribed Advil 250 MG due to the medication not being in the medication cart.

	Staff Seth Dagen stated that he did not contact a medical provider to report that on 05/16/2025 and 05/26/2025 Resident A did not receive her Advil 250 MG. Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has been established that facility staff failed to contact an appropriate health care professional after Resident A did not receive her prescribed medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/17/2025 I provided Licensee Connie Clauson with an exit conference via telephone. I explained my findings as noted above. Ms. Clauson stated she understood my findings. She had no further information to provide and had no additional questions to ask concerning this special investigation. She stated that she would submit an acceptable Corrective Action Plan.

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the licensing status.

06/17/2025

Toya Zylstra Date
Licensing Consultant

Approved By:

06/17/2025

Jerry Hendrick Date
Area Manager