GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 16, 2021

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

RE: License #: AL700289594
Investigation #: 2021A0583032
Cambridge Manor - South

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) 356-0183.

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 #:** | AL700289594 |
| | |
| **Investigation #:** | 2021A0583032 |
| | |
| **Complaint Receipt Date:** | 05/25/2021 |
| | |
| **Investigation Initiation Date:** | 05/25/2021 |
| | |
| **Report Due Date:** | 06/24/2021 |
| | |
| **Licensee Name:** | Baruch SLS, Inc. |
| | |
| **Licensee Address:** | Suite 203<br>3196 Kraft Avenue SE<br>Grand Rapids, MI 49512 |
| | |
| **Licensee Telephone #:** | (616) 285-0573 |
| | |
| **Administrator:** | Marcus Ribant |
| | |
| **Licensee Designee:** | Connie Clauson |
| | |
| **Name of Facility:** | Cambridge Manor - South |
| | |
| **Facility Address:** | 151 Port Sheldon Road<br>Grandville, MI 49418 |
| | |
| **Facility Telephone #:** | (616) 457-3050 |
| | |
| **Original Issuance Date:** | 03/25/2013 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/23/2019 |
| | |
| **Expiration Date:** | 09/22/2021 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED, AGED, ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff Amanda Rehahn mistreated Resident A. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 05/25/2021 | Special Investigation Intake<br>2021A0583032 |
| 05/25/2021 | Special Investigation Initiated - Telephone<br>Staff Angela Adrianse |
| 05/26/2021 | Inspection Completed On-site<br>Administrator Marcus Ribant, Resident A |
| 06/01/2021 | Contact – Telephone<br>Staff Amanda Rehahn |
| 06/01/2021 | Contact – Telephone<br>Staff Amy James |
| 06/07/2021 | Inspection Completed On-site<br>Administrator Marcus Ribant, Community Navigator Katie Reimink, Resident B, LARA Licensing Consultant Anthony Mullins |
| 06/10/2021 | APS Referral |
| 06/16/2021 | Exit Conference<br>Licensee Designee Connie Clauson |

**ALLEGATION: Staff Amanda Rehahn mistreated Resident A.**

**INVESTIGATION**: On 05/25/2021 I received complaint allegations from the BCAL online reporting system. The complaint alleged former staff Amanda Rehahn was observed by “kitchen staff” forcefully “jamming” a spoonful of pudding filled with medications into Resident A’s mouth.

On 05/25/2021 I interviewed staff Angela Adrianse via telephone. Ms. Adrianse stated staff Amanda Rehahn recently left employment at the facility on her own accord within the last week. Ms. Adrianse stated “a couple months” ago kitchen staff Amy James observed former staff Amanda Rehahn forcefully feed Resident A her prescribed medications mixed with pudding. Ms. Adrianse stated the incident was forceful in nature and Resident A bit Ms. Rehahn afterwards.

On 05/26/2021 I completed an unannounced onsite inspection at the facility and privately interviewed Administrator Marcus Ribant and visually observed Resident A's wellbeing

Mr. Ribant stated on approximately 03/22/2021 he was informed from "Kitchen Staff" Amy James that Resident A refused to take her prescribed medications and subsequently former staff Amanda Rehahn forcefully fed Resident A the medications in a spoonful of pudding. Mr. Ribant stated Resident A then bit Ms. Rehahn while she tried to feed Resident A the pudding. Mr. Ribant stated Ms. James directly witnessed the incident. Mr. Ribant stated he did not find the incident to be abusive in nature after he spoke with Ms. Rehahn.

I visually observed Resident A's wellbeing. She appeared clean and happy. A formal interview was not completed due to Resident's A's memory decline.

On 06/01/2021 I interviewed former staff Amanda Rehahn via telephone. Ms. Rehahn stated on 03/20/2021 she attempted to administer Resident A's medications, but Resident A refused. Ms. Rehahn stated she subsequently mixed Resident A's medication into pudding and fed Resident A the medications with a spoon. Mr. Rehahn stated she spooned the pudding into Resident A's mouth and "some pudding landed on" Resident A's "face and shirt". Ms. Rehahn stated Resident A "tried to bite" Ms. Rehahn after ingesting the pudding. Ms. Rehahn stated Mr. Ribant spoke with Ms. Rehahn after the incident occurred because Mr. Ribant stated the incident "looked forced". Ms. Rehahn denied the incident was forceful or abusive. Ms. Rehahn stated she informed Mr. Ribant that no mistreatment occurred during the incident and Mr. Ribant agreed.

On 06/01/2021 I interviewed staff Amy James via telephone. Ms. James stated she is employed by the facility "as a cook". Ms. James stated on approximately 03/22/2021 she observed former staff Amanda Rehahn attempting to administer Resident A's medications in the facility dining room. Ms. James stated Resident A "swatted" at Ms. Rehahn in an attempt not to take the medications. Ms. James stated Ms. Rehahn attempted to administer Resident A's medications a second time with a spoon full of pudding however Resident A continued to refuse the medication. Ms. James stated she observed Ms. Rehahn "forcefully" administer Resident A's medications into Resident A's mouth. Ms. James stated Ms. Rehahn "shoved" Resident A's head backwards against the wall in an attempt to open her mouth and in a "forceful" manner administered the medications into Resident A's mouth with a spoon. Ms. James stated she "felt so bad for" Resident A because the incident "looked forced". Ms. James stated Resident B observed the incident and was upset by watching. Ms. James stated she tried to verbally comfort Resident B after Resident B observed the incident. Ms. James stated she wrote "a statement" regarding the incident which was forwarded to Administrator Marcus Ribant.

On 06/07/2021 I completed an unannounced onsite investigation at the facility and interviewed Resident B. Adult Foster Care Licensing Consultant Anthony Mullins

was present. Resident B stated she observed staff Amanda Rehahn attempting to administer Resident A's medications in the facility dining room. Resident B stated Resident A did not want to ingest the medications which were being administered in a spoonful of food. Resident B stated she observed Ms. Rehahn administer Resident A's medications "forcefully" and "roughly" into Resident A's mouth. Resident B stated Ms. Rehahn pushed Resident A's head backwards against the wall and in a forceful manner to administer the medications into Resident A's mouth. Resident B stated Resident A spit the medications out multiple times. Resident B stated she observed the incident as "shocking" and the incident left Resident B "afraid" of staff.

On 06/10/2021 I emailed complaint allegations to Adult Protective Services Centralized Intake.

On 06/16/2021 I completed an Exit Conference with Licensee Designee Connie Clauson via telephone. Ms. Clauson stated she would complete an acceptable Corrective Action Plan.

| **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:** | Former staff Amanda Rehahn stated on approximately 03/20/2021 she attempted to administer Resident A's medications, but Resident A refused. Ms. Rehahn stated she subsequently mixed Resident A's medication into pudding and fed Resident A the medications with a spoon. Ms. Rehahn denied the incident was forceful or abusive.<br><br>Staff Amy James and Resident B both stated they observed staff Amanda Rehahn push Resident A's head backwards against the wall in an attempt to open her mouth and in a "forceful" manner administer the medications into Resident A's mouth with a spoon.<br><br>A violation of the applicable is established by a preponderance of evidence. |

| | |
|---|---|
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

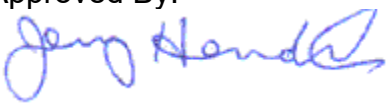
## IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

06/16/2021

Toya Zylstra — Date
Licensing Consultant

Approved By:



06/16/2021

Jerry Hendrick — Date
Area Manager