GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 16, 2021

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

RE: License #: AL700289583
Investigation #: 2021A0583038
Cambridge Manor - North

Dear Mrs. Clauson:

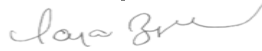
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 #:	AL700289583
Investigation #:	2021A0583038
Complaint Receipt Date:	07/01/2021
Investigation Initiation Date:	07/02/2021
Report Due Date:	07/31/2021
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Marcus Ribant
Licensee Designee:	Connie Clauson
Name of Facility:	Cambridge Manor - North
Facility Address:	151 Port Sheldon Road 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

II. ALLEGATION(S)

	Violation Established?
Staff failed to administer Resident A's seizure medication, Keppra (Levetiracetam).	Yes

III. METHODOLOGY

07/01/2021	Special Investigation Intake 2021A0583038
07/02/2021	Contact - Document Received Relative 1
07/02/2021	Special Investigation initiated - Email Relative 2
07/05/2021	Contact - Document Sent Relative 2
07/06/2021	Contact - Telephone call made Relative 2
07/07/2021	Contact - Document Received Relative 2
07/07/2021	Contact - Document Received Relative 2
07/07/2021	Inspection Completed On-site Administrator Marcus Ribant
07/09/2021	Contact – Telephone Staff Jennifer Davidson
07/09/2021	Contact – Telephone Hometown Pharmacy Justin Henges
07/09/2021	Contact – Telephone Hometown Pharmacy Justin Henges
07/15/2021	Exit Conference Licensee Designee Connie Clauson

ALLEGATION: Staff failed to administer Resident A's seizure medication, Keppra (Levetiracetam).

INVESTIGATION: On 07/01/2021 I received a complaint via email alleging that facility staff failed to administer Resident A's medication, Keppra (Levetiracetam) 1000mg, which is prescribed to prevent seizure activity. The complaint alleged that facility staff did not administer Resident A's Keppra on three occasions and contained a copy of Resident A's facility Medication Administration Log which indicates Resident A did not receive his prescribed Keppra on 06/22/2021 at 5:14 pm, 06/23/2021 at 8:38 am, and 06/23/2021 at 4:52 pm.

On 07/01/2021 I completed a file review. I noted that on 08/04/2021, Special Investigation 2020A0583035, indicated the facility was cited for a violation of R 400.15312 (1). The Special Investigation indicated Resident A stated on 08/01/2020 she did not receive her 6:00 pm medications and the facility Medication Administration Record confirmed the resident did not receive her 08/01/2020 6:00 p.m. medications. The approved Corrective Action Plan included written in-service training and an observed medication pass training supervised by a registered nurse from Hometown Pharmacy for staff Tamara Samuels. The Corrective Action Plan further included periodic competency checklist reviews to monitor competency compliance with current staff. On 10/21/2020 I received written verification that staff Tamara Samuels completed written in-service training and a medication pass observed by a Registered Nurse. I noted that on 06/01/2021, Special Investigation 2021A0583026, indicated two violations of R 400.15312 (1). The investigation indicated Resident A did not receive his prescribed Keppra (Levetiracetam) 1000 mg at 5:00 pm 04/16/2021, 8:00 am 04/17/2021, 5:00 pm 04/17/2021, 8:00 am 04/18/2021, and 5:00 pm 04/18/2021 due to staff not having the medication on hand. Resident A sustained a seizure on 04/18/2021 and was hospitalized due to staff not administering Resident A's Keppra. Special Investigation 2021A0583026 also indicated a subsequent violation of R 400.15312 (1) due to Resident A not receiving his prescribed Xarelto on 04/17/2021 and 04/18/2021 due to "med not available". A provisional license was recommended as a result of Special Investigation 2021A0583026 however a Corrective Action Plan has not been received as of the writing of this report.

On 07/02/2021 I received an email from Relative 2 which stated that on 06/24/2021 Relative 2 was alerted to Resident A not receiving his prescribed medication Keppra on 06/22/2021 and 06/23/2021 after she "saw the MAR" per her request.

On 07/07/2021 I completed an unannounced onsite investigation at the facility and interviewed Administer Marcus Ribant privately. Mr. Ribant acknowledged that Resident A did not receive his prescribed medication Keppra 1000 mg on 06/22/2021 at 5:00 pm, 06/23/2021 at 8:00 am, and 06/23/2021 at 5:00 pm due to facility staff not having the medication on hand. Mr. Ribant explained that Resident A's Keppra medication blister package contains "a blue highlighted" area "about a week" before Resident A runs out of his monthly supply which alerts staff to reorder

the medication. Mr. Ribant stated facility staff did not reorder Resident A's Keppra until 06/22/2021 after Resident A was administered his 8:00 a.m. dosage. Mr. Ribant stated on 06/22/2021 Staff Jennifer Davidson telephoned and faxed an "emergency" medication refill request to Hometown Pharmacy which should have resulted in the medication being drop shipped to the facility that same day. Mr. Ribant stated Resident A's Keppra was delivered to the facility on 06/23/2021 at approximately 7:00 p.m. Mr. Ribant stated he subsequently contacted Hometown Pharmacy manager Justin Henges who stated Hometown Pharmacy suffered a computer systems error which delayed the delivery of Resident A's medication. Mr. Ribant stated he had "no idea" if Resident A's family was alerted to Resident A running out of medication 06/22/2021 and 06/23/2021. Mr. Ribant stated Resident A was not transported to an urgent care, emergency department, or his primary care physician to request an emergency refill of Keppra. Mr. Ribant stated Resident A's primary physician was not alerted to Resident A not receiving his Keppra.

While onsite an interview was not completed with Resident A due to his pervasive disabilities and short-term memory loss.

On 07/09/2021 I interviewed staff Jennifer Davidson via telephone. Ms. Davidson stated the morning of 06/22/2021 she noticed Resident A's "facility stock" of Keppra was empty after dispensing the 8:00 a.m. dosage. Ms. Davidson stated on 06/22/2021 at approximately 11:15 am, she faxed and telephoned an emergency medication refill request for Resident A's Keppra. Ms. Davidson stated she finished her shift and "left it at that". Ms. Davidson stated she returned to work the morning of 06/24/2021 and observed that Resident A had not received his Keppra on 06/22/2021 at 5:00 p.m., 06/23/2021 at 8:00 a.m., and 06/23/2021 at 5:00 p.m. Ms. Davidson stated Resident A's Keppra medication was in the medication cart on 06/24/2021 with a note stating the medication was delivered to the facility on 06/23/2021. Ms. Davidson stated she does not know what time Resident A's Keppra was delivered on 06/23/2021. Ms. Davidson stated facility staff should have reordered Resident A's Keppra "when you hit the blue" highlighted area of Resident A's blister pack the week prior to Resident A running out of the medication. Ms. Davidson stated to her knowledge no facility staff informed Resident A's family of Resident A running out of Keppra until Relative 2 visited the facility on 06/24/2021 and requested to review Resident A's Medication Administration Log.

On 07/15/2021 I conducted by telephone an exit conference with the Licensee Designee, Connie Clauson. Ms. Clauson stated she agreed with the findings and would submit and acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician

	or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident A's Medication Administration Record indicates Resident A is prescribed Keppra (Levetiracetam) tablets twice per day (8:00 a.m. and 5:00 p.m.). This document indicates Resident A did not receive his prescribed Keppra on 06/22/2021 at 5:14 p.m., 06/23/2021 at 8:38 a.m., and 06/23/2021 at 4:52 p.m. due to staff not having the medication on hand. Administrator Marcus Ribant and staff Jennifer Davidson both stated facility staff did not administer Resident A's Keppra at 5:00 p.m. 06/22/2021, 8:00 a.m. 06/23/2021, and 5:00 p.m. 06/23/2021 due to staff not having the medication on hand. There is a preponderance of evidence to substantiate a REPEAT violation of the applicable rule. Facility staff failed to administer Resident A's prescribed anti-seizure medication, Keppra (Levetiracetam) at 5:00 p.m. 06/22/2021, 8:00 a.m. 06/23/2021, and 5:00 p.m. 06/23/2021 due to staff not having the medication on hand.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation 2020A0583035 dated 08/04/2020** **Special Investigation 2021A0583026 dated 06/01/2021**

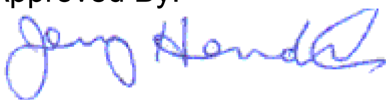
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the issuance of a Provisional License for the above referenced quality of care violations as previously indicated in Special Investigation 2021A0583026 dated 06/01/2021.

07/16/2021

Toya Zylstra — Date
Licensing Consultant

Approved By:



07/16/2021

Jerry Hendrick — Date
Area Manager