GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 26, 2022

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

RE: License #: AL700289583
Investigation #: 2022A0579022
Cambridge Manor - North

Dear Connie 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 feel free to 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,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW, 7th Floor-Unit 13
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL700289583
Investigation #:	2022A0579022
Complaint Receipt Date:	05/17/2022
Investigation Initiation Date:	05/17/2022
Report Due Date:	06/16/2022
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Steve Bunce
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:	01/27/2022
Expiration Date:	01/26/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED / AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her eyedrops once.	No
Resident A received eyedrops from another resident's bottle.	Yes

III. METHODOLOGY

05/17/2022	Special Investigation Intake 2022A0579022
05/13/2022	Special Investigation Initiated - Telephone Complainant
05/13/2022	Contact - Face to Face Resident A, Steve Bunce (Administrator), Rachel Rynbrandt (Direct Care Worker), and Robin Rogers (Direct Care Worker)
05/24/2022	Contact- Telephone Call Made Yordi Stevens, Direct Care Worker
05/24/2022	Contact- Document Sent Steve Bunce, Administrator
05/25/2022	Contact- Document Received Steve Bunce, Administrator
06/10/2022	Exit Conference Connie Clauson, Licensee Designee

ALLEGATION:

Resident A did not receive her eyedrops once.

INVESTIGATION:

On 5/17/22, I entered this referral into the Bureau Information Tracking System after receiving an email requesting, I call the complainant because they had concerns about Resident A's prescription eyedrops.

On 5/13/22, I completed a telephone interview with the complainant who reported Resident A receives a series of eyedrops, including one that is kept in a refrigerator until it is opened. Complainant stated one time, approximately two weeks ago, Resident A did not receive her medication because staff reported it was not available in the home. Complainant stated Resident A's medication is brought to the home by Relative A, so Relative A is certain Resident A was not out of eyedrops, as she has multiple bottles that were brought to the home. Complainant stated staff may not have known where to find the unopened bottles, especially the one that remains in the refrigerator. Complainant denied knowing the exact date of the incident or which staff were involved.

On 5/13/22, I completed an unannounced on-site investigation. Resident A stated after an outing with her family one day, she returned home, and staff did not pass her prescription eyedrops before bed that night because they told her there were none available in the home. She stated the next day she had problems with her vision because she needs multiple types of eyedrops, due to her diagnoses of cataracts and macular degeneration and has a significant loss of vision. She stated she believes staff do not know where her eyedrops are, because one must be refrigerated until it is opened, and she is certain she has multiple bottles of medication available so she should have never run out. She denied knowing when this occurred or which staff were involved. She expressed feeling that staff involved was newer though and not familiar with her medication.

On 5/13/22, Mr. Bunce stated Relative A and Resident A brought concerns of Resident A not receiving her eyedrops one time to his attention this week. He stated all staff who pass medications are trained and seasoned workers, although some may typically work other homes and be new to Resident A. He stated Resident A has not run out of medication, however, there is one medication that must be kept in the refrigerator, which may have caused confusion for staff. He stated he and Ms. Rogers are also investigating the alleged incident, but Resident A struggles with her memory so it is not certain the exact day this occurred or who was involved. He stated in response to these concerns, staff were reminded Resident A's unopened medication may be in the medication refrigerator, and now staff will be wearing name badges so residents know their names and can report concerns with staff more accurately. He stated Ms. Rynbrandt and Ms. Rogers should have additional information.

On 5/13/22, Ms. Rynbrandt stated on 5/2/22, Resident A told her there was a problem with her receiving her eyedrops correctly one time the week before. She stated Resident A was confused with specific details but did not report that she did

not receive her eyedrops. She stated she understood it as Resident A telling her staff may have put the eyedrops for her left eye into her right eye or put multiple drops in the eye that only needs one or vice versa. She stated she is not exactly certain what the problem was, but it was not that she did not receive the eyedrops. Ms. Rynbrandt stated after Resident A reported concerns for her eyedrops to her, she added a step in the Electronic Medication Administration Record (E-MAR) where staff must answer three questions before passing Resident A's eyedrops to ensure they know where the drops are and which eyes they go into because there are multiple drops, dosages, and some drops are in the refrigerator. She stated she does not believe there have been any problems with the eyedrops since those questions were listed in the E-MAR.

Ms. Rogers stated she was in the meeting with Resident A, Relative A, and Mr. Bunce. She stated she was further looking into the incident but was challenged by Resident A's confusion and not knowing the date or staff involved. She stated from her understanding from the meeting, Resident A is reporting that, on or about 4/28/22, staff told Resident A they were out of her eyedrops in the home and did not pass them.

Ms. Rogers and I reviewed the E-MAR. It noted Resident A did not receive her eyedrops at 5:00 PM on 04/28/2022, noting she was on an outing with family, did not take her medication with her, and returned too late to receive her 5:00 PM medication. Ms. Rogers stated the home's medication policy is that medication cannot be passed more than an hour prior to or after its assigned medication pass time so as to not intervene with other medications and they did not know Resident A was going to be gone so long so she was not given her medication to bring with her. The E-MAR noted Resident A did receive her eyedrops scheduled for that evening though.

On 5/24/22, I e-mailed Mr. Bunce to see if he and Ms. Rogers had found any additional information during their investigation of the alleged incident. He responded stating there was no additional information he found regarding an incident where Resident A did not receive her medication because the facility was out of it.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(a) Medications.**

ANALYSIS:	Complainant reported approximately two weeks prior to 5/13/22, Resident A did not receive her prescription eyedrops due to staff reporting it was not available. Resident A reported after an outing with family she did not receive her prescription eyedrops because staff reported it was not available in the home. Mr. Bunce and Ms. Rynbrandt confirmed Resident A does have multiple eyedrops, including one that must be refrigerated, which may be confusing for staff. Ms. Rynbrandt reported she changed the E-MAR to prompt additional questions to ensure staff pass Resident A's eyedrops correctly. Ms. Rynbrandt reported Resident A reported an incident with her eyedrops the week prior to 5/2/22. She stated her understanding from what Resident A said, was that Resident A received her eyedrops incorrectly, but not that she did not receive them because they were not available. Ms. Rogers and I reviewed the E-MAR which noted Resident A did not receive her eyedrops at 5:00 PM on 4/28/22 because she was on an outing with family. Ms. Rogers explained policy is that medications cannot be passed an hour prior to or after their assigned medication pass time. The E-MAR confirmed Resident A received her evening eyedrops that day since she was back in the home. Based on the interviews completed and documentation observed, there is insufficient evidence to support allegations that recommendations and instructions for Resident A's medications were not followed when staff did not give Resident A her medication due to it not being available in the home. It was reported the medication was available in the home, however Resident A went on an outing without her medication and could not receive her 5:00 PM eyedrops because she returned too late. However, she did receive her evening eyedrops because she was home for their passing time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A received eyedrops from another resident's bottle.

INVESTIGATION:

On 5/13/22, Complainant stated Resident A reported on 5/3/22 that Resident A's eyedrops were not available in the home, so staff gave Resident A the eyedrops of another resident who has the same prescription as Resident A. Complainant stated Relative A and Resident A had a meeting with Mr. Bunce and Ms. Rogers and they agreed staff should not be passing medication from another resident to Resident A, even if it is the same prescription. Complainant stated they feel the concerns were appropriately addressed by Mr. Bunce and Ms. Rogers, but wanted to ensure that licensing was aware, since issues with the medication allegedly happened twice, and they do not want it to happen again. Complainant denied knowing the date of the incident or which staff were involved.

On 5/13/22, Resident A stated last week, when it was time for her evening eyedrops, staff again told her that they were not available. She stated she did not want to deal with the problems she had after missing her eyedrops the first time, so when staff offered her the same prescription eyedrops, but in a bottle for another resident, she agreed to take them**.** She stated she and Relative A had a meeting with Mr. Bunce and Ms. Rogers after this occurred and she feels they handled the meeting appropriately by agreeing to talk to staff about where her medications are and that she should only receive medications labeled for her. She stated now staff will have nametags so she can identify who is giving her medications and report their names if there are any issues. She stated she no longer has concerns about receiving the wrong medication. She denied knowing when this incident occurred or who was involved but stated she felt this worker was newer and not familiar with her medications.

On 5/13/22, Mr. Bunce stated Relative A and Resident A brought concerns of Resident A receiving the eyedrops from another resident's bottle to his attention this week. He stated all staff who are passing medication know they may only give residents their prescribed medication from their own supply, and he has reminded staff of this after these allegations. He stated he and Ms. Rogers are investigating this alleged incident as well and the home is beginning a new, additional medication training program so staff will be retrained on the new program.

On 5/13/22, Ms. Rynbrandt stated she did not hear of an incident of Resident A getting eyedrops from another resident's bottle but if there was an incident on 5/3/22, she was working that evening. She stated she left before Resident A's evening eyedrop pass, so Direct Care Worker Yordi Stevens would have been the person who passed the medication. She stated Ms. Stevens is an experienced worker, however she typically works in a different home, so Resident A may not be familiar with her.

On 5/13/22, Ms. Rogers stated her understanding was that on or about 5/3/22, staff gave Resident A eyedrops of her prescription from another resident's bottle in the evening. She stated the date is not certain and it is not known which staff member was involved but she is investigating the alleged incident.

On 5/13/22, the E-MAR had no additional documented notes about Resident A being out of medication or missing a medication pass, outside of 4/28/22 when Resident A was on an outing.

On 5/13/22, I reviewed the staff schedule, it confirmed that on 5/3/22, Ms. Stevens passed Resident A's evening medication.

On 5/24/22, I completed a telephone interview with Ms. Stevens. She stated she has passed Resident A's eyedrops before. She stated one time, she and the staff she was working with, could not find Resident A's eyedrops in the home. She stated she is certain they were not in the home and arrived the following morning. She stated

she told Resident A that the home was out of her medication, and she could not pass it. She stated Resident A became extremely upset stating she could not go without her eyedrops. She stated due to Resident A being so upset, she knew there was another resident with the same prescription, so she offered to pass the other resident's eyedrops to Resident A. She stated she knew it was wrong, but she did not want Resident A to be upset so she passed the medication. She stated staff have been reminded they cannot pass medication labeled for another resident to a resident even if it is the same medication. She stated she is aware where Resident A's medications are and there have been no further issues with Resident A's medication that she is aware of. Ms. Stevens denied know the exact date this incident occurred or who she was working with.

On 05/24/22, Mr. Bunce stated Ms. Stevens acknowledged she passed eyedrops to Resident A from another resident's bottle and that she was aware it was not appropriate but she did not want Resident A to be upset.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Complainant, Mr. Bunce, and Ms. Rogers reported Resident A alleged she was given eyedrops of her prescription from another resident's bottle. Complainant reported this occurred on 5/3/22. Complainant, Mr. Bunce, and Ms. Rogers denied additional specific details. Resident A reported she was given eyedrops from another resident's bottle because staff told her that hers were not available in the home. Staff schedule confirmed Ms. Stevens worked the evening of 5/3/22. Ms. Stevens reported one time she and the staff she was working with could not find Resident A's prescription eyedrops for her evening eyedrop pass. She stated Resident A was very upset and to calm Resident A, she passed eyedrops from another resident's bottle of the same prescription. She acknowledged she knew this was wrong, but she did not want Resident A to be upset. Mr. Bunce confirmed Ms. Stevens told him this as well.

	Based on the interviews completed and documentation observed, there is sufficient evidence to support allegations that Resident A received eyedrops of her same prescription that were labeled and prescribed to another resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 06/10/2022, I completed an exit conference with Licensee Designee, Ms. Clauson, who did not dispute my findings or recommendations.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 5/26/22

Cassandra Duursma Date
Licensing Consultant

Approved By:

Russell Misiak 5/26/22

Russell B. Misiak Date
Area Manager