GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 29, 2024

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

RE: License #: AL700289594
Investigation #: 2024A0583029
Cambridge Manor - South

Dear Mrs. Clauson:

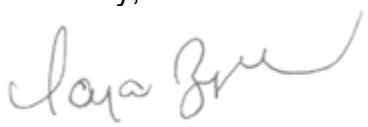
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2024A0583029
Complaint Receipt Date:	04/03/2024
Investigation Initiation Date:	04/03/2024
Report Due Date:	05/03/2024
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Rebecca Jiggens
Licensee Designee:	Connie Clauson
Name of Facility:	Cambridge Manor - South
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:	05/22/2023
Expiration Date:	05/21/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff Shania Pagan mistreated Resident A.	No
Untrained staff dispense resident medications.	Yes

III. METHODOLOGY

04/03/2024	Special Investigation Intake 2024A0583029
04/03/2024	Special Investigation Initiated - Letter APS staff Peter Mihalatos
04/03/2024	APS Referral
04/03/2024	Contact - Document Sent Administrator Rebecca Jiggens
04/04/2024	Inspection Completed On-site
04/26/2024	Exit Conference Licensee Designee Connie Clauson

ALLEGATION: Staff Shania Pagan mistreated Resident A.

INVESTIGATION: On 04/03/2024 complaint allegations were received from Adult Protective Services via the BCAL online reporting system. The complaint allegation stated that “last week between 03/20/2024-03/22/2024 staff member and caretaker at the facility, Shania Pagan, was aggressively pushing on (Resident A's) leg while assisting (Resident A)”.

On 04/03/2024 I received an email from Adult Protective Services staff Peter Mihalatos. Mr. Mihalatos confirmed that he was assigned to investigate the complaint allegations. Mr. Mihalatos stated that staff Riley Rostad recently contacted “law enforcement” and reported that staff Shania Pagan had aggressively pushed on Resident A’s leg while assisting Resident A with dressing. Mr. Mihalatos stated that a police report was taken, and no injuries were observed on Resident A’s body. Mr. Mihalatos stated that “family is not looking to move the resident and has no concerns for care of (Resident A)”.

On 04/03/2024 I interviewed staff Rylie Rostad via telephone. Ms. Rostad stated that on 03/21/2024 at 5:30 AM she worked with staff Shania Pagan. Ms. Rostad stated that she and Ms. Pagan were assisting Resident A with getting dressed. Ms.

Rostad stated that she observed Ms. Pagan “aggressively” rolling Resident A from one side to the other while dressing Resident A. Ms. Rostad stated that Resident A stated that “it hurt” while being rolled by Ms. Pagan. Ms. Rostad stated that Resident A was “in tears” during the incident because it was “aggressive”. Ms. Rostad stated that she did not observe any injuries during the incident. Ms. Rostad stated that she returned to check on Resident A ten minutes after the incident and Resident A was no longer complaining of pain. Ms. Rostad stated that at 7:00 AM, she reported her concerns to staffing director Jeff Wellman. Ms. Rostad stated that Mr. Wellman reported that the incident wasn’t the first complaint he had received about Ms. Pagan. Ms. Rostad stated that on 03/25/2024 she was working at the facility and observed that Ms. Pagan was also still working at the facility. Ms. Rostad stated that in response to observing Ms. Pagan working at the facility, Ms. Rostad telephoned law enforcement to file a report regarding the 03/21/2024 incident. Ms. Rostad stated that law enforcement subsequently visited the facility and took the report. Ms. Rostad stated that she was subsequently asked to leave the facility by administration and has not worked at the facility since 03/25/2024.

On 04/04/2024 I interviewed staffing director, Jeff Wellman, via telephone. Mr. Wellman stated that on approximately 03/21/2024 staff Rylie Rostad came into the office and reported that staff Shania Pagan has been “rough” while turning Resident A over during Resident A’s morning care. Mr. Wellman stated that Ms. Rostad reported observing that Resident A “was in pain” while being turned over by Ms. Pagan. Mr. Wellman stated that he informed Ms. Rostad that he would look into her allegation. Mr. Wellman stated that he mentioned Ms. Rostad’s allegation to administrator Rebecca Jiggens on 03/21/2024 and Ms. Jiggens directed Mr. Wellman to investigate the matter. Mr. Wellman stated that on 03/21/2024 he spoke to Resident A who is diagnosed with memory deficits and Resident A stated that she “had no idea” what Mr. Wellman was referring to. Mr. Wellman stated Resident A further stated that she is in pain “every time” a staff member rolls her over due to a previous leg injury. Mr. Wellman stated that he also observed a brief change for Resident A on 03/21/2024 and he observed no injuries. Mr. Wellman stated that he spoke to Ms. Pagan a couple days after 03/21/2024 and Ms. Pagan denied she mistreated Resident A. Mr. Wellman stated Ms. Pagan reported that she had rolled Resident A over appropriately while dressing Resident A and at no time did, she harm Resident A. Mr. Wellman stated that on approximately 03/25/2024 Ms. Rostad contacted law enforcement and reported the incident. Mr. Wellman stated that Ms. Rostad contacted law enforcement because Ms. Rostad didn’t feel like the incident had been handled appropriately by Mr. Wellman.

On 04/15/2024 I interviewed staff Shania Pagan via telephone. Ms. Pagan stated that approximately two weeks ago at 6:00 or 7:00 AM she and staff Riley Rostad were assisting Resident A with dressing. Ms. Rostad stated that Resident A has been diagnosed with dementia and often complains of pain. Ms. Pegan stated that on the date in question, Resident A was in her bed and is “dead weight”. Ms. Pagan stated that she was standing on one side of Resident A’s bed and Ms. Rostad was standing on the other side of Resident A’s bed. Ms. Pagan stated that this was “only

the second time" she was tasked with dressing Resident A and Ms. Pagan did not know that her Resident A has a "bad leg". Ms. Pagan stated that she placed Resident A's left leg over her right leg and rolled Resident A partially over. Ms. Pagan stated that Resident A complained that the roll "hurt" however Resident A has a history of complaining of pain in general. Ms. Pagan stated that Ms. Rostad informed Ms. Pagan that Resident A's left leg was her "bad leg" but did not say anything else regarding the incident to Ms. Pagan. Ms. Pagan stated that she continued to roll Resident A to her side and finished dressing and changing Resident A's adult brief. Ms. Pagan stated that Resident A did not continue complaining of any pain and she sustained no injuries. Ms. Pagan stated that two days after the incident Ms. Rostad reported the incident to other staff and Ms. Pagan is currently suspended from employment until the conclusion of the special investigation.

On 04/09/2024 I interviewed administrator Rebecca Jiggens via telephone. Ms. Jiggens confirmed that Resident A has been diagnosed with memory deficits. Mr. Jiggens stated that she had "no idea" about the complaint allegations until the police were called on 03/25/2024. Mr. Jiggens stated that staff Shania Pagan was placed on administrative leave on 03/25/2024 because Ms. Pagan presented as "shaken up" and "until we can get this figured out". Ms. Jiggens stated that she has never received complaints from staff or residents regarding Ms. Pagan's care of residents.

On 04/26/2024 I completed an Exit Conference with licensee designee Connie Clauson via telephone. Ms. Clauson stated that she agreed with the findings.

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:	Staff Rylie Rostad stated that on 03/21/2024 at 5:30 AM she observed staff Shania Pagan "aggressively" rolling Resident A from one side to the other while dressing her. Ms. Rostad stated that Resident A said that "it hurt" while being rolled by Ms. Pagan. Ms. Rostad stated that Resident A was "in tears" during the incident because it was "aggressive". Staff Shania Pagan stated that she placed Resident A's left leg over her right leg and rolled Resident A partially over. Ms. Pagan stated that Resident A complained that the roll "hurt"

	however Resident A has a history of complaining of pain in general. Ms. Pagan stated that she continued to roll Resident A to her side and finished dressing and changing Resident A's adult brief. Ms. Pagan stated that Resident A did not continue complaining of any pain and she sustained no injuries. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Untrained staff dispense resident medications.

INVESTIGATION: On 04/03/2024 complaint allegations were received from Adult Protective Services via the BCAL online reporting system. The complaint allegation stated that "untrained staff dispensed medication to residents".

On 04/03/2024 I interviewed staff Rylie Rostad via telephone. Ms. Rostad stated that on multiple occasions she was directed to administer residents' medications independently by her "supervisor, Aniyah" despite Ms. Rostad not being completely trained to do so. Ms. Rostad stated that she did not feel comfortable administering residents' medications because she had only observed other trained staff doing so and did not complete the facility's full training protocol which consists of both observation and a class. Ms. Rostad stated that she spoke to her supervisor about her concerns but was directed that she had to dispense medications because the facility was "short staffed".

On 04/09/2024 I interviewed administrator Rebecca Jiggens via telephone. Ms. Jiggens stated that the facility's protocol for training staff to administer residents' medications consists of "on cart observations with a trained staff" and the completion of a medication administration "class". Ms. Jiggens stated that staff Rylie Rostad completed "on cart observations" but did not complete the facility's medication administration class. Ms. Jiggens stated that despite not completing the facility's medication administration class, Ms. Rostad has administered residents' medications independently. Ms. Jiggens acknowledged that Ms. Rostad administered residents' medications without being fully trained to do so.

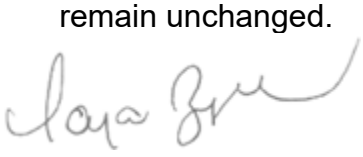
On 04/12/2024 I received and reviewed an email from administrator Rebecca Jiggens. I observed that Ms. Jiggens' email stated that "Rylie Rostad did on the cart medication training on 3/5, 3/6, and 3/7". I observed that the email contained Resident A's Medication Administration Record for the month of March 2024. I observed that Resident A's Medication Administration Record indicates that on 03/14/2024, 03/15/2024, and 03/21/2024 staff Rylie Rostad administered Resident A's medications.

On 04/26/2024 I completed an Exit Conference with licensee designee Connie Clauson via telephone. Ms. Clauson stated that she was unaware of the allegation but did not dispute the finding. She stated that she would submit an acceptable Corrective Action Plan.

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: **(a) Be trained in the proper handling and administration of medication.**
ANALYSIS:	Administrator Rebecca Jiggens stated that the facility's protocol for training staff to independently administer residents' medications consists of "on cart observations with a trained staff" and the completion of a medication administration "class". Ms. Jiggens stated that staff Rylie Rostad completed "on cart observations" but did not complete the facility's medication administration class. Ms. Jiggens acknowledged that despite not completing the facility's medication administration class, Ms. Rostad has administered residents' medications independently. Resident A's Medication Administration Record indicates that on 03/14/2024, 03/15/2024, and 03/21/2024 staff Rylie Rostad administered Resident A's medications. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule; staff Rylie Rostad administered residents' medications before she was trained to do so.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

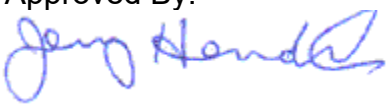
Upon receipt of an acceptable correction action plan, I recommend that the license remain unchanged.



04/26/2024

Toya Zylstra Date
Licensing Consultant

Approved By:



04/29/2024

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Jerry Hendrick Date
Area Manager