GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 23, 2024

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

RE: License #: AL700289601
Investigation #: 2024A0583033
Georgetown Manor - West

Dear Mrs. Clauson:

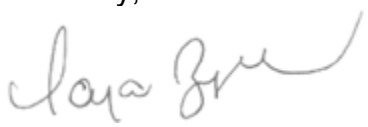
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

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 #:	AL700289601
Investigation #:	2024A0583033
Complaint Receipt Date:	05/09/2024
Investigation Initiation Date:	05/09/2024
Report Due Date:	06/08/2024
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:	Georgetown Manor - West
Facility Address:	141 Port Sheldon Road Grandville, MI 49418
Facility Telephone #:	(616) 457-3050
Original Issuance Date:	02/21/2013
License Status:	REGULAR
Effective Date:	05/22/2023
Expiration Date:	05/21/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Robert Zylema (Direct Care Worker) stole Resident A's medications.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/09/2024	Special Investigation Intake 2024A0583033
05/09/2024	Special Investigation Initiated - Telephone Administrator Rebecca Jiggens
05/09/2024	Contact - Telephone call made Staff Robert Zylema
05/09/2024	APS Referral
05/10/2024	Inspection onsite Administrator Rebecca Jiggens, staff Chelsea Fuller, Resident A
05/23/2024	Exit Conference Licensee Designee Connie Clauson

ALLEGATION: Robert Zylema (Direct Care Worker) stole Resident A's medications.

INVESTIGATION: On 05/09/2024 I received complaint allegations from administrator Rebecca Jiggens via telephone. Ms. Jiggens stated that on 05/06/2024 staff Chelsea Fuller informed Ms. Jiggens that Resident A's Adderall "count" was off. Ms. Fuller explained to Ms. Jiggens that Resident A's Medication Administration Record indicated that on 05/04/2024 staff Robert Zylema deducted two Amphetamine Salts 30 MG TAB AKA Adderall and on 05/05/2024 Mr. Zylema deducted six Amphetamine Salts 30 MG TAB AKA "Adderall". Ms. Jiggens explained that the term "deducted" means the medication was not issued but is "generally destroyed" and Resident A is administered the medication once per day. Ms. Jiggens stated that on 05/06/2024 she reviewed Resident A's Medication Administration Record and observed several days within the past month in which Mr. Zylema deducted Resident A's Adderall count. Ms. Jiggens stated that on 05/06/2024, Ms. Jiggens interviewed Mr. Zylema regarding Resident A's Adderall deductions. Ms. Jiggens stated that Mr. Zylema reported that on 05/05/2024 Mr. Zylema destroyed six tablets of the medication because he had spilled Resident B's liquid Morphine on Resident A's tablets. Mr. Zylema stated that he had destroyed Resident A's Adderall medication because they were unsalvageable. Ms. Jiggens stated that Mr. Zylema had no explanation for the other days he had deducted

Resident A's Adderall. Ms. Jiggens stated that Resident A's Adderall are pharmacy issued in individual blister packs therefore the medication would not have been damaged by spillage. Ms. Jiggens stated that Mr. Zylema was placed on administrative leave. Ms. Jiggens stated that she contacted law enforcement however Resident A refuses to press charges therefore law enforcement will be closing the matter.

On 05/09/2024 I interviewed staff Robert Zylema via telephone. Mr. Zylema stated that he is a trained medication technician at the facility. Mr. Zylema stated that on 05/05/2024 he spilled Resident B's liquid morphine onto Resident A's Adderall. Mr. Zylema stated that Resident A's Adderall was not salvageable due to damage from Resident B's Morphine and therefore Mr. Zylema placed the damaged medication into a plastic bag filled with coffee grounds and water and proceeded to throw away the bag. Mr. Zylema stated that staff Kayla Reyes was working with Mr. Zylema on 05/05/2024 and he mentioned to her that he had spilled Resident B's liquid morphine onto Resident A's Adderall and would be disposing of the damaged medications. Mr. Zylema stated that Ms. Reyes didn't seem to care about the situation, and he disposed of the medication independently. Mr. Zylema stated that 05/05/2024 is the only date in which he disposed of Resident A's Adderall and believes that the other dates identified on Resident A's Medication Administration Record must be due to another staff member logging into Resident A's Medication Administration and using his credentials to deduct Resident A's Adderall. Mr. Zylema stated that he has not given his Medication Administration Record credentials to any other staff and denied stealing Resident A's Adderall.

On 05/09/2024 I interviewed staff Kayla Reyes via telephone. Ms. Reyes stated that she worked with staff Robert Zylema on 05/05/2024 and at no time did Mr. Zylema inform her that Resident A's Adderall needed to be destroyed.

On 05/09/2024 I emailed complaint allegations to Adult Protective Services Centralized Intake.

On 05/09/2024 I interviewed staff Chelsea Fuller via telephone. Ms. Fuller stated that on 05/05/2024 she worked at the facility. Ms. Fuller stated that she observed that Resident A's Medication Administration Record indicated that staff Robert Zylema had deducted two Adderall tablets on 05/04/2024. Ms. Fuller stated that she texted administrator Rebecca Jiggens and requested to speak with her but did not explicitly state why she wanted to speak with Ms. Jiggens. Ms. Fuller stated that on 05/06/2024 she spoke in person with Ms. Jiggens and informed Ms. Jiggens of Resident A's missing Adderall tablets.

On 05/10/2024 I completed an onsite investigation at the facility and interviewed administrator Rebecca Jiggens, staff Chelsea Fuller, and Resident A.

Ms. Jiggens stated that she reviewed Resident A's Medication Administration Record since 04/08/2024 and observed that staff Robert Zylema deducted two

tablets of Adderall on 04/14/2024, two tablets of Adderall on 04/20/2024 , one tablet of Adderall on 04/21/2024 , three tablets of Adderall on 04/22/2024, one tablet of Adderall on 04/25/2024, two tablets of Adderall on 04/26/2024, three tablets of Adderall on 4/29/2023, two tablets of Adderall on 04/30/2024, two tablets of Adderall on 05/04/2024, and six tablets of Adderall on 05/05/2024. Ms. Jiggens stated that she observed that Resident B's liquid Morphine does not appear to be missing any liquid in the bottle and therefore does not appear to have been spilled. Ms. Jiggens stated that Mr. Zylema is still on administrative leave and will be terminated from employment with the facility. Ms. Jiggens stated that all medication administration technicians are trained and required to destroy damaged or expired medications in the presence of another staff member and must document the reason for the medication destruction in the residents' Medication Administration Record. Ms. Jiggens stated that a review of Resident A's Medication Administration Record indicates that Mr. Zylema never documented the rational for destroying Resident A's Adderall. Ms. Jiggens stated that during shift change, medication technicians are required to count each resident's controlled narcotic medications with the oncoming medication technician.

Staff Chelsea Fuller stated that all medication technicians are required to document the reason for destroying damaged or expired resident medications and must dispose of these medications with a second staff present. Ms. Fuller stated that medication technicians are required to count all resident narcotics jointly with the medication technician at the start of the proceeding shift and to her knowledge all medication technicians are routinely practicing this protocol.

While onsite I observed Resident A's prescribed Adderall 30 MG is administered in two tablets for a total of 60 MG once per day and contained in individual blister packs.

While onsite I observed Resident A's Medication Administration Record from 04/08/2024 until current. This document indicates that staff Robert Zylema deducted two tablets of the medication on 04/14/2024, two tablets on 04/20/2024, one tablet on 04/21/2024, three tablets on 04/22/2024, one tablet on 04/25/2024, two tablets on 04/26/2024, three tablets on 4/29/2023, two tablets on 04/30/2024, two tablets on 05/04/2024, and six tablets on 05/05/2024.

Resident A's Medication Administration Record from 04/08/2024 until current indicates that on 05/03/2024 Resident A received only one of two prescribed tablets of Adderall 30 MG from staff Yordanos Stevens because the medication was out of stock at the facility.

Resident A stated that she is her own legal decision maker. Resident A was oriented to time and place and displayed adequate grooming. Resident A stated that she has no knowledge of staff Robert Zylema stealing her medication and to her knowledge she received her medications as prescribed. Resident A stated that she

has a favorable relationship with Mr. Zylema and does not wish to pursue criminal charges regarding the theft of her medication.

On 05/15/2024 I received and reviewed an email from administrator Rebecca Jiggens which stated that Resident A is prescribed “2 tablets by mouth once daily (total 60 mg)” and that on 05/03/2024 staff Yordanos Stevens informed Ms. Jiggens that Resident A got only one tablet and that more of the medication was needed. Ms. Jiggens stated that she instructed Ms. Stevens to notify the provider and pharmacy.

On 05/15/2024 I interviewed staff Yordanos Stevens via telephone. Ms. Stevens stated that on 05/03/2024 she observed that Resident A had only one remaining tablet of her prescribed Adderall and Resident A is prescribed two tablets daily. Ms. Stevens stated that on 05/03/2024, she administered the remaining one tablet to Resident A and immediately informed administrator Rebecca Jiggens whom advised Ms. Stevens to request another refill from the pharmacy. Ms. Stevens stated that on that same date, she telephoned the pharmacy to request a refill but was informed that Resident A should have multiple remaining tablets if dosed properly. Ms. Stevens stated that on that same date, she and Ms. Jiggens reviewed Resident A’s Medication Administration Records and observed that staff Robert Zylema had been deducting Resident A’s Adderall.

On 05/23/2024 I completed an Exit Conference with Licensee Designee Connie Clauson via telephone. Ms. Clauson stated that she agreed that a rule violation had occurred and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	A review of Resident A’s Medication Administration Record indicated that staff Robert Zylema deducted 24 tablets of Resident A’s prescribed Adderall 30 MG between 04/08/2024 and 05/05/2024. Staff Yordanos Stevens stated that on 05/03/2024 she observed that Resident A had only one remaining tablet of her prescribed Adderall and Resident A is prescribed two tablets daily. Ms. Stevens stated that on that same date, she telephoned the pharmacy to request a refill but was informed that Resident A should have had multiple remaining tablets if dosed properly. Ms. Stevens stated that on that same date, she and administrator Rebeca Jiggens reviewed Resident A’s Medication

	Administration Record and observed that staff Robert Zylema had been deducting Resident A's Adderall. Staff Chelsea Fuller stated that on 05/05/2024 she observed that Resident A's Medication Administration Record indicated that staff Robert Zylema had deducted two Adderall tablets on 05/04/2024. Ms. Fuller stated that on 05/06/2024 she spoke in person with Ms. Jiggens and informed Ms. Jiggens of Resident A's missing Adderall tablets. A preponderance of evidence was discovered to substantiate a violation of the applicable rule. Direct Care Worker Robert Zylema deducted Resident A's prescribed Adderall 30 MG on multiple dates despite facility medication technicians counting the medication after each shift, documenting such counts in Resident A's Medication Administration Record, and Resident A going without her prescribed dose on 05/03/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident A did not receive her medication as prescribed.

INVESTIGATION: While onsite, on 05/10/2024, I observed Resident A's Medication Administration Record indicated that Resident A is prescribed Adderall in two 30 MG tablets administrated once per day for a total of 60 MG. The document indicates that on 05/03/2024 Resident A received only one of two prescribed tablets of Adderall 30 MG from staff Yordanos Stevens because the medication was out of stock at the facility.

Resident A stated that to her knowledge, she has been receiving her medication as prescribed.

On 05/15/2024 I received and reviewed an email from administrator Rebecca Jiggens. It stated that Resident A is prescribed 2 tablets by mouth once daily (total 60mg) of Adderall and that on 05/03/2024 staff Yordanos Stevens informed Ms. Jiggens that Resident A got only one tablet.

On 05/15/2024 I interviewed staff Yordanos Stevens via telephone. Ms. Stevens stated that on 05/03/2024 she observed that Resident A had only one remaining tablet of her prescribed Adderall and Resident A is prescribed two 30 MG tablets daily. Ms. Stevens stated that she administered the remaining one tablet to Resident A and immediately informed administrator Rebecca Jiggens.

On 05/23/2024 I completed an Exit Conference with Licensee Designee Connie Clauson via telephone. Ms. Clauson stated that she agreed that a rule violation had occurred and would submit an 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 Page 21 Courtesy of Michigan Administrative Rules 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 S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required. (2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A's Medication Administration Record indicates that on 05/03/2024 Resident A received only one of two prescribed tablets of Adderall 30 MG because the medication was out of stock at the facility. Staff Yordanos Stevens stated that on 05/03/2024 she observed that Resident A had only one remaining tablet of her prescribed Adderall and Resident A is prescribed two tablets daily. Ms. Stevens stated that she administered the remaining one tablet to Resident A. A preponderance of evidence was discovered to substantiate a violation of the applicable rule. Resident A is prescribed two tablets daily of Adderall 30 MG for a total of 60 MG. On 05/03/2024 Resident A only received one tablet of Adderall 30 MG and therefore did not receive her medication as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Facility staff did not contact the appropriate health care professional after Resident A did not receive her medication as prescribed.

INVESTIGATION: While onsite, on 05/10/2024, I observed Resident A's Medication Administration Record indicated that Resident A is prescribed Adderall in two 30 MG

tablets administrated once per day for a total of 60 MG. I observed that the document indicated that on 05/03/2024 Resident A received only one of two prescribed tablets of Adderall 30 MG from staff Yordanos Stevens because the medication was out of stock at the facility.

On 05/15/2024 I received and reviewed an email from administrator Rebecca Jiggens which stated that Resident A is prescribed 2 tablets by mouth once daily (total 60 mg) and that on 05/03/2024 staff Yordanos Stevens informed Ms. Jiggens that Resident A got only one tablet and that more of the medication was needed. Ms. Jiggens stated that she instructed Ms. Stevens to notify the provider and pharmacy.

On 05/15/2024 I interviewed staff Yordanos Stevens via telephone. Ms. Stevens stated that on 05/03/2024 she observed that Resident A had only one remaining tablet of her prescribed Adderall and Resident A is prescribed two tablets daily. Ms. Stevens stated that she administered the remaining one tablet to Resident A and immediately informed administrator Rebecca Jiggens. Ms. Stevens stated that on that same date, she notified the pharmacy nurse that Resident A had only received the one tablet of Adderall but acknowledged that she did not notify any other medical professional.

On 05/23/2024 I completed an Exit Conference with Licensee Designee Connie Clauson via telephone. Ms. Clauson stated that she agreed that a rule violation had occurred and 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: **(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:	Staff Yordanos Stevens stated that on 05/03/2024 she observed that Resident A had only one remaining tablet of her prescribed Adderall and Resident A is prescribed two tablets daily. Ms. Stevens stated that she administered the remaining one tablet to Resident A. Ms. Stevens stated that she notified the pharmacy nurse that Resident A had only received the one tablet of Adderall, but she did not notify any other medical professional.

	A preponderance of evidence was discovered to substantiate a violation of the applicable rule. Resident A is prescribed two tablets daily of Adderall 30 MG for a total of 60 MG. On 05/03/2024 Resident A only received one tablet of Adderall 30 MG and facility staff did not contact the appropriate medical professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

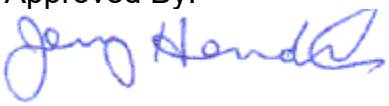
IV. RECOMMENDATION

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

05/23/2024

Toya Zylstra Date
Licensing Consultant

Approved By:



05/23/2024

Jerry Hendrick Date
Area Manager