GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 6, 2025

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

RE: License #: AL700289583
Investigation #: 2025A0583037
Cambridge Manor - North

Dear Mrs. Clauson:

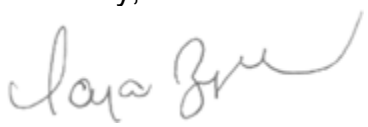
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

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) 356-0100.

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 #:	2025A0583037
Complaint Receipt Date:	05/09/2025
Investigation Initiation Date:	05/12/2025
Report Due Date:	06/08/2025
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Connie Clauson
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:	01/27/2024
Expiration Date:	01/26/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff did not provide interventions as specified in Resident A's Assessment Plan.	Yes
Facility staff did not administer Resident A's medication as prescribed.	No
Additional Findings	Yes

III. METHODOLOGY

05/09/2025	Special Investigation Intake 2025A0583037
05/12/2025	Special Investigation Initiated - Telephone Melissa Richards, Friend of Resident A
05/14/2025	Inspection Completed On-site
05/21/2025	APS Referral
06/06/2025	Exit Conference Licensee Designee Connie Clauson

ALLEGATION: Facility staff did not provide interventions as specified in Resident A's Resident Assessment Plan.

INVESTIGATION: On 05/09/2025 complaint allegations were received via the LARA-BCHS-Complaints online system. The complaint alleged that on 05/04/2025 facility staff did not execute interventions agreed upon in Resident A's Assessment Plan after Resident A displayed aggression and delusions.

On 05/12/2025 I interviewed Melissa Richards via telephone. Ms. Richards stated that she is the longtime family friend of Resident A. Ms. Richards stated that Resident A is diagnosed with dementia with agitation and that her cognition is "rapidly deteriorating". Ms. Richards stated that Relative 1 informed Ms. Richards that on 05/04/2025, Resident A was found to be delusional and agitated. Ms. Richards stated that Relative 1 requested that Ms. Richards visit the facility to check on Resident A. Ms. Richards stated that on 05/05/2025 she visited Resident A at the facility. Ms. Richards stated that Resident A acknowledged that she had "attacked" facility staff because Resident A said that she "wanted them away" from her. Ms. Richards stated she also visited the facility on 05/07/2025 and Resident A said that an unknown staff had grabbed Resident A by the wrists during the 05/04 incident. Mr. Richards stated that she observed no signs of injury to Resident A's wrists on 05/07/2025.

On 05/12/2025 I interviewed Relative 1 via telephone. Relative 1 confirmed that Resident A is diagnosed with dementia with agitation. Relative 1 stated that Resident A is currently receiving Corewell Health Hospice Services. Relative 1 stated that on 05/04/2025 at 4:30 PM, she received a telephone call from an unknown female staff who indicated that Resident A was exhibiting physically aggressive behaviors towards staff. Relative 1 stated that the staff requested that Relative 1 come to the facility to assist them. Relative 1 stated that she heard staff yell at Resident A "telling her to stop". Relative 1 stated that staff said they had attempted to administer Resident A's Seroquel, however Resident A threw the medication at the staff. Relative 1 stated that staff hung up the telephone on Relative 1 and she telephoned Hospice Staff Registered Nurse Rachel Wohlgemuth and requested that Ms. Wohlgemuth check on Resident A at the facility. Relative 1 stated that Ms. Wohlgemuth arrived at the facility quickly and reported to Relative 1 that Resident A was de-escalated in her bedroom under the supervision of two facility staff members. Relative 1 stated staff failed to implement the agreed upon safety and de-escalation interventions documented in Resident A's Assessment Plan. Relative 1 stated that facility staff escalated Resident A's behavior by raising their voices and by not providing Resident A with space to de-escalate.

On 05/14/2025 I completed an unannounced onsite investigation at the facility and interviewed administrator Tracy Wood and Resident A. Ms. Wood stated that Resident A suffers from dementia with agitation and delirium. Ms. Wood stated that she did not work on 05/04/2025 and was made aware of the incident after the fact by facility staff. Ms. Wood stated that on 05/04/2025 Resident A was displaying agitation as evidenced by "exit seeking" behaviors during the first shift. Ms. Wood stated that staff BriAysia Fizer and staff NyKaria Peoples worked at the facility on 05/04/2025 from 3:00 PM until 11:00 PM. Ms. Wood stated that during the second shift Resident A was displaying delusional, anxious, and aggressive behaviors. Ms. Wood stated that Resident A began opening and closing the door that led to the outdoor fenced patio area which continued to set off the door alarm. Ms. Wood stated that Ms. Fizer asked Resident A to stop opening the door however Resident A then proceeded to push a chair around the living room. Ms. Wood stated that Ms. Fizer asked Resident A to stop pushing the chair and then Resident A charged at Ms. Fizer with "the chair" yelling "the people are going to come kill us". Ms. Wood stated that Resident A then proceeded to punch a Ms. Fizer and Ms. Peoples. Ms. Wood stated that staff were able to redirect Resident A to her private bedroom to de-escalate and telephoned Relative 1. Ms. Wood stated that facility staff felt Relative 1 was angry that staff had contacted her and staff subsequently telephoned Corewell Health Hospice Nurse Julie Baar for assistance because staff had never observed Resident A to act in such a manner. Ms. Wood stated that Ms. Baar asked staff to provide Resident A with a snack and PRN Seroquel, however Resident A refused the medication. Ms. Wood stated that Corewell Health Hospice Nurse Rachel Wohlgemuth arrived at the facility and was able to de-escalate Resident A and provided Resident A with a dose of PRN Seroquel. Ms. Wood stated that facility staff were overwhelmed by Resident A's behaviors on 05/04/2025 and "should have provided (Resident A) with more space to de-escalate". Ms. Wood acknowledged

that the facility staff did not implement a calm and gentle approach as agreed upon in Resident A's Assessment Plan.

I attempted to interview Resident A, however she was unable to complete the interview due to the severity of dementia symptoms. She could not recall any of the details regarding the 05/04/2025 incident and stated she was doing well at the facility. She appeared clean and appropriately dressed.

While onsite I reviewed Resident A's "Resident Negotiated Service Plan," signed on 09/05/2024. Resident A has "occasional confusion and some difficulty recalling details" and suffers from "hallucinations/delusions-impaired decision-making skills, reality disorientation". Resident A suffers from "agitation, anxious, fluctuates emotionally". Facility staff must "acknowledge the resident's reality and avoid attempts to reason or argue" and "use calm and gentle approach".

On 05/21/2025 complaint allegations were sent to Adult Protective Service Centralized Intake via the mandated reporters online complaint portal.

On 05/23/2025 I interviewed staff NyKaria Peoples via telephone. Ms. Peoples stated that on 05/04/2025 staff BriAysia Fizer asked Ms. Peoples for assistance because Resident A was becoming violent. Ms. Peoples stated that she observed Resident A was agitated as evidenced by punching Ms. Peoples in the stomach. Ms. Peoples stated that Resident A also punched Ms. Fizer in the stomach and both staff attempted to verbally de-escalate Resident A. Ms. Peoples stated that both staff asked Resident A to go into her bedroom and after a short time, Resident A did enter her bedroom. Ms. Peoples stated that staff helped Resident A remove her sweater and helped her into her recliner chair. Ms. Peoples stated that they telephoned Relative 1 and informed her that Resident A was agitated and violent. Ms. Peoples stated that Relative 1 instructed staff to administer Resident A's "PRN" Quetiapine (Seroquel). Ms. Peoples stated that Ms. Fizer attempted to provide Resident A with her regularly scheduled 5:00 PM dose of Quetiapine 50MG but Resident A refused the medication. Ms. Peoples stated that Ms. Fizer called the hospice staff for assistance and Ms. Wohlgemuth arrived at the facility soon after. Ms. Peoples stated that Ms. Wohlgemuth was provided Resident A's Quetiapine 50MG and Ms. Wohlgemuth administered the medication. Ms. Peoples stated that Resident A calmed down and did not leave her bedroom for the remainder of the night. Ms. Peoples stated that she was not familiar with Resident A's Assessment Plan because she does not typically work at the facility. Ms. Peoples stated that staff did attempt to provide Resident A with space to deescalate however Resident A continued to escalate until administered her Quetiapine was administered.

On 05/23/2025 I interviewed staff Bri'Aysia Fizer via telephone. Ms. Fizer stated that after dinner on 05/04/2025, Resident A displayed agitation and paranoia as evidenced by opening and closing the back door causing the alarm to sound and by violently pushing furniture into Ms. Fizer. Ms. Fizer stated that she asked Ms. Peoples to assist her with Resident A's escalating behaviors and Resident A

punched both staff members. Ms. Fizer stated that she took Resident A by the hand and guided her into her private bedroom and telephoned Relative 1. Ms. Fizer stated that Resident 1 instructed staff to administer Resident As “PRN”. Ms. Fizer stated that she also telephoned hospice staff for additional directions and was instructed to administer Resident A with a drink and snack. Ms. Fizer stated that she attempted to administer Resident A’s regularly scheduled 50MG Quetiapine because her once daily “PRN” Quetiapine had already been administered but Resident A refused. Ms. Fizer stated that Ms. Wohlgemuth arrived at the facility and subsequently administered Resident A’s 50MG Quetiapine. Ms. Fizer stated that Resident A calmed down and did not exit her bedroom after receiving the 50MG Quetiapine. Ms. Fizer stated that she had attempted to verbally de-escalate Resident A but acknowledged that she was “not very familiar with” Resident A’s care needs.

On 06/04/2025 I interviewed Corewell Health Hospice Nurse Rachel Wohlgemuth via telephone. Ms. Wohlgemuth stated that she arrived at the facility on the evening of 05/04/2025. Ms. Wohlgemuth stated when she arrived, she entered Resident A’s bedroom and observed that Resident A smiling and was reclined in chair under the supervision of two staff members. Ms. Wohlgemuth stated that a facility staff member provided Ms. Wohlgemuth with Resident A’s Seroquel to administer however Ms. Wohlgemuth provided the medication to Resident A’s son, Relative 2. Ms. Wohlgemuth stated that Relative 2 administered the medication directly to Resident A. Ms. Wohlgemuth stated that she was not familiar with Resident A’s “baseline” because she was acting as a “fill in” nurse during the incident.

On 06/06/2025 I completed an exit conference via telephone with licensee designee Connie Clauson. I explained my findings as noted above. Ms. Clauson stated she understood my findings. She had no further information to provide and had no additional questions to ask concerning this special investigation. She agreed to submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A’s “Resident Negotiated Service Plan” signed on 09/05/2024 indicated that facility must “acknowledge the resident’s reality and avoid attempts to reason or argue” and “use calm and gentle approach”. Administrator Tracy Wood stated that facility staff were overwhelmed by Resident A’s behaviors on 05/04/2025 and should have provided Resident A with more space to de-

	escalate. Ms. Wood acknowledged that the facility staff did not implement a calm and gentle approach. Relative 1 stated that on 05/04/2025 at 4:30 PM, she received a telephone call from an unknown staff member who indicated that Resident A was exhibiting physically aggressive behaviors towards staff. Relative 1 stated that she heard staff yell at Resident A "telling her to stop". Staff Nykaria Peoples stated that she was not familiar with Resident A's Assessment Plan because she does not typically work at the facility. Staff BriAysia Fizer stated that she had attempted to verbally de-escalate Resident A but acknowledged that she was "not very familiar with" Resident A's care needs. Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has been established that facility staff did not provide personal care as specified in Resident A's Assessment Plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility staff did not administer Resident A's medication as prescribed.

INVESTIGATION: On 05/09/2025 complaint allegations were received via the LARA-BCHS-Complaints online system. The complaint alleged that "staff was unaware that a 2:37pm dose of Seroquel was given- given again at 5:30 & maybe 6:20".

While onsite on 05/14/2025, I reviewed Resident A's Medication Administration Record. On 05/04/2025, Resident A received Quetiapine (Seroquel) 50 MG at 8:00 AM and 5:00 PM and Quetiapine 50MG PRN at 2:37 PM.

On 05/15/2025 I received an email from administrator Tracy Wood. The email contained a document labeled "Corewell Health Hospice and Palliative Care Physician's Order" dated 05/14/2025 and completed by Amy Engelsman RN and Dr. Colleen Tallen. From 03/05/2025 to 05/06/2025, Resident A was prescribed Seroquel 50MG 1 tab twice daily at 8AM and 5PM and from 03/05/2025 to 05/06/2025 Resident A was prescribed Seroquel 50MG 1 tab once daily PRN for agitation.

On 05/23/2025 I interviewed staff Tricia VanKoevering via telephone. Ms. VanKoevering stated that on 05/04/2025 at 2:37 PM, she administered 50 MG Quetiapine PRN to Resident A for agitation.
On 05/23/2025 I interviewed staff Bri'Aysia Fizer via telephone. Ms. Fizer stated that Resident A was administered her 5:00 PM dose of Quetiapine 50MG on 05/04/2025 at approximately 6:00PM.

On 06/06/2025 I completed an exit conference via telephone with licensee designee Connie Clauson. I explained my findings as noted above. Ms. Clauson stated she understood my findings. She had no further information to provide and had no additional questions to ask concerning this special investigation.

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 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.
ANALYSIS:	"Corewell Health Hospice and Palliative Care Physician's Order" dated 05/14/2025 and completed by Amy Engelsman RN and Dr. Colleen Tallen stated that from 03/05/2025 to 05/06/2025 Resident A was prescribed Seroquel 50MG 1 tab twice daily at 8AM and 5PM and from 03/05/2025 to 05/06/2025 Resident A was prescribed Seroquel 50MG 1 tab once daily PRN for agitation. Resident A's Medication Administration Record indicated on 05/04/2025 Resident A received Quetiapine 50 MG at 8:00 AM and 5:00 PM and Quetiapine 50MG PRN at 2:37PM. Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it is established that Resident A did receive her medication as prescribed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Facility staff did not administer Resident A's medications as prescribed.

INVESTIGATION: While onsite on 05/14/2025, I observed Resident A's Medication Administration Record indicated Resident A is prescribed Lasix 20 MG take 1 tablet by mouth daily, saline nasal spray 44 ML instill 2 sprays into each nostril twice daily, and Tylenol 500MG take two tablets twice daily. On 05/04/2025 at 5:00 PM Resident A received Saline Nasal Spray 44ML and Tylenol 500MG. On 05/06/2025 Resident did not receive Lasix 20MG because facility "can't find in cart". On 05/10/2025 Resident A did not receive a single dose of her prescribed nasal spray because the medication was "not in the cart will order more".

Medication technician Yordi Stevens stated that on 05/10/2025 she did not pass Resident A's saline nasal spray 44 ML because she could not locate the medication. Ms. Stevens stated that the medication was "misplaced" and later found in another spot in the cart.

On 05/23/2025 I interviewed medication technician Zaliyah Haddix via telephone. Ms. Haddix stated that on 05/06/2025 at 8:00 AM, she could not locate Resident A's Lasix 20MG and therefore did not administer the medication.

On 05/23/2025 I interviewed medication technician BriAysia Fizer via telephone. Ms. Fizer stated that on 05/04/2025 at 5:00 PM she used Ms. VanKoevering's electronic MAR initials to document the administration of Resident A's Saline Nasal Spray 44ML and Tylenol 500MG but she never gave the medications to Resident A because she was busy.

On 06/06/2025 I completed an exit conference via telephone with licensee designee Connie Clauson. I explained my findings as noted above. Ms. Clauson stated she understood my findings. She had no further information to provide and had no additional questions to ask concerning this special investigation. She agreed to submit a 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 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.

ANALYSIS:	Resident A's Medication Administration Record indicated Resident A is prescribed Lasix 20 MG take 1 tablet by mouth daily, saline nasal spray 44 ML instill 2 sprays into each nostril twice daily, and Tylenol 500MG take two tablets twice daily. On 05/06/2025 Resident did not receive Lasix 20MG because the medication couldn't be located. On 05/10/2025 Resident A did not receive a single dose of her prescribed nasal spray because the medication was "not in the cart will order more". On 05/04/2025 at 5:00 PM Resident A received Saline Nasal Spray 44ML and Tylenol 500MG. Medication technician Yordi Stevens stated on 05/10/2025 she did not pass Resident A's saline nasal spray 44 ML because she could not locate the medication. Medication technician Zaliyah Haddix stated that on 05/06/2025 at 8:00AM, she could not locate Resident A's Lasix 20MG and therefore did not administer the medication. Medication technician BriAysia Fizer stated that on 05/04/2025 at 5:00PM she documented the administration of Resident A's Nasal Spray 44ML and Tylenol 500MG but she never gave the medications to Resident A because she was busy. Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has been established that on 05/04/2025, 05/06/2025, and 05/10/2025 Resident A did not receive her prescribed medications.
CONCLUSION:	**VIOLATION ESTABLISHED** **Special Investigation Report # 2024A0583034 dated 06/12/2024 and Special Investigation Report #2025A0583039 dated 06/03/2025 (Corrective Action Plan pending).**

ADDITIONAL FINDINGS: Facility staff did not contact an appropriate health care professional after medication errors.

INVESTIGATION: While onsite on 05/14/2025, I observed Resident A's Medication Administration Record indicated Resident A is prescribed Lasix 20 MG take 1 tablet by mouth daily, saline nasal spray 44 ML instill 2 sprays into each nostril twice daily, and Tylenol 500MG take two tablets twice daily. On 05/04/2025 at 5:00 PM Resident A received Saline Nasal Spray 44ML and Tylenol 500MG. On 05/06/2025 Resident did not receive Lasix 20MG because facility "can't find in cart". On

05/10/2025 Resident A did not receive a single dose of her prescribed nasal spray because the medication was “not in the cart will order more”.

Medication technician Yordi Stevens stated that on 05/10/2025 she did not pass Resident A’s saline nasal spray 44 ML because she could not locate the medication. Ms. Stevens stated that the medication was “misplaced” and later found in “another spot in the cart”. Ms. Stevens stated that she did not contact an appropriate health care provider to report the medication error.
On 05/23/2025 I interviewed medication technician Zaliyah Haddix via telephone. Ms. Haddix stated that on 05/06/2025 at 8:00 AM, she could not locate Resident A’s Lasix 20MG and therefore did not administer the medication. Ms. Haddix stated that on that same day, she telephoned “someone from hospice” to notify them of the incident, however no one answered her call, and no message was left. She stated that she was “too busy” on 05/06/2025 to document the attempt to contact an appropriate health care professional.

On 05/23/2025 I interviewed medication technician BriAysia Fizer via telephone. Ms. Fizer stated that on 05/04/2025 at 5:00 PM she used Ms. VanKoevering’s electronic MAR initials to document the administration of Resident A’s Saline Nasal Spray 44ML and Tylenol 500MG but she never gave the medications to Resident A. She stated that she did not attempt to contact a medical provider regarding Resident A not receiving her medications.

On 06/06/2025 I completed an exit conference via telephone with licensee designee Connie Clauson. I explained my findings as noted above. Ms. Clauson stated she understood my findings. She had no further information to provide and had no additional questions to ask concerning this special investigation. She agreed to submit a 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:	Medication technician Yordi Stevens stated on 05/10/2025 she did not pass Resident A’s saline nasal spray 44 ML because she could not locate the medication. Ms. Stevens acknowledged that she did not contact an appropriate health care provider to report the medication error.

	Medication technician Zaliyah Haddix stated that on 05/06/2025 at 8:00AM, she could not locate Resident A's Lasix 20MG and therefore did not administer the medication. Ms. Haddix stated that on that same day, she telephoned "someone from hospice" to notify them of the incident, however no one answered her call, and no message was left. She stated that she was "too busy" on 05/06/2025 to document the attempt to contact an appropriate health care professional. Medication technician BriAysia Fizer stated that on 05/04/2025 at 5:00PM she used Ms. VanKoevering's electronic MAR initials to document the administration of Resident A's Saline Nasal Spray 44ML and Tylenol 500MG but she never gave the medications to Resident A. She acknowledged that she did not attempt to contact a medical provider regarding Resident A not receiving her medications. Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has been established that on 05/04/2025, 05/06/2025, and 05/10/2025 Resident A did not receive her prescribed medications and facility staff failed to contact an appropriate health care professional and record and follow their instructions.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation Report # 2024A0583034 dated 06/12/2024 Corrective Action Plan dated 07/01/2024**

ADDITIONAL FINDINGS: Staff administered Resident A's medications but did not initial Resident A's Medication Administration Record.

INVESTIGATION: While onsite on 05/14/2025, I reviewed Resident A's Medication Administration Record. On 05/04/2025 at 5:00 PM, staff Tricia VanKoevering administered Resident A's Quetiapine 50 MG.

Ms. Wood stated that staff Tricia VanKoevering worked at the facility on 05/04/2025 from 7:00 AM until 3:00 PM. Ms. Wood stated that staff BriAysia Fizer and staff NyKaria Peoples worked at the facility "second shift".

Ms. VanKoevering stated that on 05/04/2025 she worked at the facility from 7:00 AM until 3:00 PM. Ms. VanKoevering stated that she did not administer Resident A's Quetiapine 50MG at 5:00PM.

On 05/23/2025 I interviewed staff BriAysia Fizer via telephone. Ms. Fizer stated that on 05/04/2025 she "forgot to sign in" and used Ms. VanKoevering's electronic MAR initials to document the administration of Resident A's Quetiapine 50MG. Ms. Fizer stated that she provided Resident A's Quetiapine 50MG tablet to a hospice staff to administer to Resident A.

On 06/06/2025 I completed an exit conference via telephone with licensee designee Connie Clauson. I explained my findings as noted above. Ms. Clauson stated she understood my findings. She had no further information to provide and had no additional questions to ask concerning this special investigation. She agreed to submit a 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: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.
ANALYSIS:	I reviewed Resident A's Medication Administration Record. According to the document, on 05/04/2025 at 5:00PM, staff Tricia VanKoevering administered Resident A's Quetiapine 50 MG. Staff Tricia VanKoevering stated that she did not administer Resident A's Quetiapine 50MG at 5:00PM. Staff BriAysia Fizer stated that on 05/04/2025 she "forgot to sign in" and used Ms. VanKoevering's electronic MAR initials to document the administration of Resident A's Quetiapine 50MG. Based upon my investigation, it has been established that on 05/04/2025 at 5:00 PM, Staff BriAysia Fizer administered Resident A's medication but failed to document her initials in Resident A's MAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/06/2025

_____

Toya Zylstra Date
Licensing Consultant

Approved By:

06/06/2025

_____

Jerry Hendrick Date
Area Manager