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 #: AL700289583
Investigation #: 2024A0583030
Cambridge Manor - North

Dear Mrs. Clauson:

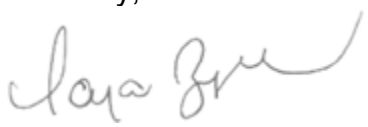
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0183.

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 #:	2024A0583030
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 - 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?
Untrained staff dispense resident medications.	Yes

III. METHODOLOGY

04/03/2024	Special Investigation Intake 2024A0583030
04/03/2024	Special Investigation Initiated - Telephone APS Peter Mihalatos
04/03/2024	APS Referral
04/04/2024	Inspection Completed On-site
04/26/2024	Exit Conference Licensee Designee Connie Clauson

ALLEGATION: Untrained staff dispense resident medications.

INVESTIGATION: On 04/03/2024 the above complaint allegation was 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. Ms. Jiggens' email stated that "Rylie Rostad did on the cart medication training on 3/5, 3/6, and 3/7". The email contained Resident A's Medication Administration Record for the month of March 2024 and indicates that on 03/10/2024, 03/11/2024, 03/12/2024, 03/19/2024, 03/20/2024, 03/23/2024 and 03/24/2024 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 03/10/2024, 03/11/2024, 03/12/2024, 03/19/2024, 03/20/2024, 03/23/2024 and 03/24/2024 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**

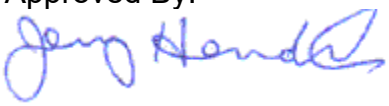
IV. RECOMMENDATION

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

Jerry Hendrick — Date
Area Manager