GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 12, 2024

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

RE: License #: AL700289583
Investigation #: 2024A0583034
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 #:	2024A0583034
Complaint Receipt Date:	05/15/2024
Investigation Initiation Date:	05/16/2024
Report Due Date:	06/14/2024
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?
Facility staff failed to administer Resident A's medications as prescribed.	Yes
Resident A's laundry was observed as soiled with feces.	No
Additional Findings	Yes

III. METHODOLOGY

05/15/2024	Special Investigation Intake 2024A0583034
05/16/2024	Special Investigation Initiated - On Site
06/05/2024	APS Referral
06/12/2024	Exit Conference Licensee Designee Connie Clauson

ALLEGATION: Facility staff failed to administer Resident A's medications as prescribed.

INVESTIGATION: On 05/15/2024 I received complaint allegations from Relative 1 via telephone call. Relative 1 stated that at "the end of March" Relative 1 received a notification from the facility staff that Resident A "only had a couple left of her blood pressure medication but had extra of her prescribed antidepressant medication". Relative 1 stated that Resident A's blood pressure medication is Olmesartan Medoxomil and her antidepressant medication is Escitalopram AKA Lexapro. Relative 1 stated that Resident A is currently under an executed power of attorney and exhibits memory decline.

On 05/16/2024 I completed an unannounced onsite investigation at the facility and privately interviewed staff Rachel Rynbrandt, staff Jennifer Davidson, staff Taya Jenison, and Resident A.

While onsite I reviewed facility "Observation" notes. I observed that on 04/01/2024 staff Jennifer Davidson documented "Spoke with daughter on needing a refill for Olmesartan. She said she spoke with Julie Baars office, and they are sending a script to Express Scripts. As soon as she receives it. She will bring it in". I observed that on 04/02/2024 Staff Jennifer Davidson documented that Resident A "is out of her Olmesartan. Her daughter is aware and waiting on espress scripts to deliver".

While onsite I observed Resident A's Medication Administration Record. I observed that on 04/03/2024 Resident A did not receive her prescribed medication,

Olmesartan 40 MG, because the facility ran out of the medication. I observed that Resident A is prescribed Lexapro 10 MG once daily and the Medication Administration Record indicates that Resident A is receiving the medication as prescribed.

While onsite I observed that the facility medication cart contained Resident A's Olmesartan and Lexapro.

Staff Rachel Rynbradt stated that her job title is "Life Enrichment Director" and she has no knowledge of Resident A not receiving her mediations as prescribed.

Staff Jennifer Davidson stated that her job description is classified as "medication technician". Ms. Davidson stated that at the end of March 2024, she recalled that Resident A was running low on her Olmesartan Medoxomil, which is prescribed to address Resident A's blood pressure. Ms. Davidson stated that she contacted Resident A's daughter via telephone and informed her that Resident A required a refill of that medication. Ms. Davidson stated that Resident A's daughter said that Express Scripts would not refill said medication because it was "too soon". Ms. Davidson stated that Resident A's daughter obtained the medication from a local pharmacy until Express Scripts would refill the order for the medication. Ms. Davidson stated that Resident A did not receive one dose of the medication on 04/03/2024 due to the facility running out and no medical professional was alerted to the missed dose. Ms. Davidson stated that facility staff are responsible for contacting a residents' pharmacy to request a medication refill when there are about ten pills left but no one takes responsibility to do it. Ms. Davidson stated that to her knowledge Resident A received her anti-depressant Escitalopram as prescribed.

Staff Taya Jenison stated that she did not work at the facility October 2024 and therefore she had no knowledge of Resident A not receiving her medications as prescribed.

Resident A stated that she is happy with the level of care provided and to her knowledge she is receiving her medications as prescribed.

On 06/05/2024 I emailed the complaint allegation to Adult Protective Services Centralized Intake.

On 06/06/2024 I interviewed administrator Rebecca Jiggens via telephone. Ms. Jiggens stated that Resident A missed a dose of her prescribed blood pressure medication, Olmesartan Medoxomil, on 04/03/2024 due to the facility running out of the medication. Ms. Jiggens reported that Resident A did receive her prescribed "Lexapro" according to provider instructions and never missed a dose.

On 06/10/2024 I received and reviewed the following email from Administrator Rebecca Jiggens: *'On November 8, 2023, the resident's provider sent a new script to the facility to increase resident's Olmesartan (Benicar) to 40mg daily. The resident*

had 20mg tablets, so staff began administering two tablets daily to equate 40mg total. This new order was sent by the provider to Hometown Pharmacy to profile the med change; however, the script was never sent to Express Script pharmacy, which is the pharmacy that fulfills the prescriptions for the resident. In March 2024, staff noticed resident's supply of the medication was running low and contacted the pharmacy and the resident's POA. Both parties stated it was "too soon" for the resident's script to be refilled. It was later discovered that Express Scripts was still showing a 20mg daily dose on file for the medication; therefore, they believed it was too soon for the medication to be refilled even though facility staff were administering the correct dose. The updated script was sent over to Express Scripts pharmacy and the medication was refilled without issue.'

On 06/12/2024 I provided Licensee Designee Connie Clauson with an exit conference via telephone. I explained my findings as noted above. Ms. Clauson acknowledged the medication error, stated she understood my findings, and indicated she would develop and submit a corrective action plan addressing the established rule violation. 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:	While onsite I observed Resident A's Medication Administration Record. I observed that on 04/03/2024 Resident A did not receive her prescribed medication, Olmesartan 40 MG, because the facility ran out of the medication. Administrator Rebecca Jiggens stated that Resident A missed a dose of her prescribed blood pressure medication, Olmesartan Medoxomil, on 04/03/2024 due to the facility running out of the medication. A preponderance of evidence was discovered during the course of the special investigation to substantiate a violation of the

	applicable rule. Resident A did not receive her medication, Olmesartan Medoxomil, as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's laundry was observed as soiled with feces.

INVESTIGATION: On 05/15/2024 I received complaint allegations from Relative 1 via telephone call. Relative 1 stated that on 10/05/2024 Relative 1 visited the facility and observed five pairs of pants with dried feces hanging in Resident A's closet. Relative 1 stated that Resident A's closet smelled "horrible" due to the pants located in Resident A's closet. Relative 1 stated that she photographed Resident A's soiled pants.

On 05/15/2024 I received a text message from Relative 1 that I observed contained three photographs. I observed that one photograph appeared to be soiled khaki pants and two photographs appeared to be soiled jeans.

On 05/16/2024 I completed an unannounced onsite investigation at the facility and privately interviewed staff Rachel Rynbrandt, staff Jennifer Davidson, staff Taya Jenison, and Resident A.

While onsite I visually observed the condition of Resident A's bedroom and laundry. I did not observe any foul odors and I did not observe any soiled clothing in her closet.

Staff Rachel Rynbrandt stated that residents' laundry is scheduled to be completed at least weekly and more often if a resident requires it due to incontinence issues. Ms. Rynbrandt stated that she has not observed Resident A's bedroom to smell of feces due to soiled laundry and has not observed soiled laundry in hanging up in her closet.

Staff Jennifer Davidson stated that Resident A suffers from incontinence issues and memory decline. Ms. Davidson stated that Resident A has begun defecating in her clean clothing and subsequently hanging the soiled clothing up in her closet as if there were not soiled. Ms. Davidson stated that soiled undergarments have also been observed in Resident A's drawers after Resident A defecated in said undergarments. Ms. Davidson stated that facility staff attempted to implement a staff assisted "toileting schedule" to assist Resident A with toileting however she refused to adhere to the schedule. Ms. Davidson stated that facility staff are continuing to work with Resident A on using the toileting schedule and placing soiled items in her dirty clothing basket for laundering.

Staff Taya Jenison stated that Resident A suffers from incontinence. Ms. Jenison stated that Resident A has been soiling her clothing and subsequently placing the

items into her bathroom, closet, and drawers. Ms. Jenison stated that Resident A has folded dirty clothing and placed them in her drawers as if the items were clean and has hung soiled items in her closet on hangers as if the items were clean. Ms. Jenison stated that laundry is completed at least weekly and is done more often when feces soiled items are observed. Ms. Jenison stated that staff are not hanging soiled items in Resident A's closet but instead are attempting to assist Resident A with using the toilet more often.

Resident A stated that she is happy with the level of care provided. Resident A stated that facility complete her laundry often and

On 06/12/2024 I provided Licensee Designee Connie Clauson with an exit conference via telephone. 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 400.15404	**Laundry.**
	A home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	Staff Jennifer Davidson stated that Resident A suffers from incontinence issues and memory decline. Ms. Davidson stated that Resident A has begun defecating in her clean clothing and subsequently hanging the soiled clothing up in her closet as if there were never soiled. Ms. Davidson stated that soiled undergarments have also been observed in Resident A's drawers after Resident A defecated in said undergarments. Staff Taya Jenison stated that Resident A has been soiling her clothing and subsequently placing the items into her bathroom, closet, and drawers. Ms. Jenison stated that Resident A has folded dirty clothing and placed them in her drawers as if the items were clean and has hung soiled items in her closet on hangers as if the items were clean. Ms. Jenison stated that laundry is completed at least weekly and is done more often when feces soiled items are observed. Ms. Jenison stated that staff are not hanging soiled items in Resident A's closet. While onsite I visually observed the condition of Resident A's bedroom and laundry. I did not observe any foul odors and I did not observe any soiled clothing in her closet. Evidence was not discovered during the special investigation to indicate citing a rule violation because facility staff are

	laundering Resident A’s clothing often and her private bedroom was observed as clean and tidy with no soiled clothing noted.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Facility staff failed to contact the appropriate health care professional after a medication error.

INVESTIGATION: While onsite I observed Resident A’s Medication Administration Record. I observed that on 04/03/2024 Resident A did not receive her prescribed medication, Olmesartan 40 MG, because the facility ran out of said medication.

Staff Jennifer Davidson stated that she was a medication technician on 04/03/2024 and was tasked with administering Resident A’s prescribed medications. Ms. Davidson stated that she recalled that Resident A was running low on her Olmesartan Medoxomil which is prescribed to address Resident A’s blood pressure. Ms. Davidson stated that Resident A did not receive one dose said medication on 04/03/2024 due to running out and no medical professional was alerted to the missed dose.

On 06/06/2024 I interviewed administrator Rebecca Jiggens via telephone. Ms. Jiggens acknowledged that Resident A missed a dose of her prescribed blood pressure medication, Olmesartan Medoxomil, on 04/03/2024 due to the facility running out of said medication. Ms. Jiggens stated that to her knowledge, facility staff failed to contact the appropriate health care professional after Resident A missed her 04/03/2024 dose of said medication.

On 06/12/2024 I provided Licensee Designee Connie Clauson with an exit conference via telephone. I explained my findings as noted above. Ms. Clauson acknowledged the violation, stated she understood my findings and indicated she would develop and submit a corrective action plan addressing the established rule violation. 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.**
	(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 Jennifer Davidson stated that she was a medication technician on 04/03/2024 and was tasked with administering Resident A's prescribed medications. Ms. Davidson stated that Resident A did not receive one dose of her medication, Olmesartan Medoxomil, on 04/03/2024 due to running out and no medical professional was alerted to the missed dose. Administrator Rebecca Jiggens stated that Resident A missed a dose of her prescribed blood pressure medication, Olmesartan Medoxomil, on 04/03/2024 due to the facility running out of the medication. Ms. Jiggens stated that to her knowledge, facility staff failed to contact the appropriate health care professional after Resident A missed her 04/03/2024 dose of said medication. A preponderance of evidence was discovered during the course of the special investigation to substantiate violation of the applicable rule; Resident A did not receive her medication, Olmesartan Medoxomil, and an appropriate medical care provider was not contacted.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

06/12/2024

Toya Zylstra Date
Licensing Consultant

Approved By:

06/12/2024

Jerry Hendrick Date
Area Manager