GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 23, 2024

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

RE: License #: AL700289594
Investigation #: 2024A0583039
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
Report contains explicit language

I. IDENTIFYING INFORMATION

License #:	AL700289594
Investigation #:	2024A0583039
Complaint Receipt Date:	06/28/2024
Investigation Initiation Date:	06/28/2024
Report Due Date:	07/28/2024
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?
Third shift staff do not provide adequate resident care.	Yes
Facility staff verbally mistreat Resident A.	No

III. METHODOLOGY

06/28/2024	Special Investigation Intake 2024A0583039
06/28/2024	Special Investigation Initiated - Telephone Admin. Rebecca Jiggens
06/28/2024	APS Referral
07/08/2024	Inspection Completed On-site
07/23/2024	Exit Conference Licensee Designee Connie Clauson

ALLEGATION: Third shift staff do not provide adequate resident care.

INVESTIGATION: On 06/28/2024 complaint allegations were received from Adult Protective Services (APS) Centralized Intake. The complaint allegations were screened out for formal Adult Protective Services Investigation. The complaint stated that staff Yusuf Mberwa and Noor Mberwa **"**work third shift and sleep on the shift". The complaint alleged that staff Yusuf Mberwa and staff Noor Mberwa "don't always get up to do the check and changes every hour".

On 06/28/2024 I interviewed administrator Rebecca Jiggens via telephone. Ms. Jiggens stated that staff Yusuf Mberwa and Noor Mberwa work third shift at the facility. Ms. Jiggens stated that staff Samantha Rowe recently "gave her two-week notice" to end her employment. Ms. Jiggens stated that Ms. Rowe briefly worked third shift with staff Yusuf Mberwa and Noor Mberwa. Ms. Jiggens stated that Ms. Rowe informed Ms. Jiggens that staff Yusuf Mberwa was observed sleeping at a table while working third shift. Ms. Jiggens stated that she asked staff Yusuf Mberwa if he had fallen asleep while working at the facility and he denied doing so. Ms. Jiggens stated that video cameras have been placed in the common areas of the facility and staff Yusuf Mberwa and Noor Mberwa have not been observed sleeping. Ms. Jiggens stated that a small number of residents require hourly bed checks and third shift adult brief "check and changes". Ms. Jiggens stated that she has heard no information regarding staff Yusuf Mberwa and Noor Mberwa not completing hourly bed checks and adult brief "check and changes".

On 07/08/2024 I completed an unannounced onsite investigation at the facility and interviewed Administrator Rebecca Jiggens and Resident A.

Administrator Rebecca Jiggens stated that to her knowledge staff Yusuf Mberwa and Noor Mberwa have provided adequate personal care to residents while working third shift.

Resident A was observed in his private bedroom with adequate hygiene. Resident A stated that he has no recollection of staff checking on him during the night because he is asleep.

On 07/16/2024 I received an email from Administrator Rebecca Jiggens which contained the Assessment Plans of Resident A, Resident B, and Resident C.

Resident A's Assessment Plan, signed 01/05/2024, stated that Resident A requires "hourly checks or more often, if needed". The document stated that Resident A "should be checked and changed at 2:00 AM and 4:00 AM".

Resident B's Assessment Plan, signed 03/26/2024, stated that Resident B requires "hourly checks or more often, if needed".

Resident C's Assessment Plan, signed 02/28/2024, stated Resident C exhibits an "altered sleep cycle" which requires facility staff to complete "hourly checks".

On 07/17/2024 I received an email from Administrator Rebecca Jiggens which contained Resident A, Resident B, and Resident C's "Task Administration Record" for the period of 05/2024 and 06/2024.

Resident A's "Task Administration Record" indicated that on the following dates and times staff did not complete "hourly checks": 05/04/2024 5:00AM, 05/04/2024 6:00AM, 05/06/2024 11:00AM, 05/06/2024 2:00PM, 05/07/2024 2:00AM, 05/07/2024 5:00AM, 05/10/2024 11:00AM, 05/10/2024 2:00PM, 05/16/2024 3:00PM, 05/16/2024 4:00PM, 05/16/2024 10:00PM, 05/21/2024 11:00AM, 05/22/2024 11:00AM, 05/24/2024 4:00PM, 05/26/2024 10:00PM, 05/28/2024 2:00AM, 05/28/2024 6:00AM, 05/31/2024 2:00PM, 05/31/2024 3:00PM, 05/31/2024 7:00PM, 05/31/2024 8:00PM

Resident B's "Task Administration Record" indicated that on the following dates and times staff did not complete "hourly checks": 05/05/2024 3:00PM, 05/06/2024 7:00PM, 05/09/2024 3:00PM, 05/15/2024 3:00PM, 05/17/2024 3:00PM, 05/17/2024 10:00PM, 05/21/2024 8:00AM, 05/22/2024 3:00PM, 5/24/2024 4:00PM, 5/25/2024 10:00PM, 05/29/2024 3:00PM, 05/31/2024 8:00PM, 06/01/2024 12:00PM, 06/02/2024 4:00PM, 06/02/2024 8:00PM, 06/10/2024 3:00PM, 6/12/2024 7:00AM, 06/12/2024 3:00PM, 06/15/2024 3:00PM, 06/19/2024 4:00PM, 06/20/2024 3:00PM, 06/23/2024 7:00AM, 06/23/2024 3:00PM

Resident C's "Task Administration Record" indicated that on the following dates and times staff did not complete "hourly checks": 05/04/2024 5:00AM, 05/04/2024 6:00AM, 05/06/2024 11:00AM, 05/06/2024 2:00PM, 05/07/2024 2:00AM, 05/16/2024 4:00PM, 05/21/2024 11:00AM, 05/24/2024 4:00PM, 05/26/2024 10:00PM, 05/28/2024 6:00AM, 05/31/2024 2:00PM, 05/31/2024 7:00PM, 05/31/2024 8:00PM, 06/03/2024 3:00PM, 06/04/2024 2:00AM, 06/04/2024 4:00AM, 06/04/2024 5:00AM, 06/09/2024 2:00PM, 06/09/204 3:00PM, 06/17/2024 3:00AM, 06/21/2024 4:00PM, 06/27/2024 3:00PM

On 07/19/2024 I interviewed staff Yusuf Mberwa via telephone. Mr. Mberwa stated that he was unaware that specific residents' Assessment Plans require that staff complete hourly third shift face-to-face checks and therefore he does not always complete this required task. Mr. Mberwa stated that he does not always document face-to-face resident checks on the facility's "Task Administration Record" because he has not been trained to do so. Mr. Mberwa stated that he does change specific residents' adult briefs regularly third shift based upon "if they are heavy wetters". Mr. Mberwa stated that he changes some residents' adult briefs every three hours and other residents less often based upon their specific care needs. Mr. Mberwa stated that he provides residents with adequate personal care.

On 07/19/2024 I interviewed staff Noor Mberwa via telephone. Mr. Mberwa stated that he completes hourly face-to-face checks as required. Mr. Mberwa stated that Resident A doesn't require third shift adult brief changes and he does not perform them for Resident A. Mr. Mberwa stated that the other staff he works with on third shift do not complete adult brief changes for Resident A because it is not required for his care.

On 07/23/2024 I completed an Exit Conference via telephone with Licensee Designee Connie Clauson. Ms. Clauson stated that she had nothing to add to the investigation and that the facility would submit an acceptable Corrective Action Plan that remediates the violation.

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 Assessment Plan stated that Resident A requires "hourly checks or more often, if needed". This document stated that Resident A "should be checked and changed at 2:00 AM and 4:00 AM". Resident B's Assessment Plan stated that Resident B requires "hourly checks or more often, if needed".

	Resident C's Assessment Plan stated Resident C exhibits an "altered sleep cycle" which requires facility staff to complete "hourly checks". Staff Yusuf Mberwa stated that he was unaware that specific residents' Assessment Plans require that staff complete hourly face-to-face checks during third shift and therefore he does not always complete this required task. Staff Noor Mberwa stated that he does not perform third shift adult brief changes for Resident A. Staff Yusuf Mberwa stated that he does not always complete hourly resident face-to-face checks during third shift and staff Noor Mberwa stated that he does not complete third shift adult brief changes for Resident A. A preponderance of evidence was discovered during the Special Investigation to support a violation of the applicable rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility staff verbally mistreat Resident A.

INVESTIGATION: On 06/28/2024 complaint allegations were received from Adult Protective Services Centralized Intake. The complaint stated that Resident A has been diagnosed with a Traumatic Brain Injury and "calls black staff racial names because he does not like them". The complaint alleged that staff Yusuf Mberwa and Noor Mberwa verbally abuse Resident A "in retaliation by calling him name like retard, tell him to shut up and that he is stupid".

On 06/28/2024 I interviewed administrator Rebecca Jiggens via telephone. Ms. Jiggens stated that staff Yusuf Mberwa and Noor Mberwa work third shift at the facility. Ms. Jiggens stated that Resident A has been diagnosed with a Traumatic Brain Injury and requires staff assistance with most of his activities of daily living. Ms. Jiggens stated that multiple staff have reported that Resident A displays verbal agitation when he receives personal care from African American staff which has been attributed to his TBI symptoms. Ms. Jiggens stated that staff Yusuf Mberwa and Noor Mberwa have reported that Resident A has called them derogatory names however Ms. Jiggens has never observed or heard that staff have retaliated.

On 07/08/2024 I completed an unannounced onsite investigation at the facility and interviewed Administrator Rebecca Jiggens and Resident A. Administrator Rebecca Jiggens stated that Resident A's verbal aggression towards staff has escalated to calling female staff "fucking bitches" and "fat asses". Ms. Jiggens stated that to her knowledge staff have not verbally mistreated Resident A in retaliation.

Resident A stated that staff Yusuf Mberwa and Noor Mberwa have called him “racist” and an “asshole Christian”. Resident A stated that he has called staff Yusuf and Noor Mberwa “Buddhist” but denied cursing at staff.

On 07/19/2024 I interviewed staff Yusuf Mberwa via telephone. Mr. Mberwa stated that he has never verbally mistreated Resident A. Mr. Mberwa stated that Resident A often calls Mr. Mberwa “racial slurs” and will instruct Mr. Mberwa to “get out of my room you Muslim”. Mr. Mberwa stated that he has never verbally retaliated towards Resident A but does find it difficult to provide personal care to Resident A because it agitates Resident A. Mr. Mberwa stated that he has never observed staff Noor Mberwa verbally mistreat Resident A.

On 07/19/2024 I interviewed staff Noor Mberwa via telephone. Mr. Mberwa stated that he has never verbally mistreated Resident A or observed staff Yusuf Mberwa verbally mistreat Resident A. Mr. Mberwa stated that Resident A routinely verbally mistreats him by calling him “racist” comments.

On 07/19/2024 I interviewed staff Yordi Stevens via telephone. Ms. Stevens stated that she has never observed staff Yusuf Mberwa or Noor Mberwa verbally mistreat Resident A in any manner.

On 07/23/2024 I completed an Exit Conference via telephone with Licensee Designee Connie Clauson. Ms. Clauson stated that she agreed with the Special Investigation findings.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A stated that staff Yusuf Mberwa and Noor Mberwa have called him “racist” and an “asshole Christian”. Resident A stated that he has called staff Yusuf and Noor Mberwa “Buddhist” but denied cursing at them. Staff Yusuf Mberwa stated that he has never verbally mistreated Resident A. Mr. Mberwa stated that Resident A often calls Mr. Mberwa “racial slurs” and instructs Mr. Mberwa to “get out of my room you Muslim”. Mr. Mberwa stated that he has never verbally retaliated towards Resident A or observed staff Noor Mberwa verbally mistreat Resident A.

	Staff Noor Mberwa stated that he has never verbally mistreated Resident A and has never observed staff Yusuf Mberwa verbally mistreat Resident A. Mr. Mberwa stated that Resident A routinely verbally mistreats him by calling him “racist” comments. Staff Yordi Stevens stated that she has never observed staff Yusuf Mberwa or Noor Mberwa verbally mistreat Resident A in any manner. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate a violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

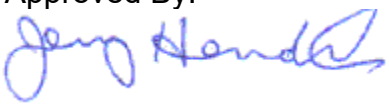
IV. RECOMMENDATION

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

07/23/2024

Toya Zylstra — Date
Licensing Consultant

Approved By:



07/23/2024

Jerry Hendrick — Date
Area Manager