GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 4, 2024

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

RE: License #: AL700289594
Investigation #: 2024A0583051
Cambridge Manor - South

Dear Mrs. Clauson:

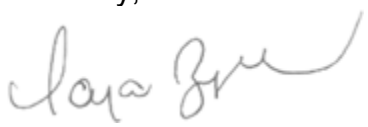
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	2024A0583051
Complaint Receipt Date:	08/19/2024
Investigation Initiation Date:	08/20/2024
Report Due Date:	09/18/2024
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 - 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, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not provided adequate personal care.	No
Facility staff were engaged in a verbal altercation that was overheard by residents.	Yes
Facility staff do not administer residents' medications as prescribed.	No
Facility staff steal residents' medications.	No

III. METHODOLOGY

08/19/2024	Special Investigation Intake 2024A0583051
08/19/2024	APS Referral
08/20/2024	Special Investigation Initiated - On Site
09/04/2024	Exit Conference Licensee Connie Clauson

ALLEGATION: Residents are not provided adequate personal care.

INVESTIGATION: On 08/19/2024 complaint allegations were received from Adult Protective Services staff Emily Fewless. The allegations came from an anonymous source and were assigned for Adult Protective Services investigation. The complaint alleged that residents are "left to sit in their own feces and urine, sometimes more than 2 hours" and "residents are not being wiped correctly because staff are limited wipes due to cost". The complaint further alleged that "residents can go up to one month without a shower".

On 08/21/2024 I completed an unannounced onsite investigation at the facility and privately interviewed administrator Rebecca Jiggens, staff Kindra Reinstra, staff Isabelle Terpstra, Resident A, and Resident B.

Administrator Rebecca Jiggens stated that residents are provided appropriate personal care and denied the allegations are true. Ms. Jiggens stated that residents are toileted and/or have their adult briefs changed at least every two hours. Ms. Jiggens stated that the facility pays for residents' wet wipes and there is no shortage of them due to cost. Ms. Jiggens stated that residents receive toileting care and there is no indication that residents are not "wiped" appropriately with wet wipes. Ms. Jiggens stated that residents are bathed "two to three" times weekly. Ms. Jiggens denied that any resident has gone up to a month without being showered or bathed.

Staff Kindra Reinstra stated that the complaint allegations are untrue. Ms. Reinstra stated that residents are toileted and/or have their adult briefs changed approximately every two hours. Ms. Reinstra stated that residents are not left in their own feces or urine and staff provide urinary care appropriately. Ms. Reinstra stated that residents are showered two to three times per week and no resident has gone up to a month without being showered.

Staff Isabelle Terpstra stated that the allegations are untrue. Ms. Terpstra stated that residents are toileted, or their adult briefs changed at least every two hours. Ms. Terpstra stated that residents are not left in soiled adult briefs and staff provide appropriate urinary care. Ms. Terpstra stated that residents are provided showering or bathing assistance two to three times per week.

Resident A presented as utilizing a wheelchair for mobility. Resident A presented with appropriate hygiene. Resident A stated that staff provide adequate assistance with personal care. Resident A stated that she is provided bathing assistance twice per week as well as appropriate urinary care. Resident A stated that she has not observed staff leaving other residents in soiled adult briefs.

Resident B presented with appropriate hygiene. Resident B stated that staff provide adequate bathing and urinary care. Resident B stated that she has not observed other residents left in soiled adult briefs. Resident B stated that she is happy with the level of care provided.

On 09/04/2024 I completed an Exit Conference with licensee Connie Clauson via telephone. Ms. Clauson agreed with the Special Investigation findings.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	Administrator Rebecca Jiggens, staff Kindra Reinstra, staff Isabelle Terpstra each reported that staff provide adequate personal care. Resident A and Resident B were observed with appropriate hygiene. Resident A and Resident B both stated that staff provide adequate personal care.

	A preponderance of evidence was not discovered during the Special Investigation to substantiate a violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff were engaged in a verbal altercation that was overheard by residents.

INVESTIGATION: On 08/19/2024 complaint allegations were received from Adult Protective Services staff Emily Fewless. I reviewed that the complaint alleged that "staff member named; Jaylin attempted to have a physical altercation with two employees on 8-16-24" and that the altercation occurred "in front of other residents, families and employees".

On 08/20/2024 I completed an unannounced onsite investigation at the facility and privately interviewed administrator Rebecca Jiggens, Resident A, and Resident B.

Administrator Rebecca Jiggens stated that she received a telephone call from staff Nya Crump on the evening of 08/16/2024. Ms. Jiggens stated that Ms. Crump was working at an adjoining facility but reported that there had been a verbal altercation that took place between staff Jailynn Washington, staff Ibety Vieyra-Tinoco, and staff Aracely Ortiz-Vieyra because Ms. Vieyra-Tinoco and Ms. Ortiz-Vieyra were upset that when they arrived to the facility the trash had not been taken out. Ms. Crump informed Ms. Jiggens that the altercation occurred in the main living area of the facility and a resident's family overheard the women cursing and threatening to assault one another. Ms. Jiggens explained that Ms. Vieyra-Tinoco and Ms. Ortiz-Vieyra have a mother and daughter relationship. Ms. Jiggens stated that Ms. Washington was terminated, Ms. Vieyra-Tinoco and Ms. Ortiz-Vieyra both resigned. Ms. Jiggens stated that she spoke to Ms. Vieyra-Tinoco and Ms. Ortiz-Vieyra and they reported that Ms. Washington instigated the verbal altercation and Ms. Washington stated that Ms. Vieyra-Tinoco and Ms. Ortiz-Vieyra instigated the verbal altercation. Ms. Jiggens stated that a physical altercation did not occur however she is uncertain if residents overheard the verbal altercation.

Resident A stated that on the evening of 08/16/2024 she had her bedroom door open and overheard a heated conversation between staff Jailynn Washington, staff Ibety Vieyra-Tinoco, and staff Aracely Ortiz-Vieyra. Resident A stated that the staff members were in the communal living area of the facility during the incident. Resident A stated that residents were in their bedrooms at the time of the incident. Resident A stated that she could not identify what each staff member said, but distinctly overheard one of the staff members yell, "are you a lazy bitch" and "you're always on your phone". Resident A stated that she also overheard doors being slammed. Resident A stated that this is the only time she has overheard staff members involved in a verbal altercation.

Resident B stated that she did not observe or overhear any verbal dispute on the evening of 08/16/2024.

On 09/04/2024 I completed an Exit Conference with licensee Connie Clauson via telephone. Ms. Clauson stated that she did not dispute the special investigation findings and would submit an acceptance Corrective Action Plan.

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 on the evening of 08/16/2024 she had her bedroom open and overheard a heated conversation between staff Jailynn Washington, staff Ibety Vieyra-Tinoco, and staff Aracely Ortiz-Vieyra. Resident A stated that the staff members were in the communal living area of the facility during the incident. Resident A stated that residents were in their bedrooms at the time of the incident. Resident A stated that she could not identify what each staff member said, but distinctly overheard one of the staff members yell “are you a lazy bitch” and “you’re always on your phone”. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. Staff subjected residents to a verbal altercation that contained profanity.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility staff do not administer resident’s medications as prescribed.

INVESTIGATION: On 08/19/2024 complaint allegations were received from Adult Protective Services staff Emily Fewless. The complaint alleged that, “staff are also charting the wrong medications in charts stating that they are providing the medications, but they really have not”.

On 08/21/2024 I completed an unannounced onsite investigation at the facility and privately interviewed administrator Rebecca Jiggens, staff Kindra Reinstra, staff Isabelle Terpstra, Resident A, and Resident B.

Administrator Rebecca Jiggens stated that staff are trained to administer all residents' medication as prescribed. Ms. Jiggens stated that she has not observed or been informed of staff charting the wrong medications or not administering medications as prescribed.

Staff Kindra Reinstra stated that she has not observed any staff member failing to administer residents' medications as prescribed. She stated that she administers all residents' medications as prescribed.

Staff Isabelle Terpstra stated that she has not observed any staff member not administering residents' medications as prescribed. She stated that she administers all residents' medications as prescribed.

Resident A stated that to her knowledge she has received her medications as prescribed.

Resident B stated that to her knowledge she has received her medications as prescribed.

While onsite I observed Resident C, Resident D, and Resident E's Medication Administration Records and did not observe any indication that the residents are not receiving their medications as prescribed. I counted each residents' narcotics medications and observed the counts matched that the staff counting sheets.

On 09/04/2024 I completed an Exit Conference with licensee Connie Clauson via telephone. Ms. Clauson agreed with the Special Investigation findings.

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.
ANALYSIS:	Administrator Rebecca Jiggens stated that staff are trained to administer all residents' medication as prescribed. Ms. Jiggens stated that she has not observed or been informed of staff

	charting the wrong medications or failing to administer medications as prescribed. Staff Kindra Reinstra stated that she has not observed any staff member not administering resident's medications as prescribed. She stated that she administers all residents' medications as prescribed. Staff Isabelle Terpstra stated that she has not observed any staff member not administering resident's medications as prescribed. She stated that she administers all residents' medications as prescribed. Resident A stated that to her knowledge she has received her medications as prescribed. Resident B stated that to her knowledge she has received her medications as prescribed. While onsite I observed Resident C, Resident D, and Resident E's Medication Administration Records and did not observe indications that the residents are not receiving their medications as prescribed. I counted each residents' narcotic medications and observed the counts matched the staff counting sheets. A preponderance of evidence was not discovered during the Special Investigation to substantial violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Facility staff steal residents' medications.

INVESTIGATION: On 08/19/2024 complaint allegations were received from Adult Protective Services staff Emily Fewless. The complaint alleged that "employees are stealing residents' medications".

On 08/21/2024 I completed an unannounced onsite investigation at the facility and privately interviewed administrator Rebecca Jiggens, staff Kindra Reinstra, staff Isabelle Terpstra, Resident A, and Resident B.

Administrator Rebecca Jiggens stated that she has no knowledge of staff stealing residents' medications. Ms. Jiggens stated that medication technicians are required to count each resident's narcotic medications with the following shifts' medication

technician and document that count. Ms. Jiggens stated that if there are any discrepancies in narcotic counts it is the responsibility of the staff to notify her.

Staff Kindra Reinstra stated that she has not observed any indication of staff theft of residents' medications. Ms. Reinstra stated that all narcotics are counted after every shift with the following shifts' medication technician and then documented. Ms. Reinstra stated that any discrepancies in narcotics require that staff notify the facility's administrator.

Staff Isabelle Terpstra stated that she has not observed any indication of staff theft of residents' medications. Ms. Terpstra stated that all narcotics are counted by two staff and documented.

Resident A stated that she has no knowledge of staff theft of residents' medications.

Resident B stated that she has no knowledge of staff theft of residents' medications.

While onsite I observed Resident C, Resident D, and Resident E's Medication Administration Records and did not observe indications that the residents are not receiving their medications as prescribed. I counted each residents' narcotics medications and observed that the counts matched the staff counting sheets.

On 09/04/2024 I completed an Exit Conference with licensee Connie Clauson via telephone. Ms. Clauson agreed with the Special Investigation findings.

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:	Administrator Rebecca Jiggens stated that she has no knowledge of staff stealing residents' medications. Ms. Jiggens stated that medication technicians are required to count each residents' narcotic medications with the following shifts' medication technician and document that count. Ms. Jiggens stated that if there are any discrepancies in narcotic counts it is the responsibility of the staff to notify her. Staff Kindra Reinstra stated that she has not observed any indication of staff theft of residents' medications. Ms. Reinstra stated that all narcotics are counted after every shift with the following shifts' medication technician and then documented. Ms. Reinstra stated that any discrepancies in narcotics require that staff notify the facility's administrator.

	Staff Isabelle Terpstra stated that she has not observed any indication of staff theft of residents' medications. Ms. Terpstra stated that all narcotics are counted by two staff and documented. Resident A stated that she has no knowledge of staff theft of residents' medications. Resident B stated that she has no knowledge of staff theft of residents' medications. I observed Resident C, Resident D, and Resident E's Medication Administration Records and did not observe indications that the residents are not receiving their medications as prescribed. I counted each residents' narcotics medications and observed that the counts matched the staff counting sheets. A preponderance of evidence was not discovered during the Special Investigation to substantial violation of the applicable rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

09/04/2024

Toya Zylstra Date
Licensing Consultant

Approved By:

09/04/2024

Jerry Hendrick Date
Area Manager