GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 3, 2025

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

RE: License #: AL700289583
Investigation #: 2025A0583039
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 feel free to 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 #:	2025A0583039
Complaint Receipt Date:	05/19/2025
Investigation Initiation Date:	05/19/2025
Report Due Date:	06/18/2025
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 administer Resident A's medication as prescribed.	Yes
Facility staff did not supervise Resident A while she was ingesting her prescribed medications.	Yes

III. METHODOLOGY

05/19/2025	Special Investigation Intake 2025A0583039
05/19/2025	Special Investigation Initiated - On Site
05/21/2025	APS Referral
XXX	Exit Conference Licensee designee Connie Clauson

ALLEGATION:

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

INVESTIGATION:

On 05/18/2025, complaint allegations were received from the LARA-BCHS-Complaints system. The allegations read that Resident A was prescribed Quetiapine "50mg in the AM, 75mg at noon, 75mg at bedtime and PRN 50mg every 8 hrs" however staff are administering a "50 mg dose" of Quetiapine "in am, noon, and 6:00pm".

On 05/20/2025, I completed an unannounced onsite investigation at the facility and interviewed regional operations director Amanda Beecham.

Ms. Beecham stated that Resident A's medications administration records (MAR) indicated that as of 05/13/2025, Resident A was prescribed Quetiapine 50 MG 3X per day at 8AM, noon, and 8PM and Quetiapine 25 MG 2X per day at noon and 8PM. Ms. Beecham stated that Resident A's MAR indicated that on 05/17/2025 at 8AM facility staff Tricia VanKoevering administered one 50 MG tablet and one 25 MG tablet of Quetiapine for a total of 75 MG of Quetiapine.

While onsite I reviewed a Corewell Health Medication Physician's Order dated 05/13/2025. I observed that the document was completed by Amy Engelsman RN and Dr. Colleen Tallen. Resident A was prescribed Quetiapine 50MG one tablet three times per day at 8AM, noon, and 8PM. In addition, Resident A was prescribed Quetiapine 25 MG one tablet twice per day at noon and 8PM. Resident A was prescribed Quetiapine 50 MG one tablet every eight hours as needed for delirium.

While onsite I reviewed Resident A's MAR. I observed that on 05/17/2025 at 8:00 AM, Resident A was administered one Quetiapine 50 MG tablet at 8AM and one 25 MG Quetiapine tablet at 8AM for a total of 75 MG of Quetiapine. Resident A's MAR read that Resident A was to be administered one 25 MG tablet of Quetiapine at 6:00 PM, and not at 8:00 PM as ordered by Dr. Tallen. I observed that Resident A's MAR indicated that she had been receiving her 8:00 PM dosage of 25 MG Quetiapine at 6:00 PM. I observed that on the evening of 05/17, staff Alicia Banks was tasked with administering Resident A's medications, but that Resident A was not provided with her 25 MG Quetiapine 8PM dose.

On 05/20/2025, I interviewed medication technician Alicia Banks via telephone. Ms. Banks stated that she was assigned to administer medications on 05/17 from 3:00 PM until approximately 9:30 PM. Ms. Banks stated that on 05/17/2025 at approximately 8:00 PM, she attempted to administer Resident A with one 50 MG tablet of Quetiapine, but Resident A refused the medication. Ms. Banks stated that she did not offer Resident A her 25 MG dose of Quetiapine anytime during the evening of 05/17.

On 05/20/2025, I interviewed Relative A via telephone. Relative A stated that she was called to the facility by Ms. Banks on the evening of 05/17 because she could not persuade Resident A to take her evening medications. Relative A stated that she arrived at the facility at approximately 9:00 PM and Ms. Banks provided Relative A with one 50 MG tablet of Quetiapine and two tablets of Tylenol. Relative A stated that Ms. Banks asked Relative A to administer the medications and left the facility shortly afterwards. Relative A stated that shortly after Ms. Banks left the facility, medication technician Shane Lovell entered Resident A's bedroom and attempted to persuade Resident A to take her medications. Relative A stated that Resident A refused. Relative A stated that after both staff left Resident A's bedroom, Relative A administered successfully the medications with no staff supervision.

On 05/21/2025, I emailed complaint allegations to Adult Protective Services Centralized Intake.

On 05/21/2025, I interviewed medication technician Tricia Van Koevering via telephone. Ms. VanKoevering stated that Resident A's medication dosages have been changed multiple times over the previous month, which has been confusing for staff to follow. Ms. VanKoevering stated that on 05/17 at 8:00 AM; Ms. Vankoevering administered one 50 MG tablet of Quetiapine and one 25 MG tablet of Quetiapine to Resident A.

On 06/03/2025 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. She agreed to submit an acceptable 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:	Facility staff are not administering Resident A's medications as prescribed. I reviewed a Corewell Health Medication Physician's Orders dated 05/13 completed by Amy Engelsman RN and Dr. Colleen Tallen. Resident A was prescribed Quetiapine 50 MG one tablet three times per day at 8AM, noon, and 8PM. In addition, Resident A was prescribed Quetiapine 25 MG one tablet two times per day at noon and 8PM. Resident A was prescribed 50 MG Quetiapine at 8:00 AM however on 05/17 at 8:00 AM, staff administered an additional 25 MG of Quetiapine for a total of 75 MG of the medication. Additionally, Resident A was prescribed 50 MG Quetiapine and 25 MG Quetiapine for a total of 75 MG at 8:00 PM. However, on the evening of 05/17, Resident A was only provided 50 MG of the medication.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation Report # 2024A0583034 dated 06/12/2024 Corrective Action Plan dated 07/01/2024**

ALLEGATION:

Facility staff did not supervise Resident A while she was ingesting her prescribed medications.

INVESTIGATION:

Ms. Beecham stated that on 05/17 Ms. Banks worked from 3:00 PM until 9:00 PM administering residents' medications and was relieved by Mr. Lovell. Ms. Beecham reported having been told that after Ms. Banks had left her shift, Mr. Lovell, at approximately 9:00 PM, entered Resident A's bedroom where he found Relative A1 attempting to persuade Resident A to take her medications left by Ms. Banks. She was told that Mr. Lovell offered words of encouragement to Resident A. However, Relative A told Mr. Lovell he was "not helping" and subsequently exited Resident A's bedroom. She said that after Mr. Lovell had left Resident A's bedroom, Relative A informed Mr. Lovell that Resident A had ingested her medications left by Ms. Banks. It was reported to her that Mr. Lovell did not document the administration of Resident A's 8pm medication.

Mr. Lovell stated at approximately 8:30 PM Ms. Banks informed Mr. Lovell that she was scheduled to leave at 9:00 PM. Mr. Lovell stated that Ms. Banks informed him that Resident A was recently provided with her scheduled 50 MG Quetiapine (Seroquel) and 1000 MG Tylenol however Resident A refused said medications. Ms. Banks said Relative A was informed that Resident A had refused to take her medications, and Relative A came to the facility to try to persuade Resident A to take the medications. Mr. Lovell stated that Ms. Banks said she provided the medications to Relative A and Relative A was in Resident A's bedroom with the medications. Mr. Lovell stated that at approximately 9:00 PM he entered Resident A's bedroom where he found Relative A attempting to persuade Resident A to take her medications. Mr. Lovell stated that he offered words of encouragement to Resident A however Relative A told Mr. Lovell he was "not helping" and therefore he exited Resident A's bedroom. Mr. Lovell stated that shortly after he left Resident A's bedroom, Relative A informed Mr. Lovell that Resident A did ingest her Quetiapine and Tylenol. Mr. Lovell stated that he did not document the administration of Resident A's Quetiapine and Tylenol in Resident A's Medication Administration Record.

Ms. Banks had documented in Resident A's 05/17 MAR that at 8:34 PM Resident A refused her scheduled Tylenol and at 8:47 PM her scheduled Quetiapine.

Ms. Banks stated that she informed Mr. Lovell that Resident A refused her Quetiapine and Tylenol, and that Relative A was attempting to administer the medications to Resident A in her bedroom. Ms. Banks stated that she left the facility at approximately 9:30 PM and was unsure if Relative A convinced Resident A to take her medications. Ms. Banks stated that prior to leaving the facility; she documented Resident A's refusals.

On 06/03/2025 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. She agreed to submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Interviews with Ms. Beacham, Mr. Lovell, Ms. Banks, and Relative A along with review of the MAR reveal that on 5/17, Resident A refused her 8 PM medications. This refusal occurred at the end of Ms. Banks shift and the beginning of Mr. Lovell. Ms. Banks left the medications to be administered in the care of Relative A and informed Mr. Lovell of having done so. Mr. Lovell had knowledge of the transaction as he had entered the room while Relative A was attempting to administer the medications to Resident A. Ms. Banks did document the refusals and left the medications in the care of a non-staff member. This transfer of responsibility from staff to Relative A was not consistent with the intent of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

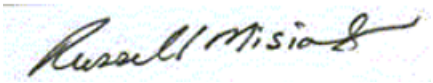
IV. RECOMMENDATION

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

06/03/2025

Toya Zylstra Date
Licensing Consultant

Approved By:



05/27/2025

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Russell Misiak Date
Area Manager