GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 5, 2023

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

RE: License #: AL410289604
Investigation #: 2024A0464009
Stonebridge 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,

Megan Aukerman, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 438-3036

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL410289604
Investigation #:	2024A0464009
Complaint Receipt Date:	11/06/2023
Investigation Initiation Date:	11/06/2023
Report Due Date:	01/05/2024
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203, 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Julie Treakle
Licensee Designee:	Connie Clauson
Name of Facility:	Stonebridge Manor - South
Facility Address:	3515 Leonard NW Walker, MI 49534
Facility Telephone #:	(616) 791-9090
Original Issuance Date:	10/22/2012
License Status:	REGULAR
Effective Date:	05/19/2023
Expiration Date:	05/18/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS/AGED

II. ALLEGATION(S)

	Violation Established?
On 11/05/2023 Resident A was found lying in the grass, with only a nightgown on.	Yes

III. METHODOLOGY

11/06/2023	Special Investigation Intake 2024A0464009
11/06/2023	APS Referral
11/06/2023	Special Investigation Initiated-Telephone Kevin Souser, Kent County APS
11/15/2023	Inspection Completed On-site Kevin Souser (APS), Julie Treakle (Administrator), Residents A & B
11/27/2023	Contact-Telephone call made Colleen Perkins, Staff
11/27/2023	Contact-Telephone call made Valeria Katona, Staff
11/27/2023	Contact-Telephone call made Alisha Rivera, Staff
11/30/2023	Contact-Telephone call made Colleen Perkins, Staff
12/05/2023	Exit Conference Connie Clauson, Licensee Designee

ALLEGATION: On 11/05/2023 Resident A was found lying in the grass, with only a nightgown on.

INVESTIGATION: On 11/06/2023, I received an online BCAL complaint from Adult Protective Services (APS). The complaint alleged Resident A has been diagnosed with dementia, behavioral disturbance, disc degeneration, and hypothyroidism. On 11/05/2023, Resident A was found lying outside the facility, in the grass wearing nothing but a nightgown. Resident A was transported to the hospital for the possibility of hypothermia.

On 11/06/2023, I spoke to Kent County APS worker, Kevin Souser to coordinate the investigation. Mr. Souser stated he visited Resident A at the facility and attempted to interview her; however, she presented as confused and did not remember walking out of the facility.

On 11/15/2023, Mr. Souser and I completed an unannounced, onsite inspection at the facility. We interviewed facility administrator, Julie Treakle. Mrs. Treakle stated on 11/05/2023, around 8:10 am, staff, Alisha Rivera called her and told her Resident A was not in her bedroom and she could not find her. Mrs. Treakle stated she arrived at the facility at 8:35 am and Resident A had been found. Ms. Rivera told Mrs. Treakle a neighbor found Resident A laying in the grass. Mrs. Treakle and Ms. Rivera were checking Resident A over and due to the coloring of her feet and legs, Mrs. Treakle called for an ambulance to transport Resident A to the hospital. Mrs. Treakle explained staff are supposed to check on residents every hour. Mrs. Treakle stated she interviewed staff and checked Resident A's records. She stated staff last documented checking on Resident A at 5:30 am on 11/05/2023. Based on staff Colleen Perkins stating she last saw Resident A around 5:30 am, Mrs. Treakle believes Resident A could have walked out of the facility around 7:00 am. Mrs. Treakle stated Resident A does not typically try to go outside. Since the incident, Mrs. Treakle explained two employees who were working the morning of 11/05/2023 have been terminated. Mrs. Treakle also explained that since this incident, Resident A was moved to the secure dementia unit. Mrs. Treakle stated staff training is also scheduled for 11/29/2023, where staff will be trained on elopement policies and procedures.

Mr. Souser and I then made face-to-face contact with Residents A and B. Resident B was observed to be napping on the couch. Attempts were made to interview Resident A; however, they were unsuccessful. Resident A stated she did not remember walking outside the facility or going to the hospital. Both Resident A and B were observed to be clean and appropriately dressed. No concerns were observed.

On 11/27/2023, I attempted to contact staff, Colleen Perkins by telephone. A message was left requesting a return phone call.

On 11/27/2023, I interviewed staff, Valeria Katona by telephone. Ms. Katona stated she was working first shift on 11/05/2023. Ms. Katona stated once she got in, she began her resident checks around 7:00 am. Ms. Katona stated she checked Resident A's bedroom and noticed she was not there. Ms. Katona figured she was already up, sitting in the dining room as she usually does. Ms. Katona then continued her rounds and began assisting other residents. Ms. Katona stated that morning a staff person did not show-up for their scheduled shift, therefore Mrs. Treakle was notified. Mrs. Treakle stated she was coming in and for Ms. Perkins to stay over from third shift, until she got there. Ms. Katona stated about an hour later she saw Ms. Perkins running by her with a wheelchair and she did not say anything.

A few moments later, Ms. Perkins and staff, Alisha Rivera wheeled Resident A in from outside. Ms. Perkins then informed Ms. Katona that Resident A was found lying outside by a neighbor. Ms. Katona stated she believes Resident A must have walked outside at some point before 7:00 am. Ms. Katona explained her employment was terminated as a result of the incident.

On 11/27/2023, I interviewed Ms. Rivera by telephone. Ms. Rivera stated she pulled into the facility at 6:40 am on 11/05/2023 to start her scheduled shift. Ms. Rivera explained it was still dark outside when she arrived. Ms. Rivera stated she was working in the adjacent facility that day. Ms. Rivera explained that around 8:00 am, a neighbor knocked on the facility door and informed her Resident A was lying in the grass and he was unable to get her up. Ms. Rivera yelled to Ms. Perkins to get a wheelchair and bring it outside. Ms. Rivera stated she ran outside and saw Resident A lying on the ground with only her nightgown on. Ms. Rivera stated she was laying in the grass where you could see her if you pulled into the facility parking lot; however, it was dark when she and Ms. Katona arrived so they did not notice Resident A. Ms. Rivera stated she and Ms. Perkins got Resident A into the wheelchair and took her into the facility. At this point Mrs. Treakle arrived. Resident A's vitals were taken, and her body temperature was low, therefore it was decided an ambulance would be contacted to transport Resident A to the hospital to get checked out. Ms. Rivera explained Resident A has returned and appears to be doing well. Ms. Rivera was unable to state when Resident A went outside of the facility but is certain it was before 7:00 am. Ms. Rivera stated she would not put it past Ms. Perkins to lie about completing her hourly checks and does not believe she really saw Resident A in her bedroom. Ms. Rivera stated Ms. Perkins has since been terminated. Ms. Rivera explained Resident A has since been moved to the secured unit.

On 11/28/2023, I received and reviewed Resident A’s Assessment Plan which was completed and signed on 05/10/2023. Under the Behavior section of the plan, it states, “(Resident A) at times can be confused and wander. Use door alarms for safety.”

On 11/30/2023, I interviewed Ms. Perkins by telephone. Ms. Perkins stated she was the only staff working third shift from 7:00 pm on 11/04/2023 to 7:00 am 11/05/2023. Ms. Perkins stated she completed resident checks every hour. She last checked on Resident A around 6:00 am on 11/05/2023. Ms. Perkins stated she observed Resident A asleep in her bed. Ms. Perkins stated he shift was supposed to end at 7:00 am that morning but she had to stay over. Ms. Perkins stated around 8:30 am, Ms. Rivera came to get her and told her Resident A was found lying outside. Ms. Perkins assisted Ms. Rivera with getting Resident A back inside and checking her vitals. Ms. Perkins stated Resident A will frequently try to go outside, but staff have always prevented her from getting out. Ms. Perkins explained her employment was terminated as a result of the incident.

On 12/05/2023, I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation findings and recommendations.

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:	On 11/06/2023, a complaint was received alleging facility staff failed to recognize Resident A had eloped from the facility. On 11/15/2023, an unannounced onsite inspection was completed at the facility. Facility administrator, Julie Treakle reported staff documented last checking on Resident A at 5:30 am on 11/05/2023. Attempts were made to interview Resident A however, Resident A stated she did not remember walking out of the facility or going to the hospital. Facility staff, Alisha Rivera and Valeria Katona both reported Resident A was found lying outside during the morning of 11/05/2023 with only a night gown on. Resident A's Assessment Plan indicated Resident A can get confused and wander. The assessment plan stated door alarms should be used as a safeguard. Based on the investigative findings, there is sufficient evidence to support a rule violation that staff failed to prevent Resident A from eloping.
CONCLUSION:	**VIOLATION ESTABLISHED**

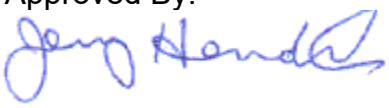
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of the license.

Megan Aukerman, MSW 12/05/2023

Megan Aukerman Date
Licensing Consultant

Approved By:



12/05/2023

Jerry Hendrick Date
Area Manager