GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Jade Somes
Hearthside Assisted Living
1501 W. 6th Ave.
Sault Ste. Marie, MI 49783

RE: License #: AH170271455
Investigation #: 2025A1035078
Hearthside Assisted Living

Dear Jade Somes:

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.
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 (517) 335-5985.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH170271455
Investigation #:	2025A1035078
Complaint Receipt Date:	07/23/2025
Investigation Initiation Date:	07/24/2025
Report Due Date:	09/22/2025
Licensee Name:	Superior Health Support Systems
Licensee Address:	Suite 120, 1501 W. 6th Ave. Sault Ste. Marie, MI 49783
Licensee Telephone #:	(906) 632-9886
Administrator:	Shelby Ehle
Authorized Representative:	Jade Somes
Name of Facility:	Hearthside Assisted Living
Facility Address:	1501 W. 6th Ave. Sault Ste. Marie, MI 49783
Facility Telephone #:	(906) 635-6911
Original Issuance Date:	08/01/2006
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	64
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility. Resident A did not have safety measures in place to prevent elopement.	Yes
Additional Findings	No

III. METHODOLOGY

07/23/2025	Special Investigation Intake 2025A1035078
07/24/2025	Special Investigation Initiated - Telephone
07/23/2025	APS Referral
08/05/2025	Contact - Face to Face
09/30/2025	Inspection Complete. BCAL Sub- Compliance.
09/30/2025	Exit Conference.

ALLEGATION:

Resident A eloped from the facility. Resident A did not have safety measures in place to prevent elopement.

INVESTIGATION:

On July 23, 2025, the Department received a complaint forwarded from Adult Protective Services (APS) which read:

> "Around 4:15pm, a neighbor called 911 advising law enforcement (LE) that Resident A was standing outside of her home. Resident A was confused. Resident A had walked two blocks from the assisted living. Resident A was unattended. The facility was unaware that Resident A left. The facility stated that Resident A got her 4pm meds, so she was gone for approximately 15 minutes without their knowledge."

On August 5, 2025, an onsite investigation was conducted. While onsite I interviewed staff person (SP)1 who states Resident A eloped at approximately 4:15 p.m. Resident A did not have a wander guard on. SP1 states "no wander guard, at

this time our wander guards aren't working and or we are waiting for new ones. We are keeping an eye on resident every 30 minutes."

While onsite, Resident A was observed in the dining area for lunch, no wonder guard applied at this time.

On August 20, 2025, a phone interview was conducted with the complainant. The complainant states Resident A should have had a wander guard on since admission she is at high risk for wandering and eloping. Complainant had taken Resident A out of the facility on 8/8/2025, complainant states the no wander guard did not sound when exiting the facility.

Through record review Sault Ste. Marie police contacted the facility at 4:24 p.m. asking if the facility was missing a resident. A staff member informed the officer they had a resident by the name in question. Resident A was brought back to the facility. Medication administration record indicates Resident A received Tylenol at 4:12 therefore it is assumed Resident A was absent from the facility for approximately 12 minutes.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Through record review Resident A is at high risk for eloping. Resident A's service plan indicates a wander guard should have been in place. The incident report indicates wander guard was not in place. SP1 states wander guard system is not working.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action, I recommend the status of this license remain unchanged.

09/22/2025

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

09/30/2025

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section