



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
ACTING DIRECTOR

February 9, 2024

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

RE: License #: AL200337124  
Investigation #: 2024A0360007  
Northern Pines Assisted Living

Dear Connie 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 (866) 865-0006.

Sincerely,

Matthew Soderquist, Licensing Consultant  
Bureau of Community and Health Systems  
931 S Otsego Ave Ste 3  
Gaylord, MI 49735  
(989) 370-8320

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL200337124
<b>Investigation #:</b>	2024A0360007
<b>Complaint Receipt Date:</b>	12/21/2023
<b>Investigation Initiation Date:</b>	12/21/2023
<b>Report Due Date:</b>	02/19/2024
<b>Licensee Name:</b>	Baruch SLS, Inc.
<b>Licensee Address:</b>	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
<b>Licensee Telephone #:</b>	(616) 285-0573
<b>Administrator:</b>	Christina Jones
<b>Licensee Designee:</b>	Connie Clauson
<b>Name of Facility:</b>	Northern Pines Assisted Living
<b>Facility Address:</b>	130 Mary Ann Street Grayling, MI 49738
<b>Facility Telephone #:</b>	(989) 344-2010
<b>Original Issuance Date:</b>	06/25/2013
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	12/25/2023
<b>Expiration Date:</b>	12/24/2025
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident A had bruises and a skin tear on her arm.	Yes
Additional Findings	No

## III. METHODOLOGY

12/21/2023	Special Investigation Intake 2024A0360007
12/21/2023	APS Referral
12/21/2023	Special Investigation Initiated - On Site
12/21/2023	Inspection Completed On-site Administrator Christina Jones, Resident A.
12/28/2023	Contact – Document Received APS Nicole Lull
01/08/2024	Contact - Telephone call received APS Nicole Lull
02/08/2024	Contact - Telephone call made DCS Dakota Demoines
02/08/2024	Contact - Telephone call made Relative A1
02/08/2024	Contact - Telephone call made Relative A2
02/08/2024	Contact - Telephone call made The Care Team Hospice Nurse Nicole Jones
02/08/2024	Contact - Telephone call made Former DCS Shannon McCleave
02/08/2024	Contact - Telephone call made Administrator Christina Jones
02/09/2024	Exit Conference

## **ALLEGATION:**

**Resident A had bruises and a skin tear on her arm.**

## **INVESTIGATION:**

On 12/21/23, I was assigned this complaint from the LARA online complaint system.

On 12/21/23, I conducted an unannounced onsite inspection at the facility. I interviewed the administrator, Christina Jones. Ms. Jones stated on 12/19/23 Resident A's son, Relative A and his wife came to visit. She stated during their visit they painted Resident A's nails, and they did not report any bruises or skin tear on Resident A's arm. She stated direct care staff (DCS) Dakota Demoinés worked later that evening and documented at the start of her shift that Resident A had a skin tear on her left hand about the size of a nickel with dried blood on it. Ms. Jones stated that the next morning, on 12/20/23 DCS Shannon McCleave reported to her that there were also three dime sized bruises on Resident A's right forearm. Ms. Jones stated that Ms. McCleave was very upset and was blaming Ms. Demoinés for the injuries. Ms. Jones stated that Ms. McCleave began yelling at her and was sent home and has been fired. Ms. Jones stated that it is not unusual for Resident A to bruise easily and that she can become combative. She stated Resident A is diagnosed with Alzheimer's and requires assistance with all her personal needs.

I then attempted an interview with Resident A. Resident A was not oriented to time, place, or person. I observed three dimes size bruises on Resident A's left forearm. I also observed a bandage covering Resident A's left hand.

On 12/28/24, I received an email from adult protective services (APS) worker Nicole Lull. Ms. Lull stated Ms. Demoinés has been suspended pending the investigation and that there have been two previous complaints about Ms. Demoinés disrespecting Residents.

On 1/8/24, I received a call from Ms. Lull who stated she would be substantiating her APS investigation with an unknown perpetrator.

On 2/8/24, I contacted Ms. Jones. Ms. Jones stated Ms. Demoinés remains on suspension from work. She stated she has received two complaints from staff in the past about Ms. Demoinés yelling at residents after they became combative with her. She stated yelling or getting physical with residents is not how their staff are trained to deal with aggressive or combative residents.

On 2/8/24, I contacted Relative A1. Relative A1 by telephone. Relative A1 stated she was aware of the bruises and cut on her mother. She stated she would have written the bruises off as part of her mother's normal aggressive and combative behavior, however the staff involved has had complaints made about them previously. Relative A1 stated she had photos of bruises and the skin tear and sent

them to me by text message. She stated her brother and sister-in-law visited her mother on 12/19/23 and painted her nails. She stated her brother reported to her that there were small dime sized bruises on his mother's right forearm but no skin tear.

On 2/8/24, I contacted Relative A2 by telephone. Relative A2 stated he went to the facility on 12/19/23 to visit his mother. He stated his wife painted his mother's fingernails and they noticed three small bruises on her right forearm. He stated bruises are not unusual on his mother because her skin is so thin. He stated he did not see any skin tear or bleeding when he was at the facility which was about 11 a.m.

On 2/8/24, I contacted The Care Team hospice nurse, Nicole Jones by telephone. Ms. Jones stated Resident A was on hospice care. She stated the bruises and skin tear were reported to her on 12/20/23. She stated she observed three dimes sized bruises on Resident A's right forearm and a skin tear the size of a nickel on her left hand. She stated there have been no other incidents of suspicious marks or bruises on Resident A.

On 2/8/24, I contacted former DCS Shannon McCleave by telephone. Ms. McCleave stated she reported for work on 12/20/23 and noticed bruising and a skin tear on Resident A's arms. She stated she reported this to Ms. Jones immediately. She stated her and Ms. Jones got into an argument about how the bruising and skin tear occurred. She stated she has serious concerns about Ms. Demoinés because she has witnessed, and other staff have complained about, how Ms. Demoinés treats residents who get combative and aggressive. She stated Ms. Jones then terminated her because she would not sign a written reprimand.

On 2/8/24, I contacted DCS Dakota Demoinés by telephone. Ms. Demoinés stated when she came on shift around 11 p.m. on 12/19/23 she checked on Resident A. She stated she noticed what looked like chocolate on Resident A's left hand. She stated when she started to clean her hand that she noticed it was dried blood and that Resident A had a small skin tear. Ms. Demoinés stated she reported it to the next shift on the morning of 12/20/23 to Ms. McCleave and went home. Ms. Demoinés stated she was contacted later that day by Ms. Jones who reported that there were also three small bruises on Resident A's right forearm. She claimed Ms. Jones stated she had not noticed the three bruises. She stated Resident A can get very combative and aggressive. Ms. Demoinés stated Resident A will flail her arms and hit staff. She denied yelling, hitting, or harming Resident A in any way that may cause the bruising and skin tear.

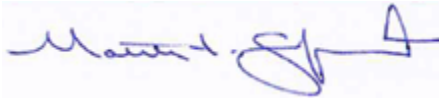
<b>APPLICABLE RULE</b>	
<b>R 400.15305</b>	<b>Resident protection.</b>
	<b>(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be</b>

	<b>attended to at all times in accordance with the provisions of the act.</b>
<b>ANALYSIS:</b>	The complaint alleges Resident A had bruises and a skin tear on her arm.  While the interview with Ms. Demoinis resulted in her denying causing bruises or a skin tear on Resident A, interviews with APS, Relative A1, Relative A2, Ms. McCleave, photos and observation of Resident A revealed that Resident A's protection from harm was not ensured as evidenced by her injury.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 2/9/24 I conducted an exit conference with administrator Christina Jones. Ms. Jones concurred with the findings of the investigation and stated she would submit a corrective action plan for approval.

#### IV. RECOMMENDATION

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



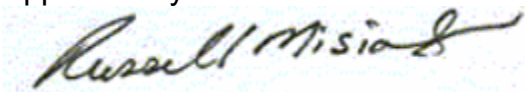
2/9/24

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Matthew Soderquist  
Licensing Consultant

Date

Approved By:



2/9/23

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Russell B. Misiak  
Area Manager

Date