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GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

August 2, 2024

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

RE: License #:	AL730301044
Investigation #:	2024A0872041
	Stone Crest Senior Living-Wing A

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 (517) 643-7960.

Sincerely,

A handwritten signature in black ink that reads "Susan Hutchinson". The script is cursive and fluid, with the first name "Susan" and last name "Hutchinson" clearly legible.

Susan Hutchinson, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(989) 293-5222

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL730301044
<b>Investigation #:</b>	2024A0872041
<b>Complaint Receipt Date:</b>	06/11/2024
<b>Investigation Initiation Date:</b>	06/11/2024
<b>Report Due Date:</b>	08/10/2024
<b>Licensee Name:</b>	Baruch SLS, Inc.
<b>Licensee Address:</b>	Suite 203 3196 Kraft Ave., SE Grand Rapids, MI 49512
<b>Licensee Telephone #:</b>	(616) 285-0573
<b>Administrator:</b>	Kendra Hall
<b>Licensee Designee:</b>	Connie Clauson
<b>Name of Facility:</b>	Stone Crest Senior Living-Wing A
<b>Facility Address:</b>	255 North Main Freeland, MI 48623
<b>Facility Telephone #:</b>	(989) 695-5035
<b>Original Issuance Date:</b>	07/20/2009
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	01/20/2024
<b>Expiration Date:</b>	01/19/2026
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

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## II. ALLEGATION(S)

	Violation Established?
The residents are left unattended. They are left in soiled briefs.	No
Staff are leaving medications in resident rooms without being passed.	Yes

## III. METHODOLOGY

06/11/2024	Special Investigation Intake 2024A0872041
06/11/2024	Special Investigation Initiated - Letter
06/25/2024	Inspection Completed On-site Unannounced
07/08/2024	APS Referral I made an APS complaint via email
07/08/2024	Contact - Document Sent I emailed the LD requesting information about this complaint
07/10/2024	Contact - Document Received I received documentation from AD Hall
07/29/2024	Contact - Document Received I received additional documentation from AD Hall
07/31/2024	Contact - Telephone call made I interviewed staff Crystal Barnes
07/31/2024	Contact - Telephone call made I interviewed staff Katie Rusch
08/01/2024	Contact - Telephone call made I interviewed staff Theresa Heath
08/01/2024	Exit Conference I conducted an exit conference with the licensee designee, Connie Clauson

08/01/2024	Inspection Completed-BCAL Sub. Compliance
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**ALLEGATION: The residents are left unattended. They are left in soiled briefs.**

**INVESTIGATION:** On 06/25/24, I conducted an unannounced onsite inspection of Stone Crest Senior Living Wing A. I interviewed the administrator (AD), Kendra Hall, the resident care manager (RCM), Kayln Green, and Resident A. I also inspected several resident bedrooms and observed several other residents who were resting in their rooms or getting ready for lunch. The residents in this facility are diagnosed with dementia and most are not able to participate in a meaningful interview.

I reviewed the allegations with AD Hall and RCM Green. AD Hall said that staff checks on the residents every two hours or more often if necessary. All residents who wear briefs are changed every two hours or more often if they notify staff that they are wet or soiled. AD Hall said that she has not received any complaints from residents or their families that the residents are not being changed or cared for.

RCM Green confirmed that staff checks on the residents every two hours or more often if necessary. RCM Green said that there are always two staff working and RCM Green also works with the residents when assistance is needed. According to RCM Green, she has not found any of the residents excessively soiled and/or not cared for properly.

I interviewed Resident A who was in his room, lying in bed watching television. I found him clean, dressed appropriately, and he was being attended by staff. Resident A said that he has lived at this facility “for a while” and he does not have any complaints. Resident A said that staff is available when he needs them, and he is never left in a soiled brief.

I inspected five resident bedrooms and attached bathrooms and observed five residents. All bedrooms and bathrooms were clean, with no malodorous odor. The residents I observed were all clean and dressed appropriately.

AD Hall emailed me a list of daily staff responsibilities for the residents of this facility. Staff responsibilities vary based on the amount of personal care each resident requires. The staff responsibilities are very specific, and the responsibilities increase based on resident needs.

On 07/31/24, I interviewed staff Crystal Barnes via telephone. Staff Barnes said that she worked at this facility since November 2023, but she resigned last week. Staff Barnes said that she typically worked day shift. Staff Barnes said that while employed at this facility, there were some occasions when the residents were not changed timely but overall, staff did check and change the residents like they were supposed to.

On 07/31/24, I interviewed staff Katie Rusch via telephone. Staff Rusch said that she has worked at this facility since February 2024, and she typically works day shift. Staff

Rusch told me that some of the residents are “heavy wetters” and when she goes to change them, they are very wet. However, she said that she does not feel that staff deliberately leaves the residents in soiled briefs for any length of time.

On 08/01/24, I interviewed staff Theresa Heath via telephone. Staff Heath said that she has worked at this facility for eight months and she typically works from 7am-7pm. According to Staff Heath, when she used to work the day shift, she would come to work and find some of the residents in soiled briefs. Staff Heath said that 3<sup>rd</sup> shift staff was not checking and changing the residents like they were supposed to.

<b>APPLICABLE RULE</b>	
<b>R 400.15303</b>	<b>Resident care; licensee responsibilities.</b>
	<b>(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.</b>
<b>ANALYSIS:</b>	<p>The administrator, Kendra Hall, resident care manager, Kayln Green, staff Crystal Barnes, and staff Katie Rusch said that the residents are checked on and changed every two hours or more often if necessary.</p> <p>Resident A said that staff is always available if he needs them, and he is never left in a soiled brief.</p> <p>On 06/25/24, I inspected five resident bedrooms and attached bathrooms and observed five residents. All bedrooms and bathrooms were clean, with no malodorous odor. The residents I observed were all clean and dressed appropriately.</p> <p>Staff Theresa Heath said that when she used to work the day shift, she would come to work and find some of the residents in soiled briefs. She said that 3<sup>rd</sup> shift staff was not checking and changing the residents like they were supposed to.</p> <p>I conclude that there is insufficient evidence to substantiate this rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:** Staff are leaving medications in resident rooms without being passed.

**INVESTIGATION:** On 06/25/24, I conducted an unannounced onsite inspection of Stone Crest Senior Living Wing A. I interviewed the administrator (AD), Kendra Hall, the resident care manager (RCM), Kayln Green, and Resident A. AD Hall said that a couple of months ago, she heard from some of the other staff that some of the new staff were

leaving Resident B's medications in her room and not making sure she took them. Resident B liked to take her medications after breakfast so staff would leave the med cup on the table in her room so she could take them when she wanted. AD Hall said that when she learned of this, she held a medication refresher staff meeting in May 2024 with all staff and to her knowledge, nothing like this has happened since that time. She said that to her knowledge, none of the residents have received the wrong medications.

RCM Green confirmed that in the past, staff complained that some of the staff had left medication cups in the resident bedrooms without making sure the residents took them. She said that when she and AD Hall found out about it, they conducted a medication refresher training for all staff. RCM Green said that they have monthly staff meetings and address issues like this during the meetings.

Resident A told me that staff have never left medications in his room, and they always make sure he takes his medications. Resident A said that staff has never left medication cups on the table in his room. Resident A also said that to his knowledge, he has never received the incorrect medication.

During my visual inspection of approximately five resident bedrooms, I did not observe any medications or medication cups in any of the rooms. I also did not see any medications in any other areas of the facility.

On 07/31/24, I interviewed staff Crystal Barnes via telephone. Staff Barnes said recently, several new staff were hired, and they were leaving medications in the resident bedrooms. Staff Barnes said that staff claimed that they did not know they were supposed to watch the residents take the medications so they would leave the medications in cups, on the residents' tables. This was brought to the attention of management and all staff had to take a medication refresher course. Staff Barnes said that to her knowledge, staff are no longer leaving medications in the resident bedrooms.

On 07/31/24, I interviewed staff Katie Rusch via telephone. Staff Rusch confirmed that on several occasions in the past, some of the staff were leaving medication cups with medications in them in resident rooms. Staff Rusch said that other staff would find the full med cups in the residents' bedrooms. Staff Rusch told me that this was brought to the attention of management and all staff had to take a medication refresher course. She said that since that time, she does not believe that medications are being left in resident bedrooms.

On 08/01/24, I interviewed staff Theresa Heath via telephone. Staff Heath said that there have been numerous occasions when she found medications in the resident bedrooms, on their floor, or in the hallway of the facility. Staff Heath said that she brought the issue to management's attention and management did not do anything about it. Staff Heath confirmed that all staff had a staff refresher course but said that the issue is continuing.

<b>APPLICABLE RULE</b>	
<b>R 400.15312</b>	<b>Resident medications.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	<p>The administrator, Kendra Hall, said that she was told that staff was leaving Resident B's medications in a cup in her room so she could take them after breakfast.</p> <p>The resident care manager, Kayln Hall, said that she was told that some staff were leaving medications in resident rooms without being passed.</p> <p>Resident A said that staff has never left medications in his room, and they supervise him when he takes his medications.</p> <p>Staff Crystal Barnes, staff Katie Rusch, and staff Theresa Heath said that on several occasions, they found medications in resident bedrooms because staff was not passing them like they were supposed to.</p> <p>I conclude that there is sufficient evidence to substantiate this rule violation.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 08/01/24, I conducted an exit conference with the licensee designee, Connie Clauson. I described the results of my investigation and explained which rule violation I am substantiating. I told her that once my report is approved, I will send her a copy requesting a corrective action plan.



**IV. RECOMMENDATION**

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

*Susan Hutchinson*

August 2, 2024

Susan Hutchinson Licensing Consultant	Date
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Approved By:

*Mary Holton*

August 2, 2024

Mary E. Holton Area Manager	Date
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