GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 4, 2024

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

RE: License #:	AL730301044
Investigation #:	2024A0872049
	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,

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

License #:	AL730301044
Investigation #:	2024A0872049
Complaint Receipt Date:	07/19/2024
Investigation Initiation Date:	07/19/2024
Report Due Date:	09/17/2024
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Ave., SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Kendra Hall
Licensee Designee:	Connie Clauson
Name of Facility:	Stone Crest Senior Living-Wing A
Facility Address:	255 North Main Freeland, MI 48623
Facility Telephone #:	(989) 695-5035
Original Issuance Date:	07/20/2009
License Status:	REGULAR
Effective Date:	01/20/2024
Expiration Date:	01/19/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

	MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Third shift staff go into empty resident rooms and sleep. They also bring liquor and marijuana into the facility.	No
Staff Ashley Royal took expired PRN medications from one of the residents.	Yes

III. METHODOLOGY

07/19/2024	Special Investigation Intake 2024A0872049
07/19/2024	Special Investigation Initiated - Telephone AFC Consultant, Martin Gonzales contacted the referral source for additional information
07/24/2024	APS Referral I made an APS referral via email
07/31/2024	Contact - Telephone call made I interviewed former 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
08/06/2024	Inspection Completed On-site Unannounced
08/09/2024	Contact - Document Sent I emailed the administrator requesting information about this complaint
08/18/2024	Contact - Document Received I received documentation from AD Hall
09/04/2024	Contact - Telephone call made I interviewed staff Ashley Royal

09/04/2024	Inspection Completed-BCAL Sub. Compliance
09/04/2024	Exit Conference I conducted an exit conference with the licensee designee, Connie Clauson

ALLEGATION: Third shift staff go into empty resident rooms and sleep. They also bring liquor and marijuana into the facility.

INVESTIGATION: On 07/31/24, I interviewed former staff, Crystal Barnes via telephone. Staff Barnes said that she worked at Stone Crest Senior Living from November 2023 until July 2024. Staff Barnes said that when she worked at this facility, she typically worked the day shift, but she would work the night shift sometimes. Staff Barnes said that she believes night shift staff sleep when they are supposed to be working. Also, night shift staff would go out to their cars for a break and when they came back in, they smelled like marijuana.

Staff Barnes said that she does not know if staff were bringing liquor in the facility, but she has witnessed some of the staff bring weed pens to work with them. Staff Barnes also said that on several occasions when she got to work in the morning, one of the night staff would be in their car, sleeping when they were supposed to be working.

On 07/31/24, I interviewed staff Katie Rusch via telephone. According to Staff Rusch, she believes that night shift staff do sleep during their shift. She said that on several occasions, she would find empty chip bags in empty resident bedrooms when she got to work in the morning. Staff Rusch said that she would also find the bedding on the beds in the empty rooms messed up as though someone had slept in the bed. Staff Rusch said that management does not discipline any of the staff when they do something wrong because they do not want to deal with it. Staff Rusch said that she does not know if staff uses drugs or alcohol while working or if they bring drugs or alcohol into the facility.

On 08/01/24, I interviewed staff Theresa Heath via telephone. Statt Heath said that she has heard that 3rd shift staff sleeps during their shift, but she does not know for sure. Staff Heath said that she has never witnessed any of the staff use alcohol or marijuana while working and she has never suspected staff of using alcohol or marijuana while working.

On 08/06/24, I conducted an unannounced onsite inspection of Stone Crest Senior Living Wing A. I interviewed the administrator (AD) Kendra Hall and Resident A. I also interacted with and observed four other residents.

AD Hall said that recently, she fired a staff member, Makayla Shivers, for sleeping during her shift. AD Hall said that one of the other staff took a picture of Staff Shivers sleeping while at work and when AD Hall called her and asked her about it, Staff

Shivers admitted it, so she was fired on 07/18/24. AD Hall read me some text messages sent to her by Staff Shivers after her employment was terminated. The text messages said that there are “a bunch of alcoholics” who work at the facility and some of them get drunk in the parking lot and sleep during their shifts. According to AD Hall, she held a staff meeting on 07/25/24 and reiterated that staff are not allowed to sleep during their shift. AD Hall also reminded staff of appropriate behaviors while working and reminded them of the facility’s policies. AD Hall said that she gave staff an opportunity to voice any complaints and none of the staff did. AD Hall also said that she told staff to come to her with any concerns or complaints and nobody has approached her since the staff meeting.

According to AD Hall, she and the Resident Care Manager (RCM), Kayln Green conduct unannounced “pop-up” visits during night shift approximately every 3 months. AD Hall said that neither of them has found staff sleeping during their shift, they have not found staff sleeping in the parking lot, nor have they ever found any of the staff drinking or using drugs while working.

Resident A told me that he has never observed or heard anything concerning from any of the staff and said that staff is always available when he needs them. Resident A told me that he does not know what staff does during the night shift and again said that they are always available whenever he needs something. Resident A said that he has no complaints about this facility.

I interacted with and observed 4 other residents while at this facility. All residents appeared to be clean, dressed appropriately, and they were being supervised and attended to by staff.

On 09/04/24, I interviewed staff Ashley Royal via telephone. Staff Royal said that she has worked at this facility for almost 3 years, and she typically works 3rd shift. Staff Royal said that she does not sleep during her shift, and she has never found any of her coworkers sleeping during shift. She also said that she does not use drugs or alcohol while working and she has never suspected or found any of her coworkers using drugs or alcohol while working.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Former staff, Crystal Barnes said that she suspects that 3rd shift staff sleeping during their shift. She also said that she suspects

	that 3rd shift staff smokes marijuana in the parking lot and brings marijuana into the facility. Staff Katie Rusch said that on several occasions, she would find empty chip bags in empty resident bedrooms when she got to work in the morning. Staff Rusch said that she would also find the bedding on the beds in the empty rooms messed up as though someone had slept in the bed. Staff Rusch said that she does not know if staff uses drugs or alcohol while working or if they bring drugs or alcohol into the facility. Staff Theresa Heath said that she has heard that 3rd shift staff sleeps during their shift, but she does not know for sure. Staff Heath said that she has never seen any of the staff use alcohol or marijuana while working and she has never suspected staff of using alcohol or marijuana while working. AD Hall said that recently, she fired a staff member, Makayla Shivers, for sleeping during her shift. She said that one of the other staff took a picture of Staff Shivers sleeping while at work and when AD Hall called her and asked her about it, Staff Shivers admitted it, so she was fired on 07/18/24. According to AD Hall, she and the Resident Care Manager (RCM), Kayln Green conduct unannounced “pop-up” visits during night shift approximately every 3 months. She said that neither of them has found staff sleeping during their shift, they have not found staff sleeping in the parking lot, nor have they ever found any of the staff drinking or using drugs while working. Resident A told me that he has never observed or heard anything concerning from any of the staff and said that staff is always available when he needs them. Resident A told me that he does not know what staff does during the night shift and again said that they are always available whenever he needs something. Resident A said that he has no complaints about this facility. Staff Ashley Royal said that she does not sleep during her shift, and she has never found any of her coworkers sleeping during shift. She also said that she does not use drugs or alcohol while working and she has never suspected or found any of her coworkers using drugs or alcohol while working.
	I conclude that there is insufficient evidence to substantiate this rule violation.

CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff Ashley Royal took expired PRN medications from one of the residents.

INVESTIGATION: On 07/31/24, I interviewed former staff Crystal Barnes via telephone. Staff Barnes said that one of the staff was caught stealing resident medications. According to Staff Barnes, on one occasion she looked in her co-worker, Ashley Royal's bag and saw a resident's medication bubble packs. Staff Barnes said that she does not know what the medication was, but she took a picture of the bubble packs and sent it to management. Staff Royal apparently told management that she took the medication because it was expired, and she thought it was okay to do so. Staff Barnes said that Staff Royal was not terminated, she was just demoted and is no longer allowed to pass medications to the residents. Staff Barnes agreed to send me pictures of the medications that she found in Staff Royal's bag.

On 07/31/24, I received two photographs via text from Staff Barnes. The photos showed two medication bubble packs of Benadryl, 25mg that were dated 03/2023. The photos did not show the name of the resident that the medications were prescribed to.

On 07/31/24, I interviewed staff Katie Rusch via telephone. Staff Rusch confirmed that on one occasion, staff Ashley Royal took one of the resident's medications home with her. Staff Rusch said that she was told that the medication was Benadryl and that even though this was brought to management's attention, Staff Royal was able to remain working, but she is no longer allowed to pass medications.

On 08/01/24, I interviewed staff Theresa Heath via telephone. Staff Heath said that she has worked at this facility for 8 months. Staff Heath told me that she heard that staff Ashley Royal stole medications from one of the residents. Staff Heath said that she does not know what medication and she does not know which resident. Staff Heath said that management was notified but all they did was remove Staff Royal from passing medications.

On 08/06/24, I conducted an unannounced onsite inspection of Stone Crest Senior Living Wing A. I interviewed the administrator (AD) Kendra Hall and Resident A. I also interacted with and observed four other residents.

AD Hall confirmed that on one occasion, she discovered that staff Ashley Royal took expired Benadryl from the medication cart. AD Hall said that when she confronted Staff Royal with this information, she admitted it and said that she was taking them home because the medications were expired, and staff would not be able to administer them to the residents, but she felt they were still usable for herself and her family. According to AD Hall, overall Staff Royal is a good employee, and she has worked at this facility for over 2 years. AD Hall gave Staff Royal a written discipline and although she still

provides resident care, she is not allowed to pass medications and she does not have access to the medication cart.

AD Hall said that once she learned of this information, she and the resident care manager (RCM) Kayln Green reevaluated their medication policy and they will be making some changes. AD Hall told me that their current pharmacy delivers excess medications which are stored in the medication cart, but the excess medications are PRNs, and they often expire before being administered to the residents. She said that she has tried working with the pharmacy by asking them to not send so many PRN medications, but the pharmacy continues to do so. Therefore, on 10/14/24 they are switching pharmacies. In addition, on the first Thursday of every month, staff will undergo a 3-hour medication training presented by their new pharmacy. Finally, RCM Green now goes through the medication cart once per week and pulls and destroys any expired medications.

I interacted with and observed 4 other residents while at this facility. All residents appeared to be clean, dressed appropriately, and they were being supervised and attended to by staff.

On 08/18/24, I reviewed the medication logs for 4 different residents. I compared the medication orders to the medication administration records and did not note any discrepancies.

On 09/04/24, I interviewed staff Ashley Royal via telephone. Staff Royal said that she has worked at this facility for almost 3 years, and she typically works 3rd shift. Staff Royal confirmed that on one occasion, she took a bubble pack of Benadryl from one of the residents. I asked her why and she said, “Because I was dumb.” She told me that she ran out of Benadryl at her own home and since the Benadryl in the medication cart was expired, she took it home with her. Staff Royal said that she has never done anything like that before or since and she knows that it was wrong of her to do so. Staff Royal stated that she is no longer allowed to pass medications to the residents, and she no longer has access to the medication cart.

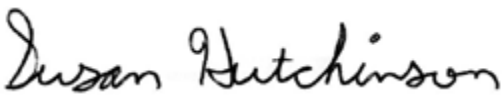
APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	The administrator (AD), Kendra Hall said that on one occasion, she was told that staff Ashley Royal took expired medications from one of the residents. AD Hall confronted Staff Royal who admitted to taking expired Benadryl from one of the residents.

	Staff Royal confirmed that on one occasion, she took expired Benadryl from one of the residents. I conclude that there is sufficient evidence to substantiate this rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 09/04/24, I conducted an exit conference with the licensee designee, Connie Clauson. I discussed the results of my investigation and told her 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

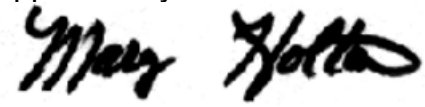
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



September 4, 2024

Susan Hutchinson Licensing Consultant	Date

Approved By:



September 4, 2024

Mary E. Holton Area Manager	Date