GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2024

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

RE: License #: AL410289604
Investigation #: 2024A0464053
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 #:	2024A0464053
Complaint Receipt Date:	08/14/2024
Investigation Initiation Date:	08/14/2024
Report Due Date:	10/13/2024
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Connie Clauson
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 AGED/ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 08/06/2024, it was discovered 41 ml. of morphine was replaced with a clear liquid.	No

III. METHODOLOGY

08/12/2024	Special Investigation Intake 2024A0464051
08/12/2024	Special Investigation Initiated - Telephone Amanda Beecham, Regional Operations Director
08/12/2024	APS Referral Centralized Intake, DHHS
08/14/2024	Inspection Completed-On-site Amanda Beecham (Regional Director), Nikitta Brown (Director of Resident Care)
08/16/2024	Contact-Telephone call received Tiffany Elliott, Walker Police Department
08/22/2024	Contact-Document received Amanda Beecham. Regional Director
08/23/2024	Inspection Completed On-site Detective Tiffany Elliott (Walker PD), Nikkita Brown (Director of Resident Care), Abrea Crawford (Staff) and Alisha Rivera (Staff)
08/23/2024	Contact-Document received Nikitta Brown, Director of Resident Care
08/23/2024	Contact-Telephone call received Detective Tiffany Elliott, Walker PD
08/29/2024	Contact-Telephone call received Detective Tiffany Elliott, Walker PD
09/03/2024	Contact-Document received Detective Tiffany Elliott, Walker PD
09/30/2024	Exit Conference Connie Clauson, Licensee Designee

ALLEGATION: On 08/06/2024, it was discovered 41 ml. of morphine was replaced with a clear liquid.

INVESTIGATION: On 08/12/2024, I received an email from Baruch Regional Operations Director, Amanda Beecham. Ms. Beecham reported they were working on an active investigation with the Walker Police Department regarding morphine that had been tampered with. She reported that on 08/06/2024, it was brought to their attention that 41.25 ml. of morphine was missing and replaced with a clear substance that appeared to be water. A special investigation was generated.

On 08/12/2024, I contacted the Department of Health and Human Services (DHHS), Centralized Intake, to complete an Adult Protective Services (APS) referral per policy.

On 08/14/2024, I completed an onsite inspection at the facility. I interviewed Ms. Beecham and director of resident care, Nikitta Brown. Ms. Beecham explained Resident A receives hospice services, who prescribed morphine for Resident A's comfort and pain. Both stated that on 08/06/2024, staff, Alisha Rivera reported that when she went to administer Resident A's morphine, she discovered it had been tampered with. When Ms. Rivera went to draw up the morphine, she noticed the liquid was clear when it is supposed to be a pink color. This prompted staff, Bathsheba Bordeaux to inspect Resident A's morphine in Stonebridge Manor North (AL410289602). It was discovered a resident in Stonebridge Manor North had morphine that was tampered with and replaced with what appeared to be water. Ms. Beecham advised she was not sure if any diluted morphine had been administered to the residents. Ms. Beecham stated she confirmed with Hometown Pharmacy that the morphine should be a pink colored liquid. It is important to note, a concurrent investigation was opened on Stonebridge Manor North (AL410289602) SIR #2024A0464051.

Ms. Beecham and Ms. Brown explained they immediately contacted the Walker Police Department and also initiated their own investigation. Ms. Brown explained they had all employees submit to a random drug screen, and the results were all negative. Based on staff interviews, Ms. Beecham and Ms. Brown narrowed the alleged suspect down to staff, Anna Madina. Ms. Brown stated that when Ms. Madina was asked to complete a drug screen, she initially became argumentative, but did complete the screen a few days later. Ms. Brown reported staff came to her and informed her that during one of Ms. Madina's shifts, she was "acting strange". Ms. Madina was carrying around a "detox" drink, became ill and vomited in the bathroom. Both Ms. Beecham and Ms. Brown stated Resident A's guardian and hospice were informed of the incident. Ms. Brown stated since the incident was discovered, she has increased medication training as well as created an anonymous reporting system, where staff can report any suspicious activity.

On 08/16/2024, I spoke with Detective Tiffany Elliott with the Walker Police Department, to coordinate the investigation.

On 08/22/2024, I received an email from Ms. Beecham stating there was another incident on 08/21/2024. At approximately 3:00 pm, during shift change, it was discovered that there were two more bottles of morphine that had been tampered with. It was also discovered that staff once again, did not count the controlled substances. Ms. Beecham explained that on 08/19/2024, Ms. Madina was caught sleeping in the living room of the facility. She was also caught licking her hands “like a cat”. Ms. Beecham stated Ms. Madina was taken off the schedule.

On 08/23/2024, Detective Elliott and I completed an onsite inspection at the facility. Ms. Madina was scheduled to come in for an interview; however, she failed to appear. Detective Elliott and I interviewed staff, Abrea Crawford. Ms. Crawford stated she is trained to administer resident medication. Ms. Crawford denied witnessing the morphine being tampered with. Ms. Crawford explained she counts all of the controlled substances at the beginning and the end of her shift. Ms. Crawford stated she has worked with Ms. Madina. Ms. Crawford stated she has witnessed Ms. Madina display “bizarre behaviors”. She has come into her shift sweaty, smelling like alcohol and would frequently go into the bathroom. Ms. Crawford also reported, when it is time to count the controlled substances, Ms. Madina has refused to do so.

I then interviewed staff, Aleisha Rivera. She stated on 08/06/2024, around 8:30 am, she attempted to administer Resident A’s morphine. She noticed that it did not look right and stated that the morphine was clear. Ms. Rivera stated this was the first incident that she noticed the morphine had been tampered with. Ms. Rivera then opened the controlled substance lock box and demonstrated how the morphine is drawn and what the color is supposed to look like.

Detective Elliott and I then met with Ms. Brown. Ms. Brown stated Ms. Madina’s behavior has become increasingly concerning. She has “no-showed” for a few shifts. She has also called Ms. Brown numerous times, yelling and cussing. Ms. Brown stated Ms. Madina was going to be removed from administering resident medications. Ms. Brown then showed Detective Elliott the morphine that had been tampered with. The morphine bottles were filled with what appeared to be a clear substance. Detective Elliott photographed the bottles for evidence.

On 08/23/2024, Detective Elliott and I received a text message from Ms. Brown stating she called Ms. Madina and informed her that her employment has been terminated.

On 08/23/2024, I spoke to Detective Elliott. She stated she was able to get in touch with Ms. Madina and she agreed to come into Walker Police Department on 08/29/2024 at 2:00 pm. Detective Elliott reported that Ms. Madina stated, “I will be sure to show up to the interview drunk”.

On 08/29/2024, I received a text message from Detective Elliott, stating Ms. Madina did not show up for her scheduled interview.

On 09/03/2024, I received an email from Detective Elliott, stating since Ms. Madina did not show for her interview or confess, the investigation will not be sent to the prosecutor's office and the case will be closed.

On 09/30/2024, I completed an exit conference with licensee designee, Connie Clauson. She was informed of the investigation findings and recommendations. A corrective action plan will be submitted.

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:	On 08/12/2024, a complaint was received alleging Resident A's prescribed morphine had been tampered with. Case coordination occurred with the Walker Police Department (report #24-008572). Onsite inspections were completed at the facility on 08/14/2024 and 08/23/2024. Regional Director, Amanda Beecham and Program Manager, Nikitta Brown provided evidence that Resident A's morphine had been tampered with on two separate occasions and replaced with a clear substance. Staff, Alisha Rivera was interviewed and reported she was the one who discovered the morphine had been tampered with. Hometown Pharmacy confirmed the morphine should be a pink, liquid substance, not clear. Based on the investigative findings, there is sufficient evidence to support a rule violation that resident morphine was tampered with.
CONCLUSION:	**VIOLATION ESTABLISHED**

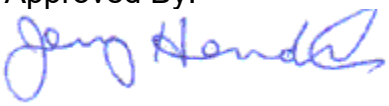
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the licensing status remain unchanged.

09/30/2024

Megan Aukerman Date
Licensing Consultant

Approved By:



09/30/2024

Jerry Hendrick Date
Area Manager