GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 14, 2025

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

RE: License #: AL410289602
Investigation #: 2025A0579018
Stonebridge Manor - North

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 I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Cassandra Duursma, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(269) 615-5050

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410289602
Investigation #:	2025A0579018
Complaint Receipt Date:	02/03/2025
Investigation Initiation Date:	02/03/2025
Report Due Date:	04/04/2025
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203, 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Jennifer Marckini
Licensee Designee:	Connie Clauson
Name of Facility:	Stonebridge Manor - North
Facility Address:	3515 Leonard NW, Walker, MI 49534
Facility Telephone #:	(616) 791-9090
Original Issuance Date:	10/22/2012
License **Status:**	REGULAR
Effective Date:	06/27/2024
Expiration Date:	06/26/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED/ AGED/ ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A and Resident B did not receive immediate medical attention for an injury.	No
Residents are not protected or treated with dignity.	Yes

III. METHODOLOGY

02/03/2025	Special Investigation Intake 2025A0579018
02/03/2025	Special Investigation Initiated - Letter Complainant
02/05/2025	Contact - Face to Face Alisha Rivera (Direct Care Worker), Rosie Velve (Direct Care Worker), Amber Nickelson (Direct Care Worker), Jennifer Marckini (Administrator), Dr. Katie Zanosky
02/06/2025	Comment Additional Allegations Received
02/06/2025	APS Referral Received from APS
02/11/2025	Contact- Face to Face Resident B, Resident C, Resident D, Alisha Rivera (Direct Care Worker), Rosie Velve (Direct Care Worker), Jennifer Marckini (Administrator)
02/13/2025	Exit Conference Connie Clauson, Licensee Designee Jennifer Marckini, Administrator

ALLEGATION: Resident A did not receive immediate medical attention for an injury.

INVESTIGATION: On 2/3/25, I received this referral which alleged second shift direct care workers (DCWs) found Resident A to have a blackened toe. Resident A was taken to the hospital via ambulance at approximately 5:00 p.m. Administrator, Ms. Jennifer Marckini, was made aware of Resident A's toe injury at 8:00 a.m. and did nothing about it.

On 2/3/25, I contacted the complainant via the contact information they provided. The e-mail came back as undeliverable.

On 2/5/25, I completed an unannounced on-site investigation at the home. Interviews were completed with Alisha Rivera (Direct Care Worker), Rosie Velve (Direct Care Worker), Amber Nickelson (Direct Care Worker), Jennifer Marckini (Administrator), and Dr. Katie Zanosky. It was reported Resident A remains hospitalized and was not present at this time.

Resident A's visiting physician, Dr. Katie Zanosky, was present. She reported she is at this home weekly, on Wednesdays. She stated she regularly visits Resident A and had been visiting him more recently to assist with managing his diabetes. She stated she was made aware from Resident A's home health nurse on a Thursday that DCWs reported to the nurse that Resident A's toe appeared blackened, and the nurse then observed it. She stated knowing Resident A's health history, she advised at that time Resident A needed to be transported to the hospital. She stated Resident A was then transported to the hospital where he remains for support in managing his diabetes and likely amputation of his toe. She stated Resident A has previously had two toes amputated on the same foot due to his diagnosis of diabetes. She stated in the fall of 2024, she ordered DCWs to keep Resident A's toe wound in a dressing and reapply the dressing if he removes it and referred him for wound care. She reported home health nurses were coming to the home twice weekly to provide wound care. She denied concern regarding Resident A's care in this home or concern that appropriate medical treatment was not sought for him.

Ms. Nickelson stated she was present when Resident A's home health wound care nurse was made aware Resident A's wounded toe had become blackened which she believes occurred on a Wednesday after Dr. Zanosky had left the home.

Ms. Velve reported she noticed when replacing Resident A's toe bandage that Resident A's toe was bleeding and appeared blackened, so she reported it to Resident A's wound care nurse immediately. She stated it was not until the next day Resident A was transported to the hospital at the direction of his wound care team, but she notified his wound care team immediately once she became aware.

Ms. Rivera reported she was working with Ms. Velve when Ms. Velve reported Resident A's toe was blackened and bleeding. She stated Ms. Velve reported this to Resident A's wound care nurse. She stated Resident A was transported to the hospital the next day after the nurse observed Resident A's toe. She stated they made his wound care team aware immediately once they became aware of concerns regarding his toe.

On 2/6/25, I received multiple referrals. Three referrals alleged Resident B obtained a head injury from a DCW and did not receive medical treatment. Resident A's injury was reported again.

On 2/6/25, I received a typed statement from Adult Protective Services (APS) which noted Resident B was observed after the allegations were reported and is doing well. APS noted an appropriate response was taken regarding Resident B's injury including contacting Resident B's guardian and seeking medical treatment for Resident B's wrist injury.

On 2/11/25, I completed an unannounced on-site investigation at the home. Ms. Marckini reported she was made aware by third shift DCWs on 1/30/25, that Resident B was found with a small wound on the back of her head and had reported a DCW pushed her. She stated third shift DCWs reported Resident B was fearful she was "going to go to jail" so they did not feel sending her out of the home would be good for her mental health, in addition to Resident B requesting not to leave the home. She stated she advised DCWs to observe Resident B overnight to ensure her safety. She stated in the morning contact was made with Dr. Zanosky. Resident B's wrist had swollen so Dr. Zanosky recommended she be sent out for an x-ray on her wrist. She stated Dr. Zanosky told her she was correct in advising DCWs to observe Resident B overnight, as she would have recommended that. She stated Resident B was not found to have any fractures.

Ms. Rivera stated she was working when Resident B was sent to the hospital in the morning after her small head wound was discovered. She stated Resident B's wrist was beginning to swell and Resident B said her wrist and bottom hurt. She stated Resident B did not present in altered state, nor did she have immediate concerns for Resident B's wellbeing. She stated she felt Resident B received appropriate medical treatment based on her observation of Resident B that morning.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Ms. Velve, Ms. Rivera, Ms. Nickelson, and Ms. Marckini reported Resident A had a wound care nurse who was made aware of Resident A's blackened toe when Ms. Velve and Ms. Rivera noticed it. They and Dr. Zanosky reported the wound care nurse reported the injury to Dr. Zanosky who requested Resident A go to the hospital. Resident A was then transported to the hospital. Ms. Rivera and Ms. Marckini reported Resident B did not present as needing immediate medical treatment when a small wound was found on her head. They reported Resident B's wrist was swelling and Dr. Zanosky requested Resident B get a wrist x-ray so Resident B was then sent for treatment. Ms. Marckini

	reported after the wound was discovered, Resident B was fearful and did not want to leave the home, so she advised direct care workers to monitor for concerns in the home. APS noted appropriate action was taken following the incident. Based on the interviews completed, there is insufficient evidence residents did not obtain needed care in case of an accident or adverse change to a resident's physical condition.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: **Residents are not protected or treated with dignity.**

INVESTIGATION: On 2/6/25, I received multiple referrals. Three referrals alleged Resident B obtained a head injury from a DCW pushing her. It was also alleged Resident C is not bathed or toileted and Resident D screams so DCWs shut her room door and ignore her.

On 2/6/25, APS documented due to Resident B's diagnosis of dementia, she could not recall the allegations or how she obtained her wrist injury. It was documented Ms. Burton admitted to pushing Resident B when spoken to by APS but denied seeing Resident B fall and denied causing injury to Resident B.

On 2/6/25, I received a typed statement from DCW, Mairleyiceica "LeeLee" Burton. Ms. Burton reported she was made aware on 1/31/25, she was removed from the home's schedule due to being investigated for "putting (her) hands on (Resident B) caused (Resident B) bruising and a head gash." She stated she did not "put (her) hands on her." She stated she witnessed Resident B's injury 15 minutes after her shift ended and discussed with another DCW the blood was dried and brown which made her feel it had been there a long time. She stated Ms. Marckini has targeted her while she has worked at the home and Ms. Marckini told her two DCWs told Ms. Marckini Ms. Burton told them she pushed Resident B. She stated she would not push Resident B, and she does not speak to the two DCWs who claim she told them she pushed Resident B. She expressed she feels she was wrongfully terminated.

On 2/11/25, Ms. Marckini reported third shift DCWs reported a second shift DCW, Ms. Burton, reported to them she pushed Resident B, but Resident B did not fall, and she did not see Resident B hit her head. She stated when Resident B's wound was found, Resident B was reporting "that girl" pushed her referring to Ms. Burton. She stated by the time she spoke to Resident B the next day; Resident B stated her daughter pushed her. She stated Resident B is diagnosed with dementia which likely explains her confusion. She stated when she spoke to Ms. Burton, Ms. Burton did not admit to pushing Resident B like she had to APS, but Ms. Burton resigned from her position before she could be terminated.

I reviewed the Incident/Accident Report form regarding the allegations which was dated 1/30/25 and signed by DCW KeAsia Clark. It noted Ms. Clark arrived on third shift and noted Resident B had blood on her head. Resident B reported Ms. Burton pushed her back and her head hit the floor. Other residents were present but said they did not witness the incident. Ms. Clark documented calling Ms. Marckini and asking Ms. Burton what happened. She stated Ms. Burton said she pushed Resident B back, but Resident B did not hit the floor. Resident B was monitored and given PRN pain medication.

I reviewed Ms. Marckini's notes regarding the allegations. She noted on 1/30/25, Ms. Clark reported the injury, and Resident B was stating "that girl pushed me down." Ms. Marckini heard Resident B in the background repeating "that girl pushed me down." Ms. Clark reported Ms. Burton told her Resident B "came up on her" so Ms. Burton pushed her, but she did not fall. She noted on 1/31/25, Dr. Zanosky was contacted, and x-rays were requested for Resident B's wrist. On 1/31/25, she spoke to DCW Ms. Dwyer who was working with Ms. Burton and denied Resident B having an injury or seeing Ms. Burton push Resident B, but she reported Ms. Burton was yelling at Resident B all evening to go to her room and was rude to Resident B. She noted on 1/31/25, she spoke to Resident B's daughter. She also contacted Ms. Burton and Licensing Consultant, Megan Aukerman. On 2/2/25, Ms. Burton responded and resigned.

Ms. Marckini stated concerns for Resident C's bathing schedule have been brought to her attention, but Resident C is bathed by a hospice bath aide due to being on hospice. She stated a DCW in the home was rude to the bath aide about Resident C's bathing schedule. She stated bath aides may only give bed baths if residents are not willing or able to shower which DCWs may not understand. She stated she does not have any concern that Resident C is not being bathed or toileted appropriately and her hospice care team is in the home regularly and has not reported any concerns either.

Ms. Marckini stated concerns for Resident D screaming have not been brought to her attention. She stated Resident D also receives hospice services so if she was having behaviors, DCWs could address those concerns with her hospice team. She stated the DCWs who work in this home regularly express their concerns to her so she feels this would have been reported to her if it was a concern.

I observed Resident B whose wrist was swollen. She reported her daughter injured her wrist and she did not know why. She stated the DCWs in the home are "wonderful people" who treat her with kindness. She denied any concern regarding her care at this home.

Ms. Rivera stated third shift DCWs reported to her Resident B said "that girl" pushed her and she was referencing Ms. Burton. She stated third shift DCWs told her Ms. Burton told them she had pushed her. She stated by the time she arrived the morning after the incident, Resident B was stating her daughter pushed her. She

stated she did not see Ms. Burton be physically or verbally abusive with residents, however she had concerns about Ms. Burton being appropriate to be a DCW because Ms. Burton was “foul” and extremely rude to older individuals who are DCWs. She stated she had concern if Ms. Burton could be inappropriate with a senior who is a DCW, she could be inappropriate with a resident as they are senior citizens too.

Ms. Rivera stated Resident C is bathed by a hospice bath aide. She stated Ms. Velve got upset with the bath aide and accused them of not bathing Resident C. She stated Ms. Velve does not work on Fridays which is Resident C’s bathing day, so Ms. Velve did not see her getting bathed. She stated she spoke to the bath aide who pulled up a schedule and showed it to her. She stated the schedule confirmed Resident C has been bathed every Friday. She stated DCWs in this home bathe residents twice weekly, as opposed to hospice, which is once weekly, so that also may have confused Ms. Velve. She stated she does not have concern about Resident C’s bathing or toileting, Resident C appears clean, and she does not have concerns for Resident C’s hygiene such as odor or skin breakdown.

Ms. Rivera stated Resident D will yell if she feels like DCWs are going give her directions to do something. She stated the best response is to give Resident D space and not direct her. She stated she does not feel like DCWs ignore or neglect Resident D due to her yelling, because it is best to leave her be when she is yelling. She denied any DCW shutting Resident D in her room. She stated if Resident D’s yelling behavior impacted her care, she would address it with her hospice team but right now it is best managed by not trying to direct Resident D when she is yelling and “leaving her be.”

Resident C was observed being assisted out of bed. She was spoken to but could not engage with interviewing. She did not report any concerns for her care when discussing the home. Resident C appeared neat, clean, and appropriately dressed. Her room was neat, clean, and free from odor.

Resident D was observed sleeping and was not awoken for interviewing. She appeared neat, clean, and free of visible concerns. Resident D’s room appeared neat and clean as well.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Ms. Marckini and Ms. Rivera denied having any concern regarding Resident C and Resident D’s care. It was reported that both Resident C and Resident D are under additional

	supervision through hospice who have not reported any concerns. I observed Resident C and Resident D and their rooms and found all to be free of visible concerns. APS, Ms. Marckini, Ms. Rivera, and an incident report completed at the time of the incident reported Resident B obtained a head wound and wrist injury after it was reported Resident B was pushed by Ms. Burton. I observed Resident B's swollen wrist. A written statement from Ms. Burton denied pushing Resident B, although APS and the incident report noted she initially admitted to pushing Resident B. Ms. Rivera and the incident report expressed concern Ms. Burton was inappropriate in her behavior in the home. It was reported Ms. Burton resigned from her position prior to being terminated. Based on the interviews completed and documentation reviewed, there is sufficient evidence to indicate that Ms. Burton did not treat Resident B with dignity or attend to her safety when she yelled at Resident B and Resident B obtained a head wound and wrist injury while in Ms. Burton's care.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/13/25, I completed an exit conference with Ms. Clauson and Ms. Marckini explaining that although I do not have current concern regarding the home and feel the allegations were addressed appropriately, due to Resident B's injury, a violation is established. Ms. Marckini responded and did not dispute my findings.

IV. RECOMMENDATION

Contingent upon a plan of corrective action, I recommend the status of the license remain the same.

Cassandra Duursma 02/14/2025

Cassandra Duursma, Consultant Date

Approved By:

Jerry Hendrick 02/14/2025

Jerry Hendrick, Area Manager Date