GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 8, 2025

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

RE: License #: AL410289602
Investigation #: 2026A0464002
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 that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Megan Aukerman, LMSW

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 #:	AL410289602
Investigation #:	2026A0464002
Complaint Receipt Date:	10/07/2025
Investigation Initiation Date:	10/07/2025
Report Due Date:	12/06/2025
LicenseeName:	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 - 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 ALZHEIMERS/AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff are mean to residents and treat them poorly.	No
Residents are not being administered their medications.	No
Resident A passed away from a stroke. Facility staff did not provide adequate care to Resident A.	Yes

III. METHODOLOGY

10/07/2025	Special Investigation Intake 2026A0464002
10/07/2025	Special Investigation Initiated - Telephone Emily Graves, Kent County APS
10/07/2025	APS Referral
10/15/2025	Inspection Completed On-site Sharon Dawson (Director of Resident Care), Trevon Robey (Staff), Eva Rodas (Staff), Resident C, and Resident D
10/15/2025	Contact-Document received Facility Records
12/05/2025	Exit Conference Barbara Rhodes-Williams, Licensee Designee

ALLEGATION: Facility staff are mean to residents and treat them poorly.

INVESTIGATION: On 10/07/2025, I received a complaint from Adult Protective Services (APS), which alleged facility staff are “not nice” to residents and Residents are not being administered their medications in a timely manner. It was also reported that Resident A recently passed away and there is concern staff were not adequately taking care of Resident A prior to her passing.

On 10/07/2025, I spoke with Kent County APS worker, Emily Graves. Mrs. Graves reported they have not had any recent investigations into the facility.

On 10/15/2025. I completed an unannounced inspection at the facility. I interviewed Director of Resident Care, Sharon Dawson, staff Trevon Robey and Eva Rodas. Ms. Dawson denied witnessing staff mistreat residents and there are no reports of staff doing so. Mr. Robey and Ms. Rodas both stated that they have worked at the facility for approximately six months. They both stated that they have never mistreated any of the home’s residents, and they have not heard any reports of other staff mistreating residents.

While at the home, I interviewed Resident C and D individually. Resident C and Resident D both stated that they are happy with the level of care provided by facility staff. They also both stated that staff treat them with dignity and respect, and they have not observed negative interactions between staff and other residents.

On 12/05/2025, I completed an exit conference with Barbara Rhodes-Williams and informed her of the investigation findings and recommendations.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.
ANALYSIS:	On 10/07/2025, a complaint was received alleging staff treat residents poorly. Staff Sharon Dawson, Trevon Robey and Eva Rodas all denied treating residents poorly or witnessing other staff treating residents poorly. Resident C and D reported that staff treat them well. They denied having any concerns regarding staff treating residents poorly. Based on the investigative findings, there is insufficient evidence to support a rule violation that staff mistreat residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Residents are not being administered their medications.

INVESTIGATION: On 10/15/2025, I completed an unannounced onsite inspection at the facility and interviewed Ms. Dawson, Mr. Robey and Ms. Rodas. Ms. Dawson stated that on 09/06/2025 and 09/07/2025 Ms. Griffin was assigned to administer Resident B’s medications. She stated that on 09/06/2025 Ms. Griffin informed Ms. Dawson that she could not locate Resident B’s Senna tabs and documented as such in his MAR. Ms. Dawson stated that she subsequently assisted Ms. Griffin in locating the medication in the cart and Resident B was administered the medication that day. Ms. Dawson stated that Ms. Griffin failed to update Resident B’s MAR with

the 09/06/2025 administration. Ms. Dawson stated that on 09/07/2025 Ms. Griffin did not administer that medication because it was out of stock.
Mr. Robey and Ms. Rodas stated that they have both worked at the facility for approximately six months. They stated that staff are provided with a day of classroom instruction and three days of supervision “on the cart” before independently administering residents’ medications. Ms. Robey and Ms. Rodas stated that they are satisfied with the level of training provided and are confident that they can administer medications appropriately.

During the inspection, I observed that Resident B’s Medication Administration Record indicates Resident B is prescribed two tabs of Senna-Docusate Tab once daily. I observed that on 09/06/2025 staff Angela Griffin documented that Resident B did not receive his prescribed dose of Senna due to the medication being “not in cart will call ph”. I observed that on 09/07/2025 staff Angela Griffin documented that Resident B did not receive his prescribed dose of Senna-Docusate Tab due to the medication being “not in cart will call Dr and ph”.

While at the home I interviewed Resident C and D individually. Both residents denied having any concern about the facility. Both Resident C and D reported they are administered their medications as prescribed.

On 12/05/2025, I completed an exit conference with Barbara Rhodes-Williams and informed her of the investigation findings and recommendations. A corrective action plan will be submitted to licensing.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	On 10/07/2025, a complaint was received alleging residents are not administered their medications as prescribed. Staff Sharon Dawson reported there were two days when Resident B was not administered his prescribed stool softener. Resident B’s Medication Administration Record (MAR) reflected that on 09/06/2025 and 09/07/2025, Resident B was not administered his Senna-Docusate Tab. Based on the investigative findings, there is sufficient evidence to support a rule violation that Resident B was not administered a prescribed medication.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident A passed away from a stroke. Facility staff did not provide adequate care to Resident A.

INVESTIGATION: On 10/15/2025, I completed an unannounced, onsite inspection at the facility and interviewed Ms. Dawson, Mr. Robey and Ms. Rodas. Ms. Dawson stated that Resident A passed at the facility while receiving hospice services approximately two weeks prior. She stated that facility staff provided adequate personal care to Resident A while residing at the facility and there are no concerns or reports of mistreatment. Ms. Dawson stated that facility staff do not mistreat residents and there are no reports of staff doing so.

While at the home I interviewed Mr. Robey and Ms. Rodas separately. Both staff stated that they have worked at the facility for approximately six months. They stated that Resident A received medical services from hospice and passed away approximately two weeks prior. They have no concerns regarding the care Resident A received while residing at the facility. Mr. Robey and Ms. Rodas both stated the facility is sufficiently staffed to provide adequate resident personal care. They stated that during daytime hours the facility is always staffed with at least two staff. They both stated that residents' adult briefs are "check and changed" every two hours and all other areas of resident care are performed according to each residents' individual care plans in a satisfactory manner.

While at the home I interviewed Resident C and D individually. Both residents stated that they are happy with the level of care provided by facility staff. They both stated that staff treat them with dignity and respect, and they have not observed negative interactions between staff and other residents. They both stated that staff provide adequate personal care, and they have not witnessed other residents lacking in personal care.

On 12/05/2025, I completed an exit conference with Barbara Rhodes-Williams and informed her of the investigation findings and recommendations.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	On 10/07/2025, a complaint was received alleging staff did not provide adequate care to Resident A.

	Staff Sharon Dawson, Trevon Robey and Eva Rodas all reported Resident A received adequate personal care prior to her passing. Residents C and D both reported the staff meet all of their personal care needs. They denied having any concerns. Based on the investigative findings, there is insufficient evidence to support a rule violation that staff did not provide adequate care to Resident A.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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

Megan Aukerman, LMSW 12/05/2025

Megan Aukerman Date
Licensing Consultant

Approved By:

12/08/2025

Jerry Hendrick Date
Area Manager