GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 3, 2026

Tiffany Marchbanks
Hearthside Assisted Living
1501 W. 6th Ave.
Sault Ste. Marie, MI 49783

RE: License #: AH170271455
Investigation #: 2026A1035052
Hearthside Assisted Living

Dear Licensee:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violation, no corrective action plan is requested and disciplinary action against the license is recommended.

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) 335-5985.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH170271455
Investigation #:	2026A1035052
Complaint Receipt Date:	07/14/2026
Investigation Initiation Date:	07/15/2026
Report Due Date:	09/13/2026
Licensee Name:	Superior Health Support Systems
Licensee Address:	Suite 120 1501 W. 6th Ave. Sault Ste. Marie, MI 49783
Licensee Telephone #:	(906) 632-9886
Administrator/ Authorized Representative:	Tiffany Marchbanks
Name of Facility:	Hearthside Assisted Living
Facility Address:	1501 W. 6th Ave. Sault Ste. Marie, MI 49783
Facility Telephone #:	(906) 635-6911
Original Issuance Date:	08/01/2006
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	64
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from facility. Facility was unaware of Resident A eloping. Facility is not maintaining a safe environment for residents that are an elopement risk.	Yes
Additional Findings	No

III. METHODOLOGY

07/14/2026	Special Investigation Intake 2026A1035052
07/15/2026	Special Investigation Initiated - On Site

ALLEGATION:

Resident A eloped from the facility. Facility was unaware of Resident A eloping until notified by local Assisted Living Home. Facility is not maintaining a safe environment for residents that are an elopement risk.

INVESTIGATION:

On July 14, 2026, the Department received a complaint through the online complaint system which read:

> "On 7/6/26 at approximately 1405 hours I (Ofc. Driedric) was dispatched to 605 W Portage Ave. in reference to a lost female with dementia. I learned that an unknown passerby dropped Resident A off at this address believing she lived there. The passerby located Resident A walking on W Easterday Ave. near the intersection of W Portage Ave. Resident A appears to suffer from dementia and is unable to speak coherently or care for herself. Hearthside Assisted Living was called and it was determined that Resident A left this facility on foot on 7/6/26 at an unknown time. An employee from Hearthside came and brought Resident A back to Hearthside."

On July 15, 2026, an onsite investigation was conducted. While onsite, I interviewed Staff Person (SP)1, who was actively cooking throughout the beginning stages of the investigation. SP1 states the facility was contacted by Freighter View Assisted Living Administrator inquiring if the facility was missing a resident. Freighter View Assisted Living provided the name ironed on the resident's shirt, for the resident that was dropped off at his facility and a description of the resident. SP1 states she had her staff do a facility search to see if they were missing a resident. It was identified at

this time that Resident A was missing. SP1 drove to Freighter View Assisted Living and picked Resident A up and returned her to the facility. SP1 states Resident A is known to remove her wander guard bracelet frequently. SP1 reviewed cameras noting Resident A exited through the rear entrance door at 12:37 p.m. on 07/06/2026. SP1 states she had an on the spot verbal education with staff working at the time of the incident, upon the return of Resident A to the facility. SP1 states formal elopement in-service will be completed on 07/21/2026.

While onsite, I interviewed SP2 who states a newer staff member walked past Resident A as she walked toward the door she exited from. SP2 states the facility has a list of residents posted on the wall in the staff office of those with wander guards due to an identified elopement risk. Wander guard devices are applied to residents at risk for eloping. The wander guard device will trigger an alarm within the facility, if the resident tries to elope. SP2 states the facility has had frequent occurrences of residents attempting to elope from the facility. SP2 states she has not received formal elopement training, but she knows what to do.

While onsite, I interviewed SP3 who states Resident A frequently removes her wander guard and frequently seeks exits. SP3 continues to state Resident A often attempts to exit seek with Resident B. SP3 states she was at the facility the day Resident A eloped and there was no education provided that day that she can recall. The alarm system had been broken for the entire day, and the door had been propped open for several hours.

While onsite, I interviewed SP4 who states Resident A went out for an appointment with family earlier in the day and had eloped while SP4 was on lunch break. SP4 states no formal education had been provided upon hire. SP4 was given a generalization of duties to complete and was assigned a set the next day.

While onsite, I interviewed SP5 who states the alarm system was not functioning properly therefore the door was propped open while troubleshooting the alarm problem. SP5 states he had to leave the building and go to town to get supplies to fix the doorbell switch that deactivates the alarm for when staff or residents that smoke exit through that door. SP5 states he was not provided with any elopement education since being hired.

While onsite, Resident A was observed sleeping in a bed of a room that was not assigned to her. Resident A did not have her wander guard on at this time. SP1, SP2, and SP3 were notified Resident A is not wearing the wander guard. Later that morning Resident A was observed exiting through the front door with family. Resident A did not have a wander guard on at this time.

While onsite, facility security camera footage for the afternoon of 07/06/2026 was reviewed, and it revealed:

- Rear door propped open at 11:02 a.m.

- Multiple residents and staff entering and exiting propped open rear door between 11:02 a.m. and 2:52 p.m.
- Rear door remained unattended and unsecured from 11:02 a.m. until 2:52 p.m.
- Resident A observed passing a caregiver and exiting the rear door at 12:37 p.m.
- Resident A returned to the facility accompanied by SP1 at 2:31 p.m.
- Rear door unpropped at 2:52 p.m.

While onsite, the presumed elopement path was walked. This writer walked out the rear exit across the back parking lot to the side street. The presumed side street Resident A walked to main road is dirt and pothole ridden. Resident A would either walk across a busy three lane road to the sidewalk or remain on roadside without a sidewalk.

Resident A walked 1.3 miles from Hearthside Assisted Living at which time she was picked up by a pedestrian in a vehicle who took her to Freighter View Assisted Living two miles from Hearthside Assisted Living. Resident A was dropped off at the front door. The facility staff and Administrator assisted Resident A into the facility. Resident A was confused and unable to answer questions. The facility Administrator checked the collar of the unknown Resident and observed a name.

At this time, local law enforcement was notified and the nearest assisted living to the location where Resident A was picked up from was called. It was identified at this time where Resident A resides. Facility staff member picked Resident A up and returned her to Hearthside Assisted Living.

On July 20, 2026, a phone interview was conducted with Officer Driedric who was dispatched to Freighter View Assisted Living in response to a confused elderly woman who appeared to have dementia that was dropped off by pedestrians in a vehicle. Officer Driedric voiced concerned related to the distance and dangers Resident A would have encountered during her elopement. Concerns were voiced on how the facility was unaware of her whereabouts.

Through direct observation of Resident's Wander Guard list posted within the facility, the list included nine residents requiring wander guard bracelets related to elopement risk behaviors. The facility was unable to provide current documentation of wander risk behaviors and interventions to prevent or minimize elopement risk. The facility was asked to provide service plans, progress notes, and elopement assessments for each resident on the list.

- Resident A: progress notes 7/2/2026 indicate "exit seeking multiple times and removing wander guard, she has gotten out of the facility several times during day shift." Resident A eloped on 7/6/2026, Resident A's incident report states "every 15-minute monitoring" will be implemented as an immediate action post elopement. No documentation was provided to support increased monitoring required related to Resident A having high elopement behavior and

noncompliance with wander guard bracelet. Resident A did not have an elopement risk assessment completed as stated in facility policy.

- Resident B: no progress notes provided, no additional monitoring implemented, risk assessment provided without completion date, last elopement risk assessment dated 8/18/2025.

- Resident C: no progress notes provided, no additional monitoring implemented, risk assessment provided without completion date, last elopement risk assessment dated 7/24/2024.

- Resident D: no progress notes provided, no additional monitoring implemented, risk assessment provided without completion date, last elopement risk assessment dated 7/29/2024.

- Resident E: no progress notes provided, no additional monitoring implemented, risk assessment provided without completion date, last elopement risk assessment dated 7/29/2024.

- Resident F: no progress notes provided, no additional monitoring implemented, risk assessment provided without completion date, last elopement risk assessment dated 7/29/2024.

- Resident G: no progress notes provided, no additional monitoring implemented, risk assessment provided without completion date, last elopement risk assessment dated 7/29/2024.

- Resident H: no progress notes provided, no additional monitoring implemented, risk assessment provided without completion date, last elopement risk assessment dated 8/18/2025.

- Resident I: no progress notes provided, no additional monitoring implemented, risk assessment provided without completion date, last elopement risk assessment dated 2/28/2025.

On July 21, 2026, SP1 emailed copies of the original resident elopement assessments that were located in onsite storage at the facility.

Through record review of Superior Health Support System SHSS states:

“Resident Elopement” policy A through Elopement Risk Assessment will be preformed during admission, quarterly, and as needed to identify those Residents are a high risk for elopement using the “resident Elopement Assessment Form” and algorithm.”

On July 29, 2026, SP1 self-reported Resident B had eloped from the building. Incident and accident report states “neighbor came into the facility asking if we had a resident that wore a wig living here, staff exited the facility to find resident sitting on her walker at the corner of the street. upon reviewing camera system, resident exited through the front door immediately after a visitor had entered.” Facility report states cameras were reviewed; Resident B exited the building through the front door at 1:49 p.m. and was returned to the building at 2:00 p.m. by staff guidance. The incident report does not identify if Resident B was wearing a wander guard at the time of elopement. However, SP1 did confirm that Resident B was wearing a wander guard at the time of elopement. It could not be determined why the alarm did not sound when Resident B eloped from the facility.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(a) Assume full legal responsibility for the overall conduct and oporation of the home.** **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**

ANALYSIS:	Resident A eloped from the facility on 07/06/2026 at 12:37 p.m. through an unsupervised propped open door. The facility was unaware of Resident A eloping until local assisted living facility contacted them inquiring if they were missing a Resident at approximately 2:05 p.m. The facility had the rear door propped open and unsupervised from 11:02 a.m. to 2:52 p.m. on 07/06/2026, offering no protection or supervision to Residents. Resident A was noted to be exit seeking 07/02/2026, with multiple successful elopements during the days shift. The facility completed an incident and accident report stating every 15-minute safety checks would be completed. No documented evidence of completion of the safety checks was provided. The facility was unable to provide an updated Elopement Risk Assessment, per policy and procedure. Nine Residents appeared on the Wander Guard list within the staff office. The facility was unable to provide current elopement risk assessments, progress notes, or any monitoring measures, and interventions to minimize elopement risk for these residents. While the facility provided elopement education to all staff on 07/21/2026, Resident B successfully eloped from the home without staff being aware on 07/24/2026. For these reasons, the facility is found in violation with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Disciplinary action is recommended.

07/30/2026

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

08/03/2026

_____

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section