GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2025

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

RE: License #: AL280369175
Investigation #: 2025A0009027
Cherry Hill Haven

Dear Ms. Clauson:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 the rule will be achieved.
- Who is directly responsible for implementing the corrective action for the violation.
- A specific time frame for the 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,

Adam Robarge, Licensing Consultant
Bureau of Community and Health Systems
Suite 11
701 S. Elmwood
Traverse City, MI 49684
(231) 350-0939

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL280369175
Investigation #:	2025A0009027
Complaint Receipt Date:	07/07/2025
Investigation Initiation Date:	07/09/2025
Report Due Date:	08/06/2025
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Jere Green
Licensee Designee:	Connie Clauson
Name of Facility:	Cherry Hill Haven
Facility Address:	4841 N. Long Lake Rd Traverse city, MI 49684
Facility Telephone #:	(231) 645-2341
License Status:	REGULAR
Effective Date:	02/17/2024
Expiration Date:	02/16/2026
Capacity:	16
Program Type:	ALZHEIMERS & AGED

II. ALLEGATION(S)

	Violation Established?
Resident A does not always receive her 10:00 p.m. medication.	Yes
Resident A's room is always cold from the air conditioning.	No

III. METHODOLOGY

07/07/2025	Special Investigation Intake 2025A0009027
07/07/2025	APS Referral
07/09/2025	Special Investigation Initiated - On-site Interview with home manager Lisa Teglas and direct care worker Sarah Mack. Observation of premises
07/29/2025	Inspection Completed – On-site Interview with direct care worker Sarah Mack. Observation of premises
07/30/2025	Contact – Telephone call made to administrator Lisa Teglas
07/30/2025	Contact – Telephone call made to home manager Jere Green
07/30/2025	Exit conference with licensee designee Connie Clauson

ALLEGATION: Resident A does not always receive her 10:00 p.m. medication.

INVESTIGATION: I conducted an unannounced site visit at the Cherry Hill Haven adult foster care facility on July 9, 2025. I spoke with home manager Lisa Teglas at that time and asked her about Resident A. She said that Resident A is independent and her own guardian. Resident A is there because of mental health issues and is able to come and go as she pleases. Home staff do administer medication for her. I asked about the report that Resident A is not receiving her 10:00 p.m. medications. Ms. Teglas stated that Resident A is very particular about when she receives her medication. They usually administer medication at 8:00 p.m. to residents but Resident A wants her medication at 10:00 p.m. Ms. Teglas said that there was an issue one evening with a new staff member who might not have known Resident A's specific request for receiving it later at night. It also might have been the case that Resident A was out after 10:00 p.m. and not there to receive her medication.

Ms. Teglas took me to the facility from her office which is located on the same campus as Cherry Hill Haven but in a different building. We spoke with direct care worker Sarah Mack who was present at that time. Ms. Mack showed me their medication administration system (MAR) on a computer application. Ms. Mack explained that Resident A's night medications show up as being administered at 8:00 p.m. because that is when they administer most night-time medications. Resident A has specifically requested that they be given to her at 10:00 p.m. They have had some problems with this because Resident A sometimes falls asleep by 10:00 p.m. and then they have been unable to wake her up to administer her medication. Another time, an overnight shift staff came in early at 9:00 p.m. to work. She believed that Resident A had been given her medication which is on the system for 8:00 p.m. but which Resident A likes to receive at 10:00 p.m. Resident A did not receive her nighttime medication that evening. Ms. Mack said that she believed this error had occurred on June 23, 2025. I asked to see Resident A's nighttime medication which was contained in bubble packs with labels printed by the pharmacy. I noted that the label instructions for four of the medications stated that they should be administered at 8:00 p.m. and the other two at 9:00 p.m. I spoke with Ms. Teglas and Ms. Mack about the fact that medication should be administered no more than one hour before or after the label instruction. They both agreed that they were aware of that. I told them that if Resident A wanted her medication administered at 10:00 p.m., she should discuss this with her doctor or pharmacy about having it changed. The label could also be changed to read "bedtime" or "nighttime" if it is a medication that has that flexibility.

Resident A was not present at the facility for me to speak to at the time of the visit.

I conducted another unannounced site visit on July 29, 2025. Direct care worker Sarah Mack was again present at the facility. Resident A was again not present. Ms. Mack said that Resident A had been hospitalized in the local psychiatric unit from July 17 through July 22, 2025. Her medications were adjusted and she is doing much better now. She is supposed to moving out on her own soon. I looked again at Resident A's nighttime medications at that time. It looked as though the times of administration on the label instructions had not changed, showing an administration time of 8:00 or 9:00 p.m.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	On or about June 23, 2025, Resident A did not receive her nighttime medication. Her medication with label instructions to be given at 8:00 p.m. has often been given to her at 10:00 p.m.

	It was confirmed through this investigation that her medication was not always given pursuant to label instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's room is always cold from the air conditioning.

INVESTIGATION: During my unannounced site visit on July 9, 2025, I took temperature readings at the facility. I noted that it was 74.8 degrees Fahrenheit in the dining room of the facility at the time of my visit. I asked about Resident A complaining about it being too cold in her room. Both Ms. Teglas and Ms. Mack explained that Resident A wants one of the rooms with it's own bathroom but those rooms are provided at a higher rate than what she pays. Resident A has access to a bathroom directly across the hall from her room which no one else uses, so it is as if she does have her own bathroom. I went with a staff person into Resident A's room. I observed a thermostat in her room and asked if Resident A was able to set the thermostat herself. I was told that she is able to set the thermostat to whatever she likes. I noted that the thermostat was set to 73 degrees but that it was "off". I noted that Resident A's window was open. I was told that Resident A had opened her room window herself. Resident A likes to smoke cigarettes out of her window even though they are a "non-smoking" campus. I measured the temperature in Resident A's room at that time as 71.2 degrees Fahrenheit.

I conducted another unannounced site visit at the facility on July 29, 2025. Ms. Mack was again present and accompanied me into Resident A's room. I noted that the room's thermostat was set at 70 degrees. Ms. Mack stated that Resident A would have been the one to make that setting. I observed that the window of the room was open. Ms. Mack said that Resident A had left the window open. The outside temperature at the time of my visit was 89 degrees Fahrenheit. I measured the temperature of Resident A's room to be 73 degrees at that time. This temperature was likely a mixture of the air conditioning being used in the home as well as the outside temperature from the open window.

I spoke with home manager Lisa Teglas by telephone on July 30, 2025. I asked her if there was anything in Resident A's health care appraisal, written assessment or resident care agreement regarding temperature variation. She checked the documents that she has access to and said that they did not. Resident A's care history has nothing documented about a need for temperature variation.

I also spoke with administrator Jere Green by telephone on July 30, 2025. She confirmed that there is nothing in Resident A's health care appraisal, written appraisal or resident care agreement about a need for temperature variation. Resident A did complain about it being too cold her room at one point. She talked to Resident A about possibly wearing a sweatshirt when she is feeling cold because she is often in shorts and a t-shirt. Ms. Green did talk to their maintenance man

about looking into the issue and knows that he did to try close the vent in her room. Ms. Green stated that they have to be careful about turning off the air conditioning in the home because the afternoon sun can make it very hot for the other residents if the air conditioning is used.

APPLICABLE RULE	
R 400.15406	**Room temperature.**
	All resident-occupied rooms of a home shall be heated at a temperature range between 68 and 72 degrees Fahrenheit during non-sleeping hours. Precautions shall be taken to prevent prolonged resident exposure to stale, noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations from the requirements of this rule shall be based upon a resident's health care appraisal and shall be addressed in the resident's written assessment plan. The resident care agreement shall address the resident's preferences for variations from the temperatures and requirements specified in this rule.
ANALYSIS:	I made two unannounced visits to the home during the course of the investigation. I measured the temperature in Resident A's room to be 71.2 degrees during the initial visit and 73 degrees Fahrenheit during the following visit. I noted that Resident A has access to her own room thermometer and is able to leave her room window open when she wishes to do so. It was reported that there is nothing in Resident A's health care appraisal, written assessment plan or resident care agreement regarding her need or preference for a variation in the temperature. This issue was only brought up during her discussion in wanting to move to another room. A maintenance worker did try to close the vent in her room and this may have addressed the issue given the aforementioned temperature readings. In consideration of the above information, it is determined that the temperature in Resident A's room is kept within a reasonable range.
CONCLUSION:	VIOLATION NOT ESTABLISHED

I conducted an exit conference with licensee designee Connie Clauson by telephone on July 30, 2025. I told her of the findings of my investigation and gave her the opportunity to ask questions.

IV. RECOMMENDATION

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

7/30/2025

Adam Robarge — Date
Licensing Consultant

Approved By:

07/30/2025

Jerry Hendrick — Date
Area Manager