GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 10, 2025

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

RE: License #: AL410375718
Investigation #: 2026A0583007
Fountain View of Lowell South

Dear Mrs. Clauson:

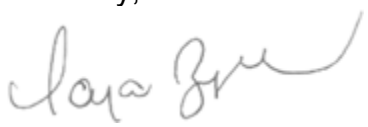
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 356-0100.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL410375718 |
| | |
| **Investigation #:** | 2026A0583007 |
| | |
| **Complaint Receipt Date:** | 10/22/2025 |
| | |
| **Investigation Initiation Date:** | 10/22/2025 |
| | |
| **Report Due Date:** | 11/21/2025 |
| | |
| **Licensee Name:** | Baruch SLS, Inc. |
| | |
| **LicenseeAddress:** | Suite 203<br>3196 Kraft Avenue SE<br>Grand Rapids, MI 49512 |
| | |
| **Licensee Telephone #:** | (616) 285-0573 |
| | |
| **Administrator:** | Connie Clauson |
| | |
| **Licensee Designee:** | Connie Clauson |
| | |
| **Name of Facility:** | Fountain View of Lowell South |
| | |
| **Facility Address:** | 11537 E. Fulton<br>Lowell, MI 49331 |
| | |
| **Facility Telephone #:** | (616) 897-8413 |
| | |
| **Original Issuance Date:** | 02/06/2019 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/06/2025 |
| | |
| **Expiration Date:** | 08/05/2027 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED, AGED, ALZHEIMERS |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| Staff are not adequately trained. | No |
| Staff fail to change residents' adult briefs in a timely manner. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 10/22/2025 | Special Investigation Intake<br>2026A0583007 |
| 10/22/2025 | Special Investigation Initiated - Telephone<br>Staff Savannah Baltruczak |
| 10/23/2025 | Inspection Completed On-site |
| 10/24/2025 | APS Referral |
| 11/03/2025 | Telephone call made<br>Staff Andrea Metzger |
| 11/04/2025 | Telephone call made<br>Staff Andrea Metzger |
| 11/05/2025 | Telephone call made<br>Staff Andrea Metzger |
| 11/07/2025 | Exit Conference<br>Licensee Designee Connie Clauson |

**ALLEGATION: Staff are not adequately trained.**

**INVESTIGATION:** On 10/22/2025 complaint allegations were received from the LARA-BCHS-Complaints system. The complaint alleged that "staff are not trained".

On 10/22/2025 I interviewed staff Savannah Baltruczak via telephone. Ms. Baltruczak stated that she worked at the facility until she "quit about a week and a half ago". She stated that staff Andrea Metzger is not adequately trained to utilize the facility's sit-to-stand. She started that on a recent occasion she walked into Resident A's bedroom and observed Ms. Metzger was in the process of transferring Resident A in the sit to stand device, however Resident A was "hanging half out of it". Ms. Baltruczak stated that Resident A's face was "turning blue" because the "belt was around her neck, choking her". She stated that Resident A was not injured. Ms. Baltruczak stated that she and staff Caitlyn Woodward helped Ms. Metzger successfully transfer Resident A to the ground and then to the commode. Ms.

Baltruczak stated that Ms. Metzger said that no one had trained her to use the sit-to-stand device.

On 10/23/2025 I completed an unannounced onsite investigation at the facility and interviewed administrator Robyn Risdon, staff Caitlynn Woodward, and staff Alyssa Nolton.

Ms. Risdon stated she had no knowledge of an incident involving Resident A sliding from a sit-to-stand device operated by Ms. Metzger. She stated that Ms. Metzger was provided adequate training prior to operating the device.

Ms. Woodward stated that about two weeks ago she entered Resident A's bedroom and observed that Resident A was sliding out of the sit-to-stand device operated by Ms. Metzger. The incident occurred in Resident A's bedroom and Resident A was not injured. She stated that she and Ms. Baltruczak immediately assisted Resident A to the ground and then to the commode with the sit-to-stand device. She stated Ms. Metzger had received adequate hands-on training prior to incident.

Ms. Nolton stated that she did not observe the incident involving Resident A. She stated that Ms. Metzger had received adequate hands-on training from multiple staff prior to operating the sit-to-date device.

On 10/24/2025 I submitted the complaint allegations to Adult Protective Services via the online portal.

On 11/03/2025 I left a voicemail for staff Andrea Metzger. I requested that she return my call.

On 11/03/2025 I received an email from Ms. Risdon that stated that Ms. Metzger, *"was trained on September 14, 15,16, & 17th. The staff are trained by the Resident Care Managers. They observe the first day, and the days to follow they assist. We also do an module training".*

On 11/04/2025 I left a voicemail and text message for Ms. Metzger. I requested that she return my call.

On 11/04/2025 I received an email from Ms. Risdon that stated Ms. Metzger, "ended up doing a no call/ no show all weekend" and "I too have not been able to get a hold of her".

On 11/05/2025 I left a voicemail for Ms. Metzger. I requested that she return my call.

On 11/07/2025 I completed an exit conference with licensee designee Connie Clauson via telephone. She was informed of the investigation findings and did not dispute them.

| APPLICABLE RULE | |
|---|---|
| **R 400.15204** | **Direct care staff; qualifications and training.** |
| | **(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:**<br>**(a) Reporting requirements.**<br>**(b) First aid.**<br>**(c) Cardiopulmonary resuscitation.**<br>**(d) Personal care, supervision, and protection.**<br>**(e) Resident rights.**<br>**(f) Safety and fire prevention.**<br>**(g) Prevention and containment of communicable diseases.** |
| **ANALYSIS:** | Administrator Robyn Risdon, staff Caitlynn Woodward and staff Alyssa Nolton each stated that staff Andrea Metzger was provided adequate hands-on training to operate the facility's sit-to-stand device.<br><br>Based on the investigative findings, there is insufficient evidence to substantiate that a violation of the applicable rule occurred. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ALLEGATION: Staff fail to change residents' adult briefs in a timely manner.**

**INVESTIGATION:** On 10/22/2025 complaint allegations were received from the LARA-BCHS-Complaints system. The complaint alleged that "staff leave residents in wet briefs".

On 10/22/2025 I interviewed staff Savannah Baltruczak via telephone. She stated that the facility provides care for residents diagnosed with Alzheimer's and dementia. She stated that staff do not change residents' briefs in a timely manner. She stated that staff are required to write their initials and the time they changed the resident's adult brief on the brief because staff were not changing residents often enough. She stated that on multiple occasions within the previous month, she started her first shift at 6:00 AM and observed residents lying in urine-soaked briefs and bedding that according to the initials on a residents' adult briefs; had not been changed since 6:00 PM the previous day. She stated that two weeks ago she observed that Resident B had not been changed since 6:00 PM the previous day and he was "soaked from his shoulders to his ankles" with urine in his bed.

While onsite on 10/23/2025, Ms. Risdon stated that staff are required to write their initials and the time they changed the residents' adult brief on the brief. She stated that doing so helps staff track the frequency residents require adult brief changes. She stated that staff change residents regularly and she has observed no indication that staff leave residents in wet adult briefs.

Ms. Woodward stated that she typically works from 6:00 AM until 2:00 PM. She confirmed that staff are required to write their initials and the time they changed the resident's adult brief on the brief. She stated that second and third shift staff are not changing residents' adult briefs often enough. She stated that on multiple occasions she started her 6:00 AM shift and observed residents laying in urine-soaked bedding that had not been changed since the preceding day at 6:00 PM, 8:00 PM, or 10:00 PM as evidenced by staff timestamps. She stated that residents "were soaked through their sheets and bed pads".

Ms. Nolton stated that she works first shift from 6:00 AM until 2:00 PM. She confirmed that staff are required to write their initials and the time they change residents' adult brief on the brief. She stated that on multiple occasions within the past month she has observed residents going 12 hours without being changed. She stated she has started her 6:00 AM shift and found residents lying in urine-soaked bedding that was "very wet" and "soaked through the fitted sheet". She stated she has observed residents that presented in urine-soaked bedding were wearing adult briefs that staff had initialed changing the previous day at 6:00 PM, 8:00 PM, 4:15 PM. She stated that she has observed Resident B laying in urine-soaked bedding and "his mattress was soaked down to his back". She stated that he had not been changed since the previous day according to staff timestamps. She stated she informed Ms. Risdon that staff were not changing residents' adult briefs since the preceding day and Ms. Risdon responded by stating that she would "take care of it".

While onsite I attempted to interview Resident C. Resident C was clean and appropriately groomed but unable to complete an interview due to her memory decline.

On 11/07/2025 I completed an exit conference with licensee designee Connie Clauson via telephone. She was informed of the investigation findings and did not dispute them. She stated that she would submit an acceptable Corrective Action Plan.

| **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:** | Staff Savannah Baltruczak, Caitlynn Woodward, and Alyssa Nolton each stated that residents' adult briefs have not been changed often enough. Each stated that on multiple occasions they have observed that residents' adult briefs had not been changed since 6:00 PM the proceeding day as evidenced by residents' lying in urine-soaked briefs and the previous staff's initials and time stamp.<br><br>Based on the investigative findings, there was sufficient evidence to substantiate that a violation of the applicable rule occurred. Staff are not changing residents' adult briefs in a timely manner. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

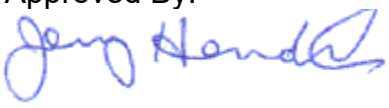
## IV. RECOMMENDATION

Upon receipt of receipt acceptable Corrective Action Plan, I recommend no change to the license.

11/07/2025

Toya Zylstra — Date
Licensing Consultant

Approved By:



11/10/2025

Jerry Hendrick — Date
Area Manager