



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 #: AL410375721
Investigation #: 2026A0583006
Fountain View of Lowell 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,

A handwritten signature in cursive script, appearing to read "Toya Zylstra".

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**
Report contains explicit language.

I. IDENTIFYING INFORMATION

License #:	AL410375721
Investigation #:	2026A0583006
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 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Connie Clauson
Licensee Designee:	Connie Clauson
Name of Facility:	Fountain View of Lowell North
Facility Address:	11537 E. Fulton Lowell, MI 49331
Facility Telephone #:	(616) 897-8413
Original Issuance Date:	07/31/2019
License Status:	REGULAR
Effective Date:	02/01/2024
Expiration Date:	01/31/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Staff Barbara Cahoon hit Resident A in the head.	No
Staff Barabara Cahoon verbally mistreats Resident A.	Yes
Staff confine Resident A in his bedroom.	Yes

III. METHODOLOGY

10/22/2025	Special Investigation Intake 2026A0583006
10/22/2025	Special Investigation Initiated - Telephone Staff Savannah Baltruczak
10/23/2025	Inspection Completed On-site
10/24/2025	APS Referral
11/07/2025	Exit Conference Licensee designee Connie Clauson

ALLEGATION: Staff Barbara Cahoon hit Resident A in the head.

INVESTIGATION: On 10/22/2025 complaint allegations were received from the LARA-BCHS-Complaints system. The complaint alleged that residents are “abused around the clock”.

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 in September 2025, Resident A said staff Barbara Cahoon hit Resident A on his head twice because she was angry with him for calling her a name. Ms. Baltruczka stated that Resident A told her the day after the incident occurred and Resident A had no visible injuries. Ms. Baltruczak stated that Resident A said the incident occurred in his bedroom with no witnesses.

On 10/23/2025 I completed an unannounced onsite investigation at the facility and interviewed administrator Robyn Risdon, staff Barbara Cahoon, and Resident A.

Ms. Risdon stated Resident A presents with many behavioral difficulties including coming out of his bedroom without clothing and cursing at staff and residents. She stated she has never observed or heard of any staff hitting Resident A.

Ms. Cahoon stated she has never hit Resident A and the allegation is false.

Resident A stated that Ms. Cahoon has never hit him in any manner and the allegation is untrue.

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

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 400.15308	Resident behavior interventions prohibitions.
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Resident A and staff Barbara Cahoon both denied that Ms. Cahoon hit Resident A in the head. Based on the investigative findings, there is insufficient evidence to support a rule violation occurred.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Staff Barbara Cahoon verbally mistreats Resident A.

INVESTIGATION: On 10/22/2025 complaint allegations were received from the LARA-BCHS-Complaints system. The complaint alleged that “staff yell at residents”.

On 10/22/2025 I interviewed staff Savannah Baltruczak via telephone. Ms. Baltruczak stated staff Barbara Cahoon “screams and yells” at Resident A. She stated that she has observed Ms. Cahoon raise her voice towards Resident A after Resident A called Ms. Cahoon “a bitch”. Ms. Baltruczak stated that on multiple occasions Ms. Cahoon yelled at Resident A to go to his bedroom in a loud tone and then screamed at Resident A to stay in his bedroom when he wanted to leave it.

On 10/23/2025 I completed an unannounced onsite investigation at the facility and interviewed administrator Robyn Risdon, staff Barbara Cahoon, staff Gloria Martinez, Resident A, and Resident B. Ms. Risdon stated that she has never observed or heard allegations from other staff that Ms. Cahoon raises her voice at Resident A or calls him derogatory names.

Ms. Cahoon stated that she has never screamed at Resident A and has never called him a derogatory name. She stated that she treats him with respect.

Ms. Martinez stated that she has never observed Ms. Cahoon raise her voice or verbally mistreat Resident A.

Resident A stated that Ms. Cahoon has called him a “bitch” and he has called her the same. He stated that Ms. Cahoon does raise her voice at him and orders him to stay in his bedroom. He stated that Ms. Cahoon’s loud tone hurts his feelings.

Resident B stated that staff have never verbally mistreated him. He stated that Resident A often “swears” at residents and staff. He stated that he has not observed staff verbally mistreat Resident A or any other resident.

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

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 400.15308	Resident behavior interventions prohibitions.
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Resident A stated that Ms. Cahoon has called him a “bitch” and he has called her the same. He stated that Ms. Cahoon raises her voice at him and orders him to stay in his bedroom. Staff Savannah Baltruczak stated staff Barbara Cahoon screams and yells at Resident A. She stated she has observed Ms. Cahoon raise her voice towards Resident A after Resident A called Ms. Cahoon a “bitch”. Ms. Baltruczak stated that on multiple occasions Ms. Cahoon yelled at Resident A to go to his bedroom in a loud tone and then “screamed” at Resident A to stay in his bedroom.

	Based on the investigative findings, there is sufficient evidence to support a rule violation occurred. Staff Barbara Cahoon verbally mistreated Resident A by raising her voice towards him.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Staff confine Resident A in his bedroom.

INVESTIGATION: On 10/22/2025 complaint allegations were received from the LARA-BCHS-Complaints system. The complaint alleged that *“Resident was locked in room for a week and not allowed out there because he called the Assisted living manager a “bitch” she proceeded to scream and yell at him anytime he tried to leave the room”*.

On 10/22/2025 I interviewed staff Savannah Baltruczak via telephone. Ms. Baltruczak stated that Resident A uses a wheelchair. Ms. Baltruczak stated that Resident A exhibits behaviors including calling staff Barbara Cahoon derogatory names. Ms. Baltruczak stated that on multiple occasions she has observed Ms. Cahoon “scream” at Resident A to go to his private bedroom after Resident A has called Ms. Cahoon a derogatory name. Ms. Baltruczak stated Resident A has been directed to stay in his bedroom, which contains a private restroom, for up to a week. She stated that when Resident A attempts to leave his bedroom staff order him to go back to his bedroom. Ms. Baltruczak stated that Ms. Cahoon is generally the staff that orders Resident A to his bedroom, however other staff do not intervene. She stated that Ms. Cahoon refuses to provide resident care to Resident A while he is in his bedroom but other staff step in to assist him. Ms. Baltruczak stated that Resident A receives his meals in his bedroom when he is forced to stay in his bedroom. Ms. Baltruczak stated that on one occasion Ms. Cahoon placed a sign in the nurse’s office that stated Resident A was not allowed to leave his bedroom “until further notice” after Resident A verbally mistreated Ms. Cahoon. Ms. Baltruczak stated that on one occasion she observed Ms. Cahoon push Resident A into his bedroom, slam the door, and tell him he could not come out.

On 10/23/2025 I completed an unannounced onsite investigation at the facility and interviewed administrator Robyn Risdon, staff Barbara Cahoon, Gloria Martinez, Resident A, and Resident B. Ms. Risdon stated that staff do not confine Resident A to his bedroom. She stated there have been incidents when Resident A exited his bedroom without clothing and staff verbally redirected him to dress. She denied any knowledge of staff directing Resident A to stay in his bedroom for up to a week.

Ms. Cahoon stated that Resident A calls her and residents derogatory names. She stated staff direct Resident A to stay in his bedroom “for the day” after he calls others derogatory terms. She stated staff direct Resident A to his bedroom and he is told to stay in his bedroom until the following morning. She clarified that Resident A has been directed by staff to isolate himself in his bedroom for up to twenty-four

hours at a time. She acknowledged that she has pushed Resident A in his wheelchair into his bedroom on multiple occasions and directed him to stay in his bedroom until the following day. She stated that if Resident A attempts to leave his bedroom staff verbally direct him to return to his bedroom or staff will push him back into bedroom. Ms. Cahoon stated that she provides all daily living care to Resident A in his bedroom, and his meals are served in his bedroom during his isolation. She stated that Ms. Risdon was aware that staff isolate Resident A in his bedroom overnight.

Ms. Martinez stated that staff direct Resident A to stay in his bedroom until the next morning after he verbally mistreats staff or residents. She stated that Resident A can spend up to twenty fours in his bedroom at a time and staff verbally direct Resident A back into his bedroom if he comes out before the following morning. She stated that staff provide daily care to him in his bedroom and Resident A must eat his meals in his bedroom during his isolation.

Resident A stated that staff have directed him to stay in his bedroom up to twenty-four hours at a time on multiple occasions. He stated that staff direct him to stay in his bedroom for verbal mistreatment of staff. He stated that Ms. Cahoon has often pushed him into his room for isolation. He stated that if he tries to exit before the following day staff tell him to go back into his bedroom and push him back into his bedroom. He stated that staff bring him his meals in his bedroom, and he receives all daily care in his bedroom during his isolation. He denied being isolated for a week straight and identified that the incidents are multiple and sporadic.

Resident B stated that he never observed staff direct Resident A to stay in his bedroom for extended periods of time.

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 400.15308	Resident behavior interventions prohibitions.
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.
ANALYSIS:	Resident A stated that staff have directed him to stay in his bedroom up to twenty-four hours at time on multiple occasions.

	<p>Staff Savannah Baltruczak, Barabara Cahoon and Gloria Martinez each stated that staff confine Resident A in his bedroom.</p> <p>Based on the investigative findings, there is sufficient evidence to support a rule violation occurred. Staff confine Resident A in his bedroom for up to twenty-four hours at a time.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



11/07/2025

Toya Zylstra
Licensing Consultant

Date

Approved By:



11/10/2025

Jerry Hendrick
Area Manager

Date