



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 10, 2026

Brian Nitz  
Baruch SLS, Inc.  
Suite 203  
3196 Kraft Avenue SE  
Grand Rapids, MI 49512

RE: License #:	AL700398469
Investigation #:	2026A0356018 Simarron AFC Home

Dear Mr. Nitz:

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. If 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 that reads "Elizabeth Elliott". The signature is written in black ink and is positioned below the word "Sincerely,".

Elizabeth Elliott, Licensing Consultant  
Bureau of Community and Health Systems  
350 Ottawa, N.W.  
Grand Rapids, MI 49503  
(616) 901-0585

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL700398469
<b>Investigation #:</b>	2026A0356018
<b>Complaint Receipt Date:</b>	01/14/2026
<b>Investigation Initiation Date:</b>	01/14/2026
<b>Report Due Date:</b>	03/15/2026
<b>Licensee Name:</b>	Baruch SLS, Inc.
<b>Licensee Address:</b>	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
<b>Licensee Telephone #:</b>	(616) 588-9131
<b>Administrator:</b>	Brian Nitz
<b>Licensee Designee:</b>	Brian Nitz
<b>Name of Facility:</b>	Simarron AFC Home
<b>Facility Address:</b>	15255 Clovernook Drive Grand Haven, MI 49417
<b>Facility Telephone #:</b>	(616) 847-4242
<b>Original Issuance Date:</b>	03/23/2020
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/24/2024
<b>Expiration Date:</b>	09/23/2026
<b>Capacity:</b>	20
<b>Program Type:</b>	PHYSICALLY HANDICAPPED ALZHEIMERS AGED



**II. ALLEGATION(S)**

	<b>Violation Established?</b>
The facility is insufficiently staffed.	Yes
Additional Findings	Yes

**III. METHODOLOGY**

01/14/2026	Special Investigation Intake 2026A0356018
01/14/2026	APS Referral Denied for investigation.
01/14/2026	Special Investigation Initiated - Face to Face Licensing Consultant, Rebecca Piccard.
01/20/2026	Contact - Telephone call made Amanda Beechum, administrator.
02/04/2026	Contact - Telephone call made A. Beechum, contact Rebecca Summerville, new administrator.
02/05/2026	Inspection Completed On-site
02/05/2026	Contact - Face to Face Rebecca Summerville, admin., Jocelenn Griffore, DCW 2nd shift, Resident's A, B, C.
02/20/2026	Contact - Document Received Natasha Grew; AFC Licensing Consultant and I reviewed documents at the facility. Reviewed IR's for D&E.
02/20/2026	Contact - Face to Face Natasha Grew and I met with Rebecca Summerville, admin. and Shane TenBrink, Director of Resident Care at the facility, interviewed DCW Kailyn Chaney and Resident F.
02/24/2026	Contact - Document Received Documents from Rebecca Summerville.
03/09/2026	Exit conference- Brian Nitz, Licensee Designee.

**ALLEGATION: The facility is insufficiently staffed.**

**INVESTIGATION:** On 01/14/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that the facility is understaffed with too many residents for one staff. The complainant reported a few days ago a worker needed help after two residents fell and she could not handle it on her own. It appears to be an unsafe situation for the staff members and residents. The complainant reported a staff member recently grabbed one of the resident's arms out of frustration and the resident was very upset afterwards. The complainant reported the resident did not sustain any marks, bruises, or injuries and there is no direct knowledge of any abuse or neglect occurring.

On 02/05/2026, I conducted an unannounced inspection at the facility and interviewed Rebecca Summerville, administrator. Ms. Summerville stated she worked at this facility, left and is newly back to working in this facility, so she is not aware of the events reported. Ms. Summerville stated there are currently 11 residents in the facility and the residents in they are largely independent and do not require a high level of care. Ms. Summerville stated during 1<sup>st</sup> shift daytime hours, there are 1-2 staff on duty, and one staff on duty for 2<sup>nd</sup> and 3<sup>rd</sup> shifts during the weekdays. Ms. Summerville stated there is 1 staff member on duty on each shift on the weekends. Ms. Summerville stated 2 residents could have fallen at the same time, but Ms. Summerville again stated she just started working at the facility and did not know about the reported incident. In addition, Ms. Summerville stated she had not heard about a staff grabbing a resident's arm out of frustration and she has not seen anything to indicate staff are not properly caring for the residents. Ms. Summerville stated if residents fall, first a determination is made on whether the resident requires emergency medical services. If the resident does not need EMS and staff are not able to get them up, the protocol is to call the DOC (director of resident care), Shane TenBrink for assistance. Ms. TenBrink works in all the buildings on the campus.

On 02/05/2026, I interviewed DCW (direct care worker) Jocelenn Griffore at the facility. Ms. Griffore works 2<sup>nd</sup> shift and stated during the week there are 1-3 staff on duty for 1<sup>st</sup> shift, 1 DCW, 1 person in the kitchen for food services and an activity person, all are trained and able to assist the main DCW if needed. Ms. Griffore stated there is 1 staff on duty for 2<sup>nd</sup> and 3<sup>rd</sup> shifts. Ms. Griffore stated there is one DCW on each shift on the weekends. Ms. Griffore stated the DCW's on staff do medications, weights, laundry, room cleaning and showers (when there are 2 DCW's on shift). Ms. Griffore stated the food/meals are prepped by the cook and the DCW's warm-up the meals and serve to the residents. Ms. Griffore stated she has never witnessed a staff grab a resident's arm out of frustration. Ms. Griffore stated had there been two residents that fell at the same time, one DCW would have a difficult time handling both situations simultaneously. Ms. Griffore stated the residents in this facility do not require the use of Hoyer Lifts or 2 person assists unless they fall and if that occurs, staff from another building on the campus are called to assist.

On 02/05/2026, I interviewed Resident A in his room at the facility. Resident A stated he has lived in the facility for over 2 years and there is 1 staff on duty during 3<sup>rd</sup> shift, but more staff on duty during the other two shifts. Resident A stated he has a call button that he uses and staff respond, sometimes quicker than others but always a response and he has no issue with that. Resident A stated the care he receives is adequate. He gets showers when they are scheduled twice weekly and three meals a day with a snack. Resident A stated he has fallen while living in this facility and staff came quickly and helped him up. Resident A stated he does not use a Hoyer Lift nor does he require two staff to assist him with any of his ADL's (activities of daily living). Resident A stated he has never seen any staff pull on residents arms or physically harm residents including himself.

On 02/05/2026, I interviewed Resident B in his room at the facility. Resident B stated he has a call button. He does not know if it works because he does not use it but staff are attentive and he has not seen staff pulling on a resident's arm or being physically aggressive with residents.

On 02/05/2026, I interviewed Resident C at the facility. Resident C stated when she pushes the call button, staff come without any delays. Resident C stated she takes showers twice weekly and always gets showers on time. Resident C stated she has never seen staff pull on residents' arms or treat residents in an abusive or poor manner. Resident C stated she fell approximately 3 years ago at this facility but has not fallen recently. Resident C stated if there is not 2 staff on duty to assist when a resident has fallen, they call another facility on the campus to have a DCW come help from that facility. Resident C stated her care at this facility is "very good".

On 02/20/2026, Licensing Consultant Natasha Grew and I conducted an inspection at the facility and interviewed Ms. Summerville and Shane TenBrink, Director of Resident Care. Ms. Summerville and Ms. TenBrink stated there are now 13 residents in care. Ms. Grew and I reviewed the resident assessment plans, resident care agreements and health care appraisals for Residents A, B, C, D, E, F, G, H, I, J, K, L and M. The plans do not document that any of the residents require a 2-person assist. Resident assistive devices do not show any residents who require the use of a Hoyer Lift or require 2 staff to provide ADL's.

Ms. Grew and I reviewed two IR's (incident reports) dated 01/11/2026. The first IR was written by DCW Kailyn Chaney, dated 01/11/2026 at 1:12p.m. The IR documented the following information for Resident D. *'Staff heard screaming down hallway and entered residents' room and observed her on the floor. No injuries noted at this time. Staff did ROM (range of motion), vitals and assisted resident up. Staff looking into getting an alarm for resident.'*

The second IR was written by DCW Kailyn Chaney, dated 01/11/2026 at 1:16p.m. The IR documented the following information for Resident E. *'Staff heard resident yelling and observed her on the floor. No injuries noted at this time. Resident stated*

*she was trying to get into recliner and got caught in her blanket causing her to fall. Staff did ROM, took vitals and assisted resident up. Asking family to get an alarm.'*

Ms. Grew and I reviewed the staff schedules from December 28, 2025, through January 31, 2026. The shifts are 1<sup>st</sup> shift, 6:00a.m.-2:00p.m., 2<sup>nd</sup> shift 2:00p.m.-10:00p.m., and 3<sup>rd</sup> shift is 10:00p.m.-6:00a.m. The staff schedule for 01/11/2026, the date of both resident falls showed Ms. Chaney as the only staff on duty on 1<sup>st</sup> shift.

The schedule shows 1 staff on duty for 1<sup>st</sup> shift but once or twice a week, there are two staff documented on the schedule, one from 6:00a.m.-10:00a.m. and another from 10:00a.m.-2:00p.m., however, only one staff on duty at a time and the shift appeared to be split. There is 1 staff member scheduled for 2<sup>nd</sup> shift but once or twice a week, there are two staff documented on the schedule, one from 2:00p.m.-6:00p.m. and another from 6:00p.m.-10:00p.m., and 8:00p.m.-10:00p.m. and again, the shift appeared to be split. The 3<sup>rd</sup> shift schedule documented 1 staff on shift from 10:00p.m.-6:00a.m. except on 01/06/2026 and 01/27/2026 when the shift is split from 10:00a.m.-2:00a.m. and 2:00a.m.-6:00a.m.

Ms. Summerville and Ms. TenBrink stated there is 1 staff on 1<sup>st</sup> shift, currently 1 staff on shift for 2<sup>nd</sup> shift, but they are going to schedule 2 staff for 2<sup>nd</sup> shift soon due to the increase in residents. Ms. TenBrink and Ms. Summerville confirmed that there is 1 staff member on 3<sup>rd</sup> shift. Ms. TenBrink stated she lives nearby and if staff need assistance, staff call her and she can be there quickly to assist. Ms. Summerville and Ms. TenBrink stated they have no knowledge of any staff grabbing a resident's arm. There are no reports of an incident that matches this allegation.

On 02/20/2026, Ms. Grew and I interviewed Resident F in her room at the facility. Resident F stated this facility is the "next best thing to home," that staff are great, her needs are met, staff are attentive and she uses the button to get staff to come into her room and they respond in an appropriate amount of time.

On 02/20/2026, Ms. Grew and I interviewed DCW Ms. Chaney at the facility. Ms. Chaney stated there is 1 staff member on every shift. Ms. Grew stated that if a resident falls, staff calls the manager and they come to assist and if they cannot assist, staff comes from the sister facility which always has 2 staff on shift. Ms. Chaney stated on a Sunday a month or so ago, she had two residents fall at the same time, she assisted one and then the other. Ms. Chaney stated she called next door to the sister facility and had someone come from that facility to assist her. Ms. Chaney stated she has never heard of or seen any staff grab a resident's arm in an aggressive or physically assaultive manner.

On 03/09/2026, I conducted an exit conference with Brian Nitz, Licensee Designee via telephone. Mr. Nitz stated they have been doing a lot of restructuring and retraining staff. Mr. Nitz stated he will examine the issues documented in the report and submit a corrective action plan.

<b>APPLICABLE RULE</b>	
<b>R 400.633</b>	<b>Staffing requirements.</b>
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.
<b>ANALYSIS:</b>	The complainant reported that the facility is understaffed with too many residents for one staff. The complainant reported that a DCW working at this facility needed help after two residents fell simultaneously and she could not handle it on her own, this DCW was the only staff on duty at this facility.  Upon review of facility documents, IR's, interviews with staff and residents, the facility appeared to be staffed to meet the minimum standards according to this rule. However, when there are incidents such as resident falls like the 2 falls that occurred on 01/11/2026, staff and residents reported that staff assistance is sought from another facility on the campus, which demonstrates there are not sufficient staff on duty to provide adequate protection to the residents and therefore, a violation of this applicable rule is established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDING**

**INVESTIGATION:** Ms. Grew and I reviewed the assessment plans for Residents A through M and none of the assessment plans were signed by the resident, the resident's designated representative (if applicable) or the licensee designee.

Ms. Summerville and Ms. TenBrink stated she was not aware that the assessment plans were not signed or that they needed to be signed and would have them reviewed and signed immediately.

On 03/09/2026, I conducted an exit conference with Brian Nitz, Licensee Designee via telephone. Mr. Nitz stated they have been retraining staff, that he will review this additional finding with facility management and submit a corrective action plan.

<b>APPLICABLE RULE</b>	
<b>R 400.685</b>	<b>Resident admission; resident assessment plan; resident care agreement; health care appraisal.</b>
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
<b>ANALYSIS:</b>	The assessment plans for Residents A through M were not signed by the resident, the resident's designated representative or the licensee designee. A violation of this applicable rule is established.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

#### IV. RECOMMENDATION

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



03/09/2026

Elizabeth Elliott  
Licensing Consultant

Date

Approved By:



03/10/2026

Jerry Hendrick  
Area Manager

Date