GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 14, 2026

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

RE: License #: AL200337124
Investigation #: 2026A0360035
Northern Pines Assisted Living

Dear Mr. Nitz:

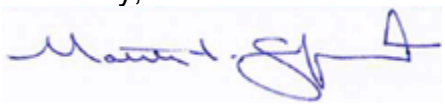
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 feel free to 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,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW Unit #13
Grand Rapids, MI 49503
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL200337124
Investigation #:	2026A0360035
Complaint Receipt Date:	05/08/2026
Investigation Initiation Date:	05/11/2026
Report Due Date:	07/07/2026
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 588-9131
Administrator:	Christina Jones
Licensee Designee:	Brian Nitz
Name of Facility:	Northern Pines Assisted Living
Facility Address:	130 Mary Ann Street Grayling, MI 49738
Facility Telephone #:	(989) 344-2010
Original Issuance Date:	06/25/2013
License Status:	REGULAR
Effective Date:	12/25/2025
Expiration Date:	12/24/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A went two weeks without prescribed medication and was hospitalized.	Yes

III. METHODOLOGY

05/08/2026	Special Investigation Intake 2026A0360035
05/11/2026	APS Referral
05/11/2026	Special Investigation Initiated - Letter
05/27/2026	Inspection Completed On-site DCSM Heaven St. Vincent
05/27/2026	Contact - Telephone call received Christina Jones Administrator
05/28/2026	Inspection Completed On-site Administrator Christina Jones, Resident Care Director Andrea Ashton
06/09/2026	Contact - Telephone call made Relative A
06/30/2026	Contact - Face to Face Resident A, Diane Wakeley Grayling Nursing Home Social Worker
07/14/2026	Exit Conference

ALLEGATION:

Resident A went two weeks without prescribed medication and was hospitalized.

INVESTIGATION:

On 5/27/26, I conducted an unannounced onsite inspection at the facility. The direct care staff member (DCSM) Heaven St. Vincent stated that Resident A was no longer at the facility, and the administrator Christina Jones was not at the facility today.

On 5/27/26, I received a call from Ms. Jones. Ms. Jones stated that Resident A was admitted to the facility at the beginning of March 2026. She stated that she only had the medication she was admitted with, and they were attempting to get Resident A's medication prescriptions filled when she ran out of several medications resulting in a hospitalization on 4/13/26. Ms. Jones stated she would be at the facility tomorrow to review any records.

On 5/28/26, I conducted another onsite inspection at the facility. The resident care director Andrea Ashton and administrator Christina Jones provided me with Resident A's resident care agreement, health care appraisal, medication administration records for March and April 2026 as well as email documentation between Ms. Ashton and Relative A regarding attempts to fill medication prescriptions. Ms. Ashton stated that Resident A was admitted to the facility on 3/6/26 from a facility in Florida. She stated that Relative A who assisted her getting admitted to the facility had very little information regarding a prescribing physician from Florida. Ms. Ashton stated that Resident A only had the medications she brought with her to the facility and was never able to get established with another provider before her medications started running out on 4/4/26. Ms. Ashton stated that almost all of Resident A's medications ran out on 4/5/26 and that on 4/13/26 Resident A started having blood pressure issues and became weak and unstable. Ms. Ashton stated that Resident A was sent to the hospital, which was her second hospitalization since being admitted. She stated she was also hospitalized on 3/28/26 for a GI bleed. Ms. Jones stated that the facility was switching from one pharmacy to another during this time frame and due to Resident A not being established with a new provider they were unable to fill Resident A's prescription medications. Ms. Ashton provided me with email communications between herself and Relative A dated 4/3/26 attempting to get contact information for the prescribing physician in Florida which Relative A was unable to provide. I reviewed the medication administration records (MAR) for Resident A for April 2026. The MAR documented that Resident A ran out of Colestid, Quetiapine and Donepezil on 4/3/26, Acetaminophen on 4/4/26, Fenofibrate, Ferrous Sulf, Liothyronine, Metoprolol, Pantoprazole, Paroxetine and Prednisone on 4/5/26. She then ran out of Levothyroxine on 4/10/26. According to the incident report dated 4/13/26 Resident A was hospitalized on 4/13/26 for blood pressure issues, weakness and being dizzy. Ms. Jones stated that Resident A did not return to the facility after her hospitalization.

On 6/9/26, I contacted Relative A. Relative A stated that she has Durable Power of Attorney for Resident A. She stated that she moved Resident A to Northern Pines to be closer to her family from a facility in Florida. Relative A stated that Resident A was admitted to the facility with approximately six weeks of medications. She stated that the facility stated they were in between pharmacies which was causing delays in getting Resident A's prescriptions refilled but that she didn't find out that Resident A had run out of her medications until Resident A was hospitalized on 4/13/26. Relative A stated that the hospital staff informed her that if Resident A was getting low on her medications the facility could have notified them during Resident A's hospitalization on 3/28/26 and they could have assisted in getting the medications

filled. Relative A stated that Resident A was discharged from the hospital and is now at the Grayling Nursing Home.

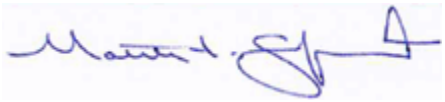
On 6/30/26, I attempted an interview with Resident A at the Grayling Nursing Home. Resident A was not oriented to time, person, or place and was unable to answer any questions. The nursing home social worker Diane Wakeley stated that Resident A has improved some since being admitted to the facility but due to her dementia diagnosis is unable to be interviewed.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Interviews with Ms. Jones, Ms. Ashton, Relative A, and Ms. Wakeley revealed that Resident A was not administered numerous prescribed medications between 4/3/26 and 4/13/26 at which time she was hospitalized due to medical issues.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/14/26 I conducted an exit conference with the administrator Christina Jones. Ms. Jones stated she would submit a corrective action plan for approval.

IV. RECOMMENDATION

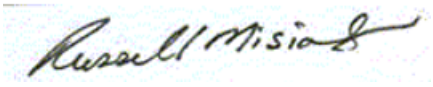
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



7/9/26

Matthew Soderquist Date
Licensing Consultant

Approved By:



7/13/26

Russell B. Misiak Date
Area Manager