



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

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

September 25, 2025

RE: License #: AL260418027  
Investigation #: 2025A1038049  
The Horizon Senior Living V

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Johnnie Daniels, Licensing Consultant  
Bureau of Community and Health Systems  
350 Ottawa Ave NW  
Grand Rapids MI 49503

enclosure

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

**I. IDENTIFYING INFORMATION**

|                                       |   |
|---------------------------------------|---|
| <b>License #:</b>                     | AL260418027   |
| <b>Investigation #:</b>               | 2025A1038049  |
| <b>Complaint Receipt Date:</b>        | 09/11/2025  |
| <b>Investigation Initiation Date:</b> | 09/12/2025  |
| <b>Report Due Date:</b>               | 11/10/2025  |
| <b>Licensee Name:</b>                 | Baruch SLS, Inc.  |
| <b>Licensee Address:</b>              | Suite 203<br>3196 Kraft Avenue SE<br>Grand Rapids, MI 49512 |
| <b>Licensee Telephone #:</b>          | (616) 285-0573  |
| <b>Licensee Designee:</b>             | Connie Clauson  |
| <b>Name of Facility:</b>              | The Horizon Senior Living V                                 |
| <b>Facility Address:</b>              | 450 Quarter Street<br>Gladwin, MI 48624                     |
| <b>Facility Telephone #:</b>          | (989) 246-1000  |
| <b>Original Issuance Date:</b>        | 03/13/2025  |
| <b>License Status:</b>                | REGULAR   |
| <b>Effective Date:</b>                | 09/12/2025  |
| <b>Expiration Date:</b>               | 09/11/2027  |
| <b>Capacity:</b>                      | 20  |
| <b>Program Type:</b>                  | AGED<br>ALZHEIMERS  |

## II. ALLEGATION(S)

|  | <b>Violation<br/>Established?</b> |
|--|-----------------------------------|
| Resident A was shoved/moved out of the way by staff. | Yes                               |

## III. METHODOLOGY

|            |  |
|------------|--|
| 09/11/2025 | Special Investigation Intake<br>2025A1038049   |
| 09/12/2025 | APS Referral<br>APS worker Ryan Christensen is currently investigating the facility.   |
| 09/12/2025 | Special Investigation Initiated - Telephone<br>call made to complainant.   |
| 09/18/2025 | Inspection Completed On-site   |
| 09/18/2025 | Contact - Face to Face<br>interview was conducted with Resident A.   |
| 09/18/2025 | Contact - Face to Face<br>interviews were conducted with resident care manager Amanda<br>Jeska and business admin Tiffany Fitzpatrick. |
| 09/18/2025 | Contact - Document Received<br>from Ms. Jeska.   |
| 09/19/2025 | Contact - Telephone call made<br>to Guardian A1  |
| 09/22/2025 | Contact - Document Received<br>from Guardian A1.   |
| 09/22/2025 | Inspection Completed-BCAL Sub. Compliance  |
| 09/25/2025 | Exit Conference  |

## **ALLEGATION:**

**Resident A was shoved/moved out of the way by staff.**

## **INVESTIGATION:**

On 9/12/25, I conducted an interview with the complainant who verified the information.

On 9/12/25, I conducted an interview via telephone with APS worker Ryan Christensen. APS worker Mr. Christensen verified he has an active investigation on the facility.

On 9/18/25, I conducted an unannounced investigation at the facility. I conducted an interview with resident care manager Amanda Jeska. Ms. Jeska stated the facility was aware of the incident regarding Resident A and direct care staff (DCS) Jenissa Hobbs. Ms. Jeska stated the facility conducted their own investigation into the incident which occurred on 8/12/25. Ms. Jeska stated DCS Hobbs denied any wrongdoing. Ms. Jeska stated DCS Hobbs stated she did not push, shove or move Resident A out of the way with any type of force. Ms. Jeska stated DCS Hobbs stated she did not yell or raise her voice at Resident A. Ms. Jeska stated she spoke with DCS Deavin Orbis, who also wrote a written statement. Ms. Jeska stated DCS Orbis stated they witnessed DCS Hobbs move Resident A out of the way and told her to move now. Ms. Jeska stated DCS Tiffany Groh provided a statement similar to DCS Orbis. Ms. Jeska stated DCS Hobbs was written up but refused to sign the disciplinary documentation as she said the allegations are false. Ms. Jeska stated staff have to repeat things to Resident A and sometimes speak louder as she sometimes has difficulty hearing and understanding staff. Ms. Jeska stated DCS Hobbs and DCS Groh no longer work at the facility.

On 9/18/25, I conducted an interview with business manager Tiffany Fitzpatrick. Ms. Fitzpatrick provided a statement consistent with Ms. Jeska.

On 9/18/25, I reviewed the incident report, DCS Orbis written statement along with the written disciplinary record on DCS Hobbs. The documents were consistent with the statements made by Ms. Jeska and Ms. Fitzpatrick.

On 9/18/25, I conducted an interview with Resident A. I was able to interview Resident A who struggled to understand what I was saying. While speaking with Resident A, I had to speak in a louder tone for Resident A to hear what I was saying.

On 9/22/25, I conducted an interview with Guardian A1 via telephone. Guardian A1 stated they were informed about the incident. Guardian A1 stated he believes Resident A1 was shoved out of the way due to everything communicated to him by the facility. Guardian A1 stated this was the first time something like this has ever happened.

| <b>APPLICABLE RULE</b> |  |
|------------------------|--|
| <b>R 400.15305</b>     | <b>Resident protection.</b>  |
|                        | <b>(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.</b>              |
| <b>ANALYSIS:</b>       | Based upon my interviews with staff, guardian A1 and the review of documents. There was corroborating evidence of staff not protecting Resident A. Resident A was moved/shoved out of the way by a staff member. |
| <b>CONCLUSION:</b>     | <b>VIOLATION ESTABLISHED</b>   |

#### **IV. RECOMMENDATION**

Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended.



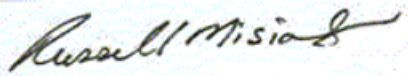
9/23/25

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Johnnie Daniels  
Licensing Consultant

Date

Approved By:



9/24/25

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Russell B. Misiak  
Area Manager

Date