GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 2, 2026

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

RE: License #: AL410289605
Investigation #: 2026A0583028
Yorkshire Manor - West

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. 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 #:	AL410289605
Investigation #:	2026A0583028
Complaint Receipt Date:	03/24/2026
Investigation Initiation Date:	03/25/2026
Report Due Date:	04/23/2026
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 588-9131
Administrator:	Jennifer Marckini
Licensee Designee:	Brian Nitz
Name of Facility:	Yorkshire Manor - West
Facility Address:	3511 Leonard St. NW Walker, MI 49534
Facility Telephone #:	(616) 791-9090
Original Issuance Date:	10/31/2012
License Status:	REGULAR
Effective Date:	04/23/2024
Expiration Date:	04/22/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Staff failed to provide adequate resident care.	No
Additional Findings	Yes

III. METHODOLOGY

03/24/2026	Special Investigation Intake 2026A0583028
03/25/2026	Special Investigation Initiated - Telephone Relative 1
03/26/2026	Inspection Completed On-site
03/27/2026	APS Referral
04/02/2026	Exit Conference Licensee designee Brian Nitz

ALLEGATION: Staff failed to provide adequate resident care.

INVESTIGATION: On 03/24/2026 the above complaint allegation was received via the LARA-BCHS-Complaints. The complaint stated that Resident A "had a fall, tripped over a cord early morning" and "she was left unattended for a moment resulting in a broken femur and resident passing at the hospital".

On 03/25/206 I interviewed Relative 1 via telephone. She stated that Resident A was 91 years old and her own legal decision maker. She stated that on 03/21/2026 between 6:30 AM and 6:50 AM, she received a telephone call from staff Emyanii Dixon who reported that Resident A had fallen in her private bedroom at the facility. Relative 1 stated that Ms. Dixon said Resident A rang her call light for toileting assistance. Relative 1 stated that Ms. Dixon said she (Ms. Dixon) placed Resident A's commode next to her bed and then Ms. Dixon left the room. Relative 1 stated that she did not ask Ms. Dixon how long she was gone. Relative 1 stated that sometime later Ms. Dixon said she found Resident A on the floor complaining of pain and Ms. Dixon reported that Resident A must have fallen while attempting to transfer herself to or from the bed to the commode. Relative 1 stated that Ms. Dixon said had contacted "911" to request their assistance with getting Resident A off the floor and into her bed. Relative 1 stated that she questioned if Resident A needed to go the hospital and Ms. Dixon told her Resident A was in pain, but she did not appear to have suffered any fractures. Immediately after the telephone call with Ms. Dixon, Relative 1 stated that she drove to the facility. Relative 1 stated that while enroute to the facility at 6:50 AM, Ms. Dixon called Relative 1 and said that Resident A "was

giving the ambulance staff a hard time getting into back into her bed". Relative 1 stated that she entered the facility at approximately 7:00 AM and observed that emergency medical staff were using a bed sheet to transfer Resident A from the floor to her bed which caused Resident A increased pain. Relative 1 stated that Resident A was saying she was in pain and had sustained a fracture. Relative 1 stated that Ms. Dixon maintained that Resident A had not fractured anything however Resident A stated that she needed to be transferred to a local emergency department. Relative 1 stated that shortly after 7:00 AM, Resident A was transferred via EMS to a local emergency department and diagnosed with a left hip and femur fracture. Relative 1 stated that Resident A was admitted to the hospital on 03/21/2026 and died on 03/22/2026 due to complications of the fall. Relative 1 stated that staff were required to assist Resident A while transferring to and from the commode and were required to supervise her while on the device.

On 03/26/2026 I completed an unannounced onsite investigation at the facility and privately interviewed administrator Jennifer Marckini and staff Emyanii Dixon.

Ms. Marckini stated that she did not work at the facility on 03/21/2026 but did review the Incident Reports drafted by Ms. Dixon. She confirmed that Resident A was transferred to the hospital on 03/21/2026 and died shortly after.

Ms. Dixon stated that she worked independently at the facility from 03/20/2026 11:00 PM until 03/21/2026 7:00 AM. She stated that shortly before 7:00 AM, Resident A used her "call light" and requested assistance with toileting. Ms. Dixon stated that she placed Resident A's commode next to her bed, removed Resident A's wet brief, and assisted her onto the commode. She stated that she stayed in the bedroom with Resident A the entire time she was on the commode. She stated that after Resident A was finished on the commode, Ms. Dixon dressed Resident A in a clean brief and assisted her back into her bed. Ms. Dixon stated that after Resident A was in bed, Ms. Dixon removed the commode and emptied it inside Resident A's attached bathroom. Ms. Dixon stated that while she was in the attached bathroom, she heard Resident A fall onto the floor. Ms. Dixon stated that she observed Resident A on the floor complaining of pain. Ms. Dixon stated she immediately left the facility and requested assistance from staff Adrienne Langlois who was working at Stonebridge Manor - South AL410289604, which is another licensed program on the campus. Ms. Dixon stated that she and Ms. Langlois attempted to pick Resident A off the floor by placing their arms under Resident A's shoulders, but they could not move her. She stated that she telephoned 911, hospice staff, and Relative 1 and "911" arrived within ten minutes. Ms. Dixon stated that "EMS" staff were able to transfer Resident A from the floor to the bed, but Resident A continued to complain of pain and was transferred via EMS to the hospital by 7:45 AM. Ms. Dixon stated that she never left Resident A unsupervised on the commode and EMS arrived within 15 minutes of Resident A's fall.

On 03/26/2026 I interviewed staff JyAir Harris via telephone. Mr. Harris stated that he worked at the facility on 03/21/2026 from 7:00 AM until 3:00 PM. He stated that

he was not present during Resident A's fall but afterwards briefly spoke with Ms. Dixon regarding the incident. He stated that Ms. Dixon said she had assisted Resident A onto the commode, transferred her back into bed, and then left the bedroom to empty the commode in the adjoining bathroom when Resident A fell onto the floor.

On 03/27/2027 I completed an Adult Protective Services complaint via the online portal.

On 03/30/2026 I interviewed Ms. Langlois via telephone. She stated that on 03/21/2026, she worked at Stonebridge Manor - South which is located on the same campus as the facility. She stated that at approximately 6:45 AM, Ms. Dixon left the facility and requested Ms. Langlois's assistance to lift Resident A off the floor because Resident A had fallen. Ms. Langlois stated that Ms. Dixon said Resident A fell while trying to "get into bed" while Ms. Dixon was emptying the commode in the attached bathroom. Ms. Langlois stated that she immediately left Stonebridge Manor – South to assist Ms. Dixon. Ms. Langlois stated that when she arrived at the facility, she observed Resident A on her bedroom floor "on her back". She stated that Resident A said, "don't get me up" and complained of pain. She stated that she and Ms. Dixon unsuccessfully attempted to pick Resident A up off the floor by using their arms under Resident A's shoulders. She stated that Ms. Dixon reported that she would contact 911 and Resident A's family and Ms. Langlois then exited the facility.

On 03/30/2026 I received an email from Ms. Marckini which included Resident A's Assessment Plan signed 04/10/2025, Incident Report signed 03/21/2026 6:53 AM, and Incident Report signed 03/21/2026 7:31 AM. Resident A's Assessment Plan stated that she required toileting assistance which included "1 assist as needed, may do it on her own when able." The document stated that Resident A required "1 assist" for bathing, grooming, dressing, and personal hygiene. The document stated that Resident A required "1 person" assistance with walking/mobility/transfers. The 3/21/2026 6:53 AM Incident Report was completed by Ms. Dixon and stated that Resident A sustained an unwitnessed fall and "resident fell when trying to get in her bed". The 3/21/2026 7:31 AM Incident Report was completed by Ms. Dixon and stated that Resident A sustained an unwitnessed fall and "resident fell on the ground, I called EMS to get her off the ground and her guardian sent her to the hospital".

On 04/02/2026 I completed an exit conference via telephone with licensee designee Brian Nitz. He stated that he did not dispute the finding.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan.

	A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Resident A's Assessment Plan states that Resident A required toileting assistance which included "1 assist as needed, may do it on her own when able." The document stated that Resident A required "1 person" assistance with walking/mobility/transfers. Staff Emyanii Dixon stated that on 03/21/206 shortly before 7:00 AM, Ms. Dixon placed Resident A's commode next to her bed, removed Resident A's wet brief, and assisted her onto the commode. She stated that she stayed in the bedroom with Resident A and allowed Resident A to use the commode before dressing Resident A in a clean brief and transferring her back into bed. Ms. Dixon stated that after Resident A was in her bed, Ms. Dixon removed the commode and emptied it inside Resident A's attached bathroom. Ms. Dixon stated that while she was in the attached bathroom, she heard Resident A fall onto the floor. Ms. Dixon stated she unsuccessfully attempted to lift Resident A off the floor, contacted EMS services, and Resident A was transported to the hospital by 7:45 AM. Staff Adrienne Langlois stated she did not observe the fall. She stated that Ms. Dixon said Resident A fell while trying to "get into bed" while Ms. Dixon was emptying the commode in the attached bathroom. The 3/21/2026 6:53 AM Incident Report completed by Ms. Dixon stated that Resident A sustained an unwitnessed fall and "resident fell when trying to get in her bed". No witnesses observed Resident A fall. A preponderance of evidence was not discovered during the special investigation to substantiate a violation of the applicable rule. Resident A's assessment plan stated that she required "1 assist as needed, may do it on her own when able." Ms. Dixon stated that she followed Resident A's assessment plan by providing toileting and transfer assistance. Ms. Dixon denied that she left Resident A unsupervised during Resident A's toileting and entered the adjoining bathroom after Resident A was in bed. Ms. Dixon stated Resident A received timely medical care and was transported via EMS to the local hospital within 45 minutes of the fall.

CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING: The facility is insufficiently staffed.

INVESTIGATION: While onsite on 03/27/2026 I interviewed Ms. Marckini and Ms. Dixon.

Ms. Marckini stated that Ms. Dixon worked independently from 03/20/2026 11:00 PM until 03/21/2026 7:00 AM and sixteen residents were present. She stated that she has informed staff not to leave the facility they are assigned to work in to assist staff at other facilities because it has been a repeated issue that administration is addressing.

Ms. Dixon stated that she worked at the facility independently from 03/20/2026 11:00 PM until 03/21/2026 7:00 AM. Ms. Dixon stated that on 03/21/2026 at approximately 6:30 AM, she left the facility to assist staff Adrienne Langlois at Stonebridge Manor - South AL410289604. She stated that she was away from the facility for approximately ten minutes and no staff were present at the facility while she was away. She stated that on that same day at approximately 7:00 AM, she left the facility, walked to Stonebridge Manor - South and requested Ms. Langlois' assistance. Ms. Dixon stated that she was away from the facility for less than five minutes. Ms. Dixon stated that it is common practice for staff to leave their assigned facility to assist in other facilities that are "short-staffed", even if it means leaving residents in building with no staff present.

On 03/30/2026 I interviewed Ms. Langlois via telephone. She confirmed that on 03/21/2026 Ms. Dixon left the facility to assist Ms. Langlois at Stonebridge Manor - South AL410289604 at approximately 6:30 AM and Ms. Dixon left the facility at 7:00 AM to request Ms. Langlois' assistance at the facility.

On 04/02/2026 I completed an exit conference via telephone with licensee designee Brian Nitz. He stated that he did not dispute the finding and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(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.
ANALYSIS:	Staff Emaynii Dixon and staff Adrienne Langlois stated that on 03/21/2026, Ms. Dixon left residents alone at the facility at approximately 6:30 AM and 7:00 AM. A preponderance of evidence was discovered during the special investigation to substantiate a violation of the applicable rule. On 03/21/2026 at approximately 6:30 AM and 7:00 AM, Ms. Dixon left facility residents alone without staff present.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: Resident A and Resident B's assessment plans are incomplete.

INVESTIGATION: On 03/30/2026 I received an email from Ms. Marckini which included Resident B and Resident C's assessment plans. Resident B's assessment plan was completed on 05/15/2025 but lacks the required signature of the licensee designee. Resident C's assessment plan was completed on 04/10/2025 but lacks the required signature of the licensee designee.

On 03/30/2026 I received an email from Ms. Marckini which stated, "my signature was missed on (Resident B). I signed it with todays date". The email further stated, "my signature was missed on (Resident C). I signed it with todays date".

On 04/02/2026 I completed an exit conference via telephone with licensee designee Brian Nitz. He stated that he did not dispute the finding and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(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.

ANALYSIS:	Resident B's assessment plan was completed on 05/15/2025 but lacks the required signature of the licensee designee. Resident C's assessment plan was completed on 04/10/2025 but lacks the required signature of the licensee designee. A preponderance of evidence was discovered to substantiate a violation of the applicable rule. Resident B and Resident C's assessment plans lack the required signature of the licensee designee.
CONCLUSION:	**VIOLATION ESTABLISHED**

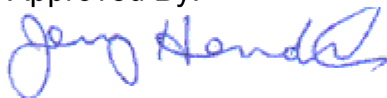
IV. RECOMMENDATION

Upon approval of an acceptable Correction Action Plan, I recommend no change to the license.

04/02/2026

Toya Zylstra Date
Licensing Consultant

Approved By:



04/02/2026

Jerry Hendrick Date
Area Manager