



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 27, 2026

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

RE: License #: AL410289605
Investigation #: 2026A0583031
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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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) 356-0183.

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**

I. IDENTIFYING INFORMATION

License #:	AL410289605
Investigation #:	2026A0583031
Complaint Receipt Date:	04/01/2026
Investigation Initiation Date:	04/01/2026
Report Due Date:	05/01/2026
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, Designee
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?
Resident A did not receive her medications as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/01/2026	Special Investigation Intake 2026A0583031
04/01/2026	Special Investigation Initiated - Letter Administrator Jennifer Marckini
04/13/2026	Inspection Completed On-site
04/14/2026	APS Referral
04/27/2026	Exit Conference Licensee Designee Brian Nitz

ALLEGATION: Resident A did not receive her medications as prescribed.

INVESTIGATION: On 04/01/2026 I received complaint that alleged while Resident A was residing at the facility she did not receive her prescribed thyroid medication, Levothyroxine, multiple months during the past year. The complaint also noted that Resident A passed away on 03/2026.

On 04/09/2026 I received Resident A's Medication Administration Records (MAR) via email from administrator Jennifer Marckini. I observed that Resident A was prescribed Levothyroxine 100 MG once daily. I observed that according to Resident A's MAR, she did not receive this medication because the facility ran out of the medication on 12/24/2025, 12/27/2025, 12/28/2025, 12/30/2025, 12/31/2025, 01/01/2026, 01/05/2026, 01/06/2026, 01/08/2026, 01/12/2026, 02/10/2026, 02/16/2026, 02/17/2026. I observed that Resident A was prescribed Gabapentin 300 MG twice daily but on the following days Resident A did not receive the medication because the facility ran out of the medication: 10/24/2025, 01/29/2026, 01/31/2026, and 02/01/2026.

On 04/13/2026 I completed an unannounced onsite investigation at the facility and interviewed Ms. Marckini. She confirmed that Resident A died around March 2026. She confirmed that Resident A's Levothyroxine ran out on approximately 12/24/2025 and a refill was obtained on 01/13/2026. Ms. Marckini confirmed that on numerous occasions staff did not administer Resident A's Gabapentin because the facility had run out of the medication.

On 04/14/2026 I received an email from Ms. Marckini which indicated that on 12/24/2025, 12/27/2025, 12/28/2025, 01/05/2026, 01/08/2026, 01/12/2026 staff Olivia Gonzalez documented that she did not administer Resident A's Levothyroxine because the medication was not in the cart. Ms. Marckini's email noted that Ms. Gonzalez no longer works at the facility.

On 04/14/2026 I completed an Adult Protective Services Complaint via the online portal.

On 04/15/2026 I completed a LARA file review and observed the facility was found in violation of the applicable rule on 06/17/2025 Special Investigation 2025A0583041 due to Resident A not receiving her prescribed medication. A Corrective Action Plan was received and approved on 07/09/2025.

On 04/16/2026 I interviewed staff Jy'Aire Harris via telephone. He stated that on 10/24/2025 he could not locate Resident A's Gabapentin and therefore did not administer it.

On 04/16/2026 I interviewed staff Eva Rodas via telephone. She confirmed that on 12/31/2026 she did not administer Resident A's Levothyroxine because the facility was out of the medication. Ms. Rodas stated that on 01/29/2026 and 01/31/2026 she did not administer Resident A's Gabapentin because the facility was out of the medication.

On 04/17/2026 I interviewed staff Desariah Trevino via telephone. She stated that on 02/01/2026 she did not administer Resident A's Gabapentin because the facility was out of the medication.

On 04/17/2026 I interviewed staff Deasia Kelly via telephone. She stated that on 02/02/2026 she did not administer Resident A's Gabapentin because the facility was out of the medication.

On 04/17/2026 I interviewed staff Jasmine Gonzalez via telephone. She stated that on 02/16/2026 she did not administer Resident A's Levothyroxine because the facility was out of the medication.

On 04/17/2026 I interviewed staff Emyanii Dixon via telephone. She stated that she could not recall if she administered Resident A's Levothyroxine on 02/17/2026. She stated that she does not dispute that on 02/17/2026 she documented in Resident A's MAR that she didn't administer the medication because the facility was out.

On 04/17/2026 I interviewed staff Samantha Downing via telephone. She stated that on 12/30/2025, 01/01/2026, and 01/06/2026 she did not administer Resident A's Levothyroxine because the facility was out of the medication. She stated that on

01/29/2026, 01/31/2026, and 02/01/2026 she did not administer Resident A's Gabapentin because the facility was out of the medication.
 On 04/17/2026 I interviewed staff Zarreya Rogers via telephone. She stated that on 02/10/2026 she did not administer Resident A's Levothyroxine because the facility was out of the medication.

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:	<p>According to Resident A's MAR, Resident A did not receive her prescribed Levothyroxine because the facility ran out of the medication on 12/24/2025, 12/27/2025, 12/28/2025, 12/30/2025, 12/31/2025, 01/01/2026, 01/05/2026, 01/06/2026, 01/08/2026, 01/12/2026, 02/10/2026, 02/16/2026, 02/17/2026.</p> <p>According to Resident A's MAR, Resident A did not receive her prescribed Gabapentin because the facility ran out of the medication on 10/24/2025, 01/29/2026, 01/31/2026, and 02/01/2026.</p> <p>Administrator Jennifer Marckini reported that on 12/24/2025, 12/27/2025, 12/28/2025, 01/05/2026, 01/08/2026, 01/12/2026 staff Olivia Gonzalez documented that she did not administer Resident A's Levothyroxine because the medication was not in the cart.</p> <p>Staff Emyanii Dixon stated that on 02/17/2026 she documented on Resident A's MAR that she didn't administer Resident A's Levothyroxine because the facility was out of the medication.</p> <p>Staff Jasmine Gonzalez stated she did not administer Resident A's Levothyroxine on 02/16/2026 because the facility was out of the medication.</p> <p>Staff Samantha Downing stated that on 12/30/2025, 01/01/2026, and 01/06/2026 she did not administer Resident A's Levothyroxine because the facility was out of the medication. Ms. Downing stated that on 01/29/2026, 01/31/2026, and 02/01/2026 she did not administer Resident A's Gabapentin because the facility was out of the medication.</p>

	<p>Staff Eva Rodas stated that on 12/31/2026 she did not administer Resident A's Levothyroxine because the facility was out of the medication. Ms. Rodas stated that on 01/29/2026 and 01/31/2026 she did not administer Resident A's Gabapentin because the facility was out of the medication.</p> <p>Staff Zarreya Rogers stated that on 02/10/2026 she did not administer Resident A's Levothyroxine because the facility was out of the medication.</p> <p>Staff Jy'Aire Harris stated that on 10/24/2025 he could not locate Resident A's Gabapentin and therefore did not administer it.</p> <p>Staff Desariah Trevino stated that on 02/01/2026 she did not administer Resident A's Gabapentin because the facility was out of the medication.</p> <p>Staff Deasia Kelly stated that on 02/02/2026 she did not administer Resident A's Gabapentin because the facility was out of the medication.</p> <p>Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has been established that on multiple dates, facility staff did not administer Resident A's medication as prescribed.</p>
CONCLUSION:	REPEAT VIOLATION ESTABLISHED SI 2025A0583041 06/17/2025

ADDITIONAL FINDINGS: Facility staff did not contact an appropriate medical provider.

INVESTIGATION: I observed that Resident A was prescribed Levothyroxine 100 MG daily. I observed that on the following days Resident A did not receive her prescribed Levothyroxine: 12/07/2025, 12/24/2025, 12/27/2025, 12/28/2025, 12/30/2025, 12/31/2025, 01/01/2026, 01/05/2026, 01/06/2026, 01/08/2026, 01/12/2026, 02/10/2026, 02/16/2026, 02/17/2026. I observed that Resident A was prescribed Gabapentin 300 MG twice daily. I observed that on the following days Resident A did not receive her prescribed Gabapentin: 10/24/2025, 01/29/2026, 01/31/2026, and 02/01/2026.

While onsite on 04/13/2026 Ms. Marckini confirmed that on numerous occasions staff did not administer Resident A's Levothyroxine and Gabapentin because the

facility had run out of the medications. She acknowledged that the facility records do not indicate that medical professionals were contacted to document each time Resident A was not provided with her medications.

On 04/14/2026 Ms. Marckini indicated via email that on 12/24/2025, 12/27/2025, and 12/28/2025 staff Olivia Gonzalez documented that she did not administer Resident A's Levothyroxine because the medication was not in the cart.

On 04/14/2026 Ms. Marckini stated via email, "I do not have the forms that staff contacted medical professional".

On 04/15/2026 I completed a LARA file review and observed that the facility was found in violation of the applicable rule on 06/17/2025 Special Investigation 2025A0583041 after Resident A did not receive her prescribed medication and staff failed to contact an appropriate medical provider. A Corrective Action Plan was received and approved on 07/09/2025.

On 04/16/2026 Mr. Harris stated via telephone that he did not contact a medical provider to report that on 10/24/2025 he did not administer Resident A's Gabapentin.

On 04/17/2026 Ms. Trevino stated via telephone that on 02/01/2026 she did not administer Resident A's Gabapentin because the facility was out of the medication and she did not contact the resident's licensed health care professional or the licensed health care professional who prescribed the medication.

On 04/17/2026 Ms. Kelly stated via telephone that on 02/02/2026 she did not administer Resident A's Gabapentin because the facility was out of the medication. She stated that the facility did not train staff to contact a medical provider regarding residents not receiving their medications, therefore she did not contact a medical provider regarding the missed administration.

On 04/17/2026 Ms. Gonzalez stated via telephone that on 02/16/2026 she did not administer Resident A's Levothyroxine because the facility was out of the medication and she did not contact a medical provider to report the missed administration.

On 04/17/2026 Ms. Dixon stated that she was never trained to contact a resident's medical provider after a resident missed a dose of medication and therefore, she did not contact a physician regarding Resident A's 02/17/2026 missed Levothyroxine administration.

On 04/17/2026 Ms. Downing stated via telephone that on 12/30/2026, 1/1/2026, and 01/06/2026 she did not administer Resident A's Levothyroxine because the facility was out of the medication. She stated that on 01/29/2026, 01/31/2026, and 02/01/2026 she did not administer Resident A's Gabapentin because the facility was out of the medication. She stated that she did not contact a medical provider regarding any of the missed medication administrations.

On 04/17/2026 Ms. Rogers stated via telephone that on 02/10/2026 she did not administer Resident A's Levothyroxine because the facility was out of the medication and she did not contact a physician regarding Resident A's 02/10/2026 missed administration.

APPLICABLE RULE	
R 400.675	Resident medications.
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (f) Contact the resident's licensed health care professional or the appropriately licensed health care professional who prescribed the medication when a medication error occurs.
ANALYSIS:	<p>Resident A did not receive her prescribed Levothyroxine on 12/07/2025, 12/24/2025, 12/27/2025, 12/28/2025, 12/30/2025, 12/31/2025, 01/01/2026, 01/05/2026, 01/06/2026, 01/08/2026, 01/12/2026, 02/10/2026, 02/16/2026, 02/17/2026. In addition, Resident A did not receive her prescribed Gabapentin on 10/24/2025, 01/29/2026, 01/31/2026, and 02/01/2026.</p> <p>Ms. Marckini confirmed that on numerous occasions staff did not administer Resident A's Levothyroxine and Gabapentin because the facility had run out of the medications. She acknowledged that the facility records do not indicate that medical professionals were contacted to document each time Resident A was not provided with her medications.</p> <p>Based upon my investigation, which consisted of multiple interviews and a review of pertinent documentation relevant to this investigation, it has been established that facility staff failed to contact an appropriate health care professional after Resident A did not receive her prescribed Levothyroxine and Gabapentin.</p>
CONCLUSION:	REPEAT VIOLATION ESTABLISHED SI 2025A0583041 06/17/2025

On 04/27/2026 I provided licensee designee Brian Nitz with an exit conference via telephone. I explained my findings as noted above. Mr. Nitz stated that he understood my findings and did not dispute the violations. He stated that he would not accept the issuance of a Provisional License because he has recently transitioned into the new position of licensee designee and has been diligently working to provide staff with additional training and support services. He stated that his organization continues to implement new policies into place to address

medication compliance. He stated that although he would not accept the issuance of a Provisional license, he would submit an acceptable Corrective Action Plan.

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license be modified to Provisional status.



04/27/2026

Toya Zylstra
Licensing Consultant

Date

Approved By:



04/27/2026

Jerry Hendrick
Area Manager

Date