



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 15, 2026

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

RE: License #:	AL250381018
Investigation #:	2026A1039027
	Living Joy AL

Dear Brian 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 (517) 643-7960.

Sincerely,



Martin Gonzales, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250381018
Investigation #:	2026A1039027
Complaint Receipt Date:	03/27/2026
Investigation Initiation Date:	03/27/2026
Report Due Date:	05/26/2026
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 588-9131
Administrator:	Erica Phipps
Licensee Designee:	Brian Nitz
Name of Facility:	Living Joy AL
Facility Address:	1525 Pierson Road Flushing, MI 48433
Facility Telephone #:	(810) 659-8507
Original Issuance Date:	05/19/2016
License Status:	REGULAR
Effective Date:	11/19/2024
Expiration Date:	11/18/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS

II. ALLEGATION(S)

Deion Keller

**Violation
Established?**

On 03/27/2026, Staff Deion Keller was rough with Resident A. Staff Keller was throwing Resident A around in his bed and chair and being disrespectful to him.	Yes
---	-----

III. METHODOLOGY

03/27/2026	Special Investigation Intake 2026A1039027
03/27/2026	Special Investigation Initiated - Letter Emailed APS worker Grant in regard to complaint.
03/27/2026	APS Referral APS forwarded complaint to BCHS.
04/06/2026	Inspection Completed On-site Interviewed Office Manager, Resident B, Resident C, DCW Black and DCW Coleman.
05/04/2026	Contact - Telephone call made Phone interview with Guardian A1.
05/04/2026	Contact - Document Received Received requested documents regarding Resident A from Administrator Erica Phipps.
05/04/2026	Contact - Document Received Guardian A1 sent video of Resident A while at Living Joy.
05/07/2026	Contact - Document Received DHS APS Worker Michael Grant informed me that he did not substantiate complaint.
05/11/2026	Exit Conference Completed with Licensee Designee Brian Nitz.
05/11/2026	Inspection Completed-BCAL Sub. Compliance
05/11/2026	Contact – Telephone Call Made Phone call with Office Manager Stacy Bohn.

05/12/2026	Contact – Telephone Call Made Phone call with Administrator Erica Phipps.
05/12/2026	Contact – Telephone Call Made Attempted phone call with Deion Keller. No answer left message.
05/13/2026	Contact – Telephone Call Made Attempted phone call with Deion Keller. No answer left message.
05/13/2026	Contact – Telephone Call Made Attempted phone call with Lovely Cook. No answer left message
05/14/2026	Contact – Telephone Call Made Attempted phone call with Lovely Cook. No answer left message
05/14/2026	Contact – Face to Face Unannounced follow up with Administrator Erica Phipps.

ALLEGATION:

On 03/27/2026, Staff Deion Keller was rough with Resident A. Staff Keller was throwing Resident A around in his bed and chair and being disrespectful to him.

INVESTIGATION:

On 03/27/2026, the Bureau of Community and Health Systems (BCSH) received the above allegation, via the BCHS online complaint system. It is alleged that on 03/27/2026, Staff were being rough with Resident A. Staff were throwing Resident A around in his bed and chair and being disrespectful to him.

On 04/06/2026, Department of Health and Human Services Adult Protective Services (APS) Worker Michael Grant informed me that he was investigating the complaint. APS Grant stated that he had completed an onsite investigation and would update me after he concluded his investigation.

On 04/06/2026, I completed an unannounced onsite investigation at Living Joy. I interviewed the following people: Office Manager Stacy Bohn, Direct Care Worker Rachel Black, Direct Care Worker Nina Coleman, Resident B and Resident C.

On 04/06/2026, I completed an interview with Office Manager (OM) Stacy Bohn concerning the allegations. OM Bohn stated that she was aware of the allegations but that she does not know anything about the incident as she was off work for the previous three weeks. OM Bohn stated that Resident A was moved out of the home by the guardian on 03/30/2026 with no notice. OM Bohn stated that Resident A's guardian put

a video camera in the room but she is not sure what was on the video as the guardian did not show them. OM Bohn stated that Resident A was a high behavioral resident who would fight staff when they tried to assist him in any way. OM Bohn stated that Resident A would go into other residents' rooms without permission and get upset when staff redirected him to leave the rooms. OM Bohn stated that she is not involved in the direct care of the staff and that I should speak with direct care staff for further details on the incident and Resident A.

On 04/06/2026, I completed an interview with Direct Care Worker (DCW) Rachel Black concerning the allegations. DCW Black stated that she was not aware of the allegations but did not believe they were true. DCW Black stated that she had not seen any staff pushing or throwing residents down in their beds or chairs. DCW Black stated that she has not seen any staff be disrespectful to residents or joke with them in a disrespectful manner. DCW Black stated that many of the residents have severe dementia and they don't play with staff that way. DCW Black stated that she was familiar with Resident A and the behaviors he displayed. DCW Black stated that when staff assisted Resident A that Resident A did not want their help and would become very combative and hit, punch, pinch or scratch staff that were helping him. DCW Black stated that staff would still assist Resident A even though he would display these behaviors on a daily basis.

On 04/06/2026, I completed an interview with Direct Care Worker (DCW) Nina Coleman concerning the allegations. DCW Coleman stated that she was not familiar with the allegations but did not believe they were true. DCW Coleman stated that Resident A was a two person assist so staff were always trying to help Resident A get up or move around. DCW Coleman stated that Resident A would yell and hit staff when they tried to help him. DCW Coleman stated that she had not witnessed any staff hit or push or be rude to Resident A. DCW Coleman stated that Resident A beat up another resident in the home and that resident had to go to the hospital for medical attention. DCW Coleman stated that the staff are very understanding of the residents as many of them are very old and have dementia and sometimes don't know what they are doing.

On 04/06/2026, I completed an interview with Resident B and Resident C separately in their rooms. Residents B and C appeared neat and clean and were able to communicate. Residents B and C stated that they were not familiar with the allegations but they did not believe they were true. Residents B and C stated that did not witness any staff hit or push Resident A. Residents B and C stated that they did not witness any staff being rude or disrespectful to Resident A. Residents B and C stated that the staff never yell at them and treat them very good. Residents B and C stated that the staff check on them a lot and they both like the home.

I reviewed Resident A's assessment plan dated 03/30/2026. The plan noted that Resident A gets confused and staff should assist with communication needs. The plan notes that Resident A is combative during care. The plan notes that Resident A requires two-person assist with toiletry, bathing, grooming, dressing and personal hygiene.

I reviewed Incident Report (IR) dated 03/27/2026. The IR notes that Direct Care Worker (DCW) Deion Keller was play fighting with Resident A pinching his nipples. DCW Keller was removed from the schedule until further investigation. Supervision and family were notified of the incident.

On 05/04/2026, I completed a phone interview with Resident A's guardian, Guardian A1, concerning the allegations. Guardian A1 stated that she was aware of the allegations and believed they were true. Guardian A1 stated that there was a camera in Resident A's room and it recorded the incident on 03/27/2026 of staff pushing Resident A down on his chair, pinching him, and punching him of some sort. Guardian A1 stated that the staff member working was very disrespectful to Resident A and was so forceful with him that she was concerned for his safety. Guardian A1 stated that Resident A is diagnosed with frontal lobe Dementia and is currently on hospice at Courtyard Manor of Swartz Creek. Guardian A1 stated that after she saw the video of staff treating Resident A so poorly, she began to look for a new home immediately. Guardian A1 stated that she moved Resident A out of the home on 03/31/2026. Guardian A1 stated that Resident A's health has declined so poorly that he can't walk or get out of bed and is unable to remember anything due to his severe dementia. Guardian A1 stated that she would send me the video via email.

On 05/04/2025, Guardian A1 sent me an email containing video footage from 03/27/2026. The video showed two direct care workers (DCW) in Resident A's room. The DCW's were Deion Keller and Lovley Cook. DCW Keller was interacting with Resident A while he was on his bed and forceable standing Resident A up and pushing him down in his chair. While DCW Keller was interacting with Resident A it appeared he was play punching Resident A, pinching Resident A's nipples and poking him. DCW Keller displayed disrespectful behavior towards Resident A as he was talking to him and telling him to stand up or he would make him stand up. DCW Lovely Cook was present in the room and was fixing Resident A's bed while these incidents were occurring. It did not appear that DCW Cook interacted with Resident A as she was changing the bed and sheets in Resident A's room. It does not appear that DCW Cook interacted inappropriately with Resident A, nor did she attempt to stop or redirect DCW Keller from interacting with Resident A inappropriately.

On 05/07/2026, I received an email from APS Worker Michael Grant. APS Grant stated that he reviewed the video and completed his investigation and would not be substantiating the complaint.

On 05/11/2026, Office Manager (OM) Stacy Bohn called me concerning the investigation. OM Bohn stated that DCW Keller was taken off the schedule on 03/27/2026 and was terminated from employment. OM Bohn stated that they were still completing their investigation on DCW Cook.

On 05/12/2026, Administrator Erica Phipps contacted me concerning the investigation. Administrator Phipps stated that she had been conducting an internal investigation on the incident. Administrator Phipps stated that she terminated DCW Keller on

04/07/2026 as his account of what happened was not consistent. Administrator Phipps stated that she was still working on her investigation of DCW Cook. Administrator Phipps was able to provide the contact information for DCW Keller and DCW Cook.

I attempted to contact Direct Care Worker (DCW) Deion Keller on 05/12/2026 and 05/13/2026 with no success. I left contact information on DCW Keller's voicemail.

I attempted to contact Direct Care Worker (DCW) Lovely Cook on 05/13/2026 and 05/14/2026 with no success. I left contact information on DCW Keller's voicemail.

On 05/14/2026, I completed an unannounced interview at Living Joy with Administrator Erica Phipps. I spoke with Administrator Phipps and requested to interview DCW Cook. She informed me that DCW Cook was on medical leave and that they were going to inform her that her employment was terminated based on the results of their investigation.

On 05/11/2026, I completed an exit conference with Licensee Designee (LD) Brian Nitz. I informed LD Nitz of the results of my investigation and that I found a rule violation and would be substantiating the complaint. LD Nitz stated that he would complete a corrective action plan once the report was received.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	<p>It was alleged that on 03/27/2026, Staff were rough with Resident A. Staff were throwing Resident A around in his bed and chair and being disrespectful to him.</p> <p>I interviewed the Office Manager, Direct Care Worker Black, Direct Care Worker Coleman, Resident B and Resident C concerning the allegations. None of the parties interviewed have seen any staff hit, punch, or throw Resident A in a chair or be disrespectful to him or any other resident.</p> <p>I interviewed Guardian A1 concerning the allegations and she believes the allegations to be true. Guardian A1 provided video footage of an incident on 03/27/2026 where DCW Keller displayed inappropriate behaviors with Resident A. The</p>

	<p>behaviors included: pushing, pinching, play punching and disrespect.</p> <p>Resident A suffers from frontal lobe Dementia. Resident A was moved from Living Joy on 03/31/2026 and is currently on hospice at Courtyard Manor of Swartz Creek.</p> <p>I attempted to interview DCW Deion Keller with no success as he did not answer his phone or return any message.</p> <p>Upon completion of my investigation, it has been determined that there is a preponderance of evidence to conclude that a rule has been violated.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Martin Gonzales

05/15/2026

Martin Gonzales Licensing Consultant	Date
---	------

Approved By:

Mary Holton

05/15/2026

Mary E. Holton Area Manager	Date
--------------------------------	------