GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 28, 2026

Laura Whaley
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL540398499
Investigation #: 2026A1033043
Evergreen Terrace Assisted Living

Dear Ms. Whaley:

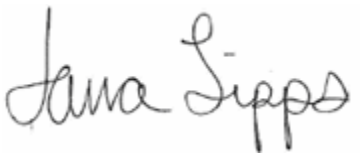
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 335-5985.

Sincerely,



Jana Lipps, 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 #:	AL540398499
Investigation #:	2026A1033043
Complaint Receipt Date:	06/12/2026
Investigation Initiation Date:	06/15/2026
Report Due Date:	08/11/2026
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 719-5100
Administrator:	Laura Whaley
Licensee Designee:	Laura Whaley
Name of Facility:	Evergreen Terrace Assisted Living
Facility Address:	801 Fuller Big Rapids, MI 49307
Facility Telephone #:	(231) 527-1050
Original Issuance Date:	04/28/2020
License Status:	REGULAR
Effective Date:	10/28/2024
Expiration Date:	10/27/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff have not been properly trained to administer tube feedings through Resident A's G-tube.	Yes

III. METHODOLOGY

06/12/2026	Special Investigation Intake 2026A1033043
06/15/2026	Special Investigation Initiated - On Site Interviews conducted with direct care staff, Alyssa Wright & Kasey Proctor, Corewell Hospice nurse, Crystal Silk. Review of resident record initiated.
06/15/2026	Contact - Telephone call received Voicemail message received from Acting Administrator, Scott Idziak.
06/16/2026	Contact - Telephone call made Telephone call returned to Acting Administrator, Scott Idziak.
06/16/2026	Contact - Document Sent- Email correspondence sent to Acting Administrator, Scott Idziak, requesting resident and direct care staff documentation.
06/17/2026	Contact - Document Received- Email correspondence received from Acting Administrator, Scott Idziak.
07/21/2026	APS Referral- No current suspicion of abuse, neglect, or exploitation.
07/23/2026	Contact – Document sent Email correspondence sent to Acting Administrator, Scott Idziak.
07/24/2026	Contact – Document received- Email correspondence with Mr. Idziak.
07/27/2026	Contact – Document received- Email correspondence with Mr. Idziak.
07/28/2026	Exit Conference Conducted via email with licensee designee, Laura Whaley.

ALLEGATION: Direct care staff have not been properly trained to administer tube feedings through Resident A's G-tube.

INVESTIGATION:

On 6/12/26 I received an online complaint regarding the Evergreen Terrace Assisted Living, adult foster care facility (the facility). The complaint alleged that Resident A requires a G-tube for nutrition and the direct care staff have not been properly trained to administer nutrition via this device. This complaint was filed anonymously; therefore, a Complainant was not available to interview regarding the allegations.

On 6/15/26 I conducted an unannounced, on-site investigation regarding the allegation. I interviewed direct care staff, Alyssa Wright and Kasey Proctor, together as they requested. Both Ms. Wright and Ms. Proctor reported that Resident A is a new resident of the facility. They could not provide the exact admission date. They reported that Resident A does require a G-tube for his nutrition and his medications. Ms. Wright and Ms. Proctor reported that Resident A is a hospice patient and receives services through Corewell Hospice. They reported that Ms. Proctor was present when the Corewell Hospice nurse came to the facility to educate the direct care staff about how to use Resident A's G-tube. Ms. Proctor reported that she and three other direct care staff were present for this training as well as acting Administrator, Scott Idziak. Ms. Proctor reported that she felt the education provided was adequate at the time but she was not certain about the plan to educate the remaining direct care staff members. Ms. Proctor reported that the nurse demonstrated how to feed Resident A via the G-tube and how to flush the G-tube after use. She reported that she did not feel fully competent in using the G-tube after the first training, but she does feel competent now. Ms. Wright reported that she was trained in how to use the G-tube and administer Resident A's nutrition and medications by Mr. Idziak. She reported that she did not feel competent after the first demonstration but noted that others were available to ask questions along the way which boosted her confidence. Ms. Wright and Ms. Proctor reported that they always work on a shift with another direct care staff and always have someone to ask questions related to resident care. Ms. Wright and Ms. Proctor reported that Resident A has dementia and is verbal to an extent but cannot articulate the process of how to use the G-tube.

On 6/15/26, during the unannounced, on-site investigation I interviewed Corewell Hospice, nurse, Crystal Silk. Ms. Silk reported that she was the nurse who provided the initial education to the direct care staff regarding Resident A's G-tube. She reported that she trained about four people on the day she completed the training. She reported that if additional training is needed, she is available for this, and the training just needs to be requested. She reported that it was a "brief" training on the day of Resident A's admission to the facility.

On 6/17/26 I spoke with Mr. Idziak via telephone regarding the allegation. I requested to review documentation regarding direct care staff training. Mr. Idziak responded via email with the following documentation:

- Evergreen Terrace Staff Directory. This document identifies the following direct care staff members working at the facility:
    - Alivia Bilicki
    - DeJah Jackson
    - Kasey Proctor
    - Justyce Larkin
    - Sharlene Powers
    - Emma Ginther
    - Alyssa Wright
    - Breanna Jackson
    - Kaytlynn Jahnke
    - Felicia Bazzett
    - Aubrey Robbins
    - Alanah Thmpson
    - Natalie Clark
    - Snow Litrenta
    - Jasmine Byers
    - Autumn Thompson
- *Resident Register*. This document identifies that Resident A was admitted to the facility on 6/2/26.
- *Physician Order Sheet*, for Resident A. I observed the following on this document:
    - Most of Resident A's medications are ordered to be administered via his G-tube.
    - *Tube Feeding Water/Flushing Directions* are noted on the physician orders with the following narrative, "Crush each medication separately and place each into separate liquid medication cups with 10-15ml of lukewarm water. Before you begin giving medication through the tube, make sure residents head is elevated 45-90 degrees and then pour 15-30ml of lukewarm water through the tube. Then begin pouring each medication, one by one, through the tube, flushing with 10-15ml of water between each med. After you have administered all medications, flush the tube one last time with 15-30ml of lukewarm water."
- *Record of Communication – Corewell Health Hospice and Palliative Care*, for Resident A, dated 6/2/26, completed by Ms. Silk. Under the section, *Visit Summary*, it reads, "Tuck in. G-tube instruction – med reconciliation, medication orders written to fax to pharmacy. Pt. anxious but denies needs or concerns.
- *Baruch Senior Ministries, Medication Administration Observation Check-Off,* this document is the training log direct care staff members go through when being trained for medication administration at the facility. There is a section for *G-tube medications/feedings* training on this checklist.

- Training records were provided for Ms. Wright, Ms. Proctor, and Ms. Thompson. None of the three had documentation pertaining to G-tube training being completed on these documents.
- *In-Service Sign in Sheet, Topic: G-tube Feeding, dated 6/2/26 – Ongoing.* This document is signed by:
    - Scott Idziak
    - Alyssa Wright
    - Kelsey Proctor
    - Natalie Clark
    - Breanna Jackson
- *Health Care Appraisal*, for Resident A. This document is signed by Suzie Haugen, BSN, RN, but it is not dated. Under the section, *14. Special Dietary Instructions and Recommended Caloric Intake*, it reads, "NPO except ice cubes. On tube feeds." The document identifies that Resident A has been diagnosed with a specific type of throat cancer, Laryngeal squamous cell carcinoma.
- *Assessment Plan for AFC Residents,* for Resident A, dated 6/2/26. Under section, *II. Social/Behavioral Assself Care Skill Assessment Plan of Action,* subsection*, A. Eating/Feeding,* it reads, G-tube staff helps with meds/feedings." Under section, *IV. Health Care Assessment Plan of Action*, subsection, *A. Taking Medication*, it reads, "Crush meds put in water. Given through G-tube." Under section, *VIII. Release of Information – Resident or Legal Guardian Signature Only*, subsection, *IX. Other information*, it reads, "Feedings every 3 hours during day. Help with medications through G-tube."

Along with these documents, Mr. Idziak provided information regarding the training process for the direct care staff in terms of administering nutrition and medications via Resident A's G-tube. Mr. Idziak reported that the direct care staff have been trained through verbal, one-on-one observation, and a physical demonstration from the hospice nurse. Mr. Idziak reported that he has 25 years of experience working with G-tubes as he has a family member who uses a G-tube. He reported that he was present for the initial hospice training and has been present to train his direct care staff members on the proper usage of the G-tube. Mr. Idziak reported that the vice president of training and orientation for the facility is a nurse and has also been available to the direct care staff to answer any further questions. Mr. Idziak reported that the week Resident A was admitted to the facility he came in on multiple shifts to demonstrate to all direct care staff how to administer nutrition and medications via the G-tube. Mr. Idziak further reported that the direct care staff do annual medication competencies and The Hometown Pharmacy has a nurse who is available for medication training and observation. Mr. Idziak reported that he has contacted Corewell Health Hospice on multiple occasions and requested that they provide an in-service the entire direct care staff can be present for to provide additional education and has not heard back regarding this request.

On 7/23/26 I sent email correspondence to Mr. Idziak and requested any additional documentation of direct care staff training related to Resident A's G-tube as well as Resident A's *Medication Administration Record* (MAR) for the month of June 2026. Mr.

Idziak responded and reported that all staff listed on the direct care staff list that he provided on 6/17/26 had administered either food or medications to Resident A via his G-tube, except Emma Ginther & Alivia Bilicki. Mr. Idziak reported that Resident A died on 6/22/26. He further reported that due to the inconsistent nature of training the direct care staff sporadically on different shifts, he neglected to obtain documentation with their signatures and dates of the trainings completed. Mr. Idziak sent a copy of Resident A's MAR for the month of June 2026. I observed the following:

- The following direct care staff administered medications or nutrition to Resident A via his G-tube:
    - Felicia Bazzett
    - Laura Whaley
    - Autumn Thompson
    - Sharlene Powers
    - Alanah Thompson
    - Alyssa Wright
    - Katlynn Jahnke
    - Justyce Larkin
    - DeJah Jackson
    - Breanna Jackson
    - Kasey Proctor
    - Jasmine Byers

On 7/24/26 I responded to Mr. Idziak's email correspondence and requested that he compile a complete list of who had been trained and what dates they were trained along with the direct care staff signatures. Mr. Idziak responded on 7/27/26 and reported that he cannot compile a complete list of direct care staff who had been trained with dates and signatures of their trainings due to the fact that the following direct care staff no longer work at the facility:

- Jasmine Byers
- Aubrey Robbins
- Kaytlynn Jahnke
- Breanna Jackson
- Justyce Larkin
- Kasey Proctor
- Dejah Jackson

Mr. Idziak supplied an In-service sign off sheet regarding training provided to direct care staff members titled, *Hospice/Pain Management/G-Tube Feeding/Meds*. This in-service was completed on 6/30/26. The following direct care staff signed acknowledging they had attended this training:

- Scott Idziak
- Jasmine Byers
- Snow Litrenta
- Aislin Dermyer
- Jodi Clark
- Braden Whaley

- Autumn Thompson
- Alyssa Wright
- Kasey Proctor
- Natalie Clark
- DeJah Jackson
- Ashley (last name unable to read clearly)

APPLICABLE RULE	
R 400.629	**Direct care staff; qualifications and training.**
	(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently: **(d) Personal care, supervision, and protection.** **(i) Nutrition and special diets.**
ANALYSIS:	Based upon interviews conducted and documentation reviewed for this investigation it can be determined that there is not adequate evidence to establish that the direct care staff were properly trained to Resident A's G-tube prior to assuming duties of administering nutrition and medication via this device. Mr. Idziak and Resident A's MAR identify that there were twelve direct care staff members who administered either nutrition or medication via Resident A's G-tube. Mr. Idziak only had documentation of five direct care staff members being trained to use this device, and he was one of the five listed. When asked to compile a list of direct care staff who were trained and dates the informal training was completed with direct care staff signatures attesting to this training, Mr. Idziak could not provide this documentation as he noted four of the direct care staff who had administered nutrition or medications via the G-tube were no longer employed by the facility. Without proper documentation of training provided and competency achieved, it cannot be determined that the direct care staff were competent to administer nutrition/medications via Resident A's G-tube prior to the assumption of these duties. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

7/27/26

Jana Lipps — Date
Licensing Consultant

Approved By:

07/28/2026

Dawn N. Timm — Date
Area Manager