GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 21, 2026

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

RE: License #: AL700398469
Investigation #: 2026A0340049
Simarron AFC Home

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

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.

If you desire technical assistance in addressing these issues, please contact me. In any event, the corrective action plan is due within 15 days.

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,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL700398469 |
| | |
| **Investigation #:** | 2026A0340049 |
| | |
| **Complaint Receipt Date:** | 06/15/2026 |
| | |
| **Investigation Initiation Date:** | 06/16/2026 |
| | |
| **Report Due Date:** | 08/14/2026 |
| | |
| **Licensee Name:** | Baruch SLS, Inc. |
| | |
| **Licensee Address:** | Suite 203<br>3196 Kraft Avenue SE<br>Grand Rapids, MI 49512 |
| | |
| **Licensee Telephone #:** | (616) 588-9131 |
| | |
| **Administrator:** | Rebecca Summerville |
| | |
| **Licensee Designee:** | Laura Whaley |
| | |
| **Name of Facility:** | Simarron AFC Home |
| | |
| **Facility Address:** | 15255 Clovernook Drive<br>Grand Haven, MI 49417 |
| | |
| **Facility Telephone #:** | (616) 847-4242 |
| | |
| **Original Issuance Date:** | 03/23/2020 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 09/24/2024 |
| | |
| **Expiration Date:** | 09/23/2026 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>AGED, ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A's oxygen failed due to mechanical failure and staff failed to administer bottled oxygen for at least two hours. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 06/15/2026 | Special Investigation Intake<br>2026A0340049 |
| 06/15/2026 | APS Referral<br>Does not pertain to APS |
| 06/16/2026 | Special Investigation Initiated - Telephone<br>Rebecca Summerville |
| 06/24/2026 | Inspection Completed On-site |
| 06/24/2026 | Contact - Telephone call made<br>staff Kayla Henderson |
| 07/06/2026 | Contact - Telephone call made<br>staff Kayla Henderson |
| 07/08/2026 | Contact – Document Received<br>Email received from Laura Whaley |
| 07/10/2026 | Contact – Telephone call made<br>Jocelyn Banks – Home Manager |
| 07/10/2026 | Inspection Completed On-Site |
| 07/17/2026 | Exit Conference<br>Laura Whaley |

**ALLEGATION: Resident A's oxygen failed due to mechanical failure and staff failed to administer bottled oxygen for at least two hours.**

**INVESTIGATION:** On June 15, 2026, a complaint was filed with the BCHS Online Complaints which stated Resident A utilizes an electric oxygen concentrator as well as portable oxygen tanks. On June 12, 2026, the electric concentrator was malfunctioning, and staff did not switch Resident A to her portable oxygen tank until at least two hours later. This complaint was filed under the incorrect facility. The

error was discovered and corrected.

On June 16, 2026, I contacted Administrator Rebecca Summerville. I informed her of the allegation, of which she was already aware. Ms. Summerville provided the name and contact information of staff Kayla Henderson, who was working the night Resident A's oxygen condenser malfunctioned and had attempted to assist her. She stated medical services were not sought for Resident A because the issue was remedied. Someone from Lincare came out the next day to service the condenser. An Incident Report was not filed because according to Ms. Summerville, it did not warrant one. Ms. Summerville stated that since this incident occurred, all staff were given oxygen training so that there is no confusion regarding what to do in these situations. I requested she send me the Assessment Plan and Health Care Appraisal for Resident A.

On June 17, 2026, I reviewed the documents received from Ms. Summerville. Resident A's Assessment Plan was signed by Ms. Summerville on 3/12/26. Under "Other" in the "Self-Care Assessment" it indicates Resident A utilizes "oxygen, nebulizer, bipap". There was no additional information or instructions documented.

On June 24, 2026, I conducted an unannounced home inspection and met with Resident A privately in her room. I introduced myself and explained the reason for my visit. She understood a complaint had been filed "with the State". Resident A informed me she moved into the Simarron home in March of this year. She stated things had been fine until this incident occurred.

I asked Resident A to tell me what happened the day of this incident. She stated the incident occurred around 1:00 am on June 12, 2026. There was a young woman working but she did not remember her name. She was the only staff working so Resident A stated I wouldn't have trouble finding out who it was. The red light and alarm on the large oxygen condenser located in Resident A's room went off and Resident A called for staff. When staff came to her room, the staff person was trying to fix the problem with the condenser and called Lincare. Resident A stated she could feel oxygen still coming through the tube, but not at the normal rate of flow. She has an oxygen monitor and remembers testing herself and it read "46". Resident A stated her hands started to feel cold and numb.

Resident A stated the staff called the on-call manager "Jocelyn" but had still not given her the portable oxygen tank that was on her wheelchair. Resident A estimated that approximately two hours had passed at this point. She does not remember when she was switched over to the portable tank nor who switched her over because she believes she must have passed out. When she woke up the next morning she was connected to the portable tank and stated "I was still alive".

I then spoke with Shane Tenbrink, Director of Resident Care. She was also aware of the incident which occurred involving Resident A. Ms. Tenbrink stated staff Kayla Henderson was working third shift by herself that night. The next day Ms. Tenbrink

spoke with family and apologized and explained that staff will be retrained how to handle these situations with oxygen. Ms. Tenbrink stated staff have since been retrained how to switch the O2 tanks and what to do if the condenser malfunctions, prioritizing switching the tanks instead of troubleshooting the malfunction.

I discussed with Ms. Tenbrink that it is not appropriate for staff to attempt to fix an oxygen condenser. Ms. Henderson should have first switched Resident A to the portable tank. Ms. Tenbrink agreed and confirmed that was addressed in the training. Ms. Tenbrink also stated there was no IR written.

On June 24, 2026, I called and left a message for Ms. Henderson.

On June 24, 2026, Ms. Henderson left me a voicemail.

On June 24, 2026, I called Ms. Henderson and again left a voicemail

On July 7, 2026, I called and left a message for Ms. Henderson.

On July 8, 2026, I received an email from Ms. Whaley stating she is stepping in for Mr. Nitz as Licensee Designee.

On July 10, 2026, I called and left a message for Ms. Henderson.

On July 10, 2026, I called and left a message for Manager Jocelyn Banks.

On July 10, 2026, Ms. Banks returned my call. She clarified that she is the Home Manager for Seville, another home on the Baruch Lakeshore campus, but she was the on-call manager on the date of the incident involving Resident A. Ms. Henderson had called her and stated the oxygen condenser was beeping and a light was flashing. Ms. Banks instructed Ms. Henderson to unplug it and plug it back in, so the condenser would reset. Ms. Banks stayed on the line while Ms. Henderson completed this task. Ms. Henderson reported to Ms. Banks that the light was green and the beeping stopped, so Ms. Banks assumed all was well. That was the end of their conversation. I asked Ms. Banks about oxygen training for staff and what it entails. Ms. Banks stated there was no training yet. It has been talked about because of what occurred, but there has not been time to have the training.

On July 10, 2026 I conducted another unannounced home inspection to review training. Staff Kayla Hendersons file included a training checklist, however, oxygen training was not checked. I reviewed several other staff files at this time and found numerous staff had not received training for oxygen. The following staff with no documented oxygen training include: Jocelyn Griffore, Shakia Gray, Rachel Elkins, Isabelle Eschman, Lauren Bridgeforth, Kailyn Chaney had training 3/3/24.

Activities Director Rachel Kooiman was present during my inspection. She provided me with a copy of meeting minutes for 6/17/26 which had a section regarding

oxygen training, but no details were included. However, there were 18 staff listed as not present during this meeting, one of whom was Ms. Henderson.

| **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:** | The allegation was made that Resident A's oxygen machine failed due to mechanical failure and staff failed to administer bottled oxygen for at least two hours.<br><br>Resident A stated her oxygen condenser was not working properly and she was not receiving sufficient oxygen. She stated staff did not switch her from her oxygen condenser to her portable oxygen tank for at least two hours.<br><br>Ms. Summerville stated no IR was written and believed staff took care of the issue.<br><br>Ms. Banks stated she spoke to Ms. Henderson the night of the incident and instructed her to unplug the condenser and then plug it in again. Ms. Banks was not aware that the issue continued. Ms. Banks stated staff have not been trained on oxygen tank protocols.<br><br>Ms. Tenbrink stated staff were re-trained on oxygen tank protocols due to this incident.<br><br>A review of random staff files revealed that five staff members did not have oxygen training documentation in their file. Ms. Kooiman provided a sign-in sheet for a staff meeting where the agenda mentioned oxygen training. I found 18 staff members were not present at this meeting.<br><br>There is a preponderance of evidence to support a rule violation due to Resident A's Assessment Plan indicating she requires oxygen and for a period of at least two hours, unobstructed oxygen was not provided. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:** While conducting the above investigation, as well as complaint investigation #2026A0340048 on the same campus, it was discovered that staff are not all trained in CPR/1st Aid. On July 10, 2026, I was reviewing staff files and was informed by Activities Director, Rachel Kooiman, that all staff work at all of the Lakeshore homes. I reviewed 12 staff files and found 9 staff to not have training in First Aid. When I brought this concern to acting Designee Laura Whaley, she was able to provide training documentation for 3 of the staff who did not have documentation in their files. The remaining staff who have not been trained in First Aid or CPR include Kayla Henderson, Shakia Gray, Isabelle Eschman, Lauren Bridgeforth, Kailyn Chaney and Alexis Fisk. Ms. Henderson was working alone on the date of the incident without having 1st Aid or CPR training.

| **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:**<br>**(b) First aid.**<br>**(c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.** |
| **ANALYSIS:** | While reviewing 12 staff files it was discovered that six staff were not trained in First aid or CPR. In addition, Ms. Henderson was working alone on the date of the incident without having 1st Aid or CPR training. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:** During the course of the above investigation, it was discovered that staffing protocols were not being followed as outlined in a Corrective Action Plan following SIR 2026A0356018 which states, “The facility will hire staff to schedule a minimum of two direct care staff during first and second shifts when the census and resident care needs require additional support.”

During the unannounced home inspection, I met staff Axel Wilder. I did not observe any other Direct Care Workers present during my inspection in the Simarron home during this first shift time frame. When asked, staff Wilder indicated they were working alone. I asked staff Wilder to show me Resident A’s care book which they

did. I obtained the Assessment Plan information and then asked staff Wilder to show me to Resident A's room. When we arrived at Resident A's room we were introduced and Resident A asked for a PRN medication which staff Wilder passed for her.

I did not observe any other Direct Care Workers present during my inspection in the Simarron home during this first shift time frame. The purpose of my visit was regarding an incident which occurred over third shift in which there was only one staff person working. It raises concern if one person is adequate to cover the needs of the aged residents during that shift, let alone during a shift when the 14 residents are awake.

| **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:**<br>**(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.** |
| **ANALYSIS:** | A previous licensing rule violation was cited on March 10, 2026, as a result of special investigation, 2026A0356018, by Licensing Consultant Elizabeth Elliott. The Corrective Action Plan (CAP) provided by the licensee in response to this citation stated that at least two staff will work in the facility during 1st and 2nd shifts.<br><br>Based upon the information provided above, it is clear that the facility is not being staffed according to what was indicated in the previous CAP. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED**<br>This is a repeat violation (2026A0356018) |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:** While conducting the above investigation I discovered that Resident A's Assessment Plan does not include use of the oxygen condenser. There is no mention of it, no direction as to its use or what to do if it were to malfunction. Under "Use of Assistive Devices" on Resident A's Assessment Plan it

states she “does not use assistive devices” yet while in Resident A’s bedroom I observed a wheelchair which Resident A also referenced during our conversation. Furthermore, in the Care Plan for Resident A, under “Mobility and Transferring” it states, “does not use assistive devices” but then also states “wheelchair, walker prn, gait belt prn, wheelchair bound, will need assistance to get around”. Baruch Lakeshore utilizes three different documents which act as a Resident Assessment Plan and Care Plan and none of them are consistent with information, nor are they clear with instruction of the residents’ needs.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.673** | **Use of assistive devices, therapeutic support.** |
| | **(1) An assistive device or therapeutic support intended to achieve or maintain a resident's proper position to enhance mobility, physical comfort, safety, and well-being must be specified in the resident's assessment plan and agreed on by the resident or resident's designated representative.** |
| **ANALYSIS:** | While reviewing Resident A’s Assessment Plan, it did not include specific information regarding assistive devices required for Resident A’s care. Resident A was observed using an oxygen condenser and wheelchair. Resident A’s statements also support this evidence. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On July 17, 2026, I conducted an exit conference with newly appointed Licensee Designee Laura Whaley. We discussed the incident involving Resident A and the cited rule violation as well as the other rule violations being cited. I requested a Corrective Action Plan from Ms. Whaley which she understood and agreed to send. I also advised her that I was going to be recommending a Provisional license for this home. Ms. Whaley and I discussed the ramifications of a Provisional license and she had no other questions.

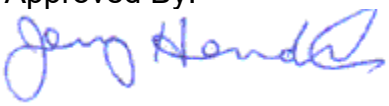
## IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, a Provisional license is recommend due to the previously cited quality-of-care violations.

Rebecca Piccard July 21, 2026

Rebecca Piccard Date
Licensing Consultant

Approved By:



July 21, 2026

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Jerry Hendrick Date
Area Manager