GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

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

October 15, 2026

RE: License #: AM490369296
Investigation #: 2026A0873018, Cedar Cove Assisted Living Specialized Care

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 (616) 356-0100.

Sincerely,

Garrett Peters, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(906) 250-9318

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

I. IDENTIFYING INFORMATION

License #:	AM490369296
Investigation #:	2026A0873018
Complaint Receipt Date:	08/16/2026
Investigation Initiation Date:	08/19/2026
Report Due Date:	10/15/2026
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 719-5100
Licensee Designee:	Laura Whaley
Name of Facility:	Cedar Cove Assisted Living Specialized Care
Facility Address:	Bldg. #2 266 South Mary L Street, Cedarville, MI 49719
Facility Telephone #:	(906) 484-1001
Original Issuance Date:	06/05/2015
License Status:	REGULAR
Effective Date:	12/05/2025
Expiration Date:	12/04/2027
Capacity:	8
Program Type:	PHYSICALLY HANDICAPPED AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility had no hot water for several weeks.	Yes
The hallways are full of cardboard boxes.	No
Additional Findings	Yes

III. METHODOLOGY

08/16/2026	Special Investigation Intake 2026A0873018
08/19/2026	Special Investigation Initiated - On Site
08/19/2026	Contact - Face to Face Interviews with employees and family
09/14/2026	Contact - Telephone call received Interview with Complainant
09/16/2026	Inspection Completed On-site
09/16/2026	Contact - Face to Face Interviews with employees
10/01/2026	Contact – Telephone call Interview with former employee Callie
10/06/2026	Inspection Completed On-site
10/06/2026	Contact - Face to Face interviews with employees
10/08/2026	Contact - Telephone call made Interview with Caralyn
10/09/2026	Exit Conference Attempted, left message for Ms. Whaley
10/15/2026	Contact – Document received Received resident weight records from Ms. Postula

10/15/2026	Exit Conference – Attempted, left voicemail for Ms. Whaley and emailed SIR

ALLEGATION:

The facility had no hot water for several weeks.

INVESTIGATION:

On 8/16/26, I received a complaint which alleged there had been no hot water in several of the rooms for several weeks.

On 8/19/26, I interviewed employee Jamie Nye at the facility. There was no hot water in several of the resident bathrooms for about three weeks. Some residents have hot water, most do not. Residents are being taken to another, connected licensed facility to shower.

On 8/19/26. I interviewed employee Tammy Tassier at the facility. There was no hot water for several weeks. Residents' moods are being negatively affected by this as it is more difficult to move them from their facility to the other facility for a shower. Residents also have to be walked or wheeled through the other facility on their way to and from the shower, often having to be moved through groups of residents of the other facility.

On 8/19/26, I interviewed Guardian A at the facility about Resident A's care. They were not aware of there being no hot water, but believed Resident A was receiving proper care at the facility and were generally happy.

On 8/19/26, I interviewed facility administrator Caralyn Postula. It was determined that the water heater serving that side of the facility was not fixable. The licensee required three quotes to be gathered for the purchase and installation of a new water heater. Due to the nature of the facility being in a rural area, those three quotes were difficult to get, leading to a delay. The licensee has recently approved a company to perform the work.

APPLICABLE RULE	
R 400.645	**Environmental health.**
	(3) A licensee shall provide hot and cold running water under pressure. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the fixture.

ANALYSIS:	For several weeks most of the facility was without hot water.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The hallways are full of cardboard boxes.

INVESTIGATION:

On 8/16/26, I received a complaint which alleged the hallways were filled with empty cardboard boxes that were interfering with resident and employee movement.

On 8/19/26, I inspected the facility and did not observe this. All means of egress appeared clear. I interviewed Ms. Postula at the facility. The facility recently held a yard sale and there were some boxes laying around. These were promptly removed.

APPLICABLE RULE	
R 400.725	**Means of egress.**
	(1) A means of egress must be considered the entire way and method of passage through the facility and out an exit door to free and safe ground outside the facility and must be arranged and maintained to provide free and unobstructed egress from all parts of the facility.
ANALYSIS:	After visually inspecting the facility all means of egress appeared clear.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

On 8/19/26, I interviewed Ms. Tassier at the facility. The residents often struggle to eat the food given them and staff must puree or further chop food to make it palatable. Ms. Tassier was concerned Residents were not getting enough nutrition.

On 10/6/26, I interviewed Ms. Nye at the facility. She believes residents may not be receiving enough food. I requested resident weight records but the facility internet was down and resident weights were unable to be accessed.

On 10/15/26, I was given access to resident weigh records. The records did not show a pattern of residents losing weight over the last several months. However, there were gaps of sometimes several months in the weight record for several residents.

APPLICABLE RULE	
R 400.691	**Resident records.**
	(1) A licensee shall complete and maintain a separate record for each resident that includes all of the following: **(g) Admission and monthly weight record.**
ANALYSIS:	Several residents had at least monthly gaps in their weight records.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 8/19/26, I inspected the facility and noticed menus were not posted. I asked Ms. Nye and Ms. Tassier about this and was told resident menus are not regularly posted by kitchen staff.

APPLICABLE RULE	
R 400.663	**Nutrition; adoption by reference.**
	(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented.
ANALYSIS:	Menus were not visibly posted.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 8/19/26, I interviewed several employees at the facility. Both Ms. Nye and Ms. Tassier independently told me that they believed some of the food being served to residents from the kitchen is expired.

On 8/19/26, I inspected the refrigerator at the facility. I noted that several products were beyond their expiration date. I further noticed that several items in the refrigerator had been removed from the original packaging and were not dated or labelled.

APPLICABLE RULE	
R 400.665	**Food service.**
	(7) When food is removed from its original packaging and stored, it must be clearly labeled to identify the prepared or opened date and an expiration or discard date. The discard date must be no more than 7 days on all perishable foods that are opened or if food is prepared and held at safe storage temperatures. The day of opening or day of preparation must be counted as day 1. If there are signs of spoilage, food must be discarded immediately. If any residents of the home have known food allergies, the label must also indicate that this food contains the food or ingredient that the resident is allergic to.
ANALYSIS:	During my inspection I noted that several items in the refrigerator were not labeled and expiration dates for some items in the kitchen had passed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/1/26, I interviewed former employee Callie over the telephone. In the recent past Ms. Callie observed a single pill from Resident B's Ativan prescription had a chip in it. She had never seen something like that before and there were no crumbs or powder in the bottom of the prescription bottle.

On 10/6/26, I inspected the chipped medication at the facility. I observed no crumbs or powder in the bottom of the prescription bottle. The medication was for Resident B who was receiving hospice services.

On 10/06/26, I interviewed McLaren hospice registered nurse Karen Sterns. She had never seen anything like that before, especially given there was no evidence the pill chipped inside the bottle. To be safe, Ms. Sterns was going to recommend Resident B begin receiving his medications in blister packs going forward.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	I found no evidence any resident or employee was purposely taking Resident B's medications. Hospice will begin sending Resident B's prescriptions in blister packs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/9/26, I left a message for licensee designee Ms. Laura Whaley asking her too call back so I could explain the findings of this report.

On 10/15/26, I left a voicemail for Ms. Whaley explaining that I will email her the report and contact me if she had any questions.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no changes to the status of this license.

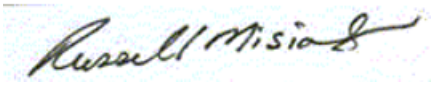


10/15/26

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Garrett Peters Date
Licensing Consultant

Approved By:



10/15/26

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Russell B. Misiak Date
Area Manager