GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 13, 2023

Connie Clauson
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL460398055
Investigation #: 2023A1032037
Tecumseh Place II

Dear Mrs. Clauson:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL460398055
Investigation #:	2023A1032037
Complaint Receipt Date:	04/25/2023
Investigation Initiation Date:	04/26/2023
Report Due Date:	06/24/2023
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	3196 Kraft Avenue SE, Suite 203 Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Keely Sanders
Licensee Designee:	Connie Clauson
Name of Facility:	Tecumseh Place II
Facility Address:	1309 Southwestern Drive Tecumseh, MI 49286
Facility Telephone #:	(517) 424-6043
Original Issuance Date:	09/13/2019
License Status:	REGULAR
Effective Date:	03/13/2022
Expiration Date:	03/12/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are insufficient employees at the home to respond to falls.	No
Employees pass the wrong diabetes medications to residents.	No
Additional Findings	Yes

III. METHODOLOGY

04/25/2023	Special Investigation Intake 2023A1032037
04/26/2023	Special Investigation Initiated - On Site Interview with administrator Keely Sanders, employee Jodi Cilley and Resident A
05/24/2023	Contact - Document Received Intake 195412 dismissed, with similar allegations
06/06/2023	Exit Conference

ALLEGATION:

There are insufficient employees at the home.

INVESTIGATION:

On 4/26/23, I interviewed administrator Keely Sanders at the home. Ms. Sanders denied that employees are not responding to falls because the home is short staffed.

I interviewed Resident A in the home. Resident A reported being in the home for two years. Resident A referenced a recent fall, where she was able to activate her pull chord, and employees responded very quickly.

I interviewed employee Jody Cilley in the home. Ms. Cilley reported that each home has its own med passer. She denied having any instances where employees did not respond to resident falls because they were short staffed. She reported that the requisite number of employees fill shifts so that residents receive the proper care, protection and supervision.

I observed the schedule, and it was in accordance with licensing rules, with two employees scheduled. While conducting the onsite inspection, I observed two employees.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on interviews with Resident A and employees at the home, as well as a review of the schedule, there is insufficient evidence to establish a violation that the home operates with inadequate employees. Moreover, there does not appear to be a link between staff ration, and slow response times to falls.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employees pass the wrong diabetes medications to residents.

INVESTIGATION:

On 4/26/23, Ms. Sanders denied that there were any medication errors logged. We discussed that the procedure to address an error would be to transmit an incident report (IR) to the AFC Home licensing division. She stated that no IR’s have been sent to the licensing division detailing any errors with medication.

On 4/26/23, Resident A denied receiving the wrong insulin dose. Resident A described a process where the employees call her up to receive her medications, and she is allowed to see what is being offered to her. She stated that her name is listed on the medication label. She described using an insulin pen with a specific dosage and name on the pen.

I observed Resident A's medication administration record, and it was in accordance with licensing rules.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Per Resident A, who receives diabetes medication, as well as a review of Incident Reports received, there were no incidents were a resident received the wrong medication. Resident A's medication administration record reflected compliance with the administrative rules governing medication administration.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/6/23, I attempted to conduct an exit conference with licensee designee Connie Clauson via telephone. Ms. Clauson was not available at the time for me to share my findings.

IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

6/13/23

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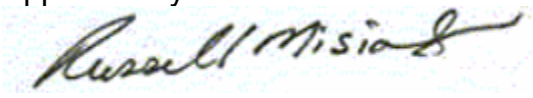
Dwight Forde Date
Licensing Consultant

Approved By:



6/20/23

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Russell B. Misiak Date
Area Manager