GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 28, 2022

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

RE: License #: AL460398056
Investigation #: 2022A1032009
Tecumseh Place I

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
(616)-240-3850

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL460398056
Investigation #:	2022A1032009
Complaint Receipt Date:	05/26/2022
Investigation Initiation Date:	05/27/2022
Report Due Date:	06/25/2022
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203 3196 Kraft Avenue SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Licensee Designee:	Connie Clauson
Administrator:	Nicole Wingenfeld
Name of Facility:	Tecumseh Place I
Facility Address:	1311 Southwestern Drive Tecumseh, MI 49286
Facility Telephone #:	(517) 423-3374
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?
Staff are sleeping and not providing proper supervision.	No
Staff do not provide proper medical care to residents.	No
Staff do not provide proper nutrition.	No
Additional Findings	No

III. METHODOLOGY

05/26/2022	Special Investigation Intake 2022A1032009
05/27/2022	Special Investigation Initiated - Face to Face
05/27/2022	Contact - Face to Face
05/27/2022	Contact - Telephone call received
05/27/2022	Contact - Telephone call received Voicemail from RS
06/01/2022	Contact - Face to Face Administrator
06/01/2022	Contact - Telephone call received RS
06/03/2022	Contact - Document Received Pictures received
06/28/2022	Contact - Document Sent Emailed pictures to Administrator
06/30/2022	Inspection Completed On-site
06/30/2022	Inspection Completed On-site
07/28/2022	Exit Conference attempted with Licensee Designee Connie Clausen

ALLEGATION:

Staff are sleeping during shifts

INVESTIGATION:

On 5/27/22, I interviewed staff member Wendy Combs at the home. Ms. Combs stated that she was unaware of staff sleeping on the job.

On 5/27/22, I interviewed staff member Kristina Peters at the home. Ms. Peters denied knowledge of staff sleeping.

On 5/27/22, I interviewed administrator Nicole Wingenfeld via telephone. Ms. Wingenfeld stated that the only staff disciplined for sleeping was Adelina Cabello. She reported that a former resident care manager had issued the discipline back in April 2022 and there have been no further issues. She stated that discipline is progressive, meaning that first a verbal warning is issued and if the behavior continues it becomes a write up.

On 5/27/22, During my inspection of the home no staff were observed sleeping.

On 6/3/22, I received by email correspondence that included pictures. One set of pictures showed an employee sleeping at what appeared to be the home.

On 6/30/22, I interviewed Ms. Wingenfeld at the home. Ms. Wingenfeld stated that the pictures are likely from several months ago and that the employee captured in the picture sleeping was disciplined.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	There was an isolated incident where a staff member was disciplined for sleeping during her shift. The home was aware of the behavior and took steps to remedy the situation. There is no evidence this is a chronic issue.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff did not properly attend to residents' medical needs.

INVESTIGATION:

On 5/27/22, Ms. Combs stated that a resident referenced in the allegation follows a treatment plan from PACE. She stated that Resident B has not had any recent falls to report. Resident B was observed in a wheelchair and did not wish to be interviewed.

On 6/1/22, I interviewed Ms. Wingenfeld at the home. Ms. Wingenfeld stated that they were following doctor's orders regarding Resident B's wound care. She stated that Resident B was provided a wheelchair and that a few months ago he had some falls in the transition period. She stated that he was very independent and had a hard time coping with the change in status. In regards to another resident, she stated that the home had contacted the hospice care agency overseeing a resident who had passed away in April and followed guidelines.

On 6/1/22, I interviewed Careline Hospice nurse Sarah Humphrey at the home Ms. Humphrey stated that patients were receiving proper wound care. She elaborated that to her knowledge, there were no issues or concerns with the way the home had been providing care to the residents.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Interviews of staff and a hospice nurse reveal that the home does seek guidance from health care professionals.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff do not properly toilet residents and leave them in soiled clothing. Rooms are not cleaned.

INVESTIGATION:

On 5/27/22, Ms. Combs denied that residents are not being properly toileted.

On 5/27/22, Ms. Peters denied that residents are not being properly toileted.

Rooms were observed to be clean and well maintained. Residents B, C and D were observed eating lunch. Resident B left and went to his room in his wheelchair and declined to speak with me. Resident C stated that she was doing well in the home.

On 5/27/22, Ms. Wingenfeld denied that the residents are left in soiled clothing or that the rooms are not routinely cleaned. Ms. Wingenfeld stated that all shifts (day, afternoon and night) are responsible for assisting residents and maintaining clean rooms. She stated that staff will typically check on residents whose plans indicate the need for assistance with toileting every two hours or as needed, should visible or olfactory signs present themselves.

On 6/3/22 I received multiple pictures from the complainant of staff sleeping, dirty linen and staff write ups.

On 6/30/22, Ms. Wingenfeld stated that more than likely the pictures were snapped before the room was cleaned. She explained that likely the clothing seen on the floor was soon gathered thereafter and placed in a laundry cart. She stated that the home has since implemented a more vigorous process for cleaning, which would be overseen by facility director John Mooneyham.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	During onsite inspections residents were observed to be clean and well dressed. The rooms were in clean condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 7/28/22, I attempted to share the findings of this report with licensee designee Connie Clauson via telephone Ms. Clauson did not respond to my request for a return call.

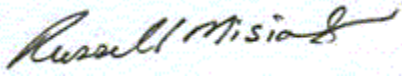
IV. RECOMMENDATION

I recommend no change to the status of this license.

7/28/22

Dwight Forde Date
Licensing Consultant

Approved By:



7/28/22

Russell B. Misiak Date
Area Manager