GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 7, 2023

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

RE: License #: AL460398056
Investigation #: 2023A1032035
Tecumseh Place I

Dear Mrs. Clauson:

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.
- On 8/1/23, your Corrective Action Plan was approved.

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
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AL460398056
Investigation #:	2023A1032035
Complaint Receipt Date:	04/19/2023
Investigation Initiation Date:	04/19/2023
Report Due Date:	06/18/2023
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 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?
Employees did not follow Resident A's plan of care.	Yes
Additional Findings	No

III. METHODOLOGY

04/19/2023	Special Investigation Intake 2023A1032035
04/19/2023	Special Investigation Initiated - Letter
04/26/2023	Inspection Completed On-site
05/02/2023	Contact - Telephone call made Interview with Careline Medical Social Worker Cheryl Moore
05/10/2023	Contact - Document Received
06/01/2023	Contact - Document Received
06/01/2023	Contact - Telephone call received
06/06/2023	Exit Conference

ALLEGATION:

Employees did not follow Resident A's plan of care.

INVESTIGATION:

On 4/19/23, I contacted administrator Keely Sanders via email, requesting Resident A's Incident Report, assessment plan, logs and health care appraisal.

On 4/26/23, I interviewed administrator Keely Sanders in the home. She provided Resident A's turn logs. I reviewed the logs dating back from March 2023 to July 2022. The logs reflected that the employees turned Resident A approximately every two hours during wake hours. Ms. Sanders stated that Resident A's son would not authorize the home to have Resident A sit in a chair.

On 5/2/23, I interviewed Careline medical social worker Cheryl Moore, via telephone. Ms. Moore stated that during onsite visits to see Resident A, there were gaps in the logs between turn times, that stretched as long as four hours. She stated that when she brought this to the staff's attention, she was told that they had turned Resident A, but did not document the occurrence in a timely fashion. She also advised that the staff were constantly being re-trained on follow up to would care, which she described as keeping the resident dry, keeping the area clean and turning the resident every two hours.

On 5/10/23, I reviewed Resident A's Incident Report and Resident Assessment Plan The incident report details that Resident A was noted to have stopped breathing. Thereafter, Careline Hospice and the resident's Power of Attorney were notified. Items noted in the assessment plan include being turned every two hours, unless noted differently by a physician. The plan read " DUE TO SOILED LINENS OR CLOTHING MAY REQUIRE INCREASED LAUNDRY SERVICES." The plan cites that Resident A was not resistant to assistance as planned and was functionally incapable of dressing and grooming. Other details in the plan include incontinence, and the need for assistance with bathing/showering.

On 6/1/23, I reviewed Careline Hospice notes detailing encounters with Resident A at the home. I noted that on three occasions, the hospice staff provided education on keeping resident A dry and turning her more frequently. The notes also detail Resident A's pressure sore getting progressively worse.

On 6/1/23, I interviewed Careline Hospice Nurse Practitioner Jennifer Paulson, via telephone. Ms. Paulson stated that she had received reports that there were gaps in Resident A's turn logs when hospice staff visited the home. She advised that employees claimed that they had turned Resident A but forgot to make the entries in the logs. Ms. Paulson stated that there were instances where Resident A was found in soiled clothing, from the day before, indicating that Resident A had not been changed from the previous day. I asked about the impact of care on Resident A's wounds, and Ms. Paulson stated that it would be difficult to determine whether or not the sore would have improved, since Resident A's skin was so thin.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the**

	instructions and recommendations shall be recorded in the resident's record.
ANALYSIS:	Based on interviews with Careline Hospice representatives, and reviews of the hospice notes, it appears that the hospice representatives made multiple attempts to encourage employees at the home to change Resident A more frequently and turn her on a regular basis. Because hospice staff had to provide direction on multiple occasions, it does not appear that the home followed Resident A's plan, which was to keep her dry and turn her every two hours. There is no evidence that Resident A refused this care.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/6/23, I attempted to conduct an exit conference with licensee designee Connie Clauson, where I shared my findings. Ms. Clauson was not available at the time that I called.

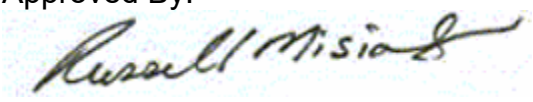
IV. RECOMMENDATION

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

6/7/23

Dwight Forde Date
Licensing Consultant

Approved By:



6/7/23

Russell B. Misiak Date
Area Manager