GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 3, 2023

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

RE: License #: AL460398057
Investigation #: 2023A1032009
The Fieldstone at Tecumseh

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 #:	AL460398057
Investigation #:	2023A1032009
Complaint Receipt Date:	11/04/2022
Investigation Initiation Date:	11/04/2022
Report Due Date:	12/04/2022
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
Name of Facility:	The Fieldstone at Tecumseh
Facility Address:	1313 Southwestern Drive Tecumseh, MI 49286
Facility Telephone #:	(517) 423-1141
Original Issuance Date:	08/12/2019
License Status:	REGULAR
Effective Date:	02/12/2022
Expiration Date:	02/11/2024
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The home improperly discharged Resident A.	No
Additional Findings	No

III. METHODOLOGY

11/04/2022	Special Investigation Intake 2023A1032009
11/04/2022	Special Investigation Initiated - Letter Thirty-day notice received from the home
11/07/2022	Contact - Face to Face Interviews with Resident A and Administrator
12/19/2022	Contact - Telephone call made Interview with complainant
12/19/2022	Exit Conference

ALLEGATION:

The home improperly discharged Resident A.

INVESTIGATION:

On 11/4/22, I received an email from District Manager Kelly Smith providing an amended copy of Resident A's discharge.

On 11/7/22, I interviewed Home Manager Athena Meza in the home. Ms. Meza reported that Resident A was given a 30-day notice of discharge. She detailed that Resident A had engaged in serious rule violations such as being intoxicated,

smoking on the property and having lighters in his bedroom. She stated that Resident A would routinely prevent employees from cleaning his rooms. Meza reported that Resident A had also recently ran over her foot with an assistive device. She explained that Resident A had been admitted to the home as a respite care client around July 2022. She mentioned that Resident A been provided housing options but he had declined them. Ms. Meza reported that Resident A was non-compliant with medication and that he was likely exhibiting some mood instability.

Ms. Meza provided a tour of Resident A's room and remarked that it had been cleaned.

I interviewed Resident A. He denied that he has been non-compliant with rules at the home. He denied smoking on the property, having lighters in his room or being intoxicated. He denied being non-compliant with medication, and explained that the home's provider, Carelink, had discontinued some of his medications. He acknowledged receiving a 30-day notice. He stated that he has a tour scheduled for another home. Resident A stated that he was previously in possession of a motorized wheelchair, which was replaced by a conventional non-motorized device. He verbalized understanding the reason why the motorized chair was replaced, because it was infested with insects.

On 12/19/22, I interviewed the complainant. I was informed that Resident A stills lives in the home, and that the home has been taking steps to facilitate placement at another home. I was advised that Resident A was provided with a new motorized wheelchair.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.**

	(ii) The alternatives to discharge that have been attempted by the licensee. **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**
ANALYSIS:	Resident A acknowledged being served with a 30-day notice. The document clearly reflects the reasons for the discharge as required by this rule. To date, he has not been discharged, and efforts were being made to find suitable housing prior to his discharge.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 12/19/22, I reached out to licensee designee Connie Clauson to conduct an exit interview to share my findings and allow her to opportunity to provide any feedback. Ms. Clauson did not respond to my request at the time of this report's conclusion.

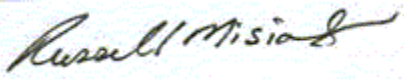
IV. RECOMMENDATION

I recommend no change to the status of this license.

1/3/23

Dwight Forde Date
Licensing Consultant

Approved By:



1/3/23

Russell B. Misiak Date
Area Manager