

GRETCHEN WHITMER GOVERNOR STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

ORLENE HAWKS DIRECTOR

January 25, 2023

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

> RE: License #: AL460398057 Investigation #: 2023A1032027 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,

Dw. Juda

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

1:	AL 40000057
License #:	AL460398057
Investigation #:	2023A1032027
Complaint Receipt Date:	01/10/2023
· · ·	
Investigation Initiation Date:	01/18/2023
	01110/2020
Report Due Date:	02/09/2023
Report Due Date.	02/09/2023
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	Suite 203, 3196 Kraft Avenue SE
	Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
	(0.0) 200 00.0
Administrator:	Kooly Sandors
Aummstrator.	Keely Sanders
	
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 Jacuarea Data:	00/40/2040
Original Issuance Date:	08/12/2019
License Status:	REGULAR
Effective Date:	02/12/2022
Expiration Date:	02/11/2024
Capacity:	20
Das susses True er	
Program Type:	ALZHEIMERS
	AGED

II. ALLEGATION(S)

	Violation Established?
The home wrongfully issued a discharge notice to Resident A.	No
Additional Findings	No

III. METHODOLOGY

01/10/2023	Special Investigation Intake 2023A1032027
01/18/2023	Special Investigation Initiated - Telephone
01/18/2023	Inspection Completed On-site
01/19/2023	Contact - Telephone call made Interview with Administrator Keely Sanders
01/24/2023	Exit Conference
02/06/2023	Contact – Document received- Resident A's 30 day discharge notice

ALLEGATION:

The home wrongfully issued a discharge notice to Resident A.

INVESTIGATION:

On 1/18/23, I interviewed Region II Area Agency on Aging case worker Ben Keaster, via telephone. He stated that Resident A has qualified for and received Medicaid Waiver so that he is able to remain in the community with supportive services. Mr. Keaster stated that waiver funding covers only part of Resident A's overall bill and that Resident A is responsible for the remaining portion. He stated that part of his role is to help Resident A secure housing when needed and has been doing this for him since the ongoing problems between Resident A and the home. He advised that Resident A has declined some housing options, but that he will continue to assist

Resident A in securing a more permanent home. Mr. Keaster stated that since Resident A is responsible for his own affairs, there is little that can be done if he refuses care and refuses to pay the home for his portion of the housing cost. Mr. Keaster stated he was aware of circumstances alleged in this complaint.

On 1/18/23, I interviewed Resident A in the home. Resident A denied being medication non-compliant. He stated that sometimes he does not like to take his medication in the morning because he has postnasal drip, which he said caused nausea. He reported that in the past, he has vomited up his medication. He reported that he has been hospitalized intermittently over the past few months, which has added to his discomfort about taking medication. He stated that the provider, Carelink, discontinued his psychotropic medications, and he was unsure of the reason. When he was advised that sometimes providers do so if there is considerable non-compliance or substance abuse, he denied abusing drugs or alcohol. He stated that he does smoke outside and claimed that no one advised him that he could not smoke on the premises. He stated that he has a case worker from Region 2 Area Agency on Aging, but claimed that the case manager was unsuccessful in obtaining housing. He denied declining housing, except for a nursing home option. He denied laying in soiled sheets or preventing employees from cleaning his bedroom or linens. He denied any current issues with mood irregularity or anxiety, despite being diagnosed with Post Traumatic Stress Disorder and Bi-Polar Disorder. Resident A stated that he owes the home money and plans to pay his portion. He did not explain why he has not paid his bill.

I interviewed Employee Courtney Hickman in the home. Ms. Hickman stated that Resident A has refused medications. She reported that in past weeks, Resident A has refused to get up to allow his linens to be cleaned. Ms. Hickman stated that there have been reports that Resident A's breath has smelled of alcohol, and that there is a suspicion that Resident A obtains his alcohol from a nearby grocery store.

I interviewed administrator Keely Sanders. Ms. Sanders advised that Resident A was in substantial arrears for rent due to his nonpayment each month.

On 1/19/23, I interviewed administrator Keely Sanders once again, via telephone. Ms. Sanders stated that Resident A was provided with a copy of the resident handbook, detailing the rules of the home. She stated that Resident A will be provided with a 30-day notice on 1/23/23, and that the notice will contain the reasons for the discharge. Ms. Sanders stated that the reasons for the discharge included rule violations and nonpayment to the home.

On 2/6/23, I reviewed a copy of Resident A's discharge notice. The document was dated February 3rd, 2023 and had been sent via email on 2/3/23. The reason listed was non-payment.

APPLICABLE RU	LE
R 400.15302	Resident admission and discharge policy;
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.
ANALYSIS:	While Resident A does have mental health diagnosis's, he remains responsible for his own personal affairs. My interview with Resident A revealed his denial to the allegations related to his refusal of medications and care. Interviews with the administrator, staff, and Resident A's area agency case manager reveal a consensus that Resident A has refused medications and care while not paying his portion of the cost of living at the home. Though there is a significant disconnect between the staff of the home and Resident A, the home has made reasonable attempts at fulfilling their requirements of his <i>Resident Assessment Plan</i> and educating him on the house rules.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 1/24/23, I attempted to conduct an exit interview with licensee designee, Connie Clauson, via telephone. Ms. Clauson was unavailable at the time.

IV. RECOMMENDATION

I recommend no change to the status of this license.

Dwy Jude

1/25/23

Date

Dwight Forde Licensing Consultant

Approved By: Kurall Misia &

2/9/23

Russell B. Misiak Area Manager Date