GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 21, 2025

Brian Nitz
Baruch SLS, Inc.
Suite 203
3196 Kraft Avenue SE
Grand Rapids, MI 49512

RE: License #: AL460398056
Investigation #: 2025A1032051
Tecumseh Place I

Dear Brian Nitz:

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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

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 #:	AL460398056
Investigation #:	2025A1032051
Complaint Receipt Date:	09/19/2025
Investigation Initiation Date:	09/23/2025
Report Due Date:	10/19/2025
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	3196 Kraft Avenue SE Suite 203 Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Brian Nitz
Licensee Designee:	Brian Nitz
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:	03/13/2024
Expiration Date:	03/12/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident medical needs not being properly attended to, leading to decline.	No
Additional Findings	No

III. METHODOLOGY

09/19/2025	Special Investigation Intake 2025A1032051
09/23/2025	Special Investigation Initiated - Letter Reviewed Information about resident.
09/23/2025	Inspection Completed On-site
11/03/2025	Contact - Document Received

ALLEGATION:

Resident medical needs not being properly attended to, leading to decline.

INVESTIGATION:

On 9/23/25, I interviewed activities director Carmen Burgess in the facility. Ms. Burgess reported that Resident A had fallen in her bedroom and that another resident had alerted staff to the incident. Resident A was transported to the hospital by ambulance and once discharged, her husband picked her up and returned her to the facility. Ms. Burgess stated that Resident A had a bruise on her head and one on her hand. Ms. Burgess reported that staff have to often remind Resident A to use her cane.

I observed Resident A, who, due to a medical condition, was not able to participate in an interview. She was observed walking around with a cane. I also observed

Resident A's room. There were no trip hazards present such as area rugs or loose carpeting. There were no bruises visible during the onsite inspection.

I interviewed administrator Geoff Byron in the facility. Mr. Byron stated that Resident B came to the facility from a behavioral unit in Ohio and had pre-existing hip issues. he reported that an agency called Home MD had stabilized her on medication and had used a mobile X-Ray machine to scan for fractures after one of her falls. He advised that the X-Ray did not detect any hip fracture but had focused on Resident B's foot. She was eventually sent to Hickman Hospital in Adrian MI, where it was determined that she did have a hip fracture, but no surgery was indicated. He added that Resident B's responsible person made the decision to have Resident B transferred to Chelsea Hospital, where hip surgery was performed. He stated that Resident B died subsequently, on 9/18/25.

On 11/3/25, I reviewed Resident B's discharge from Hickman Hospital and Chelsea Hospital. The former document indicated that Resident B did have a hip fracture but recommended pain management, while the latter outlined a course of treatment for post-surgery recovery. I reviewed Resident B's health care appraisal, detailing past history of hip fracture.

I reviewed Resident A's discharge note from Hickman Hospital indicating that she was seen for a fall and discharged.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	The facility appears to have taken steps to address Residents A and B's health care concerns. A hospital did not provide Resident B with much in the way of pain management or surgical treatment to address a hip fracture. I noted that families were consulted regarding resident health care. Resident A was taken to the hospital and treated. Resident B was transferred to another hospital to perform hip surgery, a decision made by the family. Therefore there is insufficient evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 11/25/26, I conducted an exit conference with licensee designee Connie Clauson, where I shared my findings. I also conveyed my findings to prospective licensee designee Marcia Curtis.

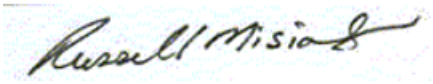
IV. RECOMMENDATION

I recommend no change to the status of this license.

11/21/25

Dwight Forde Date
Licensing Consultant

Approved By:



2/5/26

Russell B. Misiak Date
Area Manager