



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 12, 2025

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

RE: License #: AL460398056
Investigation #: 2025A1032043
Tecumseh Place I

Dear Connie 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. 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,

A handwritten signature in black ink, appearing to read "Dwight Forde".

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 #:	2025A1032043
Complaint Receipt Date:	08/04/2025
Investigation Initiation Date:	08/06/2025
Report Due Date:	10/03/2025
Licensee Name:	Baruch SLS, Inc.
Licensee Address:	3196 Kraft Avenue SE Suite 203 Grand Rapids, MI 49512
Licensee Telephone #:	(616) 285-0573
Administrator:	Geoff Byron
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:	03/13/2024
Expiration Date:	03/12/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility does not have adequate staff.	No
Resident A's healthcare needs such as falls and nutrition were not properly addressed.	No
Relative A1 was not notified properly of a serious incident.	No
Additional Findings	No

III. METHODOLOGY

08/04/2025	Special Investigation Intake 2025A1032043
08/06/2025	Special Investigation Initiated - On Site
08/15/2025	Contact - Document Received
09/05/2025	Contact - Telephone call made Call made to Relative A1, voicemail left
09/11/2025	Exit Conference with Administrator Geoff Byron

ALLEGATION:

The facility does not have adequate staff.

INVESTIGATION:

On 8/6/25, I interviewed administrator Geoff Bryon in the facility. Mr. Byron denied that the facility is improperly staffed. He explained that the residents at the facility have memory care needs. He reported that there are very few residents who have

highly acute medical issues that would necessitate more than the two staff that work the floor. He advised that while these two staff are direct care workers, there are several other auxiliary staff members on a daily basis. He advised that if there are call offs, he sometimes provides coverage.

I reviewed the staff schedule for the past month, and there were no gaps in coverage.

I attempted to interview Resident A, however she declined and stated that she was trying to rest.

APPLICABLE RULE	
R 400.15206	Staffing requirements.
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.
ANALYSIS:	I observed staff schedules that reflected compliance with the administrative rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident A’s healthcare needs such as falls and nutrition were not properly addressed.

INVESTIGATION:

On 8/6/25, Mr. Bryon discussed Resident A’s course of care in the facility. He stated that when Resident A was first admitted, she was on hospice. During the course of times, she was taken off hospice as she no longer met criteria, but is now back on. He advised that in the context of Resident A’s most recent hospitalization, she was determined to be suffering from malnutrition and dehydration, but Resident A often refuses food and drink, due to the fact that she is 93 and on hospice. He advised that she is regularly checked, two to three hours to mitigate skin breakdown if soaked.

Mr. Byron denied that Resident A is on fall precautions at this time, because there are no orders for assistive devices from her primary care physician. He stated however that Resident A is usually in the living room so that she can be monitored easier for falls.

I observed Resident A's bedroom to be clean and well organized. There was a small fridge with a note attached to drink more fluids.

On 8/15/25, I reviewed Resident A 's health care appraisal and assessment plan. There is no use of assistive devices noted on either document.

APPLICABLE RULE	
R 400.15310	Resident health care.
	<p>(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:</p> <p>(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.</p>
ANALYSIS:	The facility took steps to increase supervision on Resident A. I did not observe any trip hazards in the room. There was no medical order for assistive devices or safety mats. Reportedly, efforts were made to increase Resident A's food and water intake, with use of reminders in her room to drink more water.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Relative A1 was not notified properly of a serious incident.

INVESTIGATION:

On 8/6/25, Mr. Bryon stated during the July 4th holiday, another resident exhibited some aggression and police were called to assist. He advised that Resident A's arm was reportedly grabbed by this other resident but that a nurse had checked Resident A, who did not sustain any injuries as a result.

On 8/15/25, I reviewed an incident report where Resident A fell. The report was written in May 2025. The report indicated that Relative A1 was notified of the fall. I also reviewed the incident report where another resident was being aggressive. There was no injury reported to any of the other residents, and police were called to assist.

On 9/5/25, I left a voicemail for Relative A1 to make contact, to discuss any issues with Resident A's care that needed to be addressed.

APPLICABLE RULE	
R 400.15311	Incident notification, incident records.
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: (b) Unexpected and preventable inpatient hospital admission.
ANALYSIS:	To date, Relative A1 did not return my call. Relative A1 was notified of a fall in May 2025. The incident where another resident was aggressive towards others did not result in Resident A being injured or requiring hospitalization.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 9/11/25, I conducted an exit conference with Administrator Geoff Byron. I shared my findings and Mr. Byron agreed with the conclusions reached. He advised that Resident A had been transferred to another Baruch facility on 8/29/25.

IV. RECOMMENDATION

I recommend no change to the status of this license.

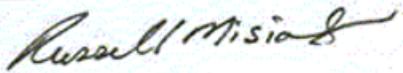


9/12/25

Dwight Forde
Licensing Consultant

Date

Approved By:



9/17/25

Russell B. Misiak
Area Manager

Date