GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 16, 2022

Sara Dickendesher
Candlestone Assisted Living
4124 Waldo Avenue
Midland, MI 48642

RE: License #: AH560360912
Investigation #: 2022A1027041
Candlestone Assisted Living

Dear Ms. Dickendesher:

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 241-1970
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH560360912
Investigation #:	2022A1027041
Complaint Receipt Date:	03/01/2022
Investigation Initiation Date:	03/02/2022
Report Due Date:	05/31/2022
Licensee Name:	Candlestone Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Avenue Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Alicia Neitzel
Authorized Representative:	Sara Dickendesher
Name of Facility:	Candlestone Assisted Living
Facility Address:	4124 Waldo Avenue Midland, MI 48642
Facility Telephone #:	(989) 832-3700
Original Issuance Date:	09/01/2015
License Status:	REGULAR
Effective Date:	03/01/2022
Expiration Date:	02/28/2023
Capacity:	66
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility could not meet Resident A's needs.	No
Resident A's authorized representative was not notified of his falls.	Yes
Resident A lost four pounds at the facility. Resident A was left in bed. Resident A did not have his boot on his wheelchair.	No
Resident A's authorized representative was not notified when he refused medications.	No
Additional Findings	No

III. METHODOLOGY

03/01/2022	Special Investigation Intake 2022A1027041
03/02/2022	Special Investigation Initiated - Letter Email sent to administrator Alicia Neitzel and AR Sara Dickendesher requesting documentation for Resident A
03/02/2022	Contact - Document Received Email received from Ms. Neitzel with requested documentation
03/16/2022	Contact - Telephone call made Telephone interview conducted with Ms. Neitzel
03/16/2022	Inspection Completed-BCAL Sub. Compliance
03/17/2022	Contact – Document Received Requested documentation received from Ms. Neitzel
03/18/2022	Contact – Document Sent Email sent to Ms. Neitzel requesting the facility's program statement
03/18/2022	Contact - Document Received Requested documentation received from Ms. Neitzel
04/13/2022	Exit Conference Conducted with authorized representative Sara Dickendesher

ALLEGATION:

The facility could not meet Resident A's needs.

INVESTIGATION:

On 3/1/2022, department received a complaint which read Resident A required a two person assist secondary to a stroke with left sided paralysis and cognitive deficits. The complaint read Resident A was assessed by facility staff prior to admission. The complaint read facility staff informed Resident A's family they could accommodate his needs and he was considered a "level 4" care by the facility. The complaint read after Resident A's admission to the facility staff ordered a hoyer lift due to state regulations of a two person assist transfer.

On 3/16/2022, I conducted a telephone interview with administrator Alicia Neitzel who stated Resident A was assessed prior to admission to the facility and deemed a "level 4" for care services, which was the highest level of care. Ms. Neitzel stated Leisure Living's policy is that the facility staff do not conduct two person transfers with a gait belt for both resident and staff safety. Ms. Neitzel stated upon Resident A's admission, she reviewed the facility's policy with Resident A's authorized representative and family in which she educated them that Resident A would be transferred by a sit to stand lift for safety. Ms. Neitzel stated home care therapy services worked with Resident A after admission to the facility and for safety, recommended a hoyer lift for transfers.

I reviewed Resident A's facesheet which read he admitted to the facility on 1/31/2022 and his authorized representative was Relative A1.

I reviewed Resident A's evaluation for admission dated 1/27/2022 which read he required two person assist for bathing needs, transferred with sit to stand lift – one person assist required, and required one person to push the wheelchair. The evaluation was signed by administrator Alicia Neitzel and Relative A1 on 2/28/2022.

I reviewed Resident A's admission contract dated and signed on 1/28/2022 by Relative A1, Resident A's conservator, and Ms. Neitzel which read

> "Medical equipment: To provide adequate personal care, supervision and protection for both residents and staff, it may be necessary to implement the use of various types of medical equipment and supplies. For both resident and staff safety, we are a 'lift free' community, which means we do not permit manual physical lifting of residents by staff. Resident needs will be evaluated on an ongoing basis. If special equipment or supplies are deemed necessary, we will help to coordinate the procurement of those supplies. Please be aware that some of these required items may not be covered by your insurance and you will be responsible for any changes associated with acquiring them."

I reviewed Resident A's service plan which read consistent with his evaluation for admission.

I reviewed Resident A's chart notes. Chart note dated 2/3/2022 read "Spoke with (Relative A1), we discussed (Resident A's) overall behaviors and Memory Care concerns. (Relative A1) is on board with the transition of (Resident A) moving from AL to MC. I also notified her of the PCP not being able to make immediate adjustments to medications and recommended AMHC and she is on board with transitioning primary care providers." Chart note dated 2/8/2022 read "Per Physical Therapist, Effective Immediately – (Resident A) is to be a Hoyer Lift Transfer."

I reviewed the facility's program statement with read consistent with Resident A's admission contract.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following: **(b) That a home shall not accept an individual seeking admission unless the individual's needs can be adequately and appropriately met within the scope of the home's program statement.**
ANALYSIS:	Review of the admission evaluation and service plan revealed the facility's assessment required staff to utilize a sit to stand lift for Resident A's transfers in which both documents were signed by Relative A1. Review of chart notes revealed staff identified additional safety needs for Resident A in which he was transitioned from the assisted living to memory care after admission. In memory care, more frequent checks were implemented for Resident A's safety as well as implementation of therapy recommendations to utilize a hoyer lift for transfers. Based on this information, it is reasonable to conclude Resident A's individual care needs were adequately met consistent within the home's program statement.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's authorized representative was not notified of his falls.

INVESTIGATION:

On 3/1/22022, the department received a complaint which read Resident A's authorized representative was not notified of his falls. The complaint read on 2/7/2022, Resident A's authorized representative was contacted by hospital staff after Resident A admitted to the emergency department for fall at the facility. The complaint read Resident A fell out of his wheelchair on 2/8/2022 in which he had no injury. The complaint read Resident A fell out of his bed on 2/9/2022. Additionally, the complaint read Resident A had another fall on 2/22/2022 in which the authorized representative was not notified.

I reviewed Resident A's admission contract which read: "Hospitalization: If you are hospitalized for any reason, our goal is follow your progress by staying in contact with you and your family."

I reviewed Resident A's chart notes titled "Fall/Suspected Fall" dated 2/7/2022 at 7:55 PM which read "Resident refused multiple attempts by staff this morning to get up, and to take his medications. I checked on (Resident A) around 10:45 and told him I would be back soon to check on him again. At 11am, I observed resident on the floor between his couch and his bed. Resident stated "I hit my head and my knee is killing me." Sent resident to hospital via EMS."

I reviewed incident reports submitted to the department. The report dated 2/14/2022 read Resident A was observed on the floor next to his bed and his authorized representative was notified on 2/14/2022 at 7:10 PM.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	Review of facility documentation revealed Resident A had falls at the facility. The chart notes revealed Resident A had a fall on 2/7/2022 requiring Resident A to be transported to the hospital which lacked documentation Resident A's authorized representative was notified nor was there other supporting documentation revealing notification to his authorized representative. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A lost four pounds at the facility. Resident A was left in bed. Resident A did not have his boot on his wheelchair.

INVESTIGATION:

On 3/1/2022, department received a complaint which read Resident A had lost four pounds while at the facility from 1/31/2022 to 2/21/2022. The complaint read Resident A was left in bed. The complaint read Resident A did not have his boot on his wheelchair.

On 3/16/2022, I conducted a telephone interview with administrator Alicia Neitzel. Ms. Neitzel stated although Resident A resided in memory care, he was not confined to the unit and could utilize the facility's 24-hour bistro available to all residents. Ms. Neitzel stated the bistro had ready to eat snacks such as but not limited to fresh fruits, cookies, muffins, chips, and beverages. Ms. Neitzel stated she observed Resident A utilize the bistro on a few occasions. Ms. Neitzel stated the facility did not document resident's percentage of food intake unless there was a physician order to monitor a resident's intake. Ms. Neitzel stated it was usually a standard order for resident's weights to monitored monthly.

I reviewed Resident A's evaluation for admission dated 1/27/2022 which read weight monitored monthly, regular diet, required staff assistance with set up of meal, and did not have an altered sleep cycle.

I reviewed Resident A's admission contract which read

> "Menus: Menus are created in conjunction with Registered Dieticians through Gordon Food Services. The "regular" menu served is based on a 2,000 calorie, no added salt, consistent carbohydrate diet We work to accommodate physician prescribed diets and will let you know if we are able to accommodate your required diet. Our goal is to enhance dining services by offering a beautiful and comfortable environment for each of our residents, while providing wholesome and nutritious meals. We do our best to accommodate preferences and the wide variety of palates."

I reviewed Resident A's service plan which read consistent with his evaluation for admission. The plan read Resident A did not have unplanned weight loss or loss of appetite. The plan read it was updated on 2/8/2022 to conduct hourly checks for Resident A from 2/8/2022 through 2/16/2022 to aid with activities of daily living and offer him snacks as well as fluids. The plan read it was updated on 2/8/2022 to conduct 30-minute checks to aid with activities of daily living, offer resident snacks and fluids, extending on 2/14/2022 to 2/21/2022.

I reviewed Resident A's chart notes. Chart note dated 2/1/2022 read

> “The resident experienced a lot of confusion throughout the night. Care staff tried explaining how to use the wrist pendant he has several times but the resident just didn’t comprehend it. Care staff went to check in on him often and asked several times if he would like to go to bed but the resident ended up staying up until 3AM because he said he worked a lot of over time the day before and wanted to watch a little tv before sleeping. The tv was off every time care staff checked on him. When the resident was ready to get to bed he took over an hour to assist into because he repeatedly refused care staffs help stating he would just roll himself into bed and he does it all the time. The resident also brushed his teeth for around 20 minutes until his gums bled but he refused to stop. The resident also stated that his arm was in pain because he had a huge gash on it. Care staff evaluated the resident but he had no wound.”

Chart note dated 2/2/2022 read

> “Resident refused breakfast and lunch. Resident is also refusing all care. Resident thought that he was in Detroit and had no idea where he was.”

Chart note dated 2/3/2022 read

> “Resident was in the common area around 1PM and was not sitting in an unsafe way in his chair, I approached the resident and asked to correct it and he refused. Resident also refused to be taken to his room or helped around in any way.”

Chart note dated 2/7/2022 read

> “Resident refused multiple attempts by staff this morning to get up, and to take his medicine. I checked on (Resident A) around 10:45 and told him I would be back soon to check on him again. At 11AM, I observed resident on the floor in between his couch and is bed. Resident stated “I hit my head and my knee is killing me.” Sent resident to hospital via EMS.”

Chart note dated 2/10/2022 read

> “Resident has a boot that he must wear while in wheelchair, staff has witnessed multiple times that resident will kick boot off, the proceed to wheel around with his affected foot dragging.”

I reviewed Resident A’s history and physical which read weight of 138 pounds on 1/28/2022.

I reviewed the Resident Diet Checklists from 2/1/2022 through 2/22/2022 which read the resident’s room numbers, beverage preference, and diet and food preferences. Additionally, the checklists marked each meal breakfast, lunch, and dinner served

from the kitchen to the resident. The checklists read Resident A was served three meals per day for that timeframe.

I reviewed clinical notes from Advance Medical House Calls dated 2/9/2022 and 2/16/2022 which read Resident A requires assistance with all meals and is therefore unable to maintain sufficient fluid and caloric intake without staff resulting in progressive weight loss.

I reviewed Resident A's home care notes from 2/2/2022, 2/3/2022, 2/4/2022, 2/8/2022, 2/9/2022, 2/11/2022, 2/12/2022, 2/13/2022, 2/15/2022, 2/17/2022, 2/18/2022, 2/20/2022. Nurse note dated 2/2/2022 read under nutrition, adequate, eats over half of most meals. Occupational therapy note from 2/20/2022 read Resident A was able to feed himself.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Resident A's admission agreement read residents have the right to refuse services in which chart notes revealed Resident A declined assistance from care staff at times. Review of Resident A's service plan revealed staff conducted frequent checks for assistance with activities of daily living and to ensure safety in which facility documentation revealed staff checks were completed. Review of home care notes lacked documentation supporting the allegations regarding Resident A. While Resident A's health care provider documented he required staff assistance to maintain sufficient caloric intake, there was lack evidence to support weight loss occurred from lack of care from facility staff. It is reasonable to assume staff provided care consistent with Resident A's service plan, thus these allegations could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's authorized representative was not notified when he refused medications.

INVESTIGATION:

On 3/1/2022, the department received a complaint which read Resident A's authorized representative was not notified that he had refused medications.

On 3/16/2022, I conducted a telephone interview with administrator Alicia Neitzel who stated Resident A's primary care provider would not change medications without seeing him in the office. Ms. Neitzel stated Resident A's family agreed with transitioning Resident A to Advanced Medical House Call services in which health care providers would come to the facility to evaluate Resident A. Ms. Neitzel stated Resident A was evaluated by practitioner Tom Schaffer with Advanced Medical House Call Services. Ms. Neitzel stated Mr. Schaffer was notified of Resident A's refusal of medications.

I reviewed Resident A's evaluation for admission dated 1/27/2022 which read staff were to assist with all medications.

I reviewed Resident A's admission contract dated and signed on 1/28/2022 which read "Medication incidents or adverse reactions are to be reported to the health care provider immediately." The contract read "While you have the right to refuse medication, repetitive refusal without physician approval may be considered to pose risk of serious harm to themselves or to others (refer to Move-out provisions)."

I reviewed Resident A's service plan which read consistent with his evaluation of for admission.

I reviewed Resident A's medication administration records (MARs) which read Resident A refused some of his medications on the following dates 2/4/2022, 2/7/2022, 2/12/2022, and two medications on 2/19/2022.

I reviewed clinical notes from Advance Medical House Calls dated 2/9/2022 and 2/16/2022 which read Resident A's medication records were reviewed.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(f) Contact the appropriate licensed health care professional if a resident repeatedly refuses prescribed medication or treatment. The home shall follow and record the instructions given.**

ANALYSIS:	Review of facility documentation revealed Resident A had refused some medications in which the facility's contract read facility staff would contact the resident's physician if it occurred repeatedly. Resident A's clinical notes read his medication records were reviewed twice by a licensed health care professional and the facility continued to follow medication orders; thus, the facility was compliant with this rule. Additionally, the allegation was not within homes for the aged licensing regulations and therefore, no violation would be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 4/13/2022, I shared the findings of this report with authorized representative Sara Dickendesher. Ms. Dickendesher verbalized understanding of the findings.

IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

3/18/2022

Jessica Rogers Date
Licensing Staff

Approved By:

04/12/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section