GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 8, 2023

Angela Hall
Hallstrom Castle Assisted Living, LLC
5638 Holton Rd
Twin Lake, MI 49457

RE: License #:	AL610395597
Investigation #:	2023A0356043
	Hallstrom Castle Assisted Living

Dear Ms. Hall:

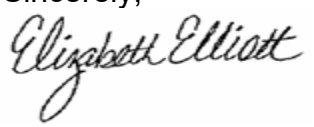
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 responsible party and a date.

If you desire technical assistance in addressing these issues, please 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL610395597
Investigation #:	2023A0356043
Complaint Receipt Date:	06/23/2023
Investigation Initiation Date:	06/23/2023
Report Due Date:	08/22/2023
Licensee Name:	Hallstrom Castle Assisted Living, LLC
Licensee Address:	5638 Holton Rd Twin Lake, MI 49457
Licensee Telephone #:	(231) 828-4664
Administrator:	Angela Hall
Licensee Designee:	Angela Hall
Name of Facility:	Hallstrom Castle Assisted Living
Facility Address:	5638 Holton Rd Twin Lake, MI 49457
Facility Telephone #:	(231) 828-4664
Original Issuance Date:	03/09/2020
License Status:	REGULAR
Effective Date:	09/09/2022
Expiration Date:	09/08/2024
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive proper care from staff at the facility.	No
Additional Findings	Yes

III. METHODOLOGY

06/23/2023	Special Investigation Intake 2023A0356043
06/23/2023	APS Referral
06/23/2023	Special Investigation Initiated - Telephone Gene Gray, APS worker.
06/26/2023	Contact - Telephone call made. Gene Gray, APS, Muskegon Co, DHHS.
06/28/2023	Contact-Telephone call made. Angela Hall, Licensee Designee.
06/28/2023	Contact - Document Received medical documents, doctor's orders.
07/03/2023	Contact - Document Received Incident Report
07/05/2023	Contact - Document Received Gene Gray, Resident placed on Hospice care.
07/06/2023	Contact-Telephone call made. Licensee Designee, Angela Hall, Resident A is not in the facility. Resident A in a hospice facility.
07/19/2023	Contact-Document received. MAR for Resident A, May, and June 2023.
08/01/2023	Contact-Telephone call made. Staff interviews, Kim Wright, and Casey Boucher.
08/01/2023	Contact-Telephone call made. Dr. Jennifer Griffin, DPM.

08/07/2023	Contact-Telephone call made. Kelly Vanderveen-Dr. Carrel's office.
08/07/2023	Exit conference-Licensee Designee, Angela Hall.

ALLEGATION: Resident A did not receive proper care from staff at the facility.

INVESTIGATION: On 06/23/2023, I received a BCAL (Bureau of Children and Adult Licensing) online complaint. The complainant reported that Resident A's foot is "noticeably black and rotting with a very noticeable foul odor". The complainant reported staff knew about the wound and Resident A has a medical appointment for July 2023, but staff should have arranged for Resident A to receive prompt medical care for the wound. Muskegon County DHHS (Department of Health and Human Services) APS (Adult Protective Services) worker, Gene Gray is investigating.

On 06/23/2023, I interviewed Gene Gray, via telephone. Mr. Gray stated he went out to the facility on 06/21/2023 and Resident A's wound is scabbed over, there was no smell, and the wound is not rotting. Mr. Gray stated wound care was going into the facility and a primary care physician and a foot doctor saw Resident A twice just prior to the time he was there on 06/21/2023. Mr. Gray stated Resident A's foot and wound are being cared for. Mr. Gray stated he is closing his investigation as unsubstantiated.

On 06/28/2023, I interviewed Angela Hall, Licensee Designee and Administrator via telephone. Ms. Hall stated that Resident A came to this facility from a nursing home and the sore on her foot was already there upon admission on 04/28/2023. Ms. Hall stated McAuley nursing home care came out, conducted an assessment, evaluated Resident A and told staff to keep the wound clean and dress the wound 1 time daily. Ms. Hall stated home care only came out one time to conduct an assessment, and on 06/27/2023, she (Ms. Hall) was informed that Harmony Care Visiting Physicians, could not officially set up wound care because Resident A did not have insurance coverage in the State of Michigan. She had Illinois insurance that did not cover services in Michigan. Ms. Hall stated the facility doctor, Dr. Carrel DO monitored Resident A's health throughout the time she resided in this facility. Dr. Carrel is the visiting physician that oversees the residents at this facility. Ms. Hall stated Dr. Carrel and Dr. J. Griffin, DPM (foot doctor) saw Resident A on 06/21/2023 and assessed Resident A's wound. Ms. Hall stated staff changed the dressings on Resident A's foot 1-2, sometimes 3 times daily, but the wound progressed rapidly, and Resident A was sent out to the hospital on 06/27/2023 and admitted. Ms. Hall stated on the last day and a half of Resident A being in the facility, the wound on her foot began to smell and that is when staff sent Resident A to the hospital. Ms. Hall stated Resident A's wound was being cared for by staff at the facility and was not black and rotting from lack of care.

On 06/28/2023, I reviewed physician's orders signed by Dr. Daniel Carrel on 05/10/2023. Dr. Carrel wrote on the document, *'order for wound care.'*

On 06/28/2023, I reviewed the physician's orders signed by Dr. Daniel Carrel on 06/21/2023. The physician's orders document an order dated 05/11/2023 written for *'Dakins Sol 0.125% SOLN, cleanse wound with Dakins, apply soaked Dakin-soaked gauze to wound bed, cover with and wrap and apply to right heel twice daily as needed for wound healing.'*

On 06/28/2023, I reviewed the physician communication form that documented main concern for patients and noted the following; *'R (right) heel need for wound care. Order for PT/OT/SN, order for airbed mattress, vertigo med discussion, possible pain med. DM order for supplies,'* signed by Dr. D. Carrel on 06/21/2023.

On 06/28/2023, I reviewed an email message from Carrie Foss, Harmony Home Care to Dr. Carrel dated 06/22/2023 that documented the following; *'Good afternoon, Dr. Carrel. I processed the Home Health referral for (Resident A) and sent it to Mary Free Bed At Home as they agreed to accept it over Care Port. Bob from Mary Free Bed At Home called to report the patient has an Aetna insurance plan that is specific only to the state of Illinois. There is no home health coverage for any state that is not IL. Please note, at this time, unless patient is willing to pay out of pocket, Home Health intake is unable to place the patient with a Home Health agency as the agencies cannot accept the out of state insurance plan. The referral I processed earlier has been cancelled. I apologize for the inconvenience. Thank you.'*

On 07/03/2023, I reviewed an IR (incident report) dated 06/28/2023 at 4:30p.m. written by staff, Rayven Roberts and signed by Ms. Hall. The IR documented the following information: *'(Resident A) has been trying to get wound care set up for a right heel ulcer. She was seen by the doctor twice and a podiatrist but because of her insurance was unable to get wound care set up. Dressing changes done at least daily sometimes three times a day if needed. Kept guardian aware of situation and sent (Resident A) into ER for evaluation and treatment.'*

On 07/06/2023, Ms. Hall reported that Resident A was discharged from the hospital to a hospice facility and did not return to this facility.

On 08/01/2023, I interviewed Direct Care Workers (DCW's) Kim Wright and Casey Boucher separately via telephone. Ms. Boucher and Ms. Wright stated wound care for Resident A's heel wound was completed daily. Ms. Boucher stated wound care was completed "multiple times daily" and Ms. Wright stated wound care was completed "three times daily." Ms. Boucher stated wound care was checked by shift leads when they came on their shifts each day. Ms. Boucher stated Resident A's wound was black from being scabbed over. Resident A would frequently rub her foot on the bed, the bandages would come off and she would rub the scab off, so the wound was open and when the scab was off the wound, there was a smell. Ms. Wright and Ms. Boucher stated they were providing care to the wound, cleaning,

dressing it and at times it would smell but denied that the wound was black from rotting.

On 08/01/2023, I interviewed Dr. Jennifer Griffin, DPM via telephone. Dr. Griffin stated she only saw Resident A once at this facility on 06/21/2023 to clip Resident A's toenails. Dr. Griffin stated Dr. Carrel was there just prior to her visit and it appeared as though staff had been soaking the wound and then Dr. Carrel took care of the debridement of the wound and wrapped it. Dr. Griffin stated the heel was bandaged and she could not see what the wound looked like. Dr. Griffin stated there was an odor to the room and stated the "odor was no different than any other odor of wound care, it smelled like a wet wound."

On 08/07/2023, I interviewed Kelly Vanderveen, nurse at Dr. Carrel's office. Ms. Vanderveen stated Dr. Carrel's referral for in-home nursing for wound care was denied because Resident A had insurance coverage only in the State of Illinois and not in the State of Michigan. Ms. Vanderveen stated staff could not do anything about that, it would have been up to others to change the insurance to Michigan in order for Resident A to get in home wound care. Ms. Vanderveen stated no one ever called with concerns about Resident A's care at the facility or Resident A's wound care except for facility staff, and that is when Dr. Carrel began seeing Resident A in the facility in May 2023. Ms. Vanderveen stated Dr. Carrel last saw Resident A on 06/21/2023 and evaluated Resident A's wound. Ms. Vanderveen stated staff at the facility did what they were supposed to do while caring for Resident A's wound. Ms. Vanderveen stated whenever there were concerns, staff consulted Dr. Carrel.

On 08/07/2023, I conducted an exit conference with Ms. Hall via telephone. Ms. Hall stated she agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The complainant reported that Resident A's foot was black, rotting and with a very noticeable foul odor. The complainant reported staff knew about the wound and should have arranged for Resident A to receive prompt medical care for the wound. Mr. Gray stated Resident A's wound had no smell, and the wound was not rotting. Mr. Gray stated that a primary care physician and a foot doctor assessed Resident A and Resident A's foot wound was cared for.

	Ms. Hall stated Dr. Carrel, DO oversaw Resident A's care in the facility and Dr. Griffin, DPM, came in to assess Resident A's foot wound. Home care was not an option because Resident A's insurance would not cover wound care in the State of Michigan. Dr. Carrel attempted to set up wound care for Resident A but was unable to get it started because Resident A had an insurance plan that is specific only to the state of Illinois. The physician's orders called for staff to provide wound care to Resident A on an as needed basis. An IR documented that Resident A was seen by a doctor twice and a podiatrist during her two-month stay but because of her insurance was unable to get wound care set up. Dressing changes were done at least daily sometimes three times a day if needed, and staff kept Resident A's guardian aware of the situation and sent (Resident A) into ER for evaluation and treatment when needed. Ms. Vanderveen stated staff cared for Resident A's wound as directed by the doctor and staff called the Dr. for evaluation and treatment when necessary. Dr. Griffin stated the wound appeared to be cared for by staff and by Dr. Carrel and the odor in the room was no different than typical wound care odor. Ms. Wright and Ms. Boucher stated staff completed wound care on Resident A's foot multiple times daily. There is not a preponderance of evidence to show that while Resident A was in the care of staff at the facility, care to the wound on Resident A's foot was not being provided. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION: On 07/19/2023, I reviewed the MARs (medication administration records) for the months of May and June 2023 for Resident A. The records show for both May and June, Dr. Carrel's order written 05/11/2023 to continue to 07/10/2023 for *'Dakins SOL 0.125%, cleanse wound with Dakins, apply soaked Dakins gauze to wound bed, cover with and wrap and apply to right heel twice daily as needed for*

wound healing.' This PRN (as needed) special medical procedure is not documented on the MAR with staff initials, there are no signatures documenting that the procedure was completed.

On 08/01/2023, I interviewed DCW's Ms. Wright and Ms. Boucher, and both reported they were trained by a wound care specialist on how to care for Resident A's wound. Ms. Wright and Ms. Boucher stated Resident A's wound care was completed up to three times daily and each time the special medical procedure was completed it was documented in the employee communication book. Ms. Wright and Ms. Boucher stated they did not document on the MAR that the Dakin's was applied because they did not realize this special medical procedure was on the MAR, both staff reported they have never seen this on the MAR but that it was completed multiple times daily.

On 08/01/2023, I conducted an exit conference with Ms. Hall via telephone. Ms. Hall stated it is unfortunate that staff did not document the MAR as required but documented their wound cares in the staff communication book. Ms. Hall stated the wound care was not always on the MAR and that is likely why staff did not realize it was added back onto the MAR as a PRN (as needed) procedure. Ms. Hall stated she will conduct an in service to supervisors and staff at the facility to make sure they are properly documenting the MAR. Ms. Hall stated she will submit an acceptable corrective action plan. Ms. Hall stated she understands the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being §333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Dr. Carrel prescribed a special medical procedure to clean and dress Resident A's heel wound on an as needed basis (PRN). The special medical procedure is documented on the MAR but there are no staff initials showing when the PRN was administered. Ms. Wright and Ms. Boucher stated they cleaned and dressed Resident A's wound up to three times daily and documented it

	in the employee communication log. Ms. Wright and Ms. Boucher stated they did not document it on the MAR with their initials because they did not realize this treatment was on the MAR. The special medical procedure prescribed by Dr. Carrel was not documented on the MAR as completed with the initial of the staff person completing the treatment and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

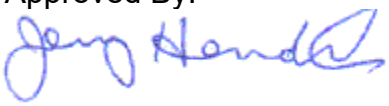
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remains the same.

08/08/2023

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



08/08/2023

Jerry Hendrick — Date
Area Manager