GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

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

September 22, 2023

RE: License #: AH560360912
Investigation #: 2023A1022012
Candlestone Assisted Living

Dear Sara 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 and a date.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH560360912
Investigation #:	2023A1022012
Complaint Receipt Date:	11/07/2022
Investigation Initiation Date:	11/09/2022
Report Due Date:	01/07/2023
Licensee Name:	Candlestone Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Avenue Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Marcie Edwards
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:	03/01/2023
Expiration Date:	02/29/2024
Capacity:	66
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility did not have a plan to deal with Resident A, when he became aggressive and caused an injury to Resident B.	No
The facility did not investigate an injury sustained by Resident B that was discovered by Resident B's family member after the physical altercation with Resident A.	Yes

III. METHODOLOGY

11/07/2022	Special Investigation Intake 2023A1022012
11/09/2022	Special Investigation Initiated - Telephone Complainant interviewed by phone
12/20/2022	APS Referral
12/20/2022	Inspection Completed On-site
09/22/2023	Exit Conference

ALLEGATION:

The facility did not have a plan to deal with Resident A, when he became aggressive and caused an injury to Resident B.

INVESTIGATION:

On 11/7/2022, the Bureau of Community and Health Systems received a complaint alleging that on 11/3/2022, during a community activity, Resident A grabbed the hand of Resident B and caused bruising to Resident B's hand. The complainant stated that she "wasn't sure if [Resident A] should have been in a group setting."

On 11/7/2022, the facility submitted two incident reports (IRs) describing the resident-to-resident altercation between Resident A and Resident B. The IR for Resident A read, "Resident [name of Resident A] resides in the memory care community and is alert to person. His homecare nurse entered the building to observe resident shouting and approaching resident [name of Resident B]. [Name of Resident A] grabbed on to [name of Resident B]'s hands and wrist and continued shouting. The nurse attempted to intervene but [name of Resident A] yelled at her to "shut up." [Name of Resident A] pushed [name of Resident B] to the point he began to lose balance. The homecare nurse was able to support him, separate them and safely get [name of Resident B] in a seated position… this behavior is very unusual for resident (A) and upon investigation, resident was taken off of his Lexapro (anti-depressant and anti-anxiety medication) on 9/15/22. Homecare nurse contacted PCP (primary care physician) and they diverted to the neurologist. Neurologist contacted regarding incident and noted behavior and they will be seeing him in office before reinstating medication. His appointment is 11/21/22. Resident will be supervised when in communal areas with [name of Resident B]."

According to the IR written for Resident B, "[Name of Resident A] pushed [name of Resident B] to the point he began to lose balance. The homecare nurse was able to support him, separate them and safely get [name of Resident B] in a seated position… No injuries noted. Old bruising noted to the right hand… No visible injuries note in the days following and resident denies any pain or discomfort."

On 11/9/2022, I interviewed the complainant by phone. The complainant stated that Resident B was her family member and that while he was legally blind, he was able to make his needs known and was aware of events going on around him. The complainant went on to say that the facility had called her just after 2 pm on 11/3/2022 and informed her that another resident had been aggressive with Resident B. The complainant went on to say that this was not first incident between the Resident A and Resident B. On at least one previous occasion, Resident B had told the complainant that Resident A had "tried to kill my dog."

On 12/20/2022, a referral was made to Adult Protective Services.

On 12/20/2022, during an onsite visit to the facility, I interviewed the administrator, the wellness director, and the regional operations specialist. The regional operations specialist was in the building because the administrator was newly hired by the facility and the operations specialist was responsible for training her. The operations specialist stated that she was very familiar with the facility and could answer most questions with the help of the wellness director. When the operations specialist and the wellness director were asked about the two residents, Resident A and Resident B who were involved in the altercation, the operations specialist indicated that Resident B had less cognitive impairment than Resident A, but both residents had dementia, confusion, and problematic behaviors.

Resident A lived in the facility's memory care (MC) unit and was described as being generally pleasant but was known to become frustrated when unable to find his belongings. He would then accuse other residents or staff of taking them. The MC unit was not a secured unit. According to the wellness director, the door to the MC unit sounded an alarm if a person opened the door without entering a passcode on a keypad, but this was only to alert the staff that someone had passed through the door. Resident A was free to leave to leave the MC unit, but usually, he did not. At the time of the onsite visit, Resident A was in his room, seated in a reclining chair, asleep. He did not waken when his name was called.

Resident B lived in the general assisted living portion of the facility. The regional operations specialist said that he was confused and that his confusion was compounded by his vision impairment. Resident B was further described as being resistant to care, and as a "veteran with PTSD (post-traumatic stress disorder)." Regardless of any problematic behaviors, Resident was a regular participant in community activities. At the time of the onsite visit, Resident B was seated at a table in the main lobby, accompanied by his dog, surrounded by other residents who were assembling a jigsaw puzzle. Resident B was friendly when greeted by the wellness director.

Neither the wellness director nor the regional operations specialist had any knowledge that prior to 11/3/2022, Resident A and Resident B had a negative encounter with each other. Further, there was no indication that Resident A had any negative encounter or altercation with any other resident.

According to the service plan for Resident A, he needed regular prompting due to confusion and disorientation, but was able to follow directions and had good safety awareness. Although he was known to wander, he did not attempt to leave the building and could be distracted from the behavior. He was generally cooperative with staff. On 11/3/2022, his service plan was updated, indicating that Resident A was "to be supervised when in communal areas with resident in Apartment #40 (Resident B).

According to the service plan for Resident B, he had occasional "verbal disruptions," but would respond to reassurance from staff. Like Resident A, on 11/2/2022 an

update was made to Resident B's service plan, indicating that he was "to be encouraged to remain separate from (resident in) Apartment #4 (Resident A)."

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	There was no evidence that Resident A had regular encounters with Resident B and when there was an encounter, the facility responded appropriately.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not investigate an injury sustained by Resident B that was discovered by Resident B's family member after the physical altercation with Resident A.

INVESTIGATION:

According to the complainant, the facility staff member who called her informed her that Resident B was not injured as a result of this altercation, but when she came into the facility the next day, 11/4/2022, Resident B said to her, "look at my hand." According to the complainant, when Resident B showed her the back of his right hand, there was a large purple bruise. The complainant stated that she brought the bruising to the attention of one of the staff members and that the staff member told her that the facility would look into it. The complainant went on to say that no one from the facility ever got in touch with her about the bruising. The complainant was unable to identify which staff member she contacted about Resident B's bruise.

According to the IR written for Resident B, dated 11/7/2022, Resident B had "No injuries noted. Old bruising noted to the right hand… No visible injuries note in the days following and resident denies any pain or discomfort."

At the time of the onsite visit, neither the wellness director nor the regional operations specialist were able to explain the origin of the "old bruising" found on Resident B's right had at time of the altercation between Resident A and Resident B.

The regional operations specialist stated that she had direct knowledge that on 11/3/2022, Resident B had a resolving bruise, because she had observed it herself. According to the regional operations specialist, the bruise “had fading purple and green colors present immediately following the incident, indicative of a bruise that was in the healing phases. Due to [name of Resident B]’s poor eyesight and use of ASA (aspirin) it is not out of the ordinary for him to have faded bruising on his hands from bumping them on things while walking with his walker.”

Review of charting notes revealed a note written by care coordinator #1, dated 11/6/2022, documenting that Resident B “has a bruise across the entire top of his left hand. He states he fell over a chair.” When the regional operations manager was asked if it was possible that care coordinator #1 had documented left hand, when the bruising was on the right hand, the regional operations manager agreed that was a definite possibility. Further, the regional operations manager confirmed that care coordinator #1 was unaware that the family member of Resident B had contacted a facility employee about bruising on Resident B’s right hand. When asked about further investigation or documentation regarding the bruise found by care coordinator #1, the regional operations manager acknowledged that no further investigation was completed, no incident report written, and no notification was made to Resident B’s family member.

According to the facility’s Standard Operating Procedure for A Resident Incident/Accident Report, the report “is completed whenever there is a need to explain/investigate an unwitnessed injury or unexplainable event to include but not limited to bruises, skin tears, fall with injury, hospital treatment, community acquired wound, or elopement.”

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements.
ANALYSIS:	An incident report should have been written as Resident B had several risk factors for bruising, including the use of aspirin as well as a propensity for bumping into furniture with his walker related to his vision deficit.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 09/22/2023. When asked if there were any comments or concerns with the investigation, the AR did have a few questions regarding the investigation, but they were resolved at the time of the exit conference.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

09/22/2023

Barbara Zabitz Date
Licensing Staff

Approved By:

09/18/2023

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