GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 28, 2024

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

RE: License #:	AL610395597
Investigation #:	2024A0356021
	Hallstrom Castle Assisted Living

Dear Ms. Hall:

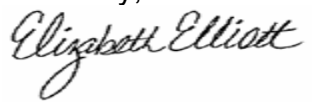
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
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 #:	2024A0356021
Complaint Receipt Date:	01/29/2024
Investigation Initiation Date:	01/29/2024
Report Due Date:	03/29/2024
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's required medical procedures were not followed by staff.	Yes
Staff failed to implement changes to Resident A's required medical procedures in a timely manner.	Yes

III. METHODOLOGY

01/29/2024	Special Investigation Intake 2024A0356021
01/29/2024	Special Investigation Initiated - Telephone Lesile Lecours, RN, MI Choice Waiver Nurse Case Manager.
01/29/2024	APS referral.
02/05/2024	Contact - Face to Face Staff, Isaac Smith, Casey Boucher, Resident A-not able to provide information pertinent to this investigation due to cognitive deficits.
02/27/2024	Contact - Telephone call made. Angela Hall, LD.
03/04/2024 & 03/08/2024	Contact - Document Received Facility documents.
03/12/2024	Contact - Document Sent Clarification re: MAR to Angela Hall.
03/13/2024	Contact - Telephone call made. Harmony Home nurse, Autumn Kraus, call Harmony medical group rather than home care.
03/13/2024	Contact-Document received. Facility documents.
03/14/2024	Contact-Telephone call made. Diane Bastian, RN-Harmony cares medical group.
03/15/2024	Contact-Telephone call received. Tammy Kastelic, Reliance social worker.

03/17/2024	Contact-Document received. Facility MAR reviewed 03/18/2024.
03/21/2024	Contact-Telephone call received. Angela Hall, Licensee Designee.
03/28/2024	Exit Conference-Angela Hall, Licensee Designee.

ALLEGATION: Resident A's required medical procedures were not followed by staff.

INVESTIGATION: On 01/29/2024, I received a BCAL (Bureau of Children and Adult Licensing) complaint. The complainant reported that Resident A's blood sugars dropped to 26 in September 2023 and as a result, Resident A was hospitalized. In November 2023, Resident A's blood sugar readings were supposed to be taken before meals, at bedtime and as needed but staff at the facility were only checking Resident A's blood sugar as needed and not four times daily as ordered by the doctor. The complainant reported staff at the facility were not keeping a log to record Resident A's blood sugar. In addition, Resident A had an adjusted order for Zyprexa 5mg, ½ tab four times per day on the discharge order from the hospital. The order was sent to Walgreens pharmacy by the hospital and staff did not implement that order or follow-up with Walgreens to notify them of the correct pharmacy for the medication order to be set to. The complainant reported on 01/07/2024, Resident A's blood sugar dropped to the 20's, EMS (emergency medical services) were called, and Resident A was taken to Trinity Health Muskegon Emergency Room for treatment. The diagnosis was Hypoglycemia. At the hospital, Resident A was monitored for six hours and when her blood sugars went up, she was discharged back to the facility.

On 01/29/2024, I interviewed Leslie Lecours, RN, Reliance Community Care Partners, MI Choice Waiver Nurse Case Manager. Ms. Lecours confirmed the information in the allegation was an issue including Resident A's adjusted order for Zyprexa 5mg, ½ tab four times daily rather than three times daily as previously prescribed. Ms. Lecours added Resident A's blood sugars were only being taken on an as needed basis when they should have been checked four times daily and documented. Ms. Lecours stated staff at the facility do not seem to know what they were doing when it comes to Resident A's blood sugar and she is not sure where the disconnect was between the facility and the medical professionals, but it has caused concern. Ms. Lecours reported on 12/08/2023, she reviewed all of Resident A's discharge instructions including medication changes from recent hospitalizations with Krista Hall, home manager so staff should have been aware of all the medical changes made regarding Resident A.

On 02/05/2024, I conducted an unannounced inspection at the facility and interviewed direct care workers (DCWs), Isaac Smith and Casey Boucher. Mr. Smith

stated for the past “month or two” staff have checked Resident A’s blood sugars at every meal and document the numbers on the DCP (daily care plan). Mr. Smith and Ms. Boucher stated there was a short amount of time that the blood sugar checks for Resident A was on a PRN (as needed) basis and that was documented on the MAR (medication administration record). Mr. Smith and Ms. Boucher stated now Resident A’s blood sugar readings are checked at every meal, three times daily and they are documented on the MAR. Mr. Smith stated if a doctor orders a medication or instructions for a resident, the order goes to LTC pharmacy and then it shows up on the MAR.

On 02/05/2024, I attempted to interview Resident A at the facility. Resident A is not capable of providing information pertinent to this investigation due to cognitive deficits.

On 02/27/2024, I interviewed Angela Hall, Licensee Designee and Administrator via telephone. Ms. Hall acknowledged that Resident A went to the hospital in September 2023 due to a seizure with a blood sugar of 26. Ms. Hall stated Resident A went to the hospital in November as the complainant reported due to poor blood sugars and at that time, there was talk about testing Resident A’s blood sugars four times daily, but it did not begin until later. Ms. Hall stated for about a week Resident A’s blood sugars were being taken PRN (as needed) and the clarity about when and how often the blood sugars were to be taken was “a mess.” In addition, Ms. Hall stated that the testing supplies were not enough to test Resident A as much as four times daily and she has been buying supplies so they can test Resident A’s blood sugars.

Ms. Hall stated when Resident A went to the hospital in November 2023, they never received any discharge paperwork from either Resident A or Resident A’s guardian, and they did not tell the hospital to send any prescriptions to Walgreens pharmacy because they were not in contact with anyone about Resident A’s discharge instructions nor were they aware there was a new order. Ms. Hall acknowledged that the medication Zyprexa, 5mg, ½ tab four times daily was not implemented because that prescription order was never received at the facility.

On 03/14/2024, I interviewed Diane Bastian, RN, Harmony Home Care Medical Group via telephone. Ms. Bastian stated she is the nurse for Kim Harper, NP (nurse practitioner) through Harmony Cares, an in-home medical group. Ms. Bastian stated on 09/18/2023, Harmony Home Medical Group requested embrace lancets with instructions to test four times daily, and this was sent to Welcome Pharmacies (which is a distribution center for LTC Pharmacy that the facility uses). Ms. Bastian stated in the same month, on 09/22/2023, they refilled and sent in an order to Benson Pharmacy in Muskegon for more test strips for testing four times daily.

Ms. Bastian stated on 10/09/2023, they switched Resident A’s blood sugar checks to before meals (3 times) and before bed (1 time) totaling 4-time blood sugar checks to be completed daily. Ms. Bastian reported on 10/09/2023, she faxed orders to the

facility to check blood sugar before meals, 3x daily and at bedtime, 1x daily and discontinued the Estradiol cream.

Ms. Bastian stated on 12/08/2024 Krista Hall, home manager, told the Reliance nurse, Leslie Lecours, that they (the facility) may not be able to test Resident A's blood sugars four times daily because the insurance company would not cover it and there would not be enough supplies to cover 4x daily blood sugar testing. Ms. Bastian stated she was also informed on 12/08/2023, that the facility was drawing Resident A's blood sugars as needed (PRN) rather than with meals 3 times daily and at bedtime (1 time) as ordered by Harmony Cares. Ms. Bastian stated blood sugar logs were not being documented or kept by staff.

Ms. Bastian stated on 12/26/2023, they ordered more diabetic testing supplies. The order was sent to Benson's and with that order was an order for a Dexcom 7 sensor to test Resident A's blood sugar four times daily. Ms. Bastian stated in December, they ordered Resident A's blood sugar four times daily and as needed (PRN), so possibly up to five times daily.

On 03/15/2024, I interviewed Tammy Kastelic, Reliance social work case manager. Ms. Kastelic stated as of March, on the MAR, Resident A's blood sugar reading is completed at 8:00a.m., 12:00p.m., 4:00p.m. and 8:00p.m. Ms. Kastelic stated the current order has been changed to four times daily testing of Resident A's blood sugars and the blood sugar/glucose numbers are documented on the MAR and signed by staff initials.

On 03/18/2024, I reviewed Resident A's MARs from September 2024 to date in March 2024. Resident A's blood sugar readings are not documented on the MAR until December 22, 2023, beginning with the 4:00p.m. reading. The instructions on the MAR document, 'check blood sugar before meals and at bedtime.

- September, October, November 2023 MAR documented Novolog Inj flexpen, 100 unit/ML SOPN, inject 3 units subcutaneously three times daily before meals and Basaglar Inj,100 unit/ML SOPN inject 30 units subcutaneously at bedtime.
- December 2023 Basaglar changes to 25 units at bedtime. The Novolog changes to 5 units before meals. The blood sugar readings begin to show up on the MAR.
- January 2024 Basaglar changes to 25 units twice daily reduce by 50% if she is eating less than 50% of her meals. The Novolog remains at 5 units with instructions. The MAR shows Blood Sugar Reading PRN, as needed with no prescriber documented.
- February 2024 documented Basaglar as discontinued, blood sugar readings continue to be documented with instructions 'check blood sugar before meals and at bedtime.' Lantus inject 25 units subcutaneously every morning and 20 units every evening is on the MAR and Novolog 5 units before meals.

- March 2024 blood sugar readings continue to be documented on the MAR. Lantus is changed to 12 units every morning and Novolog remains 5 units before meals.

On 03/18/2024, I reviewed the MAR from September 2023 to date March 2024 and reviewed Resident A's Zyprexa 5mg, ½ tab, 2.5 mgs. The medication remains on the MAR to be administered three times daily at noon, 4:00p.m., and at bedtime and was never changed for administration four times daily as reported by the complainant, reported by Ms. Lecours, and acknowledged by Ms. Hall.

On 03/21/2024, I reviewed the blood sugar logs received from Ms. Hall. The blood sugar logs are for September 2023, October 2023, November 2023, and December 2023.

- September 2023 log documented Resident A's blood sugar readings were taken three times daily at 8:00a.m., 12:00p.m. and 4:00p.m. except for when Resident A was out of the facility. On September 28, 2023, the log shows an added time of 8:00p.m. for testing Resident A's blood sugars.
- October 2023 log documented Resident A's blood sugar readings were taken 4 times on 10/01/2023 and as a PRN (as needed) until 10/15/2023 when the logging of the blood sugar readings ended and there were no more documented except for one blood sugar on 10/26/2023 and one on 10/29/2023.
- November 2023 log documented Resident A's blood sugar was taken 4 times daily at 8:00a.m., 12:00p.m., 4:00p.m. and 8:00p.m. until Resident A was out of the facility beginning on 11/22/2023 through the remainder of the month.
- December 2023 log documented Resident A's blood sugars were taken at 8:00p.m. only from 12/01/2023-12/11/2023 and then 4 times daily for the remainder of the month.

On 03/28/2024, I conducted an exit conference with Angela Hall, Licensee Designee via telephone. Ms. Hall stated she will submit an acceptable corrective action plan.

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 S333.1101 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:	Based on investigative findings, there is a preponderance of evidence to show that staff at the facility failed to implement and follow individual medical procedures on a consistent basis that was prescribed by a licensed medical professional and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Staff failed to implement changes to Resident A's required medical procedures in a timely manner.

INVESTIGATION: On 01/29/2024, I received a BCAL (Bureau of Children and Adult Licensing) complaint. The complainant reported that the in-home doctor through Harmony Cares attempted to call to change medications for Resident A due to critical lab values and it took them three days to contact any one at the facility. The complainant reported that Harmony Cares wanted to order changes to Resident A's Levothyroxine and Insulin.

On 01/29/2024, I interviewed Ms. Lecours via telephone. Ms. Lecours stated calls to the facility from medical professionals were unanswered for approximately 2-3 days when Harmony Cares called to change Resident A's Levothyroxine and insulin.

On 02/27/2024, I interviewed Ms. Hall via telephone. Ms. Hall stated she had some issues with the home manager at the time of this complaint. Ms. Hall reported the home manager is no longer working at the facility and acknowledged that calls could have gone unanswered during this time period.

On 03/14/2024, I interviewed Ms. Bastian via telephone. Ms. Bastian stated it took over three days to reach anyone at the facility and to date, she still has never talked to anyone at the facility. Ms. Bastian stated on 12/06/2023 at 9:50a.m., Resident A's blood work came in and Kim Harper, NP (nurse practitioner) emailed Ms. Bastien results and changes to Levothyroxine and Insulin for Resident A. Ms. Bastien stated she called the facility and left a message for staff. Ms. Bastien stated on 12/07/2023 at 7:04a.m. she left another message at the facility for staff. Ms. Bastien stated on 12/08/2023 at 10:55a.m. she left another message and on 12/08/2023 at 11:14a.m. she talked to Ms. Lecours, Reliance nurse and informed her of the difficulties she was experiencing contacting anyone at the facility to give updated information and instructions regarding Resident A's medications. Ms. Bastien reported on 12/08/2023 at 11:40 a.m., Ms. Lecours spoke to Krista Hall, facility manager and informed her of the changes. Ms. Bastien stated it was at this time that Ms. Hall informed Ms. Lecours she was not sure they could test Resident A's blood sugars four times daily because she was not sure insurance would cover that many daily checks.

On 03/18/2024, I reviewed Resident A's December 2023 MARs and the medication Levothyroxine tab 50mcg, take one tablet by mouth every evening for hypothyroidism is marked DC'd (discontinued) as of 12/11/2023. A new order written 12/06/2023 by Kimberly Harper NP was implemented on 12/11/2023 and is documented on the MAR, Levothyroxine 88mcg, take one tablet by mouth once daily on an empty stomach 30 minutes before breakfast. The Novolog 100 unit/ML SOPN, inject 3 units subcutaneously three times daily before meals was DC'd on 12/06/2023 and a new order for Novolog 100 unit/ML SOPN, inject 5 units subcutaneously before meals is documented on the MAR as implemented for the dinner time administration on 12/06/2023.

On 03/28/2024, I conducted an exit conference with Licensee Designee, Angela Hall via telephone. Ms. Hall stated she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(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: (a) Medications.
ANALYSIS:	Based on investigative findings, there is a preponderance of evidence to show that staff at the facility failed to follow instructions and recommendations by a licensed medical professional. This occurred for a period of at least five days because no one responded to the calls left by Ms. Bastian and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan that includes re-training staff on the administration and documentation of resident medications, I recommend the status of the license remain the same.

Elizabeth Elliott

03/28/2024

Elizabeth Elliott Date
Licensing Consultant

Approved By:

03/28/2024

Jerry Hendrick Date
Area Manager