GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 30, 2020

Carmel Slebodnik
Candlestone Assisted Living
4124 Waldo Avenue
Midland, MI 48642

RE: License #: AH560360912
Investigation #: 2020A1019077

Dear Ms. Slebodnik:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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 (248) 975-5053.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH560360912
Investigation #:	2020A1019077
Complaint Receipt Date:	08/20/2020
Investigation Initiation Date:	08/26/2020
Report Due Date:	10/19/2020
Licensee Name:	Candlestone Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Avenue Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	David Schmidt
Authorized Representative:	Carmel Slebodnik
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:	03/01/2020
Expiration Date:	02/28/2021
Capacity:	66
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B was not being monitored every two hours.	No
Medication related concerns: • Resident B's eye drops not being administered as prescribed • Facility staff are not coordinating with Resident B's physician regarding her blood pressure medication	No
Resident B's nail care was not being provided.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/20/2020	Special Investigation Intake 2020A1019077
08/26/2020	Comment Intake submitted on 8/20/20, area manager Russ Misiak assigned to licensing staff Elizabeth Gregory-Weil on 8/26/20. Intake promptly initiated upon receipt.
08/26/2020	Special Investigation Initiated - Telephone Call placed to complainant, line was busy and unable to leave message. Attempted three calls total, same issue each call.
08/26/2020	Contact - Document Sent Emailed complainant for additional information.
08/31/2020	Contact - Telephone call made Telephone interview conducted with complainant.
09/17/2020	Inspection Completed On-site
09/17/2020	Inspection Completed BCAL Sub. Compliance
09/17/2020	Comment

	Additional information and documentation requested while onsite but staff were unable to provide at that time. Correspondence is ongoing.
09/21/2020	APS Referral
09/29/2020	Contact- Telephone call made Phone call with administrator to discuss documentation submitted, also requested additional information.
09/30/2020	Exit Conference Conducted with AR by telephone

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Resident B was not being monitored every two hours.

INVESTIGATION:

On 8/20/20, a complaint was submitted involving Resident B. On 8/31/20, a telephone interview was conducted with the complainant. The complainant stated that she did not feel that Resident B was being checked on every two hours per the level of care that the family is paying for. The complainant stated that she was particularly concerned over her level of supervision on the evening of 7/27/20 when Resident B suffered a medical event. The complaint stated that Resident B's family had attempted to get ahold of her via a video monitoring device that was in the resident's apartment. The complainant stated that Resident B's family could hear her on the device but could not see her. The complainant stated that Resident B's family had difficulty getting ahold of someone at the facility to go check on her but once they did, Resident B was found in the corner of her room babbling and with slurred speech. The complainant stated that Resident B was taken to the hospital and diagnosed with a UTI, dehydration and elevated liver enzymes. The complainant stated that Resident B never returned to the facility after her hospitalization and was relocated to a different assisted living facility.

On 9/17/20, I conducted an onsite inspection at the facility. I interviewed administrator David Schmidt and director of resident care Joan Majors at the facility.

Mr. Schmidt stated that he was not the administrator during most of Resident B's tenancy at the facility and began his employment with the company only two weeks before she was discharged but stated that he has become aware of many issues that Resident B's family wanted addressed after her discharge. Mr. Schmidt and Ms. Majors confirmed that Resident B had a medical event on 7/27/20 but both attested that Resident B received checks at least every two hours and often more frequent than that. Ms. Majors stated "Her family was very involved. [Resident B] received more monitoring than anyone here because of her family's demands." Mr. Schmidt and Ms. Majors reported that staff are required to document monitoring and supervision twice per shift on the residents medication administration record (MAR) but they do not have documentation to support each and every check that they made on the resident.

Resident B's charting notes were reviewed from 7/27/20. Facility staff documented the following on 7/7/20 at 6:47pm:

> Resident was slightly delusional this afternoon and stated seeing people out in the yard (verified [sic] not by staff) and being able to also hear them yelling. Resident was reassured and redirected and resumed normal behavior. Resident prior to lunch experienced a bathroom mess and was assisted by staff to clean up and change clothing.

Facility staff documented the following on 7/27/20 at 9:11pm:

> [Resident B] was sent out tonight around 8:13pm. Her daughter [Relative B] was trying to call heron her white screen a couple of times. [Resident B] was not answering and [Relative B] was worried so she called Candlestone around 7:46pm. Jacob was walking in when I was coming down the hallway. When I got in I told Jacob to take her vitals. I reassured [Relative B] that we were going to make sure she was okay. When walking n you could visibly see something was wrong. Her left corner of her mouth was drooping. She also kept touching her left arm with her right one. She had a temperature of 97.1. we were unable to get the rest of her vial because she refused to keep them on her. I had her move her left arm and she was able to move it up and down. Jacob and I both knew something wasn't right. She was also leaning to her left against the wall by her med cabinet on the grey stool, she kept trying to pick things up off the ground that weren't there, and talking to her husband [name omitted] that is no longer alive called Joan and she walked me through what to do next. Jacob stayed with her to help keep her calm she was very confused. I got her physician order and other important documents to send with her. I ment [sic] the ambulance people at the door and then Linsey let in the EMS team. When they got there they said it looked like a stroke and she was unable to stand and walk. It took 3 EMS people to get her up standing to move her. They said she was really hot, we were unable to catch what her temp was at that time. Her BP that the EMS took was 160/100. I called [Relative B] to let her know they were taking her I also made sure that she would be able to see her mom if she went. They said that they were able to

have 1 visitor right now with COVID going on. [Resident B] didn't refuse or anything like that when they took her. They said they were going to do a urine sample of their own when she got to the hospital. Joan said she was going to email the physician so I didn't have to send a fax to him. David called and was updated on the situation and Joan was going to call the hospital to get a [sic] update from them on what was going on.

Resident B's MAR was reviewed for July 2020. The MAR allows for staff to document baseline monitoring twice per shift (2:00am, 6:00am, 12:00pm, 2:00pm, 5:00pm and 10:00pm). The records consistently show staff documenting twice per shift that Resident B was monitored. On 7/27/20, staff documented that Resident B was checked on at the following times during their twice per shift monitoring: 1:16am, 5:33am, 11:46am, 2:58pm and 5:06pm. In the 10:00pm timeslot on 7/27/20, staff appropriately documented that Resident B was "out of facility".

Attestations from multiple care staff were obtained (Presley Hyer, Jessica Metiva, Casey Peters, Abby Reich and Odalys Sims). All staff attested that Resident B received checks every two hours with Ms. Hyer, Ms. Sims and Ms. Metiva reporting that additional safety checks were provided as needed.

Resident B's service plan read "Staff are to assist [Resident B] to the bathroom at least every 2 hours and apply cream on her buttock."

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:	Attestations from multiple staff report that Resident B was supervised at least every two hours, and more often if needed. Facility staff were expected to document baseline monitoring on Resident B twice per shift, which was regularly completed. There is insufficient evidence to determine that monitoring was not being completed every two hours. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medication related concerns:

- **Resident B's eye drops not being administered as prescribed**
- **Facility staff are not coordinating with Resident B's physician regarding her blood pressure medication**

INVESTIGATION:

The complainant stated that there were medications related concerns pertaining to Resident B's eye drops and blood pressure medication. The complainant stated that Resident B receives eyedrops daily for glaucoma. The complainant stated that upon reviewing Resident B's bill from the facility's contracted pharmacy (PharmaScript) regarding the eye drops, she realized that the medication had not been reordered for several months. The complainant stated that per the pharmacist, one bottle of the solution should last roughly 20 days. The complainant stated that at the time of her discharge from the facility at the end of July, the medication had only been reordered three times total in all of 2020. The complainant believes that this shows that Resident B could not have been receiving the medication as prescribed based on the reordering infrequency. The complainant stated that Relative B was informed by facility staff that the medication run out but does not have the name of the staff who allegedly reported the medication was out.

The complainant also stated that Resident B was receiving anti-hypertensive medication(s) for blood pressure. According to the complainant, Resident B's medication was changed at some point and her cardiologist had ordered that the facility provide blood pressure readings directly to the cardiologist's office every two weeks to ensure that the medication adjustment was effective. The complainant stated that upon Resident B's discharge from the facility, it was discovered that this order was not followed by facility staff and the cardiologist's office reported that they only received one blood pressure reading record.

Regarding Resident B's eye drops, Ms. Majors reported that Resident B's family had contacted the facility inquiring about Resident B's Brimonidine eye drops and why they had not been reordered monthly. Ms. Majors stated that at the time Resident B was discharged, there were three bottles of the solution in the med cart. Ms. Majors stated that one bottle was almost empty, and two bottles were full. Ms. Majors could not provide an explanation as to why there were three bottles and can only assume that if staff reported to Resident B's family that the medication was out, they had not realized that there were two other full bottles in the medication cart. Ms. Majors stated that Resident B is compliant with her eye drops and receives them twice daily as prescribed. Ms. Majors denies any staff reporting issues to her with respect to Resident B's eye drop administration.

Mr. Schmidt provided a copy of Resident B's physician's orders at the time of her discharge. I observed that Resident B was prescribed Brimonidine solution 0.15% with the instruction "Instill 1 drop into affected eye(s) twice daily for glaucoma". Resident B's MAR lists the scheduled administration times for the Brimonidine

solution as 08:00 and 21:00. Resident B's MAR was reviewed from 5/1/20-7/27/20. Staff documented Resident B received the medication as prescribed for each day during the timeframe reviewed apart from one dose on 7/4/20 and one dose on 7/16/20. On 7/4/20, facility staff documented the reason for the missed administration as "awaiting med arrival from pharmacy". On 7/16/20, facility staff documented the reason for the missed administration as "resident sleeping in bed and refused to wake up and take pills."

While onsite, Mr. Schmidt contacted PharmaScript to request a copy of the order history for Resident B's Brimonidine solution for the year. PharmaScript faxed the order history to the facility which showed the medication was reordered on 1/17/20, 2/19/20, 3/7/20 and 7/4/20. Mr. Schmidt did not have an explanation for the inconsistent reorder history but determined that the medication as being given as prescribed based on staff documentation in Resident B's MAR.

Regarding Resident B's blood pressure medication, Mr. Schmidt and Ms. Majors both stated that staff obtain Resident B's blood pressure daily, but denied knowledge of any standing orders to report Resident B's blood pressure readings every two weeks to her cardiologist's office. Mr. Schmidt and Ms. Majors reviewed several months of Resident B's physician's orders and found that on her December 2019 order history, there was a note that read "Fax BP results from 12/6-12/20 on 12/20/19 to Dr. Showole at 633-0349". Ms. Majors stated that the readings for the timeframe requested were faxed upon receipt of the order.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Resident B is prescribed Brimonidine solution and instructed to have the eye drops administered twice daily. Review of medication administration records reveal that Resident B was receiving the medication as prescribed for the timeframe reviewed, except for two instances in which staff documented the reasons for the missed doses. PharmaScript provided order history for the medication and while it can be determined that the medication was not reordered at a fixed frequency, there isn't conclusive evidence that the medication was not being administered. After interviewing facility management staff and review of physician's orders, I was unable to find evidence that there was a standing order to submit blood pressure readings to Resident

	B's cardiologist office. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B's nail care was not being provided.

INVESTIGATION:

The complainant stated that staff at her new assisted living facility discovered that Resident B's toenails were overgrown and the skin between her toes was crusty. The complainant stated that she believes Resident B's nail care had been neglected while at the facility.

Mr. Schmidt stated that Resident B is seen by a podiatrist that comes onsite to the facility about every six-ten weeks. Mr. Schmidt stated that Resident B was scheduled to see the podiatrist on 3/26/20, however that appointment got cancelled due to visitor restrictions during COVID and was not rescheduled prior to her discharge. Mr. Schmidt stated that he was provided photos by Resident B's family after she left the facility which showed that her toenails were unkept but stated that it was not the responsibility of facility staff to provide care to her toenails, as he felt it was a liability to do so because she was at a high risk of infection if staff accidentally cut her while trimming her nails.

On 9/28/20, Mr. Schmidt provided documentation from Northeastern Foot Clinic who provided podiatry services to Resident B. Per the documentation, Resident B was last seen by podiatry on 11/8/19. The documentation read:

> The following toenails are related to be painful, consistent with onychomycosis and are described by the following: all are yellow, thick, crumbly and painful. The following toenails are noted to be painful and are consistent with onychomycosis. All the toenails are related to be painful and consistent with onychomycosis. Mycotic infection is unchanged. Without continued treatment there would be a marked limitation of ambulation. No change in medical, vascular, or neurological history is related. Without proper care these toenails would cause an infection. Previous history of painful mycotic toenails…Surgical debrided mycotic toenails greater than 5 on both left and right feet. Capillary bleeding was not observed. Used a grinder to thin and smooth rough and thick edges of the nail plates. Toenails were noted to be reduced in length and girth, and if no problems the patient is to be seen in 9-10 week(s) or longer if no pain occurs.

During a phone call on 9/29/20, Mr. Schmidt clarified he found out that Resident B was not seeing the visiting podiatrist that most residents choose to see at the facility and had an outside provider set up by her family. Mr. Schmidt stated that Resident B's family coordinated her appointments and the facility did not have any documentation from any of her podiatry visits and was unaware of any treatment or follow up her she was to have. Mr. Schmidt also confirmed that the appointment scheduled on 3/26/20 was not for Resident B and was with the facility contracted visiting podiatrist and stated that the facility opted to cancel the appointment because it was not deemed an essential service.

Resident B's service plan dated 1/9/20 read "Manages skin and nail care independently. Resident is independent with skin and nail care". The service plan does not mention that Resident B is receiving podiatry services. In addition to Resident B's service plan, Mr. Schmidt and Ms. Majors provided a *Resident Evaluation* document for Resident B dated 5/14/20. Mr. Schmidt and Ms. Majors explained that the evaluation document is used to generate updates to resident service plans. The evaluation read "Provide assistance with nail care weekly. Trim fingernails, file fingernails and toenails, clean under nail bed, and push cuticles back gently." Resident B's service plan did not include this instruction and Mr. Schmidt further clarified that staff should not be tending to Resident B's toenails for liability reasons. Mr. Schmidt did not have any documentation to support that nailcare was being provided to Resident B by facility staff.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(1) A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan.
ANALYSIS:	Resident B was receiving podiatry services through Northeastern Foot Clinic, who would come onsite to the facility for visits. Facility staff lacked any documentation regarding podiatry orders or recommendations provided to Resident B. Conflicting instruction was observed on facility authored documentation and interviews with staff reveal inconsistent instruction pertaining to Resident B's nail care. Ultimately the facility was unable to provide any evidence that nail care was provided to Resident B or that any follow through was completed regarding her podiatry recommendations. Based on this information, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident B's service plan read that she was independent with oral, skin and nail care, independent with bathing, identified that she is incontinent but read that she managed her protective devices independently and identified that she did not exhibit any resistive or uncooperative behavioral or care issues. In speaking with Ms. Majors, she reported that Resident B went from being "pretty much independent" to needing staff assistance with almost all activities of daily living, including bathing and toileting, needed reminders and cueing for oral hygiene and grooming tasks and also became increasingly resistant to care beginning in March 2020. The service plan was dated 1/9/20.

On 5/14/20, an evaluation was completed on Resident B that identified a much higher level of care than what was outlined in her service plan. Mr. Schmidt and Ms. Majors stated that the evaluation is a tool used by the facility to generate the service plan but they were unable to provide an updated service plan to coincide with the most recent evaluation that was completed.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Resident B's service plan was not updated to accurately reflect the level of care she required. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/30/20, I shared the findings of this report with authorized representative Carmel Slebodnik. Ms. Slebodnik verbalized understanding of the citations.

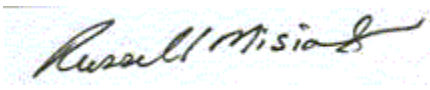
IV. RECOMMENDATION

Continent upon completion of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

9/29/20

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



9/30/20

Russell B. Misiak Date
Area Manager