STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

September 7, 2021

Connie Clauson
Hale Area Assisted Living Corporation
Suite 203
3196 Kraft Ave, SE
Grand Rapids, MI 49512

RE: License #: AH350338564
Investigation #: 2021A1028032
Hale Creek Manor

Dear Mrs. Clauson:

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 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 (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH350338564
Investigation #:	2021A1028032
Complaint Receipt Date:	06/30/2021
Investigation Initiation Date:	07/01/2021
Report Due Date:	07/30/2021
Licensee Name:	Hale Area Assisted Living Corporation
Licensee Address:	8096 Campbell Avenue Hale, MI 48739
Licensee Telephone #:	(989) 728-2525
Administrator:	Catherine Scofield
Authorized Representative:	Connie Clauson
Name of Facility:	Hale Creek Manor
Facility Address:	3191 M-65 Hale, MI 48739
Facility Telephone #:	(989) 728-1300
Original Issuance Date:	09/05/2014
License **Status:**	REGULAR
Effective Date:	03/05/2021
Expiration Date:	03/04/2022
Capacity:	43
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility did not provide Resident A appropriate supervision, assistance, or supervised personal care.	Yes
The facility did not issue a discharge notice for Resident A consistent with rules.	Yes
The facility did not report any of Resident A's incidents to the department.	Yes
Care staff improperly administered Resident A's medication.	Yes

III. METHODOLOGY

06/30/2021	Special Investigation Intake 2021A1028032
07/01/2021	Special Investigation Initiated - Letter APS referral emailed to centralized intake
07/01/2021	APS Referral APS referral emailed to centralized intake
07/01/2021	Contact - Telephone call made Interviewed Admin, Catherine Scofield by telephone
07/01/2021	Contact - Telephone call made Interviewed complainant by telephone
07/01/2021	Contact - Telephone call made Interviewed Ombudsman, Dakima Jackson, by telephone
07/01/2021	Contact – Document Received

	Received Resident A's admission contract, record notes, medication administration record (MAR), and service plan from Catherine Scofield
07/01/2021	Contact – Telephone call received Received telephone call from Ombudsman Dakima Jackson
08/05/2021	Contact – Telephone call made Follow up telephone call to complainant
08/05/2021	Contact – Telephone call made Interviewed Resident A's authorized representative by telephone
08/05/2021	Contact – Document Received Received copy of discharge letter and communication from facility office manager Wendy Lauria
08/09/2021	Contact – Document Received Received a copy of the memory care statement program and policy from Wendy Lauria
08/12/2021	Interviewed facility staff Wendy Lauria, Karli LaCosse, Synthia Shellenberger, and Tanya Shellenbarger by telephone

ALLEGATION:

The facility did not provide Resident A appropriate supervision, assistance, or supervised personal care.

INVESTIGATION:

On 6/30/21, the Bureau received the allegations from the online complaint system.

On 6/30/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 7/1/21, I interviewed administrator Catherine Scofield by telephone. Ms. Scofield reported the facility issued Resident A a less than 24-hour discharge on 6/30 due to Resident A's combative nature and behaviors during care routines since admittance on 6/1. Ms. Scofield reported Resident A's level of care has increased to where the facility can no longer meet the resident's needs. Ms. Scofield reported Resident A "has attacked other residents and care staff and we can no longer care for the

resident”. I requested a copy of Resident A’s service plan, medication administration record (MAR), record notes, admission contract, and discharge notice for my review.

On 7/1/21, I interviewed the complainant by telephone. The complainant reported Resident A has dementia with behaviors which requires 24-hour supervision and assist with all cares, and the facility was aware of this prior to Resident A’s admission. The complainant reported the facility did not appropriately assess Resident A’s needs upon admission and “should have been honest from the beginning of this process if they could not have provided the type of care [Resident A] requires”. The complainant also reported the facility did not keep the family informed of Resident A’s behaviors or level of care during Resident A’s stay at the facility.

On 8/5/21, I interviewed Resident A’s authorized representative by telephone. The authorized representative reported staff came out to the house to meet and observe Resident A with paperwork being completed to admit Resident A to the facility on 6/1/21. The authorized representative reported “we were very transparent about [Resident A] from the beginning and the type of care that [Resident A] would require. I feel the facility misrepresented themselves as being able to take care of [Resident A] and as a memory care unit”.

On 8/9/21, I received the facility memory care program statement and policy and procedures from facility office manager Wendy Lauria. The facility memory care program policy read “*In addition to our organizational Mission Statement, Hale Creek Manor, a managed program of Baruch Senior Ministries provides high quality care to elderly adults (age 60+)* in need of assistance with activities of daily living due to physical and/or cognitive ailments, limitations, disabilities or diseases. We provide 24 hour care in a manner that protects the resident’s rights and their dignity. Care is delivered in a kind and loving manner.”*

On 8/9/21, I reviewed Resident A’s service plan. The service plan revealed Resident A has impaired decision making, orientation, difficulty communicating, exhibits wandering behavior, and requires daily supervision, redirection, and assistance with all care. The service plan notates Resident A does not exhibit present or past behaviors, but staff are to perform hourly checks.

Review of Resident A’s record notes reveal Resident A demonstrated behaviors beginning the day of admittance on 6/1. The record notes revealed Resident A had a total of 18 documented behavioral incidents between 6/1 and 6/29.

On 8/12/21, I interviewed Ms. Lauria by telephone. Ms. Lauria reported she completed the admission for Resident A to the facility. Ms. Lauria reported the facility was aware of Resident A’s diagnosis and that Resident A did not demonstrate behaviors during the intake. However, Ms. Lauria reported Resident A had behaviors after admission requiring continual monitoring and redirection from care staff. Ms. Lauria reported Resident A’s authorized representative visited every

day and staff spoke with the authorized representative about Resident A's behaviors during every visit as well. However, Ms. Lauria reported the verbal communication between staff and the authorized representative were not documented in Resident A's record. However, Ms. Lauria reported the hourly checks performed by care staff in accordance with Resident A's service plan were documented. Ms. Lauria provided a copy of the hourly checks completed for Resident A and a copy of the signed service plan by the authorized representative for my review.

I interviewed care staff person (CSP) Karli LaCosse by telephone. Ms. LaCosse reported Resident A often demonstrated behaviors "like attempting to kiss or kissing other residents and/or staff". Ms. LaCosse reported Resident A also urinated in the common area and in the living area of Resident A's apartment and that "it was difficult to get [Resident A] to use the toilet appropriately". Ms. LaCosse reported care staff "had to provide [Resident A] continual monitoring and redirection with assist because of the wandering and behaviors. It would sometimes interfere with the care of other residents because we had to continually watch [Resident A]". Ms. LaCosse reported Resident A's hourly checks were completed per the service plan requirement and documented by care staff. Ms. LaCosse reported to her knowledge the verbal communication with Resident A's authorized representative about Resident A's behaviors were not documented. When questioned, Ms. LaCosse reported staff are trained and educated annually on dementia and Alzheimer's care at the facility.

I interviewed CSP Synthia Shellenbarger by telephone. Ms. Shellenbarger reported Reisdent A was verbally aggressive, requiring "constant monitoring and redirection." Ms. Shellenbarger reported also catching Resident demonstrating sexual behavior in the common areas but reported Resident A "was not really aware of what [Resident A] was doing and I could redirect [Resident A] when the behaviors happened." Ms. Shellenbarger reported staff recorded the hourly checks for Resident A but the verbal communication with Resident A's authorized representative was not documented. Ms. Shellenbarger also confirmed care staff received annual education and training on dementia at the facility.

I interviewed CSP Tanya Shellenbarger by telephone. Ms. Shellenbarger's statements are consistent with Ms. Lauria's, Ms. LaCosse, and Ms. S. Shellenbarger's statements.

On 8/13/21, Ms. Lauria emailed a copy of the facility education documentation with the most recent facility in-service staff training on dementia and Alzheimer's care for my review.

Review of the dementia and Alzheimer's care documentation and training revealed the most recent training occurred on 5/26/21, prior to Resident A's admission to the facility. The training was also signed by staff for compliance.

A review of the licensing facility file revealed no reported incidents to the department.

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.**
For Reference: **R 325.1901**	**Definitions:**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's 6 service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews with the administrator, staff, the complainant, and Resident A's authorized representative reveal Resident A was admitted to the facility on 6/1 and consistently had behaviors that were disruptive to staff and other residents up until the point of discharge. Review of the service plan revealed that staff did monitor Resident A on an hourly basis. However, it is arguable given the behaviors he demonstrated that this level of supervision was significantly long in frequency and the extreme frequency length placed others and Resident A at risk. The facility did not update the plan to reflect what methods should be instituted when Resident A urinated in public areas, was sexually inappropriate with self and others in public, was combative with staff, or combative with other residents. Interview of the complainant combined with review of Resident A's record revealed no documented evidence that Resident A's

	authorized representative was contacted and notified of the behaviors that were being demonstrating. In addition, a review of the licensing file revealed no incident report submissions regarding Resident A's behaviors staff verbalized had occurred. While review of the facility program statement and staff training program do in fact represent a capacity to deliver services for residents with dementia, the lack of adequate supervision, updating of the service plan, lack of communication to the residents authorized representative followed by issuance of a discharge notice reveals a lack of an organized program to provide services to residents with dementia.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not issue a discharge notice for Resident A consistent with rules.

INVESTIGATION:

On 7/1/21, Ms. Scofield reported she notified the family of the discharge on 6/30 and reported Resident A will be going home to family on 7/1. Ms. Scofield reported the facility cannot meet Resident A's needs and "it's just too much." Ms. Scofield reported Resident A urinated on a medication cart and a care staff member, tried to kiss another resident, hit care staff, and exposed private areas to staff and other residents. Ms. Scofield reported Resident A "requires beyond what we are capable of here."

The complainant reported the facility issued a less than 24-hour notice for Resident A on 6/30 and "are expecting us to just come pick up [Resident A] this morning". The complainant does not believe Resident A meets the criteria for a 24-hour discharge. The complainant reported the family needs more time and assistance in finding an appropriate placement for Resident A because Resident A "currently has nowhere to go". The complainant reported Resident A's family can no longer keep Resident A safe in the home and Resident A would not be returning home. The complainant reported "I am not sure why the facility is stating [Resident A] will be returning home because that is not true". The complainant reported "the facility never informed family

about the Resident A's behaviors to warrant a 24-hour discharge. Resident A is not demonstrating any behaviors that are untypical of person who has this disease."

I received a phone call from Ombudsman Dakima Jackson. Ms. Jackson's statements are consistent with the complainant's statements. Ms. Jackson reported she is "actively working to assist the family to find an appropriate placement, but the facility needs to provide us more time and not just put the resident out. The resident cannot return home due to safety". Ms. Jackson reported she is meeting with Resident A's family and Ms. Scofield today to request at minimum a 30-day discharge to allow the family to find a more appropriate setting for Resident A. Ms. Jackson reported she is also requesting the facility's assistance in finding Resident A a more appropriate placement.

I received a telephone call from assistant Ombudsman Mija Akins. Ms. Akins statements are consistent with Ms. Jackson's statements.

On 8/5/21, I made a follow up phone call to the complainant. The complainant reported the facility did not assist the family in finding a new placement for Resident A. The facility offered to allow Resident A to stay an additional 30 days until placement could be found but Resident A would require one-to-one supervision at an additional cost. The complainant reported the family decided it was in Resident A's best interest to remove Resident A from the facility on 7/1. The complainant reported Resident A was subsequently admitted to the hospital on 7/1 and while Resident A was in the hospital, the family with the help of the hospital social worker was able to locate a more appropriate placement for Resident A. The complainant reported the facility "did not try to make any alternative arrangements or recommendations for [Resident A] before discharging and did not inform anyone about the right to file a complaint about the discharge."

On 8/5/21, Resident A's authorized representative stated, "the discharge notice came as a shock with no warning". The authorized representative reported the facility did not keep the family informed of Resident A's behaviors and "never approached me about any of [Resident A's] problems. I even visited the facility several times and nothing were ever mentioned to me." The authorized representative reported Resident A would not be returning home due to safety concerns and is "not sure where the facility got that information from." The authorized representative reported the family decided to remove Resident A from the facility on 7/1 with Resident A being subsequently admitted to the hospital. The authorized representative reported the hospital social worker assisted the family with finding an appropriate placement for Resident A after leaving the hospital. Resident A did not return to the facility. The authorized representative also reported asking for copies of Resident A's record upon removing Resident A from the facility on 7/1 and received very little documentation and information to warrant a 24-hour discharge.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.** **The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged.** **(iv) (iv) The right of the resident to file a complaint with the department.** **(b) The department and adult protective services shall be notified not less than 24 hours before discharge in the event of either of the following:** **(i) A resident does not have an authorized representative or an agency responsible for the resident’s placement.** **(ii) The resident does not have a subsequent placement.** **(c) The notice to the department and adult protective services shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.**

	(iii) The location to which the resident will be discharged, if known.
ANALYSIS:	Interviews with the administrator, Ombudsman, the complainant, and Resident A's authorized representative reveal the facility issued a less than 30-day discharge. The review of the discharge notice revealed: • No alternatives attempted by the facility for Resident A were listed. • Resident A's authorized representative was not notified of the right to file a complaint with department about the issuance of the discharge. I also identified: • No notification to APS or the department when Resident A's behaviors occurred to determine appropriate place of discharge. (Resident A's authorized representative's home and the hospital were not appropriate placements for discharge).
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not report any of Resident A's incidents to the department.

INVESTIGATION:

On 8/3/21, I reviewed Resident A's record notes and communication from the facility with the department from January 2021 to July 2021. The review revealed the following incidents were documented in Resident A's record notes but not reported to the department:

- On 6/17/21 at 2am, Resident A shoved a care staff member and punched a care staff member during toileting.

- A second incident occurred on 6/17 at 12:30pm with Resident A described as being combative and noncompliant when care staff tried to assist with toileting and changing of clothing. Staff described trying to "*fix the wrong brief and put it on right. Resident became aggressive. We left brief on wrong".*

- A third incident also occurred on 6/17 at 7:30pm with Resident A described as waking up agitated and using profanity towards care staff. Resident A then grabbed care staff's arm, continuing to use profanity towards staff.

- On 6/18/21 at 11:00am, Resident A was involved in an altercation with another resident. Resident A "*grabbed another residents right arm really hard*" due to having snacks that Resident A wanted. Care staff had to *"pry [Resident A's] fingers off of the residents arm".*

- On 6/21/21 at 10:00 am, Resident A *"was bent over another male resident and talking and kissed his cheek".*

- A second incident occurred on 6/21 at 10:20 am with Resident A attempting to kiss another resident.

- On 6/23/21 at 7:30am, Resident A attempted to kiss another male resident.

- A second incident occurred on 6/23 at 8:00am, with Resident A attempting to interrupt the toileting of another resident. Resident A was redirected by a care staff member but used profanity towards care staff.

- On 6/24/21 at 10:50am, Resident A urinated on the floor in the common area and *"actually peed a little on one of the [care staff]".* After cleaning the area up, Resident A then exposed his privates while in the common area.

- On 6/25/21 at 9:50am, Resident A approached a female resident from behind. Resident A wrapped their arms around the female resident and kissed the resident on both cheeks. The female resident *"seemed angry over it."*

- A second incident occurred on 6/25 at 1:30pm, with Resident A sitting on top of a female resident's legs. Staff was able to redirect Resident A, but it is documented in the record notes by care staff *"this is the second time I've witnessed [Resident A] do that to her".*

- On 6/27/21 at 3:49am, Resident A is described as being aggressive during bedtime cares and yelling profanity.

- On 6/29/21 at 9:00am, Resident A entered the staff office and urinated on the facility records and shower schedule records.

- A second incident occurred on 6/29 at 1:00pm, with Resident A demonstrating sexual behavioral in the common area in front of other residents and care staff.

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 documents from January 2021 to July 2021, reveals the facility did not notify the department of any incidents or Resident A's developing pattern of behaviors. The facility is in violation of this rule due to lack of appropriate communication with the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Care staff improperly administered Resident A's medication.

INVESTIGATION:

On 8/5/21, the complainant reported the facility overmedicated Resident A with the medication Trazadone. The complainant reported the facility did not follow the medication administration instructions for Resident A or physician orders.

Resident A's authorized representative reported the facility failed to appropriately administer Resident A's medication Trazadone. The authorized representative stated "I feel the improper administration of this particular medication may have contributed to [Resident A's] behaviors." The authorized representative reported obtaining a copy of Resident A's medication administration record (MAR) for their review, stating "it appears [Resident A] did not receive the medication correctly and the facility kept changing the dose of the medication they were giving [Resident A] during the day, so it's no wonder there were behaviors."

On 8/9/21, I reviewed my copy of Resident A's MAR which revealed inconsistencies of medication administration. There are five different entries listed for Trazadone on Resident A's MAR.

- The first entry of Trazadone read Resident A was to *take one tablet of trazadone by mouth at bedtime. May use half a tablet as needed for agitation. (8:00pm).*
- The second entry read *Trazadone 150mg tablet; take one "half" tablet (75mg) by mouth at bedtime. (7:00pm).*

- The third entry read *take one tablet of Trazadone by mouth at bedtime. May use half a tablet as needed for agitation. (As needed).*
- The fourth entry read *Trazadone 150mg tablet*; *take one "half" tablet (75mg) by mouth at bedtime. (As needed).*
- The fifth entry read *trazadone 50mg; take ½ tab as needed for not sleeping. Only give if [Resident A] is not sleeping at 3am. (As needed).*

The review reveals Resident A initially began Trazadone on 5/31/21 with an initial end date of 6/11/21, but there is no milligram information as to the amount of Trazadone to be administered to Resident A. The next entry read Trazadone 150mg began on 6/14/21 with no end date listed. The 150mg Trazadone tablet is listed under the scheduled medication treatments section of the MAR and also under the PRN medication treatments section of the MAR. The 50mg Trazadone start date was 6/14/21 with no end date. The 50mg Trazadone is listed under the PRN medication treatments section only of the MAR.

Further review of the care staff medication administration record notes of trazadone to Resident A reveals the following inconsistencies:

- On 6/4/21 Trazadone was administered as a PRN medication at 9:54am for agitation.
- On 6/5/21 Trazadone was administered for anxiety at 10:54am.
- On 6/10/21, Trazadone was administered for bedtime at 4:08am.

According to Resident A's MAR during this time period, Trazadone is only scheduled as a bedtime medication between 7:00pm and 8:00pm. There is no evidence Resident A refused medication on these days either.

- Also, on 6/10/21 it was documented Resident A was given whole tablet of Trazadone at 6:58pm and another whole tablet of Trazadone at 12:41am. It is noted on the record that Resident A did not take Aricept, Lisinopril, or a multi-vitamin due to care staff records notations that Resident A was "not up" and "not awake". Resident A was administered twice the amount of Trazadone prescribed.

- On 6/11/21, 50mg of Trazadone was administered for agitation at 3:38pm. According to Resident A's MAR, the 50mg of Trazadone prescription start date did not begin until 6/14/21. Also, the medication instructions read Resident A is to *take ½ tab as needed for not sleeping. Only give if [Resident A] is not sleeping at 3am.* Resident A was administered twice the amount of Trazadone prescribed.

On 8/12/21, Ms. Lauria reported Resident A's authorized representative would only allow care staff to administer Trazadone per the medication schedule.

CSP Ms. LaCosse reported Resident A did not refuse medications, but it could be difficult at time to give [Resident A] medications. Ms. LaCosse reported administering Resident A's medications according to the label instructions and the medication administration record.

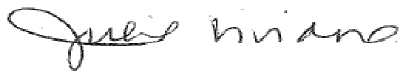
Ms. Synthia Shellenbarger's statements about Resident A's medication administration are consistent with Ms. LaCosse's statements.

Ms. Tanya's Shellenbarger's statements about Resident A's medication administration are consistent with Ms. LaCosse's statements and Ms. Synthia Shellenbarger's statements.

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:	Interviews with the complainant, Resident A's authorized representative, and facility care staff along with review of Resident A's medication administration record reveal several inconsistencies with the medication Trazadone to include: Resident A was not administered Trazadone at bedtime (from 7:00pm to 8:00pm) on 6/4, 6/5, and 6/10 as per medication instructions. There is no evidence of medication refusal from Resident A on these days either. Resident A was over-medicated twice the amount of the prescribed Trazadone on 6/10 by care staff, causing Resident A to miss other medication administration due to not being awake. The 50mg of Trazadone that was prescribed on 6/14/21 to assist Resident A with sleep was documented as being administered to Resident A on 6/11/21. It also documented that Resident A was given twice the amount prescribed, as Resident A was to take ½ of a 50mg tablet, not the whole 50mg tablet. There is significant risk for medication contraindications and harm for Resident A because the facility did not appropriately follow Resident A's medication administration instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

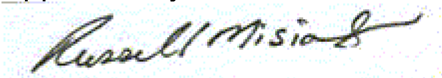
Upon receipt of an acceptable corrective action, I recommend the status of the license remain unchanged.



8/16/21

Julie Viviano　　　　　　　　　　　　Date
Licensing Staff

Approved By:



9/3/21

Russell B. Misiak　　　　　　　　　　　Date
Area Manager