GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 4, 2021

Rochelle Lyons
Candlestone Assisted Living
4124 Waldo Avenue
Midland, MI 48642

RE: License #: AH560360912
Investigation #: 2021A0784054
Candlestone Assisted Living

Dear Ms. Lyons:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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. 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 (517) 284-9730.

Sincerely,

Aaron L. Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH560360912
Investigation #:	2021A0784054
Complaint Receipt Date:	09/16/2021
Investigation Initiation Date:	09/16/2021
Report Due Date:	11/15/2021
Licensee Name:	Candlestone Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Avenue Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Alicia Neitzel
Authorized Representative:	Rochelle Lyons
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:	03/01/2021
Expiration Date:	02/28/2022
Capacity:	66
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was transferred improperly	Yes
Additional Findings	Yes

III. METHODOLOGY

09/16/2021	Special Investigation Intake 2021A0784054
09/16/2021	Special Investigation Initiated - Telephone Interview with administrator Alicia Neitzel
09/16/2021	Contact - Document Sent Investigation document request sent to Ms. Neitzel by email.
09/16/2021	Contact - Document Received Investigative documents received from Ms. Neitzel by email
10/01/2021	Contact - Telephone call made Interview with Ms. Neitzel
10/04/2021	Contact - Document Received Training documents for Kamren Kline received from Ms. Neitzel by email.
10/04/2021	Exit Conference – Telephone Conducted with authorized representative Rochelle Lyons

ALLEGATION:

Resident A was transferred improperly

INVESTIGATION:

The department received an incident report from the facility which indicated that on 9/12/21, Resident A was observed with bruising on her lower right leg and swelling on her ankle and foot. The reporting indicated Resident A had reported falling to the ground on 9/8/21 and was now experiencing pain in the right leg. The report further indicated Resident A suffered a fracture in her right leg. Additional “addendum” information was provided to the department after further inquiry which indicated associates Allison Cobb, Charlene Reyes and Kamren Kline manually transferred Resident A from her wheelchair to her bed on 9/7/21 after dinner “because there was not a sling placed under the resident”. The addendum further indicated Resident

A became too heavy during the transfer and was “lowered to the floor”, with no noted injuries or bruising until 9/10/21.

On 9/16/21, I interviewed administrator Alicia Neitzel by telephone.
Ms. Neitzel stated Resident A is to be transferred with a sit to stand lift which requires a sling to be placed behind her back that hooks to the sit to stand lift and helps pull her up. Ms. Neitzel stated the sling was not present, and instead of obtaining the sling, associates Allison Cobb, Charlene Reyes and Kamren Kline attempted to manually transfer Resident A at which time the associates had to lower her to the ground before getting her to the bed as they were unable to support her weight. Ms. Neitzel stated the staff have been trained on proper transfer techniques and that Resident A’s service plan does specify that Resident A requires a sit to stand for her transfers.

I reviewed Resident A’s service plan which was consistent with statements provided by Ms. Neitzel regarding Resident A’s need for a sit to stand.

I reviewed medical discharge documents for Resident A from MidMichigan Health, provided by Ms. Neitzel, and dated 9/15/21 which read, in part, “closed fracture of left ankle”.

I reviewed training *Transcript* for Ms. Cobb and Ms. Reyes, provided by Ms. Neitzel. According to the transcripts, Ms.
Cobb completed lift training on 7/27/21 and 8/14/21 and Ms. Reyes completed lift training on 7/23/21 and 7/25/21.

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.
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 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:	Reporting from the facility indicated that staff unsuccessfully attempted to transfer Resident A manually from her wheelchair to her bed and ended up placing her on the floor. The investigation revealed Resident A required a mechanical lift for her transfers which staff did not use. Subsequently, Resident A was found to have an injury after the improper transfer. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 9/16/21, I received an email response from Ms. Neitzel to a request regarding original transfer training documentation for Ms. Cobb, Ms. Reyes and Mr. Kline. The email read, in part, "Kamren Kline is a temp worker with Laurus Home Care. Laurus and Leisure Living fall under the same umbrella of ownership. We did request a copy of his original lift training from his Manager and am currently waiting for it to be sent over".

On 10/1/21, I interviewed Ms. Neitzel by telephone. Ms. Neitzel stated Mr. Kline had completed updated lift training on 9/17/21, after the date of the incident, but that she had not received any documentation from Laurus Home Care related to transfer training for Mr. Kline indicating he had been trained prior to the incident on 9/7/21. Ms. Neitzel stated she would have to follow up again with Laurus Home Care.

On 10/4/21, I received an email from Ms. Neitzel with an attached document titled *Certificate of Completion*. The certificate indicated Kamren Kline completed *Safe Lifting and Transfer Techniques* training on 9/16/21.

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 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:	Upon request for transfer and lift training documentation for each staff who attempted to transfer Resident A on 9/7/21, the facility was unable to provide documentation demonstrating associate Kamren Kline had been adequately trained at the time of the attempted transfer. Based on the findings the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/04/21, I discussed the findings of the investigation with authorized representative Rochelle Lyons.

IV. RECOMMENDATION

Upon receipt of an acceptable correction action plan, it is recommended that that status of the license remain unchanged.

Aaron L. Clum 10/4/21

Aaron Clum Date
Licensing Staff

Approved By:

Russell Misiak 10/4/21

Russell B. Misiak Date
Area Manager