GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 29, 2023

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

RE: License #:	AL610395597
Investigation #:	2023A0356019
	Hallstrom Castle Assisted Living

Dear Ms. Hall:

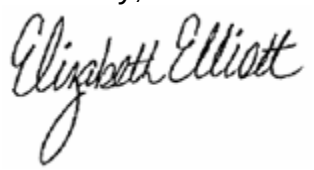
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
Unit 13, 7th Floor
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 #:	2023A0356019
Complaint Receipt Date:	02/01/2023
Investigation Initiation Date:	02/02/2023
Report Due Date:	04/02/2023
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 ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's personal care needs were not attended to by staff at the facility.	No
Additional Finding	Yes

III. METHODOLOGY

02/01/2023	Special Investigation Intake 2023A0356019
02/02/2023	Special Investigation Initiated - Telephone Sarah Raap, facility nurse.
02/16/2023	Inspection Completed On-site Interviewed Ms. Raap.
02/16/2023	Contact - Telephone call made. Pro Medica, in home care, Felisha White, supervisor, Cindy McMurray, nurse case manager.
02/16/2023	APS Referral Called in to Centralized Intake.
03/13/2023	Contact - Telephone call made. Harmony Group, Dr. Carrell's office, spoke to Kelly Vanderveen, nurse.
03/13/2023	Contact - Telephone call made. Relative #1, left mess. As of the writing of this report, Relative #1 never returned my call.
03/13/2023	Contact - Telephone call made. Relative #2- hung up on me.
03/13/2023	Contact - Telephone call made. Elara VNS-Sarah Scofield, RN, clinical manager.
03/13/2023	Contact - Document Sent Ms. Raap re: interview of staff.
03/17/2023	Contact - Telephone call made. Interview staff, they are not available.

03/21/2023	Contact - Document Received Resident Docs received, police incident report, death certificate, and APS report.
03/22/2023	Contact - Telephone call made. Darric Roesler, Muskegon Co. Sheriff Office re: death review.
03/22/2023	Contact-Document Received Case Report- Office of the Medical Examiner.
03/23/2023	Contact - Telephone call made. DCW's Becky Sands and Ashley Hall, separate interviews.
03/27/2023	Contact-Telephone call made. Promedica home care, J. Johnston.
03/27/2023	Contact-Document Received MAR for December 2022 and January 2023.
03/28/2023	Exit Conference-Licensee Designee, Angela Hall.

ALLEGATION: Resident A's personal care needs were not attended to by staff at the facility.

INVESTIGATION: On 02/01/2023, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported that on 01/03/2023, Resident A died from a coccygeal pressure ulcer. The complainant reported on 12/10/2022, Jackie (Johnston) from Promedica VNS (home care agency/visiting nurse services) informed Relative #1 & #2 of the beginning of a sore with no broken skin. On 12/15/2022, Sarah Raap, the facility nurse, called Relative #2 to inform her that Jackie suggested hospice care for Resident A and the complainant reported that was totally unnecessary as the sore was being attended to by staff with Promedica VNS support. The complainant reported that Jackie explained that Resident A's sore was not being cared for properly and getting worse. On 12/16/2022, Tracy from Promedica VNS called the complainant to try to explain the need for hospice care. On 12/21/2022, the complainant reported receiving another call from Ms. Raap saying something is wrong per VNS and she is heading to the facility. The complainant asked for an immediate picture (of Resident A's wound) and requested that Ms. Raap call 9-1-1. Resident A was evaluated in the emergency room and the ER doctor released Resident A under Relative #1 & #2's protest. The complainant reported on 01/03/2023 Relative #1 & #2 were told Resident A passed out in the shower and was transported to the ER and pronounced dead from her injury. APS (adult protective services) denied this for investigation.

On 02/02/2023, I interviewed Sarah Raap, facility nurse via telephone. Ms. Raap stated Resident A had a pressure ulcer on her coccyx that was being treated daily by staff at the facility and she was being seen in the facility by home care nurses. Ms. Raap stated the timeline given in this complaint is not accurate. Ms. Raap stated that beginning on 12/10/2022, Resident A had Promedica VNS coming into the facility treating a pressure ulcer and on 12/21/2022, Promedica approached Ms. Raap and Relative #2 with the idea of getting Resident A involved with hospice care. Ms. Raap stated Relative #2 was not pleased with the idea of starting hospice for Resident A and so she (Ms. Raap) contacted Relative #2 and suggested possibly taking Resident A to a wound clinic first. Ms. Raap stated she went to the facility on 12/21/2022 and evaluated the wound. While there she took a picture of the wound and sent it to Relative #2, who reportedly became extremely upset about the wound and asked Ms. Raap to take Resident A to the ER immediately. Ms. Raap stated she sent Resident A to the ER and Resident A returned to the facility a few hours later on 12/21/2022 with a prescription for an antibiotic, Keflex (Cephalexin). Ms. Raap stated on the same date, 12/21/2022, Relative #2 “fired” Promedica VNS and Ms. Raap stated she called Promedica and requested they remain in place until a new home care agency could be secured. Ms. Raap stated Promedica told her they could not do that. Ms. Raap stated on 12/28/2023, she took Resident A to Trinity Health wound care clinic and they cleaned Resident A’s wound, told Ms. Raap the wound did not look infected, and prescribed Dakin’s Solution for wound care. Ms. Raap stated staff at the facility cleaned and treated the wound every day according to the doctor and home care nurses’ directions. Ms. Raap stated on 01/01/2023, Elara VNA began home care and wound care services to Resident A. Ms. Raap stated due to Relative #2 becoming extremely upset over the wound Resident A had received, she (Relative #2) fired the home care agency which caused Resident A to go without home care nurses from 12/21/2022 until 01/01/2023. However, Resident A was seen in the ER, at the wound care clinic and staff at the facility were cleaning and dressing the wound daily. Ms. Raap stated at no time on 12/21/2022, 12/28/2022 or on 01/01/2023 did any of the medical professionals say Resident A’s wound was infected or septic as Relative #2 indicated.

On 2/16/2023, I interviewed Felisha White, supervisor and Cindy McMurray, nurse case manager at Promedica VNS home care via telephone. Ms. White stated Resident A was referred for care to their agency on 12/05/2022 by Resident A’s primary care physician, Dr. Daniel Carrel, DO. Ms. McMurry stated Ms. White reported the referral documented a ‘dermatological concern, buttocks, acute, stage 1, non-blanchable, not open,’ but when Promedica staff went into the facility on 12/10/2022 to initiate care, the sacral wound was determined to be stage 3.m. It was ‘cleaned, dressed and staff were educated on cleaning and dressing the wound.’ Ms. White reported they conducted two visits during the first week of care and the nursing notes documented the wound was, ‘1 cm deep, undermining and tunnelling. Called doctor and an order to J&B for wound supplies’ was made. Ms. White reported another note documented that, ‘assisted living is doing wound care BID (twice daily) as ordered.’ Ms. White stated on 12/15/2022 staff at the facility, Ashley Hall reported Resident A was being moved/turned every hour during nighttime shifts.

On 12/21/2022, Promedica nurse went out and noted that Resident A's wounds had worsened and the wound was documented as deeper. The wound was cleaned, and hospice was recommended by Promedica homecare to Relative #2, who declined consideration for hospice care, had Resident A taken to the ER and Relative #1 and #2 fired Promedica as Resident A's home care agency. Ms. White stated notes reported Relative #2 as, 'angry, belligerent, that she was a wound specialist, she was nasty, vocal and hung up on us.' Ms. White and Ms. McMurray explained the stage 3 could have happened quickly however, a stage 1 decubitus ulcer does not go from a stage 1 to a stage 3 in five days (the time between the referral from the doctor's office to their first visit with Resident A) so there could have been skin covering the wound and the wound could not been seen easily but it was open underneath the skin. Ms. White and Ms. McMurray stated the emergency department notes indicated Resident A died in the hospital on 01/03/2023 from cardiac arrest.

On 03/13/2023, I interviewed Kelly Vanderveen, Harmony Care Group, Dr. Carrel's office. Ms. Vanderveen confirmed that Resident A was being seen as a patient by Dr. Carrel for home health care and wound care prior to her death. Ms. Vanderveen stated Dr. Carrel called the family of Resident A personally whenever the Dr's office needed to contact family as there is documented poor family behavior towards Ms. Vanderveen and her staff. Ms. Vanderveen stated Dr. Carrel saw Resident A one week prior to her death, looked at her wound and did not document that he was concerned about Resident A's care or the care of her wound and had he had issues with the care of Resident A in the facility, he would have addressed the issues with Ms. Raap and with the home care agency. Ms. Vanderveen reported that Trinity Health wound care clinic also saw Resident A one week prior to her death and there were no issues documented regarding concerns related to the care of Resident A's wound.

On 03/13/2023, I called Relative #1 and left a message. As of the date of the completion of this report, Relative #1 has not returned my telephone call.

On 03/13/2023, I interviewed Relative #2 via telephone. Relative #2 stated Resident A's wound issues began on 12/10/2022 and resulted in her death on 01/03/2023. Relative #2 stated she warned Ms. Raap about Resident A's wound and that it was getting worse, not better. Relative #2 stated on 12/15/2022, she received a telephone call from Ms. Raap informing her that hospice would be calling and Relative #2 was upset and asked Ms. Raap what she was talking about. Relative #2 stated Jackie Johnston from Promedica went to the facility for Resident A's assessment and said the wound was a stage 2 and suggested Resident A be removed from the home to get proper care. Relative #2 stated Resident A was mobile and asked Ms. Johnston, "what are you talking about a pressure sore? (Resident A) is mobile." Relative #2 stated Resident A should not have a pressure sore if she is mobile. Relative #2 stated on 12/16/2022, Promedica reported Resident A's sore was rapidly decompensating and then on 12/21/2022, Promedica showed up to the facility and "freaked out" because the wound was so bad. Resident

A went to ER and the ER staff said, “no, this looks good and it is not to the bone, they did not debride the wound and sent her home.” I attempted to clarify something with Relative #2 and she said if I was not willing to listen to her timeline than I could talk to their attorney and hung up on me.

On 03/13/2023, I interviewed Sarah Scofield, RN (registered nurse) with Elara VNS. Ms. Scofield stated they began services to Resident A on 01/01/2023 as soon as the authorizations were complete and Resident A died two days later on 01/03/2023 of cardiac arrest. Ms. Scofield stated the ER notes documented Resident A’s death was from cardiac arrest. Ms. Scofield stated the pressure ulcer to the coccyx was documented as a stage 4 and deep upon their initial examination. Ms. Scofield stated from what she can see from hospital documentation, it showed Resident A did not die from the wound. She had a heart condition and she died from sudden cardiac arrest.

On 03/21/2023, I received and reviewed Resident A’s death certificate sent from the Muskegon County elder death review panel. Resident A’s death certificate documented the manner of Resident A’s death as natural, and the cause of death is documented as, ‘Coccygeal pressure ulcer’ and ‘Alzheimer’s dementia.’ No Autopsy was performed. The certificate is signed by Dr. Carrel on 01/04/2023.

03/22/2023, I interviewed Det. Darric Roesler via telephone. Det. Roesler is part of the elder death review panel and stated this case came across their panel through APS as a referral on 02/16/2023. The information on the APS did not investigate but referred this to Law Enforcement due to the nature of the complaint and the death of Resident A. Det. Roesler’s complaint was*, ‘(Resident A) had a coccygeal pressure ulcer. The facility staff did not properly care for (Resident A) resulting in her death.’* Roesler stated there was no autopsy completed but the manner of death is ruled natural so there is not much to work with as far as a negligent death investigation. Det. Roesler stated the case report from the Office of the Medical Examiner documented that this was a “witnessed cardiac arrest.” Det. Roesler stated the Office of the Medical Examiner may be requesting documents from Ms. Raap because they are conducting a records review to determine if the death certificate should have a different cause of death.

On 03/22/2023, I received and reviewed the Case Review report from the Office of the Medical Examiner, disposition by Ashleigh Butler, D-ABMDI, dated 01/03/2023. The report documented the following information, *‘Case Summary: 86-year-old, witness cardiac arrest at her assisted living home. Suspected natural. Synopsis: This was a witness cardiac arrest. Fire and EMS arrived on scene and confirmed no signs of life and began CPR. Per the attending nurse she advises EMS got ROSC (return of spontaneous circulation) and transported to Trinity ED. Decedent never returned to baseline after lifesaving efforts in the ED. Per RN no signs of trauma and not concerns for neglect. Disposition: I advised RN that this death did not warrant further investigation.*’

On 03/23/2023, I interviewed Becky Sands, DCW via telephone. Ms. Sands works first shift and is a shower aide. Ms. Sands stated staff at the facility treated Resident A's decubitus ulcer by cleaning and bandaging it up every day on first shift as well as repositioning her. Ms. Sands stated the home care agency trained staff on how to care for Resident A's wound and so they provided wound care on the days the home care staff was not in the facility. Ms. Sands stated Resident A got a shower twice weekly and on 01/03/2023, she showered Resident A. Ms. Sands stated when she showered Resident A, she did her wound care and the entire time, Resident A was acting as she normally did, talking and laughing. Ms. Sands stated once she got Resident A out of the shower, her legs gave out, and she began to have an unexpected medical emergency. Staff called 9-1-1 and Ms. Raap. Ms. Sands stated staff provided medical care to Resident A until EMS (emergency medical services) arrived and took over care.

On 03/23/2023, I interviewed Ashley Hall, 3rd shift DCW via telephone. Ms. Hall stated Resident A's wound was deep, but home care nursing came in and cared for the wounds. In addition, staff at the facility were cleaning, putting ointment on and packing the wound as trained by the home care nurse. Ms. Hall stated she works five nights a week and she cleaned, and bandage Resident A's wound every day on 3rd shift as well as reposition her. Ms. Hall stated they labeled Resident A's bandage, so they knew when it was changed. Ms. Hall stated she assisted Ms. Sands with Resident A's shower on 01/03/2023. Ms. Hall stated they completed wound care after Resident A's shower and began to assist with transferring Resident A to her chair when she went limp and experienced a sudden medical emergency. Staff Aubrey Beeman immediately got the telephone, they called 9-1-1, Ms. Raap and began emergency life saving measures until EMS arrived.

On 03/23/2023, I reviewed a statement from DCW Ms. Beeman that documented she worked 3rd shift on 01/02/2023-01/03/2023 and assisted with showering Resident A. Ms. Beeman's statement documented the same information provided by Ms. Sands and Ms. Hall. Ms. Sands showered Resident A in the shower chair and she and Ms. Hall assisted Ms. Sands in transferring Resident A from the shower chair to her wheelchair when she "passed out." Ms. Beeman documented that staff called 9-1-1 and Ms. Raap.

On 03/28/2023, I conducted an exit conference with Licensee Designee, Angela Hall via telephone. Ms. Hall stated she agrees with the information, analysis and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be

	attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The complainant reported that on 01/03/2023 Resident A died from a coccygeal pressure ulcer, and the wound was not cared for properly at the facility. Ms. Raap, Ms. Sands and Ms. Hall stated Resident A's wound was cared for by staff at the facility as well as by in-home nursing care. Ms. White, Ms. McMurry, and Ms. Scofield did not report any concerns regarding the care Resident A received at the facility including wound care. All stated from ER notes, that Resident A died from cardiac arrest. Ms. Vanderveen reported that Dr. Carrel did not document any concerns regarding the care of Resident A or the care of her wound at the facility. On 12/28/2022 Trinity Health wound care clinic and on 12/21/2022 Trinity Health ER evaluated Resident A and sent her back to the facility. Resident A's death certificate documented the manner of death as natural, and the cause of death as coccygeal pressure ulcer and Alzheimer's dementia. Det. Roesler stated there was no autopsy completed but the manner of death was ruled natural. The Case Review report from the Office of the Medical Examiner, documented this as a witnessed cardiac arrest, no autopsy was performed, no signs of trauma or neglect were noted. Based on investigative findings, there is not a preponderance of evidence to show that staff at the facility neglected Resident A's wound care. Therefore, a violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION: On 03/27/2023, I received and reviewed the MAR for December 2022 for Resident A. The MAR documented a prescription for Cephalexin (Keflex) 500 MG Caps, take 1 capsule 4 times daily beginning 12/22/2022 and Dakin's SOL 0.125%, apply topically to affected area(s) once daily beginning 12/28/2022. The MAR documented the following:

- Cephalexin, 12/25/2022, 4:00p.m. dose is not signed by staff as administered and there is no explanation.
- Cephalexin, 12/29/2022, 8:00a.m., 12:00p.m., 4:00p.m., 8:00p.m. doses are not signed by staff as administered and there is no explanation.
- Cephalexin, 12/31/2022, 4:00p.m. dose is not signed by staff as administered and there is no explanation.
- Dakin's SOL, 12/28/2022, 12/29/2022, 12/30/2022 & 12/31/2022, 12:00p.m., there is no signatures on the MAR by staff as administered.

On 03/27/2023, I received and reviewed the MAR for January 2023 for Resident A. The MAR documented a prescription for Cephalexin (Keflex) 500 MG Caps, take 1 capsule 4 times daily and Dakin's SOL 0.125%, apply topically to affected area(s) once daily. The MAR documented the following:

- Cephalexin, 01/02/2023, 12:00p.m. dose is not signed by staff as administered and there is no explanation.
- Dakin's SOL, 1/01/2023 and 01/02/2023, 12:00p.m. there is no signatures by staff as administered.

On 03/27/2023, I interviewed Ms. Raap via telephone. Ms. Raap stated staff administered the Cephalexin and the Dakin's Solution as ordered by the physician and the empty spots on the MAR are a result of staff not signing the MAR, not because they did not administer the medication or apply the Dakin's solution. She described the documentation omission as an "oversight".

On 03/28/2023, I conducted an exit conference with Licensee Designee, Angela Hall via telephone. Ms. Hall stated most likely staff got busy and overlooked signing the MAR, so this is unfortunate because the medications were administered by staff. Ms. Hall stated she will submit a 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 §333.1101 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:	A review of Resident A's MAR for December 2022 and January 2023 showed Cephalexin 500 MG CAPs and Dakin's SOL 0.125% were prescribed for administration to Resident A. Administration of those medications were not documented on the MAR as administered by staff on several dates. Ms. Raap stated staff administered Resident A's Cephalexin caps and applied the Dakin's solution as prescribed however, staff failed to document the administration of those medications on the MAR. The December 2022 and January 2023 MAR do not have staff signatures or initials on some dates/times documenting that Resident A's prescribed Cephalexin 500 MG Caps and Dakin's SOL 0.125% were administered as prescribed. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Elizabeth Elliott

03/28/2023

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

Jerry Hendrick

03/29/2023

Jerry Hendrick — Date
Area Manager