GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 26, 2022

Lucijana Tomic
Care Cardinal Cascade
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410410352
Investigation #: 2022A1010052
Care Cardinal Cascade

Dear Ms. Tomic:

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 (517) 241-1970.

Sincerely,

Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410410352
Investigation #:	2022A1010052
Complaint Receipt Date:	06/22/2022
Investigation Initiation Date:	06/22/2022
Report Due Date:	08/22/2022
Licensee Name:	CSM Cascade, LLC
Licensee Address:	1435 Coit Ave. NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 308-6915
Administrator:	Bridget Lutzke
Authorized Representative:	Lucijana Tomic
Name of Facility:	Care Cardinal Cascade
Facility Address:	6117 Charlevoix Woods Ct. Grand Rapids, MI 49546-8505
Facility Telephone #:	(616) 954-2366
Original Issuance Date:	05/24/2022
License Status:	TEMPORARY
Effective Date:	05/24/2022
Expiration Date:	11/23/2022
Capacity:	77
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 6/17/22, staff told Resident I she could not go outside.	No
Staff have left Resident I’s bedding soiled and unchanged for 24 hours.	No
Resident I did not get her prescribed medications on 6/19/22.	Yes

III. METHODOLOGY

06/22/2022	Special Investigation Intake 2022A1010052
06/22/2022	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
06/22/2022	APS Referral APS referral emailed to Centralized Intake
06/28/2022	Contact - Telephone call made Interviewed the complainant by telephone
06/28/2022	Inspection Completed On-site
06/28/2022	Contact - Document Received Received Resident I's service plan, MAR
09/26/2022	Exit Conference Completed with authorized representative Lucijana Tomic

ALLEGATION:

On 6/17/22, staff told Resident I she could not go outside.

INVESTIGATION:

On 6/22/22, the Bureau received the allegations from the online complaint system. The complaint read, “on 6/17 [Resident I] requested to go outside to one of the enclosed courtyards. Staff refused to allow this.” The complaint also read, “per

[Resident I], staff were sitting in chairs on their phones."

I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 6/28/22, I interviewed the complainant by telephone. The complainant reported Resident I informed her staff would not allow her to go outside when she asked on 6/17/22. The complainant stated Resident I resides in the secured memory care unit in the facility. The complainant said Resident I and all residents in the secured memory care unit should be allowed to go outside when they ask per resident rights.

On 6/28/22, I interviewed administrator Bridget Lutzke at the facility. Ms. Lutzke reported it is the facility's policy and procedure that staff accompany residents in the secured memory care unit outside, even in the secured unit's courtyard. Ms. Lutzke said there may be instances in which staff are assisting residents and cannot go out with a resident right when they ask. Ms. Lutzke explained staff do their best to accommodate residents in the secured memory care unit when they ask do go outside.

Ms. Lutzke stated the facility has hired a life enrichment staff person who started last week. Ms. Lutzke reported there were several weeks in which the life enrichment position was vacant. Ms. Lutzke said care and maintenance staff did fill in and take residents outside for gardening and for popsicles several times.

On 6/28/22, I interviewed wellness coordinator Katrina Christian at the facility. Ms. Christian's statements were consistent with Ms. Lutzke. Ms. Christian reported she had also gone outside with residents for popsicles before the new life enrichment staff person started last week.

On 6/28/22, I interviewed shift manager Hailey Gallentine at the facility. Ms. Gallentine's statements were consistent with Ms. Lutzke and Ms. Christian.

On 6/28/22, I interviewed shift manager Dajiah Roby at the facility. Ms. Roby's statements were consistent with Ms. Lutzke, Ms. Christian, and Ms. Gallentine.

On 6/28/22, I interviewed Resident I at the facility. Resident I reported there were instances when she asked staff to go outside and she was told "no." Resident I reported there were also instances when she asked to go outside and staff did take her. Resident I stated she and other residents in the secured memory care unit have to quarantine in their rooms due to positive COVID-19 cases in the facility.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage

	residents to function physically and intellectually with independence at the highest practical level.
ANALYSIS:	The interviews with staff, along with Resident I, revealed staff did their best to accommodate Resident I's request to go outside when the facility's life enrichment position was vacant. Ms. Lutzke and Ms. Christian revealed the newly hired life enrichment staff person started at the facility last week.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff have left Resident I's bedding soiled and unchanged for 24 hours.

INVESTIGATION:

On 6/22/22, the complaint read, "[Resident I's] bed has been soiled with urine and gone unchanged for 24 hours other than replacing the chuck."

On 6/28/22, the complainant reported she observed Resident I's bedding was soiled so she changed her sheets. The complainant stated Resident I's family provides her linens and they are kept in Resident I's room. The complainant expressed concern Resident I's bedding has gone unchanged for 24 hours on several different occasions.

On 6/28/22, Ms. Lutzke denied knowledge regarding Resident I's soiled bedding not being changed for 24 hours. Ms. Lutzke reported staff were trained to "strip" the bedding on all the residents' beds in the secured memory care unit daily. Ms. Lutzke denied knowledge that this was not being done. Ms. Lutzke stated she and Ms. Christian recently completed third shift "check ins" on staff to ensure they were completing their job duties. Ms. Lutzke reported she and Ms. Christian found staff on third shift were completing their job tasks and found no concerns.

Ms. Lutzke provided me with a copy of Resident I's service plan for my review. The *RESITIVE TO CARE* section of the plan read, "Hygiene checks after every incontinent, in the morning and bedtime. Is on safety checks every 2 hours at night." The *BLADDER* section of the plan read, "Assistance needed to use toilet and maintain bladder continence. Bladder incontinence care needs to provided. Is incontinent of bladder. Reminders/cues to use toilet for voiding. Report to nurse changes in bladder continence."

On 6/28/22, Ms. Christian's statements were consistent with Ms. Lutzke.

On 6/28/22, Ms. Gallentine's statements were consistent with Ms. Lutzke and Ms. Christian.

On 6/28/22, Ms. Roby's statements were consistent with Ms. Lutzke, Ms. Christian, and Ms. Gallentine.

On 6/28/22, Resident I reported her bedding was changed daily by Relative I1 and staff at the facility. Resident I denied concerns regarding her bedding not being changed. I observed the sheets and bedding on Resident I's bed. The sheets and bedding were clean. I did not detect any foul odors present in Resident I's room.

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:	The interviews with staff and Resident I, along with my observations of Resident I's bedding and her overall room, revealed her sheets are changed daily by either staff or Relative I1. I observed clean bedding on Resident I's bed and there were no foul odors in her room.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident I did not get her prescribed medications on 6/19/22.

INVESTIGATION:

On 6/22/22, the complaint read that on 6/19/22 Resident I did not get her prescribed medication.

On 6/28/22, the complainant stated staff did not administer Resident I's medication to her on 6/19/22. The complainant said Resident I left the facility for the evening at approximately 4:00 pm on 6/19/22. The complainant reported Resident I left the facility overnight with the medications she needed to take. The complainant stated staff did provide the medications Resident I needed to take while she was out of the facility.

On 6/28/22, Ms. Christian explained an agency staff person was scheduled in the secured memory care unit on 6/19/22. Ms. Christian reported the agency staff person was supposed to administer resident medications in the secured memory

care unit, however he did not. Ms. Christian said she arrived at the facility in the afternoon on 6/19/22 and was informed the agency staff person did not administer the secured memory care unit resident medications.
Ms. Christian reported after she was informed of the incident, she and another staff person began contacting the resident physicians and family members of those who did not get their medications. Ms. Christian said resident medications that could still be administered in the secured memory care unit on 6/19/22 were given. Ms. Christian reported staff provided Relative I1 with Resident I's evening and morning medications because she was signed out of the facility for the night. Ms. Christian said Resident I returned to the facility on 6/20/22.

Ms. Christian stated the agency staff person who failed to administer the secured memory care unit medication said he did not think there were any medications that needed to be administered. Ms. Christian reported she followed up with the agency told them their staff person was not allowed to return to the facility.

Ms. Christian provided me with a copy of Resident I's June medication administration record (MAR) for my review. The MAR read Resident I did not get her prescribed medications on 6/19/22.

On 6/28/22, Ms. Gallentine's statements were consistent with Ms. Christian and Resident I's MAR. Ms. Gallentine reported she worked second shift on 6/19/22, therefore she had first hand knowledge regarding the incident.

On 6/28/22, Ms. Roby's statements were consistent with Ms. Christian, Ms. Gallentine, and Resident I's MAR. Ms. Roby reported she worked first shift and checked in with the agency staff person in the secured memory care unit during their shift. Ms. Roby stated the agency staff person told her he was "ok" and did not need her assistance during the shift. Ms. Roby explained when it was discovered that the agency staff person did not administer the secured memory care unit resident medications, he told her he "did not see any medications that needed to be passed" in the facility's electronic MAR.

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:	The interviews with staff, along with review of Resident I's June MAR, revealed her medications were not administered on 6/19/22 because an agency staff person did not administer them.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized Lucijana Tomic by telephone on 9/26/22.

IV. RECOMMENDATION

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

7/13/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

09/26/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section