STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

December 1, 2022

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

RE: License #: AH410410352
Investigation #: 2023A1010005
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
Unit 13, 7th Floor
350 Ottawa, N.W.
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 #:	2023A1010005
Complaint Receipt Date:	10/17/2022
Investigation Initiation Date:	10/18/2022
Report Due Date:	12/16/2022
Licensee Name:	CSM Cascade, LLC
Licensee Address:	1435 Coit Ave. NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 308-6915
Administrator:	DaleTron Thompson
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:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not receiving their medications as prescribed.	No
Additional Findings	Yes

III. METHODOLOGY

10/17/2022	Special Investigation Intake 2023A1010005
10/18/2022	Contact - Document Received Email received from Mr. Kahler
10/18/2022	Special Investigation Initiated - Letter Emailed assigned APS worker Bryan Kahler
10/25/2022	Comment Intake ID 191243 dismissed, allegations added to this SI
10/28/2022	Comment Intake ID 191336 dismissed, allegations added to this SI
11/02/2022	Comment Intake ID 191402 dismissed, allegations added to this SI
11/03/2022	Inspection Completed On-site
11/03/2022	Contact - Document Received Received resident service plans and MARs
11/16/2022	Comment Intake Id 191631 dismissed, allegations added to this SI
12/01/2022	Exit Conference Completed with Ms. Thompson

ALLEGATION:

Residents are not receiving their medications as prescribed.

INVESTIGATION:

On 10/17/22, the Bureau received the allegations from Adult Protective Services (APS). The complaint read, “There is concern that [Resident A] is not receiving her medications as prescribed including her Hydrocodone. [Resident A] had a recent medical appointment and it was learned that she has too much medication left over as well as still having full prescription that still needs to be filled.”

On 10/25/22, I emailed assigned APS worker Bryan Kahler. Mr. Kahler reported he “did not have any concerns” after he made face to face contact with Resident A. Mr. Kahler stated Resident A’s “biggest complaint is she is prescribed by the doctor to get meds at 8am, 2pm, and 8pm. She is getting them within an hour of those times.”

On 10/25/22, 10/28/22, 11/2/22, and 11/16/22 the Bureau received allegations that Resident B and Resident C were not getting their medications as prescribed from APS.

On 11/3/22, I interviewed administrator DaleTron Thompson at the facility. Ms. Thompson reported all resident medications are administered as prescribed. Ms. Thompson stated the facility’s wellness director Starlin Williams discovered Resident A’s physician office continuously sent refill prescriptions for her Hydrocodone to the facility’s contracted “in house” pharmacy to be filled even though she did not need the medication refilled. Ms. Thompson said she has not received any complaints from Resident A that she has not been receiving her prescribed Hydrocodone. Ms. Thompson explained Resident A recently switched to the facility’s contracted “in house” physician. Ms. Thompson reported Resident A’s former physician was continuously sending her Hydrocodone prescription refills to the pharmacy, however this has not occurred since Resident A switched to the facility’s “in house” physician.

Ms. Thompson provided me with a copy of Resident A’s September and October medication administration records (MARs) for my review. The MARs read Resident A’s medications were administered as prescribed. Ms. Thompson provided me with a copy of Resident A’s service plan for my review. The *Behavior/Mood* section of the plan read, “Evaluate the effectiveness of any measures taken to lessen pain/discomfort. If the pain/discomfort if not relieved, notify the physician. Exhibits normal, functional behavior patterns. I set up my own appointments and schedule my rides when I see my counselor. Report changes from baseline behaviors to Nurse.”

Ms. Thompson denied knowledge regarding Resident B not getting her prescribed medications. Ms. Thompson reported Resident B has a traumatic brain injury and behavioral issues. Ms. Thompson said Resident B “fixates” on infections she does not have. Ms. Thompson stated Resident B also recently intentionally flooded the shower in her bathroom. Ms. Thompson said Resident B also has a history of going into other resident rooms. Ms. Thompson explained Resident B went into another resident’s shower and intentionally broke the shower handle. Ms. Thompson

reported Resident B did not get along with her previous roommate and called law enforcement on her twice. Ms. Thompson said as a result, Resident B is in the process of moving to a new room.

Ms. Thompson provided me with a copy of Resident B's October MAR for my review. The MAR read there were some instances when Resident B did not get her prescribed medications because she either refused, was hospitalized, or was "absent from home without meds." Ms. Thompson provided me with a copy of Resident B's service plan for my review. The *Behavior/Mood* section of the plan read, "Exhibits normal, functional behavior patterns."

Ms. Thompson reported Resident C had several changes to her seizure medication. Ms. Thompson stated every time Resident C's physician changed her seizure medication, staff administered it as prescribed. Ms. Thompson provided me with a copy of Resident C's October MAR for my review. The MAR read there were a few instances when Resident C's prescribed medication was not administered because she either refused or was "hospitalized." Ms. Thompson provided me with a copy of Resident C's service plan for my review. The plan did identify any behavioral issues or medication administration instruction.

On 11/3/22, I interviewed Ms. Williams at the facility. Ms. Williams' statements were consistent with Ms. Thompson. Ms. Williams reported she called the facility's "in house" pharmacy regarding Resident A's prescriptions. Ms. Williams stated the pharmacy informed her Resident A's physician's office was sending three months' worth of Resident A's prescription into the pharmacy at one time. Ms. Williams explained the pharmacy would then hold the refills until the facility contacted them for a refill.

On 11/3/22, I was unable to interview Resident A. Ms. Thompson stated Resident A often signs herself out of the facility and goes out into the community as outlined in her service plan. Ms. Thompson reported Resident A was signed out of the facility at the time I requested to interview her.

On 11/3/22, I interviewed Resident B at the facility. Resident B reported staff administer her medications as prescribed. Resident B denied concerns regarding her medications or the care she receives at the facility. Resident B said she recently had a medical procedure that her worker through Reliance help arrange for her. Resident B stated there were no issues getting to her appointment or the treatment she received from staff at the facility afterwards. Resident B reported Ms. Thompson "goes out of her way" to ensure her needs are met, despite times when Resident B exhibited bad behaviors.

On 11/3/22, I interviewed Resident C at the facility. Resident C denied concerns regarding her medications. Resident C reported staff administer her medications daily and as prescribed. Resident C said she has had changes to her prescribed seizure medications; however staff have administered them as prescribed.

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 Ms. Thompson, Ms. Williams, Resident B, Resident C, along with review of Resident A, Resident B, and Resident C's MARs revealed their medications were administered as prescribed unless they refused, were hospitalized, or not present in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 11/3/22, Ms. Thompson identified Resident B exhibits behavioral issues. Review of resident B's service plan revealed these behavioral issues and appropriate staff interventions were not outlined.

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:	Review of Resident B's service plan revealed it was not consistent with Ms. Thompson's statements regarding her behavioral issues. Resident B's plan did not outline any behaviors or how staff were to intervene when any behavioral issues occur.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with administrator DaleTron Thompson by telephone on 12/1/22. I left a voicemail regarding this investigation for licensee authorized representative Lucijana Tomic on 12/1/22.

IV. RECOMMENDATION

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

11/29/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

11/29/2022

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