GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 8, 2023

Bridget Lutzke
Care Cardinal Cascade
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410410352
Investigation #: 2023A1021023
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 authorized representative 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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410410352
Investigation #:	2023A1021023
Complaint Receipt Date:	12/20/2022
Investigation Initiation Date:	2/21/2022
Report Due Date:	02/19/2023
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:	Bridget Lutzke
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:	REGULAR
Effective Date:	11/24/2022
Expiration Date:	11/23/2023
Capacity:	77
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Facility failed to protect Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

12/20/2022	Special Investigation Intake 2023A1021023
12/21/2022	APS Referral referral came from APS
12/21/2022	Special Investigation Initiated - Telephone left message with administrator
01/04/2023	Contact - Telephone call made left message with administrator
01/04/2023	Contact - Telephone call received interviewed administrator
01/06/2023	Contact - Telephone call made interviewed SP1
01/23/2023	Contact-Telephone call made Interviewed Deputy David John Ziomkowski Jr. Kent County Sheriff's Office
02/08/2023	Exit Conference

ALLEGATION:

Facility failed to protect Resident A.

INVESTIGATION:

On 12/20/2022, the licensing department received a complaint with allegations law enforcement was dispatched to the facility due to Resident A attempted suicide. The complainant alleged Resident A was on suicide watch and had cut herself with a sharp object. The complainant alleged when law enforcement was contacted, facility

staff members left Resident A alone in her room and Resident A began to cut herself again. The complainant alleged Resident A was not properly supervised.

The complaint came from Adult Protective Services (APS). APS was not investigating the complaint.

On 1/4/2023, I interviewed administrator DaleTron Thompson by telephone. Ms. Thompson reported on 12/6/2022, Resident A came into her office and reported she was having suicidal thoughts. Ms. Thompson reported Resident A did not have a plan just that she wanted to see her dogs. Ms. Thompson reported she contacted Resident A's physician and Resident A was sent out to the hospital for a psychological evaluation. Ms. Thompson reported she checked Resident A's room and did not find any objects that Resident A could use to commit suicide. Ms. Thompson reported the hospital cleared Resident A and she was sent back to the facility later that day. Ms. Thompson reported Relative A1 was to have Resident A follow up with a psychiatrist. Ms. Thompson reported on 12/19/2022, caregivers went to check on Resident A and staff observed blood on Resident A's sheets. Ms. Thompson reported Resident A reported she had cut herself and 911 was contacted. Ms. Thompson reported caregivers left the room and that is when Resident A started to cut herself again. Ms. Thompson reported police took the object and Resident A was sent to the hospital. Ms. Thompson reported Relative A1 petitioned Resident A for an inpatient psychological evaluation and Resident A has not yet returned to the facility. Ms. Thompson reported staff person 1 (SP1) acted appropriately and provided the appropriate attention and protection to Resident A.

On 1/6/2023, I interviewed SP1 by telephone. SP1 reported during her shift Resident A was her baseline and did not appear upset or in distress. SP1 reported in her shift Resident A attempted to go outside to smoke a cigarette and she stopped her because Resident A was trying to quit smoking. SP1 reported around 11:00pm she went into Resident A's room and Resident A did not respond when she called her name. SP1 reported she observed blood on Resident A's sheets and Resident A was difficult to wake. SP1 reported she had her telephone on her and she contacted 911 inside Resident A's room. SP1 reported she attempted to ask Resident A what happened, and Resident A did not respond. SP1 reported she looked for the object but did not see any object. SP1 reported when law enforcement arrived, she went outside in the hallway to speak with them and provided them with a face covering because Resident A's roommate had Covid-19. SP1 reported when they came into the room, Resident A was cutting herself again. SP1 reported law enforcement took the object and Resident A was sent to the hospital.

On 1/23/2023, I interviewed Deputy David John Ziomkowski Jr. at the Kent County Sheriff's Office. Mr. Ziomkowski reported he was dispatched to the facility on 12/19/2022 at 2307, on scene at 2309, and to Resident A's room within minutes. Mr. Ziomkowski reported he is familiar with the facility and therefore when he arrived on scene, he entered the facility and started to walk towards the residents' rooms. Mr. Ziomkowski reported when he arrived at Resident A's room, Resident A was

unsupervised. Mr. Ziomkowski reported he observed SP1 to be outside Resident A's room. Mr. Ziomkowski reported he had a brief interaction with SP1 and then he entered Resident A's room. Mr. Ziomkowski reported Resident A was unsupervised and was found cutting her wrist with a small sharp object. Mr. Ziomkowski reported he observed other caregivers near Resident A's room that could have supervised Resident A while SP1 interacted with police officers.

I reviewed Resident A's service plan. The service plan read,

> *"history of harming self/others/property. (Resident A) has a history of vocalizing desire to self harm, as well as self harming. Staff to report to supervisor and doctor if any self harm behavior is observed. Unit requires decluttering daily.*"

I reviewed progress notes for Resident A. The notes read,

> *"12/6/22: Resident came into my office today very tearful and states she is depressed because she hates being in Michigan and she wants to see her dogs who were put to sleep years ago. I asked her if she has thought about suicide, and she stated yes. I asked her what her plan was or how would she carry that out and she stated she did not have a plan. Room was searched and it does not appear that resident has anything that would assist her in carrying out a suicide. she will be place on close observation for 24 hours. PCP will be contacted for further direction. Left message for responsible to call ED or DOW. Will continue to monitor.*
>
> *12/19/22: (Resident A) was sent out to the hospital upon my 11pm check I went to check on her and she wouldn't wake up (so I went over to her bed and shook her awake that's when I noticed her bleeding and kind of out of it) so called Starlynn, the house manager and 911."*

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:	Resident A was found bleeding in her room from a suicide attempt. Caregivers left Resident A unsupervised and Resident A was able to attempt suicide again. The facility failed to ensure the safety and well-being of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/08/2023, I conducted an exit conference with authorized representative Bridget Lutzke by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kimberly Horst 1/23/2023

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 02/06/2023

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