GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 20, 2023

Lisa Sikes
Care Cardinal Kentwood
4352 Breton Rd. SE
Kentwood, MI 49512

RE: License #: AH410413166
Investigation #: 2023A1010048
Care Cardinal Kentwood

Dear Ms. Sikes:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 #:	AH410413166
Investigation #:	2023A1010048
Complaint Receipt Date:	02/09/2023
Investigation Initiation Date:	02/09/2023
Report Due Date:	04/11/2023
Licensee Name:	CSM Kentwood LLC
Licensee Address:	4352 Breton Road SE Kentwood, MI 49512
Licensee Telephone #:	(312) 837-0704
Administrator:	Chelsea Lindsey
Authorized Representative:	Lisa Sikes
Name of Facility:	Care Cardinal Kentwood
Facility Address:	4352 Breton Rd. SE Kentwood, MI 49512
Facility Telephone #:	(616) 281-5170
Original Issuance Date:	05/11/2018
License Status:	REGULAR
Effective Date:	11/11/2022
Expiration Date:	11/10/2023
Capacity:	103
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident J was not rotated in bed every two hours, was left in dried feces, and her catheter bag was not emptied.	Yes
Soiled linens were left in Resident J's room.	Yes
Additional Finding	Yes

III. METHODOLOGY

02/09/2023	Special Investigation Intake 2023A1010029
02/09/2023	Special Investigation Initiated - Telephone Interviewed the complainant by telephone
02/13/2023	Contact - Document Received Email received from admin regarding resident's death on 2/12/23 while on hospice
02/16/2023	Inspection Completed On-site
02/16/2023	Contact - Document Received Received resident service plan
02/22/2023	Contact - Telephone call made Interviewed resident's Reliance case manager by telephone
02/22/2023	Contact -Telephone call made Interviewed resident PCP by telephone
02/22/2023	APS Referral APS referral emailed to Centralized Intake

ALLEGATION:

Resident J was not rotated in bed every two hours, was left in dried feces, and her catheter bag was not emptied.

INVESTIGATION:

On 2/9/23, I received the allegations from the complainant by telephone. The complainant reported staff were supposed to reposition Resident J in bed every two hours, however it was evident this was not done. The complainant stated care staff admitted they were not providing care to Resident J "because she was receiving hospice services." The complainant said Resident J was receiving hospice services through Hospice of Michigan. The complainant reported Resident J was left soiled, she was observed with dried feces on her buttocks. The complainant said Resident J's catheter bag was also not emptied by staff.

On 2/13/23, I received an incident report dated 2/12/23. The report read Resident J passed away and Hospice of Michigan staff were notified.

On 2/16/23, I interviewed administrator Chelsea Lindsey at the facility. Ms. Lindsey reported she did receive concerns from Resident J's family that Resident J was observed soiled and not repositioned in bed every two hours. Ms. Lindsey stated staff instruction to reposition Resident J in bed every two hours was outlined in her medication administration record (MAR). Ms. Lindsey said to her knowledge, staff were repositioning Resident J as outlined. Ms. Lindsey reported staff at the facility were responsible for emptying Resident J's catheter bag and Hospice of Michigan was responsible for completing the bag changes. Ms. Lindsey said to her knowledge, staff emptied Resident J's catheter bag.

Ms. Lindsey provided me with a copy of Resident J's service plan for my review. The *BATHING* section of the plan read, "Check skin with bath/shower and report any reddened/open area to Nurse. Hospice will provide bed baths." The *COGNITION* section of the plan read, "Is on safety checks every 2 hrs at all times." The *CATHETER* section of the plan read, "CATHETER: Requires full assistance with all catheter care. CATHETER: Change as per Physician's Orders." The *MOBILITY* section of the plan read, "AMBULATION: Can not get out of bed without full assistance. AMBULATION: Is NOT AMBULATORY." The *HOSPICE* section of the plan read, "Hospice Aide Services: through Hospice of Michigan weekly. Registered Nurse Visits: Through Hospice of Michigan weekly. Social work through hospice of Michigan weekly."

Ms. Lindsey provided me with a copy of Resident J's February MAR for my review. The MAR read, "Reposition resident every 2 hours side to side. Every 2 hours for skin integrity Start Date- 2/10/23." The MAR read Resident J was not repositioned in bed at 10:00 pm on 2/10/23, at 6:00 am, 8:00 pm, and 10:00 pm on 2/11/23, and at 12:00 am, 2:00 am, 4:00 am, and 6:00 am on 2/12/23. The MAR also read, "Empty Foley Catheter every 2 hours during repositioning of resident in bed. Every 2 hours for Bladder. Start date – 02/10/2023" The MAR read Resident J's catheter bag was not emptied at 10:00 pm on 2/10/23, at 6:00 am and 10:00 pm on 2/11/23, and at 2:00 am, 4:00 am, and 6:00 am on 2/12/23.

On 2/16/23, I interviewed Staff Person 1 (SP1) at the facility. SP1's statements were consistent with Ms. Lindsey.

On 2/22/23, I interviewed Witness 1 (W1) by telephone. W1 reported she observed Resident J at the facility approximately two weeks before she passed away. W1 stated at that time, she observed Resident J's catheter bag was full and it was evident staff were not emptying it each shift. W1 said that was the only concerns she observed at that time. W1 explained she recently spoke with Resident J's primary care physician (W2). W1 reported W2 informed her she observed several stage four wounds on Resident J's buttocks and on her back on her spine the Sunday before Resident J passed away. W1 said W2 informed her she took pictures of Resident J because she was concerned regarding what she saw. W1 reported she has not observed the pictures W2 took.

W1 reported W2 informed her she was concerned Resident J was not being repositioned in bed as evidenced by her stage four wounds and how W2 observed Resident J on her back in bed. W1 stated W2 also informed her she observed Resident J in dried feces in her bed. W1 said when W2 went to talk to staff, the staff person told W2 that "she was told by a supervisor that she did not need to provide care to Resident J because she was on hospice." W1 reported she did not know the name of the staff person; however the staff person was recently hired.

On 2/22/23, I interviewed W2 by telephone. W2 explained she was Resident J's primary care physician for several years and until Resident J started hospice in December. W2 reported she received a telephone call from Relative J1 on 2/4/23. W2 explained Relative J1 expressed concerns regarding Resident J's care needs being neglected by staff. W2 stated she informed Relative J1 that she would go to the facility to see Resident J on 2/5/23.

W2 reported when she walked into Resident J's room in the secured memory care unit on 2/5/23, she observed Resident J laying on her back in her bed. W2 said Relative J2 was also present and expressed concerns regarding the condition Resident J was in. W2 stated she and Relative J2 repositioned Resident J in bed because it was evident staff were not doing so. W2 explained when she and Relative J2 were repositioning Resident J, they observed her buttocks was covered in feces, some of which was dried. W2 stated it was evident staff had not changed Resident J for several hours.

W2 described Resident J's odor as "horrendous" and explained she observed multiple untreated stage four wounds and skin breakdown on Resident J's buttocks and lower back area going up her spine. W2 said one of the stage 4 wounds on Resident J's buttocks was approximately 2 and a half centimeters and was almost to resident J's bone. W2 described the wound as "a gaping hole." W2 explained it was evident Resident J's wounds were not treated by staff in any way.

W2 reported she also observed Resident J's mouth was very dry. W2 said she instructed Relative J2 to get a nearby mouth swab wet and put it on Resident J's lips to moisten them. W2 expressed concern that Resident J was severely neglected by staff as evidenced by the condition she observed Resident J in.

W2 stated she spoke to a care staff person who told her she started working at the facility five days prior. W2 did not know the name of the staff person she spoke to. W2 reported the staff person told her she was instructed not to provide care to Resident J. W2 said the staff person did not provide an explanation as to why she could not provide care to Resident J. W2 said she instructed the care staff person to use saline and water to clean Resident J's wounds and skin breakdown. W2 described feeling "hurt and angry" by the condition Resident J was in and the lack of care she received from staff.

W2 said she took pictures of Resident J's wounds and skin breakdown. W2 provided me with the pictures via text message. I observed Resident J's wounds and skin breakdown were as W2 described.

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 interview with W1, along with review of Resident J's February MAR revealed Resident J's catheter bag was not emptied every two hours. The interview with W2 revealed Resident J was left soiled in feces and had several open stage four wounds that were untreated and uncovered. Staff admitted to W2 that care was not being provided to Resident J. The interview with Resident J revealed it was also evident Resident J was left soiled due to her extremely foul odor.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SPECIAL INVESTIGATION REPORT (SIR) NUMBER 2022A1028020 DATED 1/20/2022**

ALLEGATION:

Soiled linens were left in Resident J's room.

INVESTIGATION:

On 2/9/23, the complainant reported she was informed soiled linens were left in Resident J's room. The complainant stated she received this information second hand and did not observe Resident J's room.

On 2/16/23, Ms. Lindsey denied knowledge regarding soiled linens being left in Resident J's room. Ms. Lindsey reported staff were trained to remove soiled linens immediately from a resident's room and place them in the soiled linen laundry areas in the facility.

On 2/16/23, SP1's statements were consistent with Ms. Lindsey.

On 2/16/23, I inspected each resident room in the facility. I observed one resident in the general assisted living area had dirty, stained sheets on his bed. I also observed Resident K in the general assisted living area had feces covered bedding on her bed. I observed Resident K was dressed and sitting in a chair in her room. Resident K was sleeping, however it appeared she was dressed for the day and staff made her bed with the soiled bedding. Ms. Lindsey reported the Resident K's bedding is changed daily due to her incontinence; however, it appeared staff did not immediately remove the soiled bedding as the bed was made.

I observed Resident L in the general assisted living area was laying in bed with no sheets on her bed. Resident L was laying on the bare mattress. I also observed several residents in the secured memory care unit sleeping in bed with their heads on dirty, stained pillows that had no pillow covers on them.

On 2/22/23, W1 denied seeing soiled linens left in Resident J's room when she was there approximately two weeks ago.

On 2/22/23, W2 reported despite the soiled sheets on Resident J's bed when she observed her on 2/5/23, she did not observe any soiled sheets or linens left in Resident J's room.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing**
	(1) Bedding shall be washable, in good condition, and clean, and shall be changed at least weekly or more often as required.

ANALYSIS:	Resident J was observed with soiled bedding on 2/5/23. On 2/16/23, I observed Resident K had soiled bedding on her bed, Resident L was laying in her bed with no sheets, and several residents in the secured memory care unit were sleeping in bed with their heads on dirty, stained pillows with no pillowcases. The facility continues to be in non-compliance with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SPECIAL INVESTIGATION REPORT (SIR) NUMBER 2022A1028017 DATED 1/20/2022 AND SIR NUMBER 2023A1010022 DATED 2/10/2023**

ADDITIONAL FINDING:

INVESTIGATION:

On 2/16/23, I asked Ms. Lindsey to provide me with a copy of the staff schedule for 2/5/23. Ms. Lindsey reported due to issues with the facility's scheduling software, Onshift, she was unable to provide previous staff schedules. Ms. Lindsey stated the staff schedule is not printed or posted.

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(2) The home shall prepare a work schedule showing the number and type of personnel scheduled to be on duty on a daily basis. The home shall make changes to the planned work schedule to show the staff who actually worked.
ANALYSIS:	The interview with Ms. Lindsey revealed copies of the staff schedule, showing what staff persons actually worked, was not printed or maintained outside of the scheduling software called Onshift. Ms. Lindsey stated there was an issue with the Onshift software that would not allow her to produce previous staff schedules, therefore I was unable to determine who the staff persons were that worked in the secured memory care unit on 2/5/23.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the issuance of a corrective notice order.

02/23/2023

Lauren Wohlfert Date
Licensing Staff

Approved By:

04/19/2023

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