GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 23, 2023

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

RE: License #: AH410413166
Investigation #: 2023A1010051
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, 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 #:	AH410413166
Investigation #:	2023A1010051
Complaint Receipt Date:	01/13/2023
Investigation Initiation Date:	01/17/2023
Report Due Date:	03/12/2023
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
A staff person aggressively put Resident E in bed on 1/16/23.	Yes
Several residents are left soiled and residents in the secured memory care unit are neglected.	No
Resident bedding is dirty and not changed.	Yes
The secured memory care unit is dirty and unsanitary.	Yes

III. METHODOLOGY

01/13/2023	Special Investigation Intake 2023A1010022
01/17/2023	Special Investigation Initiated - Letter Emailed administrator and reviewed incident reports regarding Norovirus reported in the facility
01/17/2023	Contact - Document Received Received resident service plan via email
02/02/2023	Inspection Completed On-site
02/02/2023	Contact - Document Received Received resident service plans
02/09/2023	Contact - Document Sent Emailed assigned Kent Co. APS worker Lacey Lott

ALLEGATION:

A staff person aggressively put Resident E in bed on 1/16/23.

INVESTIGATION:

On 1/23/23, the Bureau received the allegations from Adult Protective Services (APS). The complaint read, “[Witness E1] reported that [Resident E] was in her room on 1/16/23 at 6:15 pm, staff (tall skinny girl) told [Resident E] it was time to go to bed. [Resident E] did not want to go to bed. [Resident E] is very alert and oriented. [Resident E] and staff got into an argument. [Resident E] is in a wheelchair. Staff forced [Resident E] into bed and there is an injury to her index finger and thumb.”

On 2/2/23, I interviewed the facility’s administrator Chelsea Lindsey at the facility. Ms. Lindsey reported the facility’s wellness director Katrina Christian was working the evening Resident E reported she was put in bed against her will. Ms. Lindsey said after the incident, Resident E pushed her pendant and Ms. Christian responded. Ms. Lindsey stated Resident E did not report the incident to Ms. Christian when she responded to her pendant.

Ms. Lindsey reported she and Ms. Christian were not made aware of the incident until the following day when Witness E1 called the facility and said a staff person “forcefully put Resident E in bed” and picked Resident E “up by her fingertips.” Ms. Lindsey stated after she spoke with Witness E1, she and Ms. Christian went to Resident E’s room to assess and speak with her. Ms. Lindsey reported Resident E informed her and Ms. Christian that a “tall skinny black girl put her in bed” and that she and the staff person “argued.” Ms. Lindsey stated Resident E did not disclose being injured and she had no visible injuries after she and Ms. Christian assessed her.

Ms. Lindsey stated Resident E prefers to stay up late and sleep in during the day. Ms. Lindsey reported Resident E’s service plan was updated after this incident to reflect this preference. Ms. Lindsey said it was determined Staff Person 1 fit Resident E’s description and was scheduled in Resident E’s hallway when the incident occurred. Ms. Lindsey reported the allegations were out of character for SP1 and she received resident rights training when she started at the facility.

Ms. Lindsey reported Resident E no longer works at the facility. Ms. Lindsey said after the incident with Resident E, SP1 was scheduled to work on the other side of the facility. Ms. Lindsey explained SP1 did not agree and subsequently quit. Ms. Lindsey provided me with a copy of SP1’s resident rights training document for my review. The document read SP1 read and received a copy of the resident rights. SP1 signed but did not date the document.

Ms. Lindsey provided me with a copy of Resident E’s service plan for my review. The *ACTIVITIES, ROUTINES, and HABITS* section of the plan read, “Daily routine includes: wake up, assistance with dressing, grooming, attending activities of interest with escort, HS care. Does like to stay up late on some evening to watch sporing events. Prefers specific daily routine. Likes to stay up late and watch sporting events." The *TRANSFERRING* section of the report read, “Unable to get in and out of bed, chair, car ect., without total physical assistance or cueing.” The *COGNITION* section of the plan read, “A am oriented and able to recall or retain

information (i.e. recent events, directions, time, place or situation).” The *MOBILITY* section of the plan read, “I am able to independently ambulate with my wheelchair. I cannot ambulate long distances without guidance or assistance.”

On 2/2/23, I interviewed Resident E at the facility. Resident E reported a tall, thin, African American staff person picked her up and aggressively put her in bed. Resident E stated she told the staff person she did not want to get in bed because she wanted to watch a sporting event on television. Resident E said the staff person hurt her hand and fingers when she grabbed her aggressively and made her get in bed. Resident E reported her hand and fingers were still sore the following day.

Resident E did not know the staff person’s name who forcefully put her in bed. Resident E stated she has not seen the staff person since the incident and the staff person has not provided care to her since. Resident E reported she called Witness E1 after the incident and described what happened.

Resident E is diagnosed with hereditary ataxia, causing her to have verbal and physical limitations. Resident E can articulate and recall incidents, however it took her time to communicate with me due to speech limitations caused by her diagnosis.

On 2/2/23, I interviewed Witness E1 at the facility. Witness E1’s statements were consistent with Resident E. Witness E1 said she did contact Ms. Lindsey the following day to report the incident to her.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician’s assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician’s assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	The interviews with Resident E and Witness E1 revealed SP1 used physical force to place Resident E in bed after she told SP1 she did not want to get in bed. Resident E reported SP1 hurt her hand and finger after she used force to place her in bed. This is not consistent with a resident's right to be free from physical harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Several residents are left soiled and residents in the secured memory care unit are neglected.

INVESTIGATION:

On 1/13/23, the Bureau received the allegations from APS. The complaint read, "On 1/10/2023, a man known to have dementia was found laying on the floor of his room. He was covered in feces and the walls of his room were covered with feces. Staff last checked on him around 5 AM, and he was not discovered until 9 or 10 AM." The complaint also read residents in the secured memory care unit, residents are observed slumped over in chairs and wheelchairs not being tended to by staff. The complaint was not assigned for APS investigation.

A complaint received from APS on 1/15/23 read, "On 1/14/23, [Resident F] was left sitting in her urine and feces for an unknown length of time, at least an hour. Another unknown resident in the facility was found on the floor. The unknown resident who had been on the floor for hours had been calling for help but no staff came to help her. There was a nurse outside of the door on her phone ignoring the resident. The facility has a memory care unit; there are several residents on this unit that are not changed properly – they are left soiled in urine and feces. This causes the entire unit to be filled with an odor of feces. The staff in the facility neglect all of the residents." This complaint was not assigned for APS investigation.

A complaint received from APS on 1/25/23 read, "Recently, Resident E was sitting on a towel that was soaked in urine. [Resident E's] Pull-Up was dry. It is believed staff put her back down on a wet towel." The complaint also read, "Staff members frequently do not answer service bells when [Resident E] rings them for utensils, which sometimes results in her not eating until lunchtime." This complaint was not assigned for APS investigation.

On 2/2/23, Ms. Lindsey reported Resident G was recently moved to the secured memory care unit due to his behavior of sitting himself on the floor in his room and defecating and smearing it. Ms. Lindsey stated Resident G was sent to the hospital

on 1/13/23 or 1/14/23 when there was a Norovirus outbreak in the facility. Ms. Lindsey provided me with a copy of Resident G's service plan for my review. The *TOILETING* section of the plan read, "I refuse to wear a brief, despite the staff trying and encouraging me to do so. I soil my pants and get agitated with the staff when they try to change me. Bathroom equipped with grab bars for toileting activities. Dependent in toileting activities or unable to recognize need to use toilet. Needs help to negotiate clothing after toileting." The *BEHAVIORS* section of the report read, "Exhibits inappropriate behavior: Has a history of smearing bowels on self and belongings. Encourage to allow staff to assist with cleanliness and call brother."

Ms. Lindsey reported all resident care needs are met consistent with their service plans. Ms. Lindsey said all residents are checked on every two hours and are changed and toileted at that time and as needed. Ms. Lindsey denied knowledge regarding residents being intentionally left soiled. Ms. Lindsey reported Resident F is incontinent and wears briefs. Ms. Lindsey stated Resident F can make her needs known and uses her pendant to summon staff for assistance as needed.

Ms. Lindsey provided me with a copy of Resident F's service plan for my review. The *TOILETING* section of the plan read, "I need assistance to change my pull-ups. Check me every 2 hours to ensure my pull-up is dry. I require assistance with peri-care. I use pull-ups. Supply and disposal managed by my family. Dispose of my used incontinent products every shift. My bathroom is equipped with grab bars for toileting activities." The *COGNITION* section of the plan read, "I have mild to moderate disorientation or difficulty recalling/retaining information. I need cueing. I require reminders for activities. I required reminders for meals."

Ms. Lindsey denied knowledge regarding Resident E being dry and placed on a soiled towel. Ms. Lindsey reported staff are trained to remove and launder soiled clothing, towels, and linens immediately upon discovery. The *TOILETING* section of Resident E's plan read, "I am dependent in toileting activities. I need help to negotiate clothing after toileting. I require assistance with peri-care. I use pull-ups. Supply and disposal managed by family and staff. Dispose of my used incontinent products every shift. My bathroom is equipped with adaptive devices for toileting activities (grab bars)."

Ms. Lindsey reported she has not received any complaints from Resident E or Witness E1 regarding Resident E not getting utensils at mealtimes. Ms. Lindsey stated Resident E prefers to eat meals in her room and staff accommodate this. Ms. Lindsey said resident E can eat independently. The *EATING/MEALS* section of Resident E's service plan read, "Diet: minced & moist texture, honey thick liquids. I eat in the Dining Room or my room, please ask at each meal. I need preparation of all meals."

On 2/2/23, I interviewed SP2 at the facility. SP2's statements were consistent with Ms. Lindsey.

On 2/2/23, I interviewed SP3 at the facility. SP3's statements were consistent with Ms. Lindsey and SP2.

On 2/2/23, I observed Resident E was clean and appropriately groomed. Resident E was wearing clean clothing and stated staff assist her in the bathroom. I observed the lunch time meal that was brought to Resident E in her room. I observed utensils were provided to Resident E. I also observed Witness E1 asked staff to provide Resident E with a napkin, to which they provided upon this request.

On 2/2/23, I interviewed Resident F at the facility. Resident F reported she has not been left soiled. Resident F showed me the pendant she has that is used to summon staff for assistance. Resident F reported the individual who resides across the hall from her often yells out during the night. Resident F said she often uses her pendant to summon staff for assistance for that resident and they respond.

On 2/2/23, I attempted to interview Resident G at the facility. I was unable to engage Resident G in meaningful conversation. I observed Resident G was in clean clothing and was appropriately groomed.

I observed several residents in the common area in the secured memory care unit. The residents were wearing clean clothing and appeared to be adequately groomed. There were two staff persons in the common areas with the residents. I did not observe any residents "slumped over" or appearing to slide out of their chairs or wheelchairs.

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 Resident E and Resident F, along with my observation of several residents in the secured memory care unit, revealed there is insufficient evidence to suggest residents are intentionally left soiled. I observed several residents were wearing clean clothing and were appropriately groomed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident bedding is dirty and not changed.

INVESTIGATION:

On 2/2/23, I inspected the secured memory care unit with Ms. Lindsey. I observed two residents sleeping in bed with their heads on dirty, stained pillows with no pillowcases on. There were also several resident beds made with no sheets on them with dirty and stained soaker pads. The beds were made for residents to get in and sleep in without sheets and dirty soaker pads present. I observed one resident bed was made with a dirty stained comforter.

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:	My inspection of the secured memory care unit revealed several residents had dirty, stained pillows on their beds with no pillowcases. I observed one resident's head was on a dirty stained pillow, with no pillowcase on, while he slept in bed. Several resident beds were made with no sheets and dirty soaker pads were on the beds. 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**

ALLEGATION:

The secured memory care unit is dirty and unsanitary.

INVESTIGATION:

On 2/2/23, I observed several resident rooms had soiled, dirty linens present. The secured memory care unit had a strong smell of urine, as evidenced by soiled linens being left in resident rooms. It was evident soiled linens are not removed from resident rooms or placed in the soiled laundry areas to be washed. I did not observe any urine on the floors, or feces on the walls however. I observed clothing was strewn about on floors and not put away in several resident rooms.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

ANALYSIS:	My inspection of the secured memory care unit revealed dirty, soiled linens are not removed from resident rooms in a timely manner. I detected a strong smell of urine in the secured memory care unit consistent with soiled linens not being removed or laundered.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend issuance of a correction notice order.

02/10/2023

_____

Lauren Wohlfert Date
Licensing Staff

Approved By:

04/19/2023

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