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 #: 2023A1010052
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 #:	2023A1010052
Complaint Receipt Date:	12/13/2022
Investigation Initiation Date:	12/13/2022
Report Due Date:	02/12/2023
Licensee Name:	CSM Kentwood LLC
Licensee Address:	4352 Breton Road SE Kentwood, MI 49512
Licensee Telephone #:	(312) 837-0704
Administrator:	Chelsea Lindsey
Authorized Representative:	Lucijana Tomic
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?
A staff person yelled at Resident D when she asked to be repositioned in bed.	No
Resident D is not receiving adequate care from staff.	Yes

III. METHODOLOGY

12/13/2022	Special Investigation Intake 2023A1010017
12/13/2022	Special Investigation Initiated - Letter Email exchange with assigned Kent Co APS worker Bryan Kahler
01/03/2023	Inspection Completed On-site
01/03/2023	Contact - Document Received Received resident service plan and staff resident rights training documents
02/02/2023	Inspection Completed On-site

ALLEGATION:

A staff person yelled at Resident D when she asked to be repositioned in bed.

INVESTIGATION:

On 12/13/2022, the Bureau received the allegations from Adult Protective Services (APS). The complaint read that on 12/8/22, when Resident D asked to be repositioned in bed, “an unknown female staff member yelled at [Resident D] and left her in that same position.”

On 12/13/22, I emailed and interviewed assigned Kent County APS worker Bryan Kahler. Mr. Kahler reported he interviewed staff and Resident D on 12/12/22. Mr. Kahler stated he was informed there was an incident in which Resident D and a staff person got into a verbal altercation. Mr. Kahler said Resident D was verbally aggressive towards a staff person and the staff person responded by being verbally aggressive back. Mr. Kahler reported the staff person who got into the verbal

altercation with Resident D no longer works at the facility. Mr. Kahler explained the staff person was terminated for not calling in or showing up for one of her shifts, not for the verbal altercation with Resident D.

On 1/3/23, I interviewed administrator Bridget Lutzke at the facility. Ms. Lutzke reported she was currently acting as the interim administrator; therefore, she did not have any knowledge regarding the allegations.

On 1/3/23, I interviewed the facility's wellness director, Katrina Christian at the facility. Ms. Christian reported she spoke with Resident D after the verbal altercation with a staff person. Ms. Christian stated Resident D admitted she "got snippy" with Staff Person 1 (SP1) first and SP1 "got snippy" back with Resident D. Ms. Christian said Resident D has a history of being verbally aggressive towards staff. Ms. Christian said staff receive resident rights training upon hire at the facility. Ms. Christian reported SP1 was terminated for not calling in or showing up for one of her shifts, not for the incident with Resident D. Ms. Christian reported staff are trained not to engage in verbal altercations with residents.

Ms. Christian provided me with a copy of SP3's resident rights training documents for my review. SP3 signed that she received a copy of resident rights.

On 1/3/23, I interviewed SP2 at the facility. SP2 denied having firsthand knowledge regarding any incidents in which staff have engaged in a verbal altercation with Resident D or any other residents in the facility. SP2's statement regarding Resident D being verbally aggressive towards staff were consistent with Ms. Christian. SP2 stated she received resident rights training when she started at the facility. SP2 reported she was trained to leave and re-approach a resident when they became verbally or physically combative. SP2 said it would be out of character for staff at the facility to be verbally aggressive towards Resident D or any other residents in the facility.

On 1/3/23, I was unable to interview Resident D as she was admitted to the hospital and was not present at the facility.

On 2/2/23, I attempted to interview Resident D at the facility. I was informed Resident D was in the hospital awaiting a procedure to have one of her legs amputated. The status of Resident D's return to the facility is unknown.

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 Ms. Christian and SP2 revealed Resident D had a history of being verbally aggressive towards staff. Ms. Christian reported there was an incident in which Resident D was verbally aggressive towards SP1 and SP1 responded. SP1 no longer works at the facility. There is insufficient evidence to suggest staff harmed Resident D by being verbally aggressive towards her. The interviews with Ms. Christian and SP2, along with review of staff training documents, revealed staff receive resident rights training upon hire at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident D is not receiving adequate care from staff.

INVESTIGATION:

On 12/13/22, the complaint read, "On 12/08/22, [Resident D] was turned on her right side and was left there from 7am-10:40am. Her catheter was kinked, causing her and her lines to be urine soaked." The complaint also read, "[Resident D] needs to be turned every two hours because she has pressure wounds on her right side. This is not being done. The physician's order states that she needs to be turned every four hours. As well, [Resident B] had feces in her vaginal area, as she was not cleaned appropriately. She had not had a bowel movement for two days." The complaint also read staff take over 30 minutes to respond to Resident D's pendant after she pushes it to summon staff for assistance.

On 12/13/22, Mr. Kahler reported Resident D told him she was not aware of a kink in her catheter or being left “soaked.” Mr. Kahler stated Resident D said staff “rotate” her every four hours or whenever she requests it. Mr. Kahler said Resident D admitted she tells staff to “leave” when they enter her room to “turn” her at night. Mr. Kahler reported he also spoke with Ms. Christian, and she informed him she also “rotates” Resident D in bed. Mr. Kahler reported Resident D receives catheter maintenance from an outside service provider. Mr. Kahler stated Resident D said it has taken staff 30 minutes to respond after she pushed her pendant to summon them for assistance.

On 1/3/23, Ms. Christian reported Resident D is non ambulatory. Ms. Christian stated Resident D decides whether she wants to be up and placed in her wheelchair during the day. Ms. Christian said it is the facility’s policy and procedure for staff to check on all residents every two hours. Ms. Christian reported when staff check on Resident D every two hours, they rotate her in bed if she requests it. Ms. Christian said staff do rotate Resident D in bed every four hours to prevent pressure sores.

Ms. Christian said Resident D has neuropathy in her legs and has a wound on her heel. Ms. Christian reported this wound is being treated by outside home care services through Spectrum. Ms. Christian stated Resident D also has a suprapubic catheter that is maintained and flushed by Spectrum home health services.

Ms. Christian denied knowledge regarding Resident D being intentionally left soiled. Ms. Christian reported Resident D is changed as needed and when staff check on her every two hours. Ms. Christian stated Resident D’s care needs are met in accordance with her service plan. Ms. Christian said staff answer resident pendants in a timely manner. Ms. Christian reported there have been some issues with resident pendants not clearing when staff respond and attempt to re-set them. Ms. Christian stated maintenance staff are addressing this issue.

Ms. Christian provided me with a copy of Resident D’s service plan for my review. The *TRANSFERRING* section of the plan read, “Unable to get in and out of bed, chair, car ect., without total physical assistance or cueing.” The *TOILETING* section of the plan read, “Bed pan or commode at night. I am dependent in toileting activities and will need assistance with my catheter and bed pan. I use incontinence products (briefs). Supply and disposal managed by my family and staff. Dispose of used incontinent products every shift. Needs help to negotiate clothing after toileting. Requires assistance with peri-care.”

The *CATHETER* section of the plan read, “18 French Suprapubic-Latex Free 18 French. Tandem 360 to change monthly. CATHETER: Change as per Physician’s Orders. Tandem 365 orders my supplies and changes my catheter. I require a one person assist with my catheter (ordering/refilling supplies, cleansing, changing). Report leaking/pain/concerns to nurse.”

Ms. Christian provided me with a copy of Resident D's staff pendant response times for 12/30/22 through 1/2/23. Ms. Christian reported the response time of 4 hours and 27 minutes on 12/31/22 was due to staff not being able to clear the pendant when they responded. The report read there were a total of "57 events" with a 25-minute average response time. Ms. Christian stated this was not accurate due to the issues with staff not being able to clear the resident pendants.

On 1/3/23, SP2's statements were consistent with Ms. Christian.

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 Ms. Christian and SP2 revealed Resident D's care needs were met consistent with her service plan. However, review of Resident D's plan revealed how often she is to be repositioned in bed was not outlined. The wound care treatment Resident D received from an outside home care provider was also not outlined in her plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the issuance of a corrective notice order.

2/6/2023

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Lauren Wohlfert
Licensing Staff

Date

Approved By:

04/19/2023

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