GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 18, 2023

Lisa Sikes
Care Cardinal Cascade
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410410352
Investigation #: 2023A1010030
Care Cardinal Cascade

Dear Ms. Sikes:

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) 241-1970.

Sincerely,

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 #:	2023A1010030
Complaint Receipt Date:	02/09/2023
Investigation Initiation Date:	02/10/2023
Report Due Date:	04/11/2023
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:	Lisa Sikes
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?
Staff administered Resident H's prescribed Invega Susten shot without authorization to do so. This medication can only be administered by a registered nurse (RN) at Network180.	No
Additional Finding	Yes

III. METHODOLOGY

02/09/2023	Special Investigation Intake 2023A1010030
02/10/2023	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
02/10/2023	APS Referral APS referral emailed to Centralized Intake
02/13/2023	Inspection Completed On-site
02/13/2023	Contact - Document Received Received resident February MAR
02/14/2023	Contact – Telephone call made Interviewed the complainant by telephone
02/14/2023	Contact – Document received Received Resident H's Network 180 staff and nursing progress notes and staff at the facility's note regarding Resident H's injection on 2/5/23
02/27/2023	Contact – Telephone call received Received telephone call from administrator DaleTron Thompson
05/18/2023	Exit Conference Completed with licensee authorized representative Lisa Sikes

ALLEGATION:

Staff administered Resident H's prescribed Invega Susten shot without authorization to do so. This medication can only be administered by a registered nurse (RN) at Network180.

INVESTIGATION:

On 2/9/23, the Bureau received the allegations from the online complaint system. The complaint read, "[Resident H] presented for her scheduled appointments with ICM providers on 2/6/23 reported to staff that her AFC home staff had administered her intramuscular injection medication the previous day. This injection is prescribed by Network180 psychiatrist Dr Robert Lafleur and is not is not authorized to be administered by anyone other than a Network180 RN. [Resident H] produced a letter written by Parleah [sic] Buggs which stated 'To whom it may concern [Resident H] received 156MG of INVEGA SUSTEN on 2/5/2023 at 11am."

On 2/10/23, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 2/13/23, I interviewed wellness director Starlin Williams at the facility. Ms. Williams was unable to recall the exact date of the incident, however she said it occurred during a recent weekend. Ms. Williams reported she received a telephone call from Staff Person 1 (SP1) who is a "house manager." Ms. Williams stated SP1 told her "she gave [Resident H] her shot." Ms. Williams said she questioned SP1 and responded by stating "what shot?" Ms. Williams reported she knew Resident H did not have any previously prescribed "shots," therefore she did not know what SP1 was referring to. Ms. Williams explained when she returned to the facility the following Monday, she began to investigate the incident.

Ms. Williams reported she discovered Resident H's prescribed "Invega Susten" injection arrived at the facility when it is only supposed to be delivered to Network180. Ms. Williams said the facility's "in house" pharmacy through Mercy Health, incorrectly sent Resident H's injection to the facility and entered it in Resident H's electronic medication administration record (eMAR). Ms. Williams reported SP1 administered the injection as it was on Resident H's eMAR to do so. Ms. Williams said she did not know why the pharmacy delivered Resident H's "Invega Susten" to the facility and not to Network180.

Ms. Williams provided me with a copy of Resident H's February MAR for my review. The MAR read SP1 administered Resident H's "INVEGA SUSTEN 156 MG PFS INJECT 156MH INSTRAMUSCULARLY EVERY 30 DAYS (indications for use: Antipsychotics)" on 2/5/23. Ms. Williams reported this was a monthly injection Resident H was supposed to receive at Network180 by their staff. Ms. Williams said this was the first time this medication was delivered to the facility and administered by staff. Ms. Williams stated she immediately discontinued this medication in Resident H's eMAR after she learned the incident occurred.

Ms. Williams reported Resident H is alert and oriented and knows what her prescribed medications are. Ms. Williams stated Resident H knows she receives her prescribed "Invega Susten" monthly at Network180, not by staff at the facility. Ms. Williams said med techs are trained to either contact herself, or the facility's

administrator DaleTron Thompson, if there are any questions or uncertainties regarding any resident medications.

On 2/13/23, I interviewed Resident H at the facility. Resident H reported she is diagnosed with Schizophrenia and gets her “shot” to treat this condition once a month by a nurse at Network180. Resident H stated on 2/3/23 or 2/4/23, [SP1] told her she had to “take the shot” that she knew only staff at Network180 “were authorized” to give her. Resident H said she argued with SP1 about not taking the shot because she was not supposed to receive it at the facility.

Resident H explained she did not “want to continue to argue with SP1, so she allowed her to “give her the shot.” Resident H stated she was “worried” SP1 would “contact security” and “remove” her from the facility if she continued to refuse to “take the shot,” so she let SP1 administer it. Resident H reported she is supposed to receive the shot in her buttocks, however SP1 administered it in her lower back. Resident H said she had SP1 write a letter that read “she gave her the shot” so staff at Network180 “would believe” SP1 gave it to her. SP1 said when she went to Network180 the following day, she gave her case manager the letter SP1 wrote.

Resident H said she did not know why her pharmacy sent “the shot” to the facility when it is only supposed to go to Network180. Resident H reported this was the first time this occurred.

On 2/14/23, I interviewed the complainant by telephone. The complainant reported Resident H did provide Network180 staff with a note that read staff at the facility administered Resident H’s Invenga Susten injection. The complainant stated only a registered nurse at Network180 is permitted to administer Resident H’s prescribed Invenga Susten injection once a month. The complainant said the pharmacy usually designates which medication for Resident H is to be delivered to the facility and which medication is to be delivered to Network180. The complainant explained this designation was not made recently, therefore the Invenga Susten injection was incorrectly delivered to the facility.

The complainant provided me with a copy of Resident H’s Network180 nursing *Progress Note* that was dated 2/6/23 for my review. The note read, “Called Care Cardinal at the number listed to inquire about the administration, namely who it was administered by (including credentials), where it was administered, who ordered the prescription (as Dr. Lafleur's order was not sent to the AFC home) and why it was administered outside of her Network180 treatment team. AFC home's house manager, [SP1], answers the phone. She states that the individual who administered the injection as "a med tech;" when asked for the individual's name she states that "I would have to look at the schedule" to get this information and "I can call you back." This writer advises that a call-back with this information would be appreciated, but for right now the call will continue. When asked to provide the individual's credentials [sp1] states "to pass medications;" this writer asks about specific credentials or licensure, and she states she is unsure but "some of them are CNAs" and "med

techs have to take a course about how to administer medications." This writer requests that the individual's credentials be included in the call back with their name. Writer asks about site of administration, and [SP1] states "her buttocks." This writer asks for clarification about which side of the body, and after some pause [SP1] states "her left buttocks." This writer inquires as to why AFC staff administered a long-acting injection when they were not provided with an order to do so, and [SP1] states "All of our orders come from Mercy Health Pharmacy. I know this one is Mercy Health because it's in all caps." [SP1] states that 'I'm just the house manager' and this writer should contact the Wellness Director, Starling [sic] for additional information. This writer thanks her for the information and reiterates that a call back with the individual's name and credentials will be expected for documentation purposes."

The complainant provided me with a copy of Resident H's case manager *Progress Note* dated 2/6/23 for my review. The note read, "[Resident H] reported she received her injection at her AFC home yesterday and had informed the ICM psychiatrist and RN of this. She stated one of the "med techs" administered the injectable medication and gestured to her right gluteal region as the injection site. She stated she did not know why she was given the medication at her AFC home, as this had previously never occurred, and she had always previously been administered her IM medication by the ICM RN in the ICM office. CM will coordinate with ICM RN to confirm voracity of this report and the guidelines under which IM medication prescribed by the ICM psychiatrist can be administered."

The complainant provided me with a copy of the note staff at the facility gave Resident H regarding their administration of her Invenga Susten. The note read, "to whom it may concern [Resident H] received 156MG of INVENGA SUSTEN on 2/5/23 at 11am." SP1's name was at the bottom of the note.

On 2/24/23, I interviewed administrator DaleTron Thompson by telephone. Ms. Thompson's statements were consistent with Ms. Williams'.

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. Williams, Ms. Thompson, and the complainant revealed the facility's "in house pharmacy" incorrectly delivered Resident H's Invenga Susten injection to the facility and entered it on Resident H's eMAR. SP1 administered the medication as it was outlined in Resident H's eMAR. It was discovered the facility's "in house pharmacy" made the error.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

On 2/13/23, Ms. Williams stated she and medication technicians (med techs) were unaware what medication(s) staff at Network180 administer to Resident H. Ms. Williams reported this is not documented anywhere within Resident H's resident record at the facility. Ms. Williams said SP1 did not think to question or contact her prior to administering Resident H's Invenga Susten, as this was a medication staff had not previously administered to Resident H.

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.**
ANALYSIS:	The interview with Ms. Williams revealed SP1 did not question why Resident H's Invenga Susten injection arrived at the facility and was put into her eMAR by the pharmacy. Ms. Williams said this injection had not previously arrived at the facility and staff had never administered it before. Ms. Williams stated staff are trained to contact herself or Ms. Thompson if there are ever any unusual circumstances regarding resident medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Lisa Sikes and Ms. Thompson by telephone on 5/18/23.

RECOMMENDATION:

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

02/27/2023

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Lauren Wohlfert Date
Licensing Staff

Approved By:

05/17/2023

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