GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 21, 2023

Allison Freed
Cascade Trails Senior Living
1225 Spaulding Road
Grand Rapids, MI 49546

RE: License #: AH410394304
Investigation #: 2023A1021077
Cascade Trails Senior Living

Dear Ms. Freed:

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 #:	AH410394304
Investigation #:	2023A1021077
Complaint Receipt Date:	07/26/2023
Investigation Initiation Date:	07/27/2023
Report Due Date:	09/25/2023
Licensee Name:	Cascade Trails Senior Living, LLC
Licensee Address:	Suite 200 3196 Kraft Ave Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Matthew Fellows
Authorized Representative:	Allison Freed
Name of Facility:	Cascade Trails Senior Living
Facility Address:	1225 Spaulding Road Grand Rapids, MI 49546
Facility Telephone #:	(616) 328-6440
Original Issuance Date:	05/06/2020
License Status:	REGULAR
Effective Date:	11/06/2022
Expiration Date:	11/05/2023
Capacity:	71
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A received improper care.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/26/2023	Special Investigation Intake 2023A1021077
07/27/2023	Special Investigation Initiated - Letter referral sent to APS
07/27/2023	Contact - Telephone call made left message with private duty agency
07/28/2023	Contact-Telephone call made Interviewed Private Duty Worker
07/31/2023	Inspection Completed On-site
08/21/2023	Exit Conference

ALLEGATION:

Resident A received improper care.

INVESTIGATION:

On 07/26/2023, the licensing department received a complaint with allegations Resident A received improper care. The complainant alleged at 8:00am on 07/22/2023, Resident A's private duty caregiver came to the facility and found Resident A sitting in her recliner chair and appeared to have slept in the chair. The complainant alleged Resident A's ointment was not applied, her catheter bag was not changed, she was not put into pajamas, and was not checked on throughout the night.

On 07/27/2023, these allegations were referred to Adult Protective Services (APS). Initially the case was assigned to an APS worker. However, Resident A passed away on 08/08/2023 and therefore APS dismissed the case.

On 07/28/2023, I interviewed Gauthier Family Home Care worker Jasmine Martez by telephone. Ms. Martez reported she provides morning care to Resident A at the facility. Ms. Martez reported she arrived at the facility on 07/22/2023 and found Resident A sitting in her recliner chair. Ms. Martez reported she questioned Resident A if she slept in the chair, and Resident A reported she did. Ms. Martez reported Resident A's catheter bag was not changed and her cream that is to be applied to her buttocks was not applied. Ms. Martez reported she reported these concerns to management at the facility and they reported they would be looking into these concerns.

On 07/31/2023, I interviewed Resident A at the facility. Resident A reported that she has been left in her chair overnight. Resident A reported care staff provide good care but at times she is left alone for long period of time.

On 07/31/2023, I interviewed wellness director Ashley Nisley at the facility. Ms. Nisley reported Relative A1 has brought concerns about care to the management team. Ms. Nisley reported Resident A has private duty care in the morning for morning cares as the family wants more individual attention for Resident A. Ms. Nisley reported on the evening of 07/21/2023, second shift tried to get Resident A into bed and Resident A requested to stay in her chair. Ms. Nisley reported when third shift attempted to get Resident A into bed, Resident A complained of pain and shortness of breath. Ms. Nisley reported third shift caregivers contacted the on-call worker and were advised to take vitals, document vitals, and continue to monitor the resident. Ms. Nisley reported caregivers took vitals and vitals were within normal range. Ms. Nisley reported Resident A's catheter bag and clothes were changed. Ms. Nisley reported caregivers cannot force Resident A to get into bed. Ms. Nisley reported Resident A was checked on appropriately and provided appropriate care.

On 07/31/2023, I interviewed staff person 1 (SP1) at the facility. SP1 reported on a few occasions, first shift caregivers have observed Resident A to be left overnight in her recliner chair. SP1 reported she has observed Resident A's catheter bag to not have been changed.

I reviewed the medication administration record (MAR) for July 2023. The MAR read,

"When putting to bed make sure to put cream on buttocks and pull brief up as far as possible." The MAR revealed staff did not initial that this was completed on 07/05, 07/11, and 07/21. In addition, the MAR read, "*PM change leg bag to large catheter bag for during night."* The MAR revealed this was not completed on 07/11 and 07/21. In addition, there were no vitals recorded for the evening of 07/21.

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:	Interviews conducted and review of documentation revealed Resident A requested to stay in her chair on the evening of 07/21/2023. While caregivers cannot force Resident A to go to bed, bedtime care is still to be provided to Resident A. Review of Resident A's MAR revealed Resident A's ointment was not applied and the catheter bag was not changed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I observed two ½ bed rails attached to Resident A's bed.

Ms. Nisley reported Resident A received a hospital bed from Carelinc with the bedrails. Ms. Nisley reported the family was educated the facility did not allow bed rails. Ms. Nisley reported the maintenance department took the bedrails off the bed and then family put them back on. Ms. Nisley reported the family insisted Resident A have the bedrails attached to the bed.

I reviewed Resident A's service plan. The service plan omitted all information about the devices related to purpose of use, staff responsibility to ensure devices were safe, and ongoing maintenance schedules. For instance, instruction regarding whether the resident could summon staff independently for help or require monitoring on a predetermined frequency was not defined. In addition, it lacked what staff were responsible for, and what methods were to be used in determining if the device posed a risk.

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:	Upon my inspection, Resident A had bedside assistive devices attached to her bed. The service plan for Resident A lacked information about the devices related to purpose of use, staff responsibility to ensure devices were safe, and ongoing maintenance schedules. For instance, instruction regarding whether the resident could summon staff independently for help or require monitoring on a predetermined frequency was not defined. In addition, it lacked what staff were responsible for, and what methods were to be used in determining if the device posed a risk.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Nisley reported Resident A had private duty caregivers come every morning for morning care. Ms. Nisley reported Resident A was also on Corewell Health Hospice Services. Ms. Nisley reported Resident A had a pressure sore on her buttocks and caregivers were to assist with pressure relief by placing pillows on her back and having Resident A move out of her chair.

SP1 reported caregivers try to relieve pressure off Resident A's buttocks to assist with the healing of the pressure sore.

I reviewed Resident A's service plan. The service plan omitted all information on private duty care, hospice care services, and pressure relief.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Review of Resident A's service plan revealed lack of detail regarding her specific care needs. For instance, there was no mention of private duty care and hospice care involvement. In addition, Resident A required pressure relief on her buttocks, and this was not information was not detailed in the service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/15/2023

Kimberly Horst — Date
Licensing Staff

Approved By:

08/21/2023

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