GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 21, 2023

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

RE: License #: AH410410352
Investigation #: 2023A1028057
Care Cardinal Cascade

Dear Lisa 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 responsible party 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**
**BUREAU OF COMMUNITY AND HEALTH SYSTEMS**
**SPECIAL INVESTIGATION REPORT**

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH410410352 |
| | |
| **Investigation #:** | 2023A1028057 |
| | |
| **Complaint Receipt Date:** | 06/09/2023 |
| | |
| **Investigation Initiation Date:** | 06/12/2023 |
| | |
| **Report Due Date:** | 08/09/2023 |
| | |
| **Licensee Name:** | CSM Cascade, LLC |
| | |
| **Licensee Address:** | 1435 Coit Ave. NE<br>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.<br>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 did not follow Resident A's service plan on multiple occasions. | Yes |
| Resident A was given a double dose of Seroquel. | No |
| Additional Findings. | No |

## III. METHODOLOGY

| | |
|---|---|
| 06/09/2023 | Special Investigation Intake<br>2023A1028057 |
| 06/12/2023 | Special Investigation Initiated - Letter |
| 06/12/2023 | APS Referral<br>APS made referral to HFA through Centralized Intake. |
| 06/15/2023 | Contact - Face to Face<br>Interviewed facility Admin/DaleTron Thompson at the facility. |
| 06/15/2023 | Contact - Face to Face<br>Interviewed Employee A at the facility. |
| 06/15/2023 | Contact - Face to Face<br>Interviewed Employee B at the facility. |
| 06/15/2023 | Contact - Face to Face<br>Interviewed Employee C at the facility. |
| 06/15/2023 | Contact - Face to Face<br>Received Resident A's record from Admin/DaleTron Thompson at the facility. |

**ALLEGATION:**

**Staff did not follow Resident A's service plan on multiple occasions**.

**INVESTIGATION:**

On 6/12/2023, the Bureau received the allegations through Centralized Intake.

On 6/12/2023, Adult Protective Services (APS) made the referral to Homes for the Aged (HFA) through Centralized Intake.

On 6/15/2023, I interviewed facility administrator, DaleTron Thompson, at the facility who reported Resident A was admitted to the facility on 9/15/2022. During [their] stay, Resident A demonstrated significant behaviors to include stealing from other residents, verbal outbursts, and making false accusations. Resident A was caught stealing items from other resident's rooms on multiple occasions and continued to demonstrate inappropriate judgment and did not understand boundaries. Ms. Thompson reported the authorized representative was conferenced with on multiple occasions concerning Resident A's behaviors, but the authorized representative also had difficulty managing Resident A's behaviors and outbursts. Resident A would refuse care, be difficult with staff during care routines, and flooded the bathroom in early 2023 due to getting in the shower unsupervised and without staff assistance. Ms. Thompson reported Resident A was inconsistent using the call light and would often try to do things on [their] own despite staff instruction to call for assistance and wait for staff to arrive. Resident A often demonstrated daily outbursts towards staff, other residents, and even [their] authorized representative as well. Resident A would also inappropriately contact staff, former staff, and other resident's family members on social media. Staff were instructed to not engage Resident A on social media and Ms. Thompson had multiple conferences with Resident A and the authorized representative about this behavior. Ms. Thompson reported Resident A would consistently say to staff and the authorized representative that "no one was going to tell [them] what to do". Ms. Thompson reported Resident A was allowed to leave the facility as long as [they] signed out and notified staff and [their] authorized representative agreed to it as well. Ms. Thompson reported on 5/31/2023 Resident A wanted to go out in the community with another resident but [their] authorized representative said Resident A could not go. Ms. Thompson called Resident A's authorized representative on the telephone with Resident A present. The authorized representative confirmed Resident A is not to leave the facility. Resident A had an outburst and became angry and left Ms. Thompson's office to return to [their] room. Ms. Thompson remained on the phone with the authorized representative to conference about Resident A's increased behaviors and outbursts with both agreeing that Resident A needed to be sent to the hospital for a psych evaluation and to rule out a urinary tract infection. Ms. Thompson went to Resident A's room to discuss going to the hospital and could not find Resident A. Ms. Thompson and staff searched the facility and discovered Resident A left the facility with another resident to go to a dispensary. Resident A did not have permission from the facility or [their] authorized representative to leave and Resident A did not sign out or notify staff [they] were leaving. Ms. Thompson was able to contact the other resident via cellphone and confirm that Resident A was on the public transportation Go-Bus with [them] to go to the dispensary. The other resident was unaware Resident A was not allowed to leave the facility but allowed Ms. Thompson to speak with Resident A via [their] cellphone. Ms. Thompson reported she told Resident A [they] did not have

permission to leave the facility and placed [themselves] at risk of harm or injury by leaving without permission. Resident A stated [they] would return by 4:30 pm but Resident A did not return to the facility until 7:00 pm. Resident A's authorized representative was immediately notified of Resident A's noncompliance and contacted Resident A by telephone as well to inform Resident A that upon return to the facility, Resident A would be sent to the hospital for evaluation. Ms. Thompson also reported Resident A continually vaped as well despite staff instruction not to. The facility is a smoking campus with a designated area outside away from the facility, but Resident A continued to smoke in [their] room despite staff warnings. On 5/31/2023, Resident A was sent to the hospital for psych evaluation and evaluation of urinary tract infection as well. Resident A did not return to the facility. Ms. Thompson provided Resident A's record for my review.

On 6/15/2023, I interviewed Employee A at the facility who reported Resident was difficult and had multiple daily outbursts with staff, residents, and visitors at the facility. Employee A confirmed Resident A was caught stealing from other residents on multiple occasions and was caught vaping in [their] room despite staff instruction not to. Resident A did not understand boundaries and contacted multiple staff and other residents and their families on social media despite being instructed not to. Employee A also reported Resident A demonstrated inappropriate behavior and even "purposely tripped another resident in front of others causing a fall and laughed about it". Employee A reported Resident A would not use the call light consistently and would often get in the shower on [their] own despite staff instruction not to. Employee A confirmed Resident A flooded the bathroom early in 2023 due to entering the shower without staff assistance. Employee A confirmed Resident A left the building on 5/31/2023 without permission, without signing out, and without notifying staff to go to a local dispensary with another resident. Employee A reported there is a physician order for Resident A to use marijuana as a PRN medication and it is to be used in the designated smoking area outside and away from the building. Employee A reported Resident A was sent to the hospital on 5/31/2023 for further psych evaluation and evaluation of urinary tract infection. Resident A did not return to the facility and the authorized representative removed Resident A's belongings from the facility.

On 6/15/2023, I interviewed Employee B and Employee C at the facility whose statements were consistent with Ms. Thompson's statements and Employee A's statements.

On 6/22/2023, I reviewed Resident A service plan which revealed the following:

- Resident A is non-ambulatory, chairfast, and uses a quad cane next to the bed with transfers intermittently.
- Resident A can transfer in and out bed, chair, car etc. without assistance.
- Receives *showers/bathes 2x/week but will sometimes take a daily shower without requesting assistance.*
- Resident A's bathroom is equipped with adaptive equipment that allows Resident A to use the toilet independently.

- Requires minimal supervision with grooming and *encouragement to wear socks and shoes.*
- Is incontinent of bladder.
- *Exhibits inappropriate behavior: taking belongings to others, showing anger, provocation, verbal abuse, making false accusation of theft of personal belongings, false sexual accusations, calling 911 unnecessarily or other extreme or erratic behavior pattern.*
- *Demonstrates inappropriate judgement, behavior, and ability to function in social settings.*
- *Has verbal outbursts, profane language, yells down hallway.*
- *Unable to follow directions.*
- *One to one supervision required to address behaviors. Call guardian as necessary to be a voice of reason.*
- Evidence of staff instruction to use redirection and reapproach techniques to deescalate behaviors.

I reviewed Resident A's record noted which revealed Resident A demonstrated behaviors despite staff instruction and redirection, vaped in the building, and left the building without permission. The notes also reveal evidence of communication between the facility and Resident A's authorized representative about demonstrated behaviors.

I also reviewed Resident A's medication record which revealed a PRN physician order for pain management with a start date of 4/13/2023 and discharge date of 6/1/2023.

| **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:** | It was alleged staff did not follow Resident A's service plan on multiple occasions. Interviews, on-site investigation, and review of documentation reveal Resident A demonstrated significant and defiant behaviors while at the facility. The facility conferencing with Resident A's authorized representative consistently to address behaviors but Resident A's behaviors only increased.<br><br>On 5/31/2023, Resident A left the facility without permission, without signing out, and without notifying staff or [their] authorized representative [they] were leaving with another resident to go to a local dispensary using the public transportation Go-Bus. Resident A's authorized presentative and physician were immediately notified of Resident A's departure from the facility with Resident A later returning to the facility around 7:00 pm.<br><br>It is documented in Resident A's service plan that Resident A requires *one to one supervision to address behaviors and is unable to follow directions* as well. The facility did not provide Resident A supervision consistent with service plan to prevent Resident A from the leaving the facility, which placed Resident A at potential risk of harm outside in the local community. Therefore, the facility is in violation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Resident A was given a double dose of Seroquel.**

**INVESTIGATION:**

On 6/15/2023, Ms. Thompson reported no knowledge of Resident A being administered a double does of Seroquel. Ms. Thompson reported the facility managed all medications and that Resident A was monitored when taking medication to ensure Resident A swallowed the medications and did not pocket the medications. Ms. Thompson also reported routine medication audits occur to ensure accuracy of all resident's medications. Ms. Thompson provided me Resident A's medication administration record (MAR) for my review.

On 6/15/2023, Employee A reported no knowledge of Resident A receiving a double dose of Seroquel. Employee A reported Resident A was to receive one tablet of Seroquel two times a day. Employee A confirmed Resident A had to be monitored

when swallowing medications to prevent Resident A from pocketing the medication in [their] mouth. Employee A reported Resident A would refuse medications intermittently, but it was documented in the MAR when it occurred. Employee A also reported medication audits of all residents MARs occur routinely to ensure accuracy.

On 6/15/2023, Employee B's statements and Employee C's statements were consistent with Ms. Thompson's statements and Employee A's statements.

On 6/15/2023, I reviewed Resident A's MAR for March 2023 to May 2023 which revealed the following:

- Resident A was to receive 1 tablet orally two times a day for depression of Quetiapine 100mg tab (generic for Seroquel).
- Prescription start date was 9/28/2022 and was discontinued on 5/3/2023.
- Evidence of Resident A's refusing medication and staff documenting refusal appropriately in the MAR.
- Evidence of appropriate medication administration in accordance with physician orders.

| **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:** | Interviews, on-site investigation, and review of documentation reveal there is no evidence to support this allegation. Staff followed physician medication orders and Resident A was administered medication in accordance with those orders. No violation found. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remain the same.

Julie Viviano

6/22/2023

_____

Julie Viviano Date

Licensing Staff

Approved By:

08/17/2023

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