GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 26, 2023

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

RE: License #: AH410410352
Investigation #: 2023A1010076
Care Cardinal Cascade

Dear Licensee:

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
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 #:	AH410410352
Investigation #:	2023A1010076
Complaint Receipt Date:	07/25/2023
Investigation Initiation Date:	07/26/2023
Report Due Date:	09/24/2023
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 Person 1 (SP1) got into an altercation with Resident K 7/22/23. Resident K does not feel comfortable around SP1.	No
SP1 did not respond to Resident K's pendant after he pushed it for assistance on 7/22/23.	Yes

III. METHODOLOGY

07/25/2023	Special Investigation Intake 2023A1010076
07/26/2023	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
07/26/2023	APS Referral APS referral emailed to Centralized Intake
07/27/2023	Contact – Document received Received email from administrator DaleTron Thompson regarding Resident K
08/03/2023	Inspection Completed On-site
08/03/2023	Contact - Document Received Received resident service plan
08/22/2023	Contact - Document Received SP1's training documents received
08/25/2023	Contact – Telephone call made Interviewed Resident K by telephone
10/16/2023	Exit Conference

ALLEGATION:

Staff Person 1 (SP1) got into an altercation with Resident K 7/22/23. Resident K does not feel comfortable around SP1.

INVESTIGATION:

On 7/25/23, the Bureau received the allegations from the online complaint system. The complaint read SP1 “has been having an attitude” towards Resident K and “started yelling a bunch of things” at Resident K on 7/22/23. SP1 followed Resident K to the dining room and “kept on harassing [Resident K] saying that [Resident K’s] prayer wasn’t going to help” and Resident K “better hope he’s not working on [Resident K’s] side.” The complaint read Resident K felt threatened during the incident.

On 7/26/23, I emailed an Adult Protective Services (APS) complaint to Centralized Intake.

On 7/27/23, I received an email from administrator DaleTron Thompson regarding Resident K and SP1. Ms. Thompson provided me with a copy of Resident K’s *CONCERN FORM* that was dated 7/24/23 for my review. The *Resident, family, visitor or employee suggested solution* section of the form read, “[Resident K] does not want [SP1] taking care of him.” The *Action taken (please be sure to give, all details including dates, times and description if applicable)* section of the form read, “After a through investigation the decision has been made to terminate [SP1’s] employment.”

On 8/3/23, I interviewed director of wellness Starlin Williams at the facility. Ms. Williams reported she called the facility at approximately 8:00 am on 7/22/23 and spoke with SP2. Ms. Williams stated SP2 informed her Resident K and SP1 got into a verbal altercation and SP1 followed Resident K to the dining room. Ms. Williams said Resident K said something to SP1 that upset him, causing SP1 to react and yell at Resident K. Ms. Williams reported other staff were present and intervened.

Ms. Williams reported this was the first and only incident in which SP1 and Resident K got into any kind of altercation. Ms. Williams stated SP1 and Resident K got along well prior to the incident on 7/22/23. Ms. Williams said SP1 received resident rights training when he started at the facility.

On 8/3/23, I interviewed SP3 at the facility. SP3 reported she was entering the facility to begin her first shift on 7/22/23. SP3 stated as she was entering the facility, she heard Resident K and SP1 yelling at each other near the dining room. SP3 said she then observed SP1 leave the facility as his shift had ended. SP3 reported she did not know why Resident K and SP1 were yelling at each other as the incident appeared to end as she entered the facility.

SP3 stated the incident was out of character for SP1. SP3 reported she was not aware of any other incidents in which SP1 acted inappropriately or yelled at any other residents in the facility. SP3 said she completed resident rights training when she was hired at the facility.

On 8/3/23, I interviewed SP4 at the facility. SP4 stated she heard yelling coming from Resident K's room the morning of 7/22/23. SP4 reported she then observed Resident K wheel himself out of his room towards the dining room. SP4 said she observed SP1 follow behind Resident K and he continued to yell at Resident K. SP4 reported she heard from another staff person that Resident K told SP1 "to be a man" and this started the verbal altercation.

SP4's statements regarding this being an isolated incident were consistent with Ms. Williams and SP3. SP4 stated she received resident rights training when she started at the facility.

On 8/3/23, I was unable to interview Resident K as he was signed out of the facility.

On 8/22/23, I interviewed administrator DaleTron Thompson at the facility. Ms. Thompson's statements were consistent with Ms. Williams. Ms. Thompson's statements regarding SP1's termination were consistent with the *CONCERN FORM* she submitted to me via email on 7/27/23.

Ms. Thompson provided me with a copy of SP1's *Community Care Giver Training Check List* for my review. The document read SP1 completed resident rights training on 11/10/22.

On 8/25/23, I interviewed Resident K by telephone. Resident K reported he heard SP1 ask SP2 what Resident K wanted when SP2 responded to his room on 7/22/23. Resident K explained he confronted SP1 and told SP1 "you can ask me man to man." Resident K stated SP1 then "went off on him" meaning SP1 began to yell. Resident K said he attempted to separate himself by going to the dining room, however SP1 followed behind him.

Resident K stated SP1 was terminated after the incident.

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. Williams and Ms. Thompson, along with review of SP1's staff training documents, revealed he received resident rights training upon hire at the facility. Ms. Williams and Ms. Thompson reported the incident between SP1 and Resident K was isolated and SP1's employment was terminated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

SP1 did not respond to Resident K's pendant after he pushed it for assistance on 7/22/23.

INVESTIGATION:

On 7/25/23, the complaint read during the early morning hours on 7/22/23, SP1 did not respond when Resident K pushed his pendant to be changed. Resident K's pendant went off for approximately three hours until first shift staff came in and responded to it.

On 8/3/23 Ms. Williams reported she received a text message from Resident K at approximately 6:35 am on 7/22/23 regarding staff not answering his pendant. Ms. Williams stated SP1 was scheduled to work on Resident K's hall during third shift on 7/22/23. Ms. Williams said when SP2 arrived at the facility to start her morning shift on 7/22/23, she observed Resident K's pendant had been on for several hours, so she responded to Resident K's room and assisted him.

Ms. Williams stated observed Resident K's pendant response report for 7/22/23. Ms. Williams reported Resident K pushed his pendant at approximately 3:55 am and it was not answered until approximately 7:00 am when SP2 arrived. Ms. Williams said she spoke to SP1 regarding Resident K's response time the morning of 7/22/23. Ms. Williams reported SP1 admitted that he had fallen asleep "because he did not feel good" that morning. Ms. Williams said this incident also led to SP1's termination.

Ms. Williams provided me with a copy of Resident K's service plan for my review. The *Toileting* section of the plan read, "Bed pan or commode at night per request.

Check and change per request and at least once during the night. Needs 1 assist to change incontinence product."

On 8/3/23, SP4 reported when she arrived to the facility to start her first shift on 7/22/23 she "logged in" and observed Resident K's pendant had not been responded to for three hours. SP4 said she then went to Resident K's room and observed SP2 was present and responded to the pendant when she also arrived to begin her first shift. SP4 said SP1 was on third shift and was assigned to Resident K's hall. SP4 reported she did not know why SP1 did not respond when Resident K pushed his pendant.

On 8/22/23, Ms. Thompson's statements were consistent with Ms. Williams.

On 8/25/23, Resident K reported he pressed his pendant in the early morning hours on 7/22/23, however no one responded until first shift staff started their shift. Resident K stated he was aware SP1 was the staff person scheduled on his hall, however SP1 never responded to his request to be changed. Resident K said he did not know why SP1 did not respond and left him soiled.

Resident K stated there have been other incidents in which staff did not respond after he pressed his pendant to be changed in the middle of the night. Resident K said staff are aware he is supposed to be changed at night. Resident K reported because of staff not responding to his pendant, he has a sore on his buttocks. Resident K said the sore is now being treated by an outside service provided twice a week.

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. Williams, SP4, Ms. Thompson, and Resident K revealed SP1 did not respond after Resident K pushed his pendant to summon him for assistance during third shift on 7/22/23. Resident K's service plan read staff are to "Check and change per request and at least once during the night." This care need was not met for Resident K on 7/22/23. Resident K reported there were other incidents in which staff did not respond timely to his request to be changed at night. Resident K stated this resulted in a sore on his buttocks that is being treated by an outside provider.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Lisa Sikes on 10/16/23.

IV. RECOMMENDATION

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

08/25/2023

Lauren Wohlfert — Date
Licensing Staff

Approved By:

10/25/2023

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