GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 5, 2023

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

RE: License #: AH410410352
Investigation #: 2023A1010077
Care Cardinal Cascade

Dear Mrs. 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
350 Ottawa, N.W.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 #:	2023A1010077
Complaint Receipt Date:	08/03/2023
Investigation Initiation Date:	08/04/2023
Report Due Date:	10/02/2023
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?
On 8/2/23, Resident L was left on the floor for approximately one hour. Staff did not respond to Resident L's pendant when it was pushed to summon them for assistance.	Yes

III. METHODOLOGY

08/03/2023	Special Investigation Intake 2023A1010077
08/04/2023	Special Investigation Initiated - Letter Email received from assigned Kent Co APS worker Emily Graves
08/22/2023	Inspection Completed On-site
08/22/2023	Contact - Document Received Received resident service plan and pendant response times
08/31/2023	Contact -Telephone call made Interviewed Relative L1 by telephone
09/05/2023	Contact – Telephone call made Interviewed Resident M by telephone

ALLEGATION:

On 8/2/23, Resident L was left on the floor for approximately one hour. Staff did not respond to Resident L's pendant when it was pushed to summon them for assistance.

INVESTIGATION:

On 8/3/23, the Bureau received the allegations from Adult Protective Services (APS). The complaint read, "On 08/02/2023 about 4:15 am, EMS was called to the Assisted Living Facility regarding [Resident L] being on the floor for over an hour. He and [Resident M] attempted to get help from staff, but no one responded. EMS and Fire services arrived to find [Resident L] still on the floor. Staff reported this being [Resident L's third fall within the last 24-hours. They reported that they stopped responding to his requests for help and did not call EMS for assistance. EMS found [Resident L] to have a skinned right knee, facial bruising, skin tear at top of the head, neck pain, back pain and right should [sic] pain. Staff was not cooperative with providing much information."

On 8/4/23, I emailed assigned Kent County APS worker Emily Graves. Ms. Graves reported she planned to interview staff at the facility on 8/11/23.

On 8/22/23, I interviewed administrator DaleTron Thompson at the facility. Ms. Thompson reported Resident L resided in the facility with his wife, Resident M. Ms. Thompson stated Resident L died while at the hospital after he was admitted there on 8/2/23. Ms. Thompson said Resident L was on hospice before the incident on 8/2/23.

Ms. Thompson denied knowledge regarding Resident L falling three times within 24 hours on 8/2/23. Ms. Thompson reported Resident M contacted emergency medical services (EMS) staff herself on 8/2/23. Ms. Thompson said Staff Person 1 (SP1) observed EMS staff arrive and did not know who they arrived to assist. Ms. Thompson stated SP1 denied receiving an alert that Resident L's pendant was pushed. Ms. Thompson said the facility's director of wellness Starlin Williams spoke with SP1 regarding the incident.

On 8/22/23, I interviewed Ms. Williams at the facility. Ms. Williams reported SP1 told her she responded to Resident L's when his pendant was pushed on 8/2/23, however she could not find the "magnet" to clear it. Ms. Williams stated Resident L's pendant had to be cleared for it to be pushed again and alert staff. Ms. Williams said Resident L's pendant was pushed multiple times in the early morning hours of 8/2/23 and there were some response times that were 50 minutes or more.

Ms. Williams provided me with a copy of Resident L's staff pendant response times for 8/2/23 for my review. A pendant response time at 1:22 am on 8/2/23 was 50 minutes, a response time at 3:25 am on 8/2/23 was 53 minutes, and a response time at 3:52 am on 8/2/23 was 29 minutes. Ms. Williams reported SP1 received a three-day suspension as discipline for the incident on 8/2/23.

Ms. Williams provided me with a copy of Resident L's incident report dated 8/2/23. The *Explain What Happened/Describe Injury (if any)* section of the report read, "Staff noticed first responders at the door. Staff ask responders who they were here for. Staff escorted responders to residents [sic] room; in which resident was lying on the floor (near bathroom) on his stomach/righ [sic] side left arm extended behind left hip. Head off the ground. Responders approached resident." The *Action taken by Staff/Treatment Given* section of the report read, "Staff assisted responders while informing that resident is hospice. Staff then contacted DOW and hospice." The *Corrective Measures Taken to Remedy and/or Prevent Recurrence* section of the report read, "Will follow discharge instructions upon return."

Ms. Williams provided me with a copy of Resident L's service plan for my review. The *Transferring* section of the plan read, "Report any changes in ability to transfer to Nurse. Resident has wheelchair now needs to be pushed to and from meals.

Unable to get in and out of bed, chair, car etc.., without total physical assistance or cueing. Resident has hospital bed."

On 8/22/23, I was unable to interview Resident L as he is deceased. I was unable to interview Resident M because she no longer resides in the facility. Resident M moved out of the facility on 8/4/23.

On 8/31/23, I interviewed Relative L1 by telephone. Relative L1 reported she spoke to Resident M regarding Resident L's pendant response times on 8/2/23. Relative L1 stated Resident M informed her the first time she pushed Resident L's pendant to summon staff for assistance in the early morning hours, it took staff over a half hour to respond. Relative L1 said this caused Resident M to use the emergency pull cord in their bathroom to summon staff for assistance because Resident M fell. Relative L1 reported staff still did not respond so Resident M decided to call 911 after 3:00 am. Relative L1 reported Resident M did not return to the facility after Resident L passed away because she felt it was "unsafe" due to staff's lack of responding to resident pendants.

On 09/05/2023, I interviewed Resident M by telephone. Resident M's statements were consistent with Relative L1. Resident M reported Resident M also had a fall in the early morning hours in July 2023 when they resided in the facility. Resident M said during this incident, it also took staff over a half hour to respond after she pushed her pendant. Resident M stated she went out into the hallways and was unable to find a staff person to assist Resident L. Resident M reported that Resident L was able to get off the floor with her assistance and back into bed.

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 Relative L1, along with review of Resident L's pendant response times for the early morning hours of 8/2/23 revealed it took staff over an hour to respond to Resident L. Due to the long response times, Resident M called EMS services herself to get Resident L assistance after he fell on the floor. Review of Resident L's incident report dated staff did not know who EMS staff arrived for. This is not consistent with an organized program of protection.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

09/01/2023

Lauren Wohlfert — Date
Licensing Staff

Approved By:

10/25/2023

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