GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 14, 2023

Heather Rosenbrock
Cascade Senior Living II, Inc.
PO Box 3
Auburn, MI 48611

RE: License #: AL560274370
Investigation #: 2023A1033072
Cascade Senior Living II

Dear Mrs. Rosenbrock:

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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL560274370
Investigation #:	2023A1033072
Complaint Receipt Date:	09/19/2023
Investigation Initiation Date:	09/21/2023
Report Due Date:	11/18/2023
Licensee Name:	Cascade Senior Living II, Inc.
Licensee Address:	4617 Eastman Rd. Midland, MI 48640
Licensee Telephone #:	(989) 631-7299
Administrator:	Heather Rosenbrock
Licensee Designee:	Heather Rosenbrock
Name of Facility:	Cascade Senior Living II
Facility Address:	4617 Eastman Road Midland, MI 48640
Facility Telephone #:	(989) 631-7299
Original Issuance Date:	10/06/2005
License Status:	REGULAR
Effective Date:	03/23/2022
Expiration Date:	03/22/2024
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
There are several residents who require a two-person assist from direct care staff with mobility, transfers, and/or personal care and there are shifts where only one staff member is scheduled to work.	Yes
Resident B is not receiving adequate personal care from direct care staff.	No
Direct care staff are not keeping the medications in a locked cabinet.	No
Resident medications are not being administered as prescribed.	Yes

III. METHODOLOGY

09/19/2023	Special Investigation Intake 2023A1033072
09/21/2023	APS Referral- Denied APS referral.
09/21/2023	Special Investigation Initiated – Telephone call made Interview with Citizen 1 via telephone.
10/06/2023	Inspection Completed On-site Interview with licensee designee, Heather Rosenbrock, direct care staff, Bethany Chlupac, and Resident A. Review of resident Assessment Plans and Medication Administration Records for Resident A, B, C, D, E, & F. Medication reconciliation completed for Resident A.
10/06/2023	Inspection Completed-BCAL Sub. Compliance
10/23/2023	Telephone call made- Interview with Citizen 2.
10/23/2023	Telephone call made- Interview with direct care staff, Emily Bickham, via telephone.
10/23/2023	Telephone call made- Interview with Citizen 3, via telephone.
10/23/2023	Telephone call made- Interview with direct care staff, Jenifer Bieszke, via telephone.
10/23/2023	Telephone call made- Interview with licensee designee, Heather Rosenbrock, via telephone.

11/02/2023	Exit Conference- Conducted via telephone with licensee designee, Heather Rosenbrock. Voicemail message left.

ALLEGATION: There are several residents who require a two-person assist from direct care staff with mobility, transfers, and/or personal care and there are shifts where only one staff member is scheduled to work.

INVESTIGATION:

On 9/19/23 I received an online complaint regarding the Cascade Senior Living II, adult foster care facility (the facility). The complaint alleged that there are several residents who reside at the facility and require two-person direct care staff member assistance with mobility, transfers, and personal care needs. The complaint alleged the facility is not staffing at least two direct care staff members per shift and there are numerous times when there is only one direct care staff available for resident care. On 9/21/23 I interviewed Citizen 1, via telephone. Citizen 1 reported that she is aware that there are four residents who require two-person direct care staff member assistance with mobility, transfers, and these residents are, Resident A, Resident C, Resident D, and Resident F. Citizen 1 reported that she is personally aware of times when only one staff member was on shift due to insufficient staffing available at the facility. Citizen 1 reported that licensee designee, Heather Rosenbrock, will be counted in the staffing ratio when she is present in the building, but also reported that Ms. Rosenbrock does not provide direct care to residents.

On 10/6/23 I completed an unannounced on-site investigation at the facility. I requested to review the employee schedule for the month of September 2023. I spoke with direct care staff, Logan Rosenbrock, who reported that when she tried to print the schedule for September 2023 the computer program being utilized would not print names of direct care staff who are no longer employed by the organization. Ms. Rosenbrock reported that the printed schedule would not give accurate accounts for who worked in the month of September 2023, but instead offered me employee timecards to review. I reviewed the employee timecards for 9/10/23 through 9/23/23 and made the following notations:

- 9/12/23: There were periods of time in the morning and the midnight shift where only one direct care staff was paid.
- 9/14/23: There were periods of time in the morning and the midnight shift where only one direct care staff was paid.
- 9/15/23: There were periods of time in the morning and afternoon where only one direct care staff member was paid.
- 9/16/23: There was a period in the morning where only one direct care staff member was paid.
- 9/17/23: There was a period in the morning where only one direct care staff members was paid.

- 9/19/23: There were periods of time in the afternoon and the midnight shift where only one direct care staff was paid.
- 9/20/23: There was a period on the midnight shift where only one direct care staff was paid.
- 9/21/22: There was a period on the midnight shift where only one direct care staff was paid.
- 9/22/23: There were periods of time in the morning and on the midnight shift where only one direct care staff was paid.
- 9/23/23: There was a period on the midnight shift where only one direct care staff was paid.

During on-site investigation on 10/6/23 I reviewed the *Assessment Plan for AFC Residents* forms for Resident A, C, D, and F. I made the following observations:

- Resident A's assessment plan, dated 2/9/23, states on page 2, under the section, *II. Self Care Skill Assessment*, subsection, *C. Bathing*, "2 person Hoyer/physically unable"
- Resident C's assessment plan, dated 2/9/23, states on page 1, under the section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, "unable to ambulate 2 x assist." On page 2, under section, *II. Self Care Skill Assessment*, subsection, *B. Toileting* and *C. Bathing*, it states, "2 x assist, Hoyer." Under subsection, *D. Grooming (hair care, teeth, nails, etc.)* it states, "1 person assist. 2 person if hauling to get up/down."
- Resident D's assessment plan, dated 1/10/23, does not contain any notations about requiring a two-person assist with mobility/transfers/personal care.
- Resident F's assessment plan, dated 5/27/23, states on page 1, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, "uses amigo, can't ambulate at all, 2 person assist Hoyer lift." On page 2, under section, *II. Self Care Skill Assessment*, subsection, *E. Dressing*, it states, "2 person Hoyer assist."

On 10/6/23, during on-site investigation, I interviewed Resident A. Resident A reported that she has a diagnosis of Multiple Sclerosis and requires a Hoyer lift to get herself out of her hospital bed. She reported that it takes two direct care staff members to use her Hoyer lift. She reported that there have been instances when only one direct care staff member has been on the schedule due to staffing shortages. She further reported that when this occurs, she is not able to get out of her bed and the direct care staff will provide for her care while she is in bed.

On 10/6/23, during on-site investigation, I interviewed licensee designee, Heather Rosenbrock. Ms. Rosenbrock reported that the staffing ratio for this facility is meant to be 2-3 direct care staff members per shift. She reported that due to staffing shortages they have experienced times when they have only been able to staff one direct care staff member at a time on the midnight shifts.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based upon interviews with Citizen 1, Resident A, Logan Rosenbrock, and Heather Rosenbrock, as well as review of the *Assessment Plan for AFC Residents* forms for Resident A, C, D, & F, and review of the direct care staff timecards for the period 9/10/23 through 9/23/23, it can be determined that the direct care staff have not been able to provide the supervision, protection, and personal care as identified in Resident A, D, & F's assessment plans, due to inadequate staffing. Each of these residents' assessment plans call for two-person direct care staff member assistance with mobility, transfers, and personal care needs and having periods of time with only one direct care staff member working is not providing for this need, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based upon interviews with Citizen 1, Resident A, Logan Rosenbrock, and Heather Rosenbrock, as well as review of the *Assessment Plan for AFC Residents* forms for Resident A, C, D, & F, and review of the direct care staff timecards for the period 9/10/23 through 9/23/23, it can be determined that the direct care staff have not been able to provide the supervision, protection, and personal care as identified in Resident A, D, & F's assessment plans, due to inadequate staffing. Each of these residents' assessment plans call for two-person direct care staff member assistance with mobility, transfers, and personal care needs and having periods of time with only one direct care staff member working is not providing for this need, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B is not receiving adequate personal care from direct care staff.

INVESTIGATION:

On 9/19/23 I received an online complaint alleging direct care staff at the facility are not providing adequate personal care to Resident B. On 9/21/23 I interviewed Citizen 1, via telephone. Citizen 1 reported that Resident B is incontinent of urine and is required to be changed every two hours. Citizen 1 reported direct care staff are not changing Resident B based on this frequency and Resident B is required to sit in her own urine for prolonged periods of time.

On 10/6/23 during on-site investigation, I reviewed the *Assessment Plan for AFC Residents* form, dated 12/8/22, for Resident B. On page 2, under section, *II. Self Care Skill Assessment*, this document noted that Resident B requires a one-person assist with grooming, dressing, personal hygiene. Under subsection, *B. Toileting*, it reads, "help with pants."

On 10/24/23 I received an email correspondence from licensee designee, Heather Rosenbrock, providing documentation of toileting schedules and daily progress notes for Resident B for the month of October 2023. I reviewed the document titled, *Region VII Area Agency on Aging, Direct Care Service Log,* for the dates 10/2/23 – 10/22/23, for Resident B. Under the sections, *Toileting* & *Personal Hygiene*, on each date reviewed, all the entries were marked that Resident B received care from direct care staff for these tasks. I also reviewed Resident B's *Progress Notes* for the same timeframe. I did not notice any documentation from direct care staff members that would indicate Resident B was not receiving toileting or personal care from direct care staff members.

On 10/23/23 I interviewed Citizen 2, via telephone. Citizen 2 reported she had previously worked at the facility. Citizen 2 stated that there were occasions when she would provide incontinence care to Resident B and find that she had a rash in her groin area. She was not able to state whether Resident B was not receiving personal care or toileting assistance from direct care staff members.

On 10/23/23 I interviewed direct care staff, Emily Bickham, via telephone. Ms. Bickham reported that she has worked at the facility since April 2023. She reported that Resident B receives frequent checks from direct care staff to address her incontinence. Ms. Bickham reported that the direct care staff document when they provide toileting assistance to Resident B in the “Waiver Book”. Ms. Bickham reported that she has no concerns for any direct care staff not providing for Resident B’s care needs.

On 10/23/23 I interviewed Citizen 3, via telephone. Citizen 3 reported that she previously worked at the facility and is currently on a leave of absence. Citizen 3 reported that she has provided care for Resident B and sometimes Resident B had a tendency to refuse care. She reported that there is documentation that Resident B could be rude with direct care staff members. Citizen 3 reported that regular checks were provided to Resident B regarding hygiene and toileting and the direct care staff would document these checks in the “Waiver Book”.

On 10/23/23 I interviewed direct care staff, Jenifer Bieszke, via telephone. Ms. Bieszke reported that she has a three-year history working on and off at the facility. Ms. Bieszke reported that Resident B can be very demanding with direct care staff. Ms. Bieszke reported that Resident B has a pull cord in her bedroom and will pull this for direct care staff assistance. She further reported that she has no concerns about Resident B not receiving personal care or toileting assistance.

During on-site investigation on 10/6/23 I interviewed Resident A regarding direct care staff assistance with personal care, hygiene, toileting. Resident A reported that she receives assistance with personal care, hygiene, toileting from the direct care staff, but she has her favorites and tends to refuse care from other direct care staff if these “favorites” are not scheduled to work. She reported that this is her choice, and she only feels comfortable with certain direct care staff members who she finds more skilled than others.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based upon interviews with Citizen 1, Citizen 2, Citizen 3, Ms. Rosenbrock, Resident A, Ms. Bieszke, & Ms. Bickham, as well as review of Resident B's assessment plan, direct care service log, and progress notes for 10/2/23 – 10/22/23, it can be determined that there is not adequate evidence to suggest that the direct care staff are not providing for the supervision, protection, and personal care needs of Resident B. A majority of those interviewed agreed that Resident B is receiving regular checks and care from direct care staff, and this was also documented in Resident B's resident record. Due to lack of substantial evidence a violation cannot be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Direct care staff are not keeping the medications in a locked cabinet.

INVESTIGATION:

On 9/19/23 I received an online complaint alleging direct care staff are not keeping resident medications in a locked cabinet at the facility. On 9/21/23 I interviewed Citizen 1, via telephone. Citizen 1 reported that she is aware resident medications are being kept in a medication cart that does not lock as the lock is broken. Citizen 1 reported that the medication cart is kept in the kitchen of the facility in a closet, but the direct care staff are not keeping the closet door locked.

On 10/6/23 I completed an unannounced, on-site investigation at the facility. I observed the medication cart to be in the kitchen, inside a cabinet, which had a lock on the door. The cabinet door was unlocked at this time as direct care staff, Bethany Chlupac, was currently administering resident medications.

On 10/23/23 I interviewed Citizen 2 regarding the allegation. Citizen 2 reported that there is a medication cart at the facility, located in the kitchen, but the lock on the medication cart is broken. Citizen 2 reported that the medication cart is kept in a closet which has a lock on the door.

On 10/23/23 I interviewed Ms. Bickham, regarding the allegation. Ms. Bickham reported that the medication cart is kept in the kitchen in a closet. She reported direct care staff are required to use a key to access the cart and that the closet is always locked when not in use by direct care staff members.

On 10/23/23 I interviewed Citizen 3 regarding the allegation. Citizen 3 reported medications are kept in a medication cart in the kitchen. She reported the medication cart lock is broken, but the medication cart is kept in a closet with a locked door.

Citizen 3 reported only direct care staff have access to the medication cart and key to this closet.

On 10/23/23 I interviewed Ms. Bieszke regarding the allegation. Ms. Bieszke reported medications are kept in a medication cart in the kitchen. She reported the medication cart does not lock, but it is kept in a closet behind a locked door. She reported that only direct care staff have access to the key and the closet is locked when not in use by direct care staff.

On 10/23/23 I interviewed licensee designee, Heather Rosenbrock, via telephone. Ms. Rosenbrock reported that the medications are kept in a medication cart in the kitchen of the facility. She reported that the lock on the medication cart is broken but the cart is kept in a closet with a locked door in the kitchen. She reported the medication cart is never accessible to anyone besides a direct care staff member.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based upon interviews with Citizen 1, Citizen 2, Citizen 3, Ms. Rosenbrock, Ms. Bieszke, & Ms. Bickham, as well as observations made during the on-site investigation, there is not adequate evidence to suggest that the direct care staff are not keeping the medication closet locked when it is not in use by direct care staff members, therefore a violation cannot be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident medications are not being administered as prescribed.

INVESTIGATION:

On 9/19/23 I received an online complaint alleging that resident medications are not being administered as prescribed. On 9/21/23 I interviewed Citizen 1, via telephone.

Citizen 1 reported that resident medications are not being administered appropriately and some residents are missing medications prescribed to them, specifically Resident A.

On 10/6/23 I completed an unannounced, on-site investigation at the facility. I requested to review the resident Medication Administration Records (MAR) for Resident A, C, D, & E. Upon review of these documents, I observed that all medications were either marked as given or there was an appropriate notation as to why the medication was not received, either due to the resident being out of the facility, resident refusal, or awaiting medication from the pharmacy. I did not note any prolonged periods where medications were awaiting delivery from the pharmacy.

On 10/6/23 during on-site investigation, I interviewed Resident A. Resident A reported that she has been ordered Melatonin medication, but she feels she has not been receiving this medication routinely. I completed a medication reconciliation of Resident A's medications and found that Resident A's Melatonin was not accounted for in the medication cart. I interviewed Ms. Chlupac regarding Resident A's Melatonin medication and she reported that Resident A's Melatonin is to be provided by her family and they have not brought a new supply of this medication to the facility. Ms. Chlupac reported that Resident A's medical insurance does not cover this medication. I reviewed Resident A's MAR for the month of October 2023 and found that Resident A has been prescribed, "Melatonin 10 MG Tablets, Give 2 tablets by mouth at bedtime". The Melatonin is documented as being administered by direct care staff members 10/1/23 – 10/5/23. Ms. Chlupac reported that she could not advise why this medication is marked as being administered on these dates as it was not available in the facility to be administered.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon interviews with Citizen 1, Resident A, and Ms. Chlupac as well as review of MARs for Resident A, C, D, & E, it can be determined that the direct care staff have been marking Resident A's Melatonin medication as being administered when the medication was not available for administration at the facility. Therefore, a violation has been established as Resident A's Melatonin was not on-site to be administered and incorrectly documented as being administered on her MAR for the month of October 2023.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Based upon receipt of an approved corrective action plan, no change to the status of the license is recommended at this time.

11/02/23

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Jana Lipps Date
Licensing Consultant

Approved By:

11/14/2023

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Dawn N. Timm Date
Area Manager