GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 3, 2023

Lisa Sikes
Care Cardinal Kentwood
4352 Breton Rd SE
Kentwood, MI 49546

RE: License #: AH410413166
Investigation #: 2024A1010003
Care Cardinal Kentwood

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

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 #:	AH410413166
Investigation #:	2024A1010003
Complaint Receipt Date:	10/04/2023
Investigation Initiation Date:	10/06/2023
Report Due Date:	12/03/2023
Licensee Name:	CSM Kentwood LLC
Licensee Address:	1435 Coit Ave. NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 308-6915
Administrator:	Diana Billows
Authorized Representative:	Lisa Sikes
Name of Facility:	Care Cardinal Kentwood
Facility Address:	4352 Breton Rd SE Kentwood, MI 49546
Facility Telephone #:	(616) 288-4151
Original Issuance Date:	04/13/2023
License Status:	REGULAR
Effective Date:	10/13/2023
Expiration Date:	10/12/2024
Capacity:	131
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell in the vestibule area of the facility and was on the ground for several hours during third shift. Staff are living in unoccupied resident rooms in the facility.	Yes

III. METHODOLOGY

10/04/2023	Special Investigation Intake 2024A1010003
10/06/2023	Special Investigation Initiated - Telephone Interviewed APS complainant by telephone
10/11/2023	Inspection Completed On-site
10/11/2023	Contact - Document Received Received resident incident report, service plan, and staff education
01/03/2024	Exit Conference

ALLEGATION:

Resident A fell in the vestibule area of the facility and was on the ground for several hours during third shift. Staff are living in unoccupied resident rooms in the facility.

INVESTIGATION:

On 10/4/23, the Bureau received the allegations from Adult Protective Services (APS). The complaint was not assigned for APS investigation. The complaint read, “On 9/27 [Resident A] was found outside the facility in a nightgown in the cold on the floor. Staff is supposed to be doing bed checks every 2 hours, but [Resident A] was out there over 3 hours. [Resident A] ‘struggles’ sometimes.”

The complaint also read, “A new program started 6 months ago to bring people up from South America and assist them with job placement. The South Americans in the program are working in the facility but they are also living there. They are in the hallways at night loud and intoxicated. There are 2 workers living in the building that have been there for 2 or 3 months.”

On 10/6/23, I interviewed the APS complainant by telephone. The APS complainant reported Staff Person 1 (SP1) arrived for his shift on 9/27/23 in the morning and found Resident A on the floor in the vestibule entryway of the facility. The APS complainant said resident A was only wearing a night gown and it was cold outside. The APS complainant reported Resident A opened the main door of the facility at 2:42 am and SP1 found her at approximately 6:00 am. The APS complainant said care staff did not complete their rounds on third shift because staff did not know Resident A opened the main entrance door and was in the vestibule area.

The APS complainant said Resident A was also soiled when SP1 arrived and found her on the ground. The APS complainant reported when SP1 found Resident A, he found a medication technician (med tech) who assessed Resident A and took her vitals. The APS complainant stated Resident A had a history of wandering around the general assisted living area of the facility. The APS complainant said Resident A resided in the general assisted living area, not in the facility's secured memory care unit.

The APS complainant reported two staff persons were observed residing in two unoccupied resident rooms. The APS complainant said the two staff persons live in resident rooms 81 and 83. The APS complainant reported these two individuals have been observed loud and intoxicated in the hallways during second shift.

On 10/11/23, I interviewed administrator Diana Billows at the facility. Ms. Billows reported she recently started at the facility. Ms. Billows stated the former administrator completed an incident report and investigated the incident on 9/27/23. Ms. Billows stated Resident A was identified as an induvial with wandering behavior, therefore the facility is in the process of moving her to the secured memory care unit in the facility.

Ms. Billows stated there are two staff persons residing in resident rooms 81 and 83. Ms. Billows reported the two staff persons are participating in the facility's South American staffing program. Ms. Billows said resident rooms in the facility have housed staff in the past as well until alternate housing was located. Ms. Billows denied knowledge regarding the staff persons being loud and intoxicated in the hallways. I observed resident rooms 81 and 82 were occupied by SP2 and SP3.

On 10/11/23, I interviewed the facility's director of wellness Adeysia Foster at the facility. Ms. Foster reported SP1 did find Resident A in the vestibule area on 9/27/23 at approximately 5:00 or 6:00 am when he was entering the facility for his shift. Ms. Foster stated it was unknown how long Resident A was in the vestibule area.

Ms. Foster reported it is unknown why third shift staff did not complete the required two-hour checks on residents during third shift. Ms. Foster said staff are also supposed to check residents who wear briefs to ensure they are dry every two hours. Ms. Foster said staff will be provided with small flashlights to wear with their name tags so they can see when they check on residents during third shift. Ms.

Foster reported the flashlights will also make it easier for staff not to disturb residents while they are sleeping.

Ms. Foster stated staff were re-educated on the importance of completing rounds during their shifts. Ms. Foster said the staff persons who were on third shift on 9/27/23 also received written reprimands in their employee record. Ms. Foster provided me with copies of SP4 and SP5's written reprimand for my review. The *Details of Incident* section of SP4 and SP5's written reprimand read, "Resident walking out of facility at 2:41a to the front sidewalk and was found by maintenance at 6:15am. Employees are not physically opening doors and checking rooms for resident and their safety." The *Recommended Corrective Action* section read, "Physical rounds of all rooms and common areas every 2 hours, if resident is not in room search facility, outside grounds, call ED or DOW immediately. Pair up with Med Tech or other caregiver and do rounds together so that you are 100% sure all residents are accounted for."

Ms. Foster's statements regarding Resident A's wandering behavior and transition to the facility's secured memory care unit were consistent with Ms. Billows. Ms. Foster's statements regarding the two staff persons residing in the facility were also consistent with Ms. Billows.

Ms. Foster provided me with a copy of Resident A's incident report that was dated 9/27/23 for my review. The *Explain What Happened/Describe Injury (if any)* section of the report read, "Resident observed sitting in entrance way of facility upon maintenance arrival to facility." The *Action Taken by Staff/Treatment Given* section of the report read, "Assisted back to her room, checked over for injuries or bruises." The *Corrective Measures Taken to Remedy and/or Prevent Recurrence* section read, "Talk with family about memory care."

Ms. Foster provided me with a copy of Resident A's staff *Progress Notes* for my review. Notes dated 9/12/23, 9/13/23, and 9/18/23 read Resident A experienced confusion and wandering behavior during evening hours.

On 10/11/23, I interviewed SP1 at the facility. SP1 reported Resident A was in a nightgown on the ground on her left side in the vestibule area of the main entrance of the facility when he arrived at approximately 6:00 am on 9/17/23. SP1 said it was cold in that area and Resident A was soiled. SP1 reported he found a care staff person who assessed and assisted Resident A after he found her.

SP1 explained he accessed the facility's software program that records the times the main door of the facility is opened. SP1 reported Resident A opened the main door of the facility at 2:42 am. SP1 stated he was unable to provide me with a copy of the times the main door was opened on 9/27/23 because the software does not save the data. SP1 reported there was also footage from the facility's outdoor "Blink" camera that showed Resident A was also outside for several minutes 9/27/23. SP1 said he and the facility's former administrator observed the video footage. SP1 explained

this video footage can no longer be viewed because the facility has not paid to keep the “Blink” video footage.
SP1’s statements regarding staff residing in resident rooms in the facility were consistent with Ms. Billows and Ms. Foster. SP1 reported he has observed various staff persons living in the facility in the past intoxicated in the hallways during second shift.

On 10/11/23, I attempted to interview Resident A at the facility. I was unable to engage Resident A in meaningful conversation. I observed Resident A was clean and appropriately dressed as she sat in her recliner chair in her room.

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 interviews with Ms. Billows, Ms. Foster, SP1, along with review of Resident A’s incident report revealed Resident A got out of the facility at 2:42 am on 9/27/23. Resident A was not found until SP1 arrived at the facility at approximately 6:00 am. Staff failed to complete their rounds during third shift on 9/27/23 and therefore were unaware Resident A fell in the vestibule area. There were also documented incidents regarding Resident A's wandering behavior prior to 9/27/23. The interviews with Ms. Billows, Ms. Foster, SP1, along with my observations on 10/11/23 revealed staff persons have been residing in unoccupied resident rooms. These incidents are not consistent with an organized program of protection.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the results of this report with licensee authorized representative Lisa Sikes on 1/3/24.

IV. RECOMMENDATION

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

11/03/2023

Lauren Wohlfert Date
Licensing Staff

Approved By:

01/03/2024

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