GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 5, 2024

Rochelle Lyons
Cascade Trails Senior Living
1225 Spaulding Road
Grand Rapids, MI 49546

RE: License #: AH410394304
Investigation #: 2024A1010001
Cascade Trails Senior Living

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 #:	AH410394304
Investigation #:	2024A1010001
Complaint Receipt Date:	09/29/2023
Investigation Initiation Date:	10/03/2023
Report Due Date:	11/29/2023
Licensee Name:	Cascade Trails Senior Living, LLC
Licensee Address:	Suite 200 3196 Kraft Ave Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Matthew Fellows
Authorized Representative:	Rochelle Lyons
Name of Facility:	Cascade Trails Senior Living
Facility Address:	1225 Spaulding Road Grand Rapids, MI 49546
Facility Telephone #:	(616) 328-6440
Original Issuance Date:	05/06/2020
License Status:	REGULAR
Effective Date:	11/06/2022
Expiration Date:	11/05/2023
Capacity:	71
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
A staff person was observed sleeping in the secured memory care unit on 6/13/23. There was no third shift staff starting on 6/20/23 through 6/21/23.	No
Resident A did not receive her prescribed Tramadol from 6/7/23 through 6/15/23.	Yes

III. METHODOLOGY

09/29/2023	Special Investigation Intake 2024A1010001
10/03/2023	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
10/03/2023	APS Referral APS referral emailed to Centralized Intake
10/18/2023	Inspection Completed On-site
10/18/2023	Contact - Document Received Received resident's urine analysis order
10/20/2023	Contact - Document Received Received resident's MAR and staff schedule
01/05/2024	Exit Conference

ALLEGATION:

A staff person was observed sleeping in the secured memory care unit on 6/13/23. There was no third shift staff starting on 6/20/23 through 6/21/23.

INVESTIGATION:

On 9/29/23, the Bureau received the allegations from the online complaint system. The complaint read on 6/13/23 the doorbell to the secured memory care unit had to be rung twice. Staff Person (SP1) responded to open the door and SP2 was observed “sound asleep in a chair” in the secured memory care unit. The compliant also read, “Left [Resident A] at 8pm in her recliner. Returned at 10am on 6/21/23 to

find [Resident A] sound asleep in her recliner. She reported she was left in her chair all night with no one checking on her until 7:20am. SP3 came into room and confirmed that she came on duty at 6am and there was no 3rd shift staff on duty for memory care and hadn't been all night."

On 10/3/23, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 10/18/23, I interviewed administrator Matthew Fellows at the facility. Mr. Fellows stated he was not informed SP2 was observed sleeping in the secured memory care unit during her shift on 6/13/23. Mr. Fellows said SP2's employment was terminated on 6/14/23. Mr. Fellows reported SP2 was terminated due to poor work performance and poor attendance. Mr. Fellows said SP3 was also terminated due to poor work performance as well.

Mr. Fellows reported there were third shift staff scheduled in the secured memory care unit 6/20/23 through the morning of 6/21/23. Mr. Fellows stated the secured memory care unit in the facility is staffed according to resident acuity. Mr. Fellows said in June 2023, there were six residents in the secured memory care unit. Mr. Fellows reported as a result, one staff person was scheduled in the secured memory care unit. Mr. Fellows reported staff from the general assisted living area were available to assist in the secured memory care unit as needed. Mr. Fellows said the secured memory care unit currently has ten residents, therefore there are two staff persons scheduled there now.

On 10/18/23, I interviewed the facility wellness director Ashley Nisley by telephone. Ms. Nisley's statements were consistent with Mr. Fellows.

On 10/18/23, I interviewed SP1 at the facility. SP1's statements regarding staffing in the facility's secured memory care unit were consistent with Mr. Fellows and Ms. Nisley. SP1 denied ever seeing staff sleeping in the secured memory care unit. SP1 explained if he did observe staff sleeping during their shift, he would report it to Mr. Fellows and Ms. Nisley who would then follow up with the staff person. SP1 denied seeing SP2 sleeping in the secured memory care when he opened the door for visitors.

On 10/18/23, I interviewed SP4 at the facility. SP4's statements were consistent with Mr. Fellows, Ms. Nisely, and SP1.

On 10/18/23, I attempted to interview Resident A at the facility. Resident A was signed out of the facility with family; therefore I was unable to interview Resident A.

On 10/20/23, Ms. Nisely provided me with a copy of the staff schedule for 6/20/23 through the morning hours of 6/21/23 via email for my review. I observed the schedule was consistent with Mr. Fellows and Ms. Nisley's statements. There were

two staff persons scheduled in the secured memory care unit for third shift on 6/20/23 and 6/21/23. One staff person was noted to be in training.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The interviews with Mr. Fellows, Ms. Nisley, SP1, along with review of the staff schedule for 6/20/23 and 6/21/23 revealed there were staff scheduled in the secured memory care unit on third shift. SP1 denied seeing SP2 asleep during her shift in the secured memory care unit. Mr. Fellows and Ms. Nisely reported SP2 and SP3 were terminated due to poor work performance. There is insufficient evidence to suggest the facility was out of compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A did not receive her prescribed Tramadol from 6/7/23 through 6/15/23.

INVESTIGATION:

On 9/29/23, the complaint read, “Resident was not given ordered Tramadol from 6/7/23-6/15/23 (PM dose)-15 doses missed.” The complaint also read, “Ipratropium 0.03% ordered 4/27/23, on 9/8/23 [complainant] checked bc (sic) they still didn’t refill it and discovered it was over half full and expired 8/31/23 but was still being used. No way that her order lasted 4 months.”

On 10/18/23, Mr. Fellows reported Resident A’s medications were administered as prescribed by her physician. Mr. Fellows denied knowledge regarding Resident A not receiving her prescribed Tramadol from 6/7/23 through 6/15/23. Mr. Fellows also denied knowledge of Resident A having expired Ipratropium.

On 10/18/23, SP4 denied knowledge regarding Resident A’s medications not being administered as prescribed. SP4 reported the medication carts in the facility are regularly audited by the care coordinators on staff. SP4 also denied knowledge regarding any of Resident A’s prescribed medications being expired.

On 10/18/23, I observed Resident A's medications that were in the medication cart. I observed the medications were not expired.

On 10/20/23. I reviewed Resident A's June 2023 medication administration record (MAR). The MAR read Resident A was prescribed, "TRAMADOL HCL TAB 50MG TAKE 1 TABLET BY MOUTH TWICE A DAY NOT TO EXCEED >#60 MONTHLY." The MAR read Resident A's Tramadol was not administered as prescribed on 6/8/23, 6/9/23, 6/11/23, 6/12/23, 6/13/23, and 6/14/23. The *Reason* section of the MAR read, "AWAITING MED ARRIVAL FROM PHARMACY." I observed Resident A was not prescribed Ipratropium 0.03% in June 2023.

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:	My review of Resident A's June 2023 MAR revealed she did not receive doses of her prescribed "TRAMADOL HCL TAB 50MG" six times because staff were waiting for it to arrive from the pharmacy. There is insufficient evidence to suggest staff followed up with the pharmacy to ensure this medication's arrival to the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Rochelle Lyons by telephone on 1/5/24.

IV. RECOMMENDATION

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

Lauren Wohlfert

11/09/2023

Lauren Wohlfert   Date
Licensing Staff

Approved By:

01/03/2024

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

Date