GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 25, 2024

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

RE: License #: AH410413166
Investigation #: 2024A1010018
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, 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 #:	2024A1010018
Complaint Receipt Date:	12/05/2023
Investigation Initiation Date:	12/07/2023
Report Due Date:	02/04/2024
Licensee Name:	CSM Kentwood LLC
Licensee Address:	1435 Coit Ave. NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 308-6915
Administrator:	Diana Billow
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 B was observed soiled on multiple occasions and had untreated wounds on her legs.	Yes
Resident B was administered too much Geodon.	No

III. METHODOLOGY

12/05/2023	Special Investigation Intake 2024A1010018
12/07/2023	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
12/07/2023	APS Referral APS referral emailed to Centralized Intake
12/07/2023	Contact - Telephone call made Interviewed the complainant by telephone
12/08/2023	Contact - Document Received Pictures and video of Resident B via email from the complainant
12/19/2023	Inspection Completed On-site
12/19/2023	Contact - Document Received Received Resident service plan, incident reports, and staff progress notes
01/06/2024	Contact - Document Received Email received from complainant
01/25/2024	Contact – Document Received Received Resident B's September and October MARs via email from Ms. Billow
03/25/2024	Exit Conference

ALLEGATION:

Resident B was observed soiled on multiple occasions and had untreated wounds on her legs.

INVESTIGATION:

On 12/5/23, the Bureau received the complaint that read Resident B was found "on multiple occasions sitting in her chair covered in feces and urine, she had venous ulcers weeping onto her sock and onto the floor."

On 12/7/23, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 12/7/23, I interviewed the complainant by telephone. The complainant stated that on more than one occasion, when he arrived to visit Resident B at the facility, Resident B was soiled. The complainant reported Resident B had a foul odor as a result. The complainant said he observed staff were nearby and likely observed and smelled Resident B was soiled. The complainant expressed concern regarding Resident B's hygiene needs not being met by staff.

The complainant reported he also observed Resident B had wounds on her legs that were "leaking." The complainant stated the wounds did not have band-aids on them and did not appear to be treated in any way by staff. The complainant said the wounds "leaked" onto Resident B's socks and soiled them.

The complainant reported Resident B was initially admitted to the general assisted living area of the facility. The complaint explained Resident B declined and experienced behavioral issues, such as calling out for help frequently. The complainant stated Resident B was moved to the secured memory care unit in the facility after she was discharged from Pine Rest.

On 12/8/24, I received pictures of the wounds on Resident B's legs via email from the complainant. I observed Resident B had a wound on her left leg that had visible drainage coming out of it, going down Resident B's leg.

On 12/19/23, I interviewed administrator Diana Billow at the facility. Ms. Billow reported staff did not intentionally leave Resident B soiled for long periods of time. Ms. Billow denied knowledge regarding Resident B being left soiled for long periods of time. Ms. Billow stated it is the facility's policy and procedure to check on and change residents who need it every two to three hours.

Ms. Billow denied knowledge regarding Resident B having open wounds on her legs. Ms. Billow reported staff have not reported seeing any open wounds on Resident B. Ms. Billow said staff observe and assess Residents' skin when they assist with dressing and bathing. Ms. Billow stated staff are trained to document and report any wounds, bruises, or injuries that are observed on a resident's skin.

Ms. Billow's statements regarding Resident B's decline and behavioral issues, such as frequently yelling out for help, were consistent with the complainant. Ms. Billow reported Resident B was admitted to Pine Rest and was there from 8/17/23 until she returned to the facility on 9/7/23. Ms. Billow said resident B was moved into the facility's secured memory care unit when she returned on 9/7/23. Ms. Billow stated after Resident B was moved into the secured memory care unit, she continued to call out for help and stopped responding to staff cueing.

Ms. Billow said Resident B's decline was becoming outside of the scope of care staff at the facility could provide. Ms. Billow reported Resident B would no longer stand or bear weight, therefore it took multiple staff to transfer her. Ms. Billow stated Resident B also declined to the point she needed assistance from staff to eat because she would no longer respond to staff cues. Ms. Billow reported Resident B also had three or four falls while she was in the secured memory care unit.

Ms. Billow reported Resident B is currently in the hospital. Ms. Billow stated Resident B will be assessed to determine whether the facility can continue to meet her care needs when she is ready to be discharged from the hospital. Ms. Billow said an alternative placement for Resident B will be sought if it is determined the facility can no longer meet Resident B's care needs consistent with the facility's secured memory care program statement.

Ms. Billow provided me with a copy of Resident B's service plan for my review. The *BATHING* section of the plan read, "Assistance required- transfers in/out; steadying; cueing to wash self; cueing to dry self; shampooing/rinsing/drying hair; applying lotion. Check skin with bath/shower and report any reddened/open areas to nurse. Needs daily or repetitive cues; cannot bathe self. Report any changes in ability to bathe to Nurse. Showers/bathes 2x weekly. Toenail and fingernail care after each bath/shower. Uses a shower chair."

The *TOILETING* section of the plan read, "Independent with 4ww in toileting activities. Report any changes in toileting ability to Nurse. Uses incontinence products (pull-up, liner, brief). Supply and disposal managed by (resident/family/staff). Dispose of used incontinent products every shift."

The *BEHAVIORS* section of the plan read, "Exhibits inappropriate behavior; disrobing, taking things belonging to others, wandering aimlessly, showing anger, provocation, verbal abuse or other extreme erratic behavior patterns. Report changes from baseline behaviors to Nurse. Resident gets upset over money and medication from before living here. Please remind her per son/DPOA, that money and medication are the reasons she lives here and that he takes care of all her needs for her. Gets upset over toilet paper and TV daily. Responds to reorientation and redirection when wandering."

The *COGNITION* section of the plan read, "Demonstrates inappropriate judgment related to safety. Needs cues and reminders from staff. Resident gets upset at times

if she feels staff are incorrect. Has mild to moderate disorientation or difficulty recalling/retaining information. Needs cueing. Moderate dementia with significant short-term and possibly long-term memory loss. Requires Hygiene reminders daily. Requires reminders for activities. Requires reminders for meals. Resident will wander to and from the dining room frequently. Responds well to prompts and cueing. Resident will get upset if she forgets things and has to ask staff." The plan read Resident B is continent of bowel and bladder.

Ms. Billow provided me with a copy of Resident B's staff *Progress Notes* for my review. A note dated 10/17/23 read, "She had all meds, and meals in her room, stayed in her chair most of the time, her left leg were [sic] sore, and with blood, resident was crying and anxious, had prn for anxiety. Resident watched tv until bedtime." A note dated 10/22/23 read, "around 10pm my caregivers and I were trying to change [Resident B] so she can go to bed, we tried to lift her up but her legs gave up on her, we asked for more assistance. In total was 5 people trying to get [Resident B] up from her chair. Staff could not get her up we had to call for lift assistance and paramedics came and helped us transfer her to her chair. DOW and ED were called house manager helped me with the resident, guardian was called as well. DOW and ED are going to have a meeting for more further care."

Ms. Billow provided me with copies of Resident B's incident reports from October 2023. The *Explain What Happened/Describe Injury (if any)* section of a report dated 10/9/23 read, "Resident has bruising on both arms and both breast [sic]." The *Action taken by Staff/Treatment Given* section of the report read, "Reported to DOW." The *Corrective Measures Taken to Remedy and/or Prevent Recurrence* section of the report read, "DOW reported to provider." There were no incident reports regarding any open wounds or sores on Resident B's left leg.

The *Explain What Happened/Describe Injury (if any)* section of a report dated 10/23/23 read, "Resident not seeming like herself, unable to help w/cares or follow directions. Multiple falls recently. The *Action taken by Staff/Treatment Given* section of the report read, "Contacted EMS." The *Corrective Measures Taken to Remedy and/or Prevent Recurrence* section of the report read, "Resident sent to Metro." Resident B was admitted to the hospital and did not return to the facility.

On 12/19/23, I interviewed Staff Person 1 (SP1) at the facility. SP1's statements were consistent with Ms. Billow and Resident B's service plan. SP1 said Resident B was able to communicate her needs and toilet herself. SP1 reported there were incidents when Resident B located staff to report she soiled her brief and needed to be changed. SP1 said it is out of character for staff at the facility to intentionally leave a resident soiled for long periods of time. SP1 reported it seemed Resident B experienced a quick decline when she moved to the secured memory care unit that caused her to be admitted to the hospital in October 2023.

SP1 stated there were some instances in which Resident B refused to allow care staff to complete her activities of daily living (ADLs). SP1 reported staff would then

have to re-approach Resident B. SP1 said Resident B had to be redirected often after she moved into the secured memory care unit due to her behavior of yelling out for help for no reason.

SP1 denied seeing any open wounds on Resident B, including on her legs. SP1's statements regarding the facility's policy and procedure for reporting any wounds, injuries, or marks on a resident's skin were consistent with Ms. Billow.

On 12/29/23, I interviewed SP2 at the facility. SP2's statements were consistent with Ms. Billow, SP1, and Resident B's service plan.

On 1/6/23, I received an email from the complainant. The complainant stated Resident B passed away earlier this morning in a hospice facility.

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 interview with Ms. Billow, SP1, SP2, along with review of Resident B's October incident reports revealed staff were unaware of the open wound and discharge on Resident B's left leg. Resident B's service plan instructed staff to "Check skin with bath/shower and report any reddened/open areas to nurse." Staff's lack of awareness regarding Resident B's wound is inconsistent with her service plan. Resident B's plan read she was continent of bladder and bowel and could toilet herself. This was consistent with SP1 and SP2's statements. SP1 and SP2 reported Resident B was able to notify staff when she had an incontinence episode. Staff reported Resident B was not intentionally left soiled for long periods of time.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident B was administered too much Geodon.

INVESTIGATION:

On 12/5/23, the complaint read Resident B appeared to be “snowed out.” The complaint also read, “Found out on 12/4 [Resident B] was on 2 heavy dosage of Geogon. 80mg at night and 40 in the AM. A contraindicated medication for patients with Dementia.”

On 12/7/23, the complainant reported when he observed Resident B, she appeared to be “out of it” and like a “zombie.” The complainant expressed concern that this was a result of Resident B being administered a heavy dose of Geodon. The complainant reported Resident B did have medication changes from her inpatient stay at Pine Rest, however medication changes were not discussed with him.

On 12/19/23, Ms. Billow reported Resident B’s medications were administered as prescribed by her physician and by the prescribing physicians she saw at Pine Rest. Ms. Billow stated Resident B’s responsible person was informed any issues he had with Resident B’s prescribed medications needed to be reviewed with the prescribing physician. Ms. Billow said Resident B’s responsible person did not want Resident B taking her prescribed psychiatric medications. Ms. Billow explained she instructed Resident B’s responsible person to address this with the prescribing physician as staff at the facility cannot alter physician orders.

On 1/25/26, Ms. Billow provided me with a copy of Resident B’s September and October 2023 medication administration records (MARs) for my review. The September MAR read Resident B was prescribed, “ZIPRASIDONE 40 MG CAPSULE TAKE 1 CAPSULE BY MOUTH ONCE DAILY WITH BREAKFAST” and “ZIPRASIDONE 80 MG CAPSULE TAKE 1 CAPSULE BY MOUTH ONE DAILY WITH DINNER.” The MAR read the medication was administered as prescribed.

Resident B’s October MAR read Resident B was prescribed, “ZIPRASIDONE 60 MG CAPSULE TAKE 1 CAPSULE BY MOUTH EVERY MORNING (Related Diagnosis: BIPOLAR DISORDER) Start date-10/05/2023 D/C Date-10/31/2023, ZIPRASIDONE 40 MG CAPSULE TAKE 1 CAPSULE BY MOUTH ONCE DAILY WITH BREAKFAST Start date-09/07/2023 D/C Date-10/05/2023, ZIPRASIDONE 80 MG CAPSULE TAKE 1 CAPSULE BY MOUTH ONCE DAILY WITH DINNER Start Date-09/07/2023 D/C Date-10/31/2023.” The MAR read the medication was administered as prescribed.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

ANALYSIS:	The interview with Ms. Billow, along with review of Resident B's September and October 2023 MARs revealed her Ziprasidone (Geodon) was administered as prescribed. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

I shared the findings of this report with licensee authorized representative Lisa Sikes by telephone on 3/25/24.

IV. RECOMMENDATION

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

01/26/2024

Lauren Wohlfert — Date
Licensing Staff

Approved By:

03/15/2024

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