GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 2, 2022

Allison Freed
Cascade Trails Senior Living
1225 Spaulding Road
Grand Rapids, MI 49546

RE: License #: AH410394304
Investigation #: 2022A1010019
Cascade Trails Senior Living

Dear Ms. Freed:

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 (616) 356-0100.

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 #:	2022A1010019
Complaint Receipt Date:	01/10/2022
Investigation Initiation Date:	01/10/2022
Report Due Date:	03/09/2022
Licensee Name:	Cascade Trails Senior Living, LLC
Licensee Address:	Suite 200 3196 Kraft Ave Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Loren Duemler
Authorized Representative:	Christine McClellan
Name of Facility:	Cascade Trails Senior Living
Facility Address:	1225 Spaulding Road Grand Rapids, MI 49546
Facility Telephone #:	(616) 464-1564
Original Issuance Date:	05/06/2020
License Status:	REGULAR
Effective Date:	11/06/2021
Expiration Date:	11/05/2022
Capacity:	71
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff are not administering Resident B's medications as prescribed.	Yes

III. METHODOLOGY

01/10/2022	Special Investigation Intake 2022A1010019
01/10/2022	Special Investigation Initiated - Telephone Contacted assigned APS worker Heather Autsema. A joint investigation was coordinated.
01/11/2022	Inspection Completed On-site
01/11/2022	Contact - Document Received Received resident's service plan and MAR
02/02/2022	Exit Conference Completed with licensee authorized representative Allison Freed

ALLEGATION:

Staff are not administering Resident B's medications as prescribed.

INVESTIGATION:

On 1/10/22, the Bureau received the complaint from Adult Protective Services (APS). The complaint read staff have not been administering Resident B's medications as prescribed. Resident B admitted herself to the facility recently for help with medication management and administration, however she has not been receiving her medications. Resident B still maintains her home and checks herself out of the facility often to go there. Staff have not been giving Resident B her medications when she leaves to go to her home.

On 1/10/22, I interviewed assigned APS worker Heather Autsema by telephone. Ms. Autsema reported she had contact with Resident B at the facility. Ms. Autsema stated Resident B informed her staff have not been administering her medications. Ms. Autsema said Resident B also told her staff have not been giving the medications to her when she leaves on the weekend to go to her home. Ms. Autsema and I coordinated a joint investigation.

On 1/11/22, Ms. Autsema and I interviewed administrator Loren Duemler at the facility. Ms. Duemler reported Resident B was admitted to the facility on 12/29. Ms. Duemler stated there were some instances in which Resident B did not follow the facility's sign in/out policy and procedure, therefore staff were unaware she left. Ms. Duemler said during these incidents, staff were unable to give Resident B her prescribed medications to take with her. Ms. Duemler reported staff documented when Resident B was not in the facility and did not receive her medications on her medication administration record (MAR).

Ms. Duemler reported the only medication she was aware that Resident B did not receive was her eyedrops. Ms. Duemler explained this occurred because Resident B did not provide staff with her eyedrops when she was admitted.

Ms. Duemler provided me with copies of Resident B's December and January MARs for my review. The MAR read Resident B's prescribed "KETOTIFEN OPTH SOLN 0.025%" was not administered on 12/30, 12/31, 1/1, 1/2, 1/3, 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, and 1/11. The *Reason* section of the MAR read, "AWAITING MED ARRIVAL FROM PHARMACY. The MAR read Resident B's prescribed OMEPRAZOLE CAP 20MG" was not administered on 12/31, 1/2, 1/3, 1/6, and 1/7. The *Reason* section of the MAR for 12/31 read, "AWAITING MED ARRIVAL FROM PHARMACY." The *Reason* section of the MAR for 1/2, 1/3, 1/6, and 1/7 read, "OUT OF FACILITY."

The MAR read Resident B's prescribed "PRAVASTATIN TAB 40MG" was not administered on 1/1, 1/2, 1/3, 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, and 1/10. The *Reason* section of the MAR read, "AWAITING MED ARRIVAL FROM PHARMACY." The MAR read Resident B's prescribed "ASPIRIN EC TAB 81MG" was not prescribed on 1/2, 1/3, 1/6, and 1/7. The *Reason* section of the MAR read, "OUT OF FACILITY." The MAR read Resident B's prescribed "bupropion XL TAB 150MG" was not administered on 1/2, 1/3, 1/6, and 1/7. The *Reason* section of the MAR read, "OUT OF FACILITY." The MAR read Resident B's prescribed "DONEPEZIL TAB 10MG" was not administered on 1/2, 1/3, 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, and 1/11. The *Reason* section of the MAR read, "AWAITING MED ARRIVAL FROM PHARMACY." The MAR read Resident B's prescribed "ESCITALOPRAM TAB 20MG" was not administered on 1/2, 1/3, 1/6, and 1/7. The *Reason* section of the MAR read, "OUT OF FACILITY."

Ms. Duemler provided me with a copy of Resident B's service plan for my review. The *Medication Administration* section of the plan read, "Staff to assist with all medication administration. Resident takes 10 or more medications/OTC/Supplements daily." The *Routine Medication Frequency* section of the plan read, "Requires assist/administer medications at least daily." The *Community Movement* section of the plan read, "Independent with safety awareness and may be outside on grounds and leave campus unsupervised as desired. Remind resident to sign in and out when leaving campus."

On 1/11/22, Ms. Autsema and I interviewed wellness director Gabby Stephens at the facility. Ms. Stephens' statements regarding Resident B leaving the facility without her medications were consistent with Ms. Duemler.

Ms. Stephens reported Resident B did go several days without her prescribed Aricept, Pravastatin, and Aspirin. Ms. Stephens stated these medications were not in the medication cart possibly due to a staff "miscommunication." Ms. Stephens reported these medications were documented as waiting for their arrival from the pharmacy when Resident B was admitted, however staff likely never followed up with the pharmacy to ensure they were ordered. Ms. Stephens said staff were trained to inform her when a resident's medication is not available or not in the medication cart. Ms. Stephens stated she was not informed Resident B was missing medications until yesterday.

Ms. Stephens stated staff were verbally re-educated on the facility's policy and procedure for re-ordering resident medications when they are not in the medication cart. Ms. Stephens reported staff were trained to verify the pharmacy received the re-fill order if it does not arrive at the facility.

On 1/11/22, Ms. Autsema and I interviewed resident care coordinator Sonya Butler at the facility. Ms. Butler reported she often administers resident medications. Ms. Butler's statements regarding Resident B's medications were consistent with Ms. Duemler and Ms. Stephens. Ms. Butler reported it was unusual for a resident to go several days without a medication after they were admitted to the facility. Ms. Butler stated if a medication on a resident medication list is not at the facility, staff were trained to follow up with her, Ms. Stephens, or the pharmacy to confirm the order was received.

On 1/11/22, Ms. Autsema and I interviewed Resident B at the facility. Resident B reported there have been instances when she went several days without her prescribed medications. Resident B said staff informed her some of her prescribed medications were "not in the med cart," therefore she did not receive them. Resident B said staff have not provided an explanation as to why some of her medications are not in the med cart.

Resident B said she does follow the facility's policy and procedure of signing herself in and out of the facility when she goes home. Resident B reported staff do provide her with her medications when she leaves the facility to go home.

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:	The interviews with Ms. Stephens, Ms. Butler, and Resident B, along with review of Resident B's MAR revealed she went several days without her prescribed medications. Resident B's MAR read she went ten days without her prescribed Pravastatin, and Donepezil and 13 days without her prescribed Ketotifen.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Allison Freed by telephone. Ms. Freed reported the facility's process for ensuring resident medications are available at the facility will be outlined in the corrective action plan.

IV. RECOMMENDATION

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

1/14/22

Lauren Wohlfert — Date
Licensing Staff

Approved By:

01/31/2022

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