GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 7, 2022

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

RE: License #:	AH410394304
Investigation #:	2022A1021057
	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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410394304
Investigation #:	2022A1021057
Complaint Receipt Date:	09/01/2022
Investigation Initiation Date:	09/02/2022
Report Due Date:	11/01/2022
Licensee Name:	Cascade Trails Senior Living, LLC
Licensee Address:	Suite 200 3196 Kraft Ave Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Matthew Fellows
Authorized Representative:	Allison Freed
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:	11/06/2021
Expiration Date:	11/05/2022
Capacity:	71
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had unexplained fall.	Yes
Facility is unsanitary.	No
Additional Findings	No

III. METHODOLOGY

09/01/2022	Special Investigation Intake 2022A1021057
09/02/2022	Special Investigation Initiated - Telephone interviewed APS worker
09/07/2022	Inspection Completed On-site
09/07/2022	Contact - Telephone call made interviewed SP1
09/07/2022	Contact - Telephone call made interviewed SP2
09/07/2022	Contact - Document Received received Resident A's service plan, notes, MAR
09/12/2022	Contact-Telephone call made Interviewed SP2
	Exit Conference

ALLEGATION:

Resident A had unexplained fall.

INVESTIGATION:

On 9/2/22, the licensing department received a complaint from Adult Protective Services (APS) with allegations Resident A had an unexplained fall at the facility. APS alleged Resident A went to the bathroom unassisted and fell in the bathroom.

The APS worker alleged the facility did not appropriately notify family nor seek medical attention.

On 9/2/22, I interviewed APS worker Kevin Souser by telephone. Mr. Souser reported Resident A's family came to the facility to visit and observed Resident A to be in pain. Mr. Souser reported Resident A's family took Resident A to a local urgent care and it was discovered that Resident A had three broken ribs.

On 9/7/22, I interviewed health and wellness director Elizabeth Guigelaar by telephone. Ms. Guigelaar reported Resident A had an unwitnessed fall on second shift on 8/22/22. Ms. Guigelaar reported caregivers found Resident A on her bottom in her bathroom. Ms. Guigelaar reported Resident A reported no pain and requested assistance to stand. Ms. Guigelaar reported Resident A reported she did not hit her head. Ms. Guigelaar reported the next day Resident A complained of pain and pain medication was administered. Ms. Guigelaar reported family came to visit Resident A and decided to take Resident A to the local urgent care. Ms. Guigelaar reported it was found that Resident A had three broken ribs. Ms. Guigelaar reported Resident A did not like to call for assistance and would try to be as independent as possible. Ms. Guigelaar reported Resident A was on hourly checks and was not a fall risk.

On 9/7/22, I interviewed staff person 1 (SP1) by telephone. SP1 reported she worked the day Resident A fell. SP1 reported she responded to Resident A's call light and found Resident A on the floor in her bathroom. SP1 reported Resident A complained of no pain and did not have any injuries. SP1 reported the following day an incident report was completed by management. SP1 reported she believes family was notified the following day. SP1 reported Resident A did not have a history of falls and did not like to ask for help.

On 9/12/22, I interviewed SP2 by telephone. SP2 reported she worked on 8/23. SP2 reported she came into Resident A's room to administer pain medication per the resident's request. SP2 reported Resident A's family was visiting and Resident A told her family that she had fallen. SP2 reported she was not aware that Resident A had a fall. SP2 reported she administered pain medication and that was the end of her interactions with Resident A.

I reviewed chart notes for August 2022 for Resident A. There was no documentation of the fall.

I reviewed the medication administration record (MAR) for Resident A. The MAR revealed Resident A was prescribed Hydroco/Apap Tab 7.5-325 with instructions to administer one tablet by mouth three times daily as needed for pain. Resident A was administered this medication on 8/23 for pain.

I reviewed incident report completed for Resident A. The report was dated 8/24/22 The narrative and corrective actions of the report read,

"Resident's family came to visit and resident stated that her side was really hurting her. Family decided to take resident to the urgent care to be checked out. Resident came back with a report of closed fracture of multiple ribs on right side. Resident admitted to a self-transfer that ended on the floor earlier in the week. Remind resident to lock wheelchair when transferring. Consider a therapy consult for strengthening and balance. Encourage resident to press pendent for staff assistance with transfers."

I reviewed Leisure Living Management Policies and Procedures for Resident Fall Management. The document read,

"1. When a resident experiences a fall or suspected fall, care staff member shall follow policy QS 359 medical Emergency procedure for resident fall.
2. Notify the resident's health care provider (HCP) and resident/responsible party of the fall incident. Implement any new order(s) as directed by physician.
3. Notify Administrator (ADM) or Director of Nursing (DON). Director of Resident Care (DRC)/Resident Care Manager (RCM) of the fall incident.
4. Competed LLM Investigation form (QS 102A)
5. Consider review of the resident's medication regimen with physician/pharmacy to evaluate the possibility of medication(s) contributing to the fall.
6. Update the resident's care guide/service plan with any fall precautions.
7. Document fall incident in resident's clinical chart.
8. Administrator or designee to notify applicable agencies as warn warranted.
9. If warranted, Administrator or Designee contact Sentinel Occurrence Support Hotline.

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.** **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and

	personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Resident A had an unwitnessed fall at the facility on 8/22. The facility assisted Resident A back into bed and Resident A did not complain of pain. However, the day following the fall, Resident A complained of pain and requested pain medication. No medical attention was obtained for Resident A until Resident A's family took Resident A to an urgent care. From the time of the fall to when medical attention was provided was two days. The facility did not comply with ensuring Resident A was provide adequate and appropriate care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility is unsanitary.

INVESTIGATION:

The complainant alleged the facility is unsanitary. The complainant alleged Resident A's bathroom has been covered in feces.

At the time of my inspection, Resident A was no longer a resident at the facility and therefore, I was unable to observe Resident A's room.

On 9/6/22, I interviewed SP2 at the facility. SP2 reported she is responsible for cleaning the facility. SP2 reported she cleans the resident's bathroom and then bedroom. SP2 reported she also cleans the general areas of the facility. SP2 reported she did not receive any complaints regarding the cleanliness of the facility.

While onsite, I observed the common areas of the facility including the living area, dining area, hallways, and bathrooms. The common areas of the facility were clean as observed by the floors were vacuumed, there was no litter on the floor, and the facility smelt clean.

I observed multiple resident rooms and bathrooms. The rooms were tidy and clean. The bathrooms were also clean.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Interviews conducted and observations made at the facility revealed the facility is kept clean. There is lack of evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kimberly Horst 9/12/22

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 09/21/2022

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