GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 19, 2022

Lucijana Tomic
Care Cardinal Cascade
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410410352
Investigation #: 2022A1028068
Care Cardinal Cascade

Dear Ms. Tomic:

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 responsible party 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH410410352
Investigation #:	2022A1028068
Complaint Receipt Date:	07/21/2022
Investigation Initiation Date:	07/21/2022
Report Due Date:	09/20/2022
Licensee Name:	CSM Cascade, LLC
Licensee Address:	1435 Coit Ave. NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 308-6915
Administrator:	DaleTron Thompson
Authorized Representative:	Lucijana Tomic
Name of Facility:	Care Cardinal Cascade
Facility Address:	6117 Charlevoix Woods Ct. Grand Rapids, MI 49546-8505
Facility Telephone #:	(616) 954-2366
Original Issuance Date:	05/24/2022
License **Status:**	TEMPORARY
Effective Date:	05/24/2022
Expiration Date:	11/23/2022
Capacity:	77
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility is short staffed.	No
Resident A was provided medication in accordance with the service plan.	Yes
The call light system does not work appropriately resulting in Resident B's fall.	Yes
Additional Findings	No

III. METHODOLOGY

07/21/2022	Special Investigation Intake 2022A1028068
07/21/2022	Special Investigation Initiated - Letter 2022A1028068
07/21/2022	APS Referral
08/11/2022	Inspection Completed On-site On-site inspection completed due to investigation.
08/11/2022	Contact - Face to Face Interviewed Admin/DaleTron Thompson at the facility.
08/11/2022	Contact - Face to Face Interviewed Employee A at the facility.
08/11/2022	Contact - Face to Face Interviewed Employee B at the facility.
08/11/2022	Contact - Face to Face Interviewed Employee C at the facility.
08/11/2022	Contact - Face to Face Interviewed Employee D at the facility.
08/11/2022	Contact - Document Received

	Received Resident A's and Resident B's service plan with record notes and MAR from Admin/DaleTron Thompson.
10/19/2022	Exit – Report sent to AR/Lucijana Tomic and Admin/DaleTron Thompson.

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

On 7/21/2022, the Bureau received the allegations from the online complaint system.

On 7/21/2022, A n Adult Protective Services (APS) referral was sent to Centralized Intake.

On 8/11/2022, I interviewed administrator, DaleTron Thompson, at the facility. Ms. Thompson reported the facility is not currently short staffed but was in the past. Ms. Thompson reported the facility is appropriately staffed and a on-call system, float staff, and agency staff are used to fill any shift vacancies. Management assists as well with shift vacancies. Ms. Thompson provided me the working staff schedule for June 2022 to August 2022.

On 8/11/2022, I interviewed Employee A at the facility who reported the facility was short staffed prior to the new management onboarding but has not been short staffed since. Employee A reported call-ins do occur but on-call staff, float staff, agency staff are utilized. Employee A reported staff will also stay over to cover shift vacancies and management assists as well.

On 8/11/2022, I interviewed Employee B at the facility who reported there was an issue with the facility being short staffed in the past, but the new management has corrected the issue. Employee B reported call-ins do occur, but there are fewer now and staff will stay over to fill the shift vacancy as needed. On-call staff, float staff, and agency staff are utilized as well.

On 8/11/2022, I interviewed Employee C and D at the facility. Their statements are consistent with Ms. Thompson’s, Employee A’s, and Employee B’s statements.

On 8/11/2022, I completed an on-site inspection which revealed a more than adequate amount of staff on duty at the facility.

On 8/11/2022, I reviewed the working staff schedule from June 2022 to August 2022 which revealed some call-ins but adequate staff to fill any shift vacancies.

APPLICABLE RULE	
325.1931	**Employee; 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 facility demonstrates an appropriate staff to resident ratio. There is adequate staff to meet the needs of residents and the resident service plans.
CONCLUSION:	**VIOLATION NOT ESTABLISHED.**

ALLEGATION:

Resident A was provided medication in accordance with the service plan.

INVESTIGATION:

On 8/11/2022, Ms. Thompson reported no knowledge of Resident A or any other resident not having diabetic supplies in the medication cart. However, Ms. Thompson reported this could have occurred prior to her onboarding at the facility as the administrator. Ms. Thompson also reported no knowledge of any issues with Resident A's oxygen tank or oxygen concentrator while Resident A was at the facility. Resident A was their own person and could make needs known. Ms. Thompson reported Resident A did not vocalize any complaints to her while at the facility and Resident moved from the facility in July 2022. Ms. Thompson provided me a copy of Resident A's medication administration record and service plan for my review.

On 8/11/2022, Employee A reported all current residents requiring diabetic supplies have the appropriate amount in the medication cart. Employee A reported no knowledge of Resident A missing any diabetic supplies and insulin not being administered appropriately or in a timely manner due to this. However, Employee A reported there were issues with ordering supplies and medications in the past from the pharmacy and Resident A could have been affected then. Employee A reported no knowledge of any issues with Resident A's oxygen tank and was able to demonstrate the protocol for switching oxygen tanks. Employee A also showed me

where the diabetic supplies are located in the medication cart and which current residents require diabetic medication and supplies.

On 8/11/2022, Employee B reported knowledge of Resident A not having enough diabetic supplies in the cart and the facility “ran out of needles to administer insulin”. The pharmacy was called immediately to rectify the situation, but Employee B reported the error should not have occurred. Employee B reported this occurred prior to new management and ordering from the pharmacy has significantly improved since the new management onboarded at the facility, but there was a prior issue with ordering medical supplies. Employee B reported all staff are trained to switch oxygen tanks and was able to demonstrate the correct protocol. Employee B reported the issue with Resident A’s oxygen tank “was not the switching of it by us. It ran out due to CareLine not supplying the oxygen tanks on time.” Employee B reported CareLine was contacted immediately, and new oxygen tanks were delivered. Resident A had a concentrator in their room to utilize as well.

On 8/11/2022, Employee C reported knowledge that Resident A did not have diabetic supplies in the medication cart and that the facility ran out supplies to administer insulin in a timely manner. Employee C reported the pharmacy was contacted immediately for supplies and has not run out of diabetic supplies since for any resident. Employee C reported knowledge that Resident A’s oxygen tanks ran out due to CareLine not providing them in a timely manner despite the facility ordering them. Employee C demonstrated appropriate knowledge of the protocol to replace oxygen tanks.

On 8/11/2022, Employee D reported no knowledge of Resident A or any resident not having the correct amount of diabetic medication and supplies in the medication cart.

On 8/11/2022, I completed an inspection of the facility medication carts which revealed a current appropriate amount of diabetic supplies for residents.

On 8/22/2022, I reviewed Resident A’s MAR from April 2022 to July 2022 and service plan revealed the following:

- Resident A had an order for Lantus Solostar injectable insulin of 20 units sub-q to be injected twice daily.
- The June 2022 MAR revealed Resident A only received one injection of Lantus Solostar injectable insulin/20 units sub-q on 6/23/22, 6/24/22, 6/25/22, 6/27/22.
- Date 6/26/22 on the June 2022 is not documented. It cannot be determined if Resident A received the Lantus Solostar injectable insulin/20 units sub-q as ordered by the physician.
- Resident A had an order for 3L of Oxygen at all times due to acute respiratory failure.
- Oxygen was to be checked every shift.
- Resident A’s oxygen levels were to be documented twice daily.
- Facility managed all medications.

APPLICABLE RULE	
R 325.1932	**Resident Medications**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	It was alleged that Resident A's oxygen tanks were not switched out correctly by facility staff, but staff interviewed demonstrated appropriate protocol. It was revealed the oxygen tanks were not supplied in a timely manner by CareLine, but the issue has since be corrected. Interviews and on-site inspection reveal the facility did not have appropriate diabetic supplies on hand in June 2022 to administer Resident A's in accordance physician orders. Review of documentation also revealed Resident A did not receive the appropriate amount of insulin on 6/23, 6/24, 6/25, and 6/27. Date 6/26 is not documented on the June 2022 MAR and it cannot be determined if Resident A received insulin in accordance with physician orders. The facility did not provide medication in accordance with physician orders and/or the service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATON:

The call light system does not work appropriately resulting in Resident B's fall.

INVESTIGATION:

On 8/11/22, Ms. Thompson reported Resident B is independent with ambulation and transfers and is modified independent with most care. Resident B often does not use the call light and/or does not wait for staff to assist if needed. Resident B fell in the bathroom attempting to shower. Resident B does not require assistance with showering but can require assistance with changing of ostomy bag intermittently. Resident B is currently at physical habitation due to recent fall. Ms. Thompson

reported the call light system is being re-vamped due to prior issues. The call light system alerts the med techs, but the call light signal does not go to a walkie talkie. The signal is sent to a pager at the mech tech station and staff are then alerted to resident call lights. Ms. Thompson reported corporate IT is working to provide the facility walkie talkies that are connected to the call light system to make response time more efficient for staff. Ms. Thompson reported all current staff are trained with use of the call light system. Ms. Thompson was unable to provide me the call light log due to do being unable to access it. Ms. Thompson provided me Resident B's service plan with record notes for my review.

On 8/11/2022, Employee A reported Resident B is independent with mobility and modified independent with most care. However, Resident B can demonstrate poor safety awareness intermittently and does not use the call light system or request staff assist with care. Employee A reported Resident B fell in the bathroom attempting to take a shower independently, but "really should have staff supervision". Employee A reported Resident B did not fall due to the call light system but reported the new call light system is not efficient and [they] struggle utilizing the pager to notify other staff for an appropriate response time. Employee A reported "the old call light system worked better, and we need more walkie talkies too". Employee A was able to demonstrate where the call light signal is received at the med tech station but reported there are issues with logging into the call light system often. Employee A was unable to demonstrate use of the call light pager, reporting care staff complete hourly resident rounds to ensure care because the call light system is difficult to use.

On 8/11/2022, Employee B reported "[Resident B] is independent for the most part and will not ask for help". Resident B can shower independently but can require assist with ostomy bag. Employee B reported Resident B did not fall due to an inoperable call light, Resident B fell in the bathroom due to attempting to take a shower without supervision. Employee B reported the call light system works intermittently and there are issues with logging into the call light system, receiving call light signals, and being able to alert staff in a timely manner. Employee B reported all staff are trained with use of the call light system, but it is difficult to use and causes delayed response times. Employee B reported staff complete hourly resident rounds because staff "don't trust the call light system or you can't use it sometimes".

On 8/11/2022, Employee C's and Employee D's statements are consistent with Ms. Thompson's, Employee A's, and Employee B's statements.

On 8/22/2022, I reviewed Resident B"s service plan which revealed the following"

- Independent with ambulation and transfers using a 4WW.
- Independent with toileting but requires assistance with ostomy appliances.
- May bath/shower without assistance.
- Can toilet independently but requires assistance with negotiating clothing after toileting.
- Requires assistance with dressing.

- Independent with grooming.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	It was alleged Resident B fell resulting in injury due to the call light system not working appropriately. Review of Resident B's service plan reveals Resident B may shower without assistance. However, interviews and on-site inspection reveal the call light system does not work appropriately to notify staff in a timely to respond to resident needs. It was also revealed that despite training, facility staff have difficulty accessing and utilizing the call light system to respond to residents in a timely manner as well.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remain unchanged.

Julie Viviano

8/22/2022

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Julie Viviano Date
Licensing Staff

Approved By:

_____

Andrea Moore
Area Manager

Date