GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2022

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

RE: License #: AH410410352
Investigation #: 2023A1028007
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 #:	2023A1028007
Complaint Receipt Date:	11/07/2022
Investigation Initiation Date:	11/09/2022
Report Due Date:	01/07/2023
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:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff do not provide care in accordance with Resident A's service plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/07/2022	Special Investigation Intake 2023A1028007
11/09/2022	Special Investigation Initiated - Letter 2023A1028007
11/09/2022	APS Referral APS referral made to Centralized Intake.
11/21/2022	Contact - Face to Face Interviewed Employee A at the facility.
11/21/2022	Contact - Face to Face Interviewed Employee B at the facility.
11/21/2022	Contact - Face to Face Interviewed Employee C at the facility.
11/21/2022	Contact - Face to Face Interviewed Resident A at the facility.
11/21/2022	Contact - Document Received Received Resident A's service plan from Employee A.
11/22/2022	Contact - Telephone call made Interviewed Admin/DaleTron Thompson by telephone.
11/22/2022	Contact - Document Received Received Resident A incident report from Admin/DaleTron Thompson.
11/22/2022	Contact - Telephone call made Interviewed the complainant by telephone.

11/23/2022	Contact - Document Received Received Resident A's call light log from 11/19/2022 from DaleTron Thompson.
11/23/2022	Contact – Document Received Received evidence from the complainant pertaining to TED hose placement on Resident A.
11/30/2022	Contact – Document Received Received staff documentation for pendant and pager training from Ms. Thompson.
12/1/2022	Contact – Telephone Call Made Phone call made to Resident A's hospice. No answer. Voicemail left requesting return phone call.

ALLEGATION:

Staff do not provide care in accordance with Resident A's service plan.

INVESTIGATION:

On 11/7/2022, the Bureau received the allegations from the online complaint system.

On 11/9/2022, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 11/21/2022, I interviewed Employee A at the facility who reported Resident A requires assistance for transfers and ambulation for safety; and that Resident A fell in the bathroom on 11/2/2022 with a staff member present. Employee A reported the staff member was terminated for completing an improper transfer, not supervising Resident A appropriately, and for not following Resident A's service plan. Employee A report the staff member also did not report the fall in a timely manner. Employee A reported Resident A's authorized representative has expressed concerns about Resident A's care at the facility and management has conferenced with the authorized representative to address the concerns. Employee A reported there was also an issue with staff assisting Resident A to don compression socks. Employee A reported staff placed the compression hose on backwards due to inexperience and education was provided to all staff along with the posting of instructions in Resident A's room. Employee A provided me Resident A's service plan for my review.

On 11/21/2022, I interviewed Employee B at the facility who reported knowledge of Resident A's fall on 11/2/2022 and that corrective action was taken with the staff member involved. Employee B confirmed Resident A requires assistance with

transfers and ambulation for safety. Employee B reported staff were re-educated on Resident A's service plan following the incident. Employee B reported knowledge of posted instructions to assist Resident A with the donning of compression socks due to staff placing the socks on backwards resulting in constriction of Resident A's bilateral lower extremities. Employee B reported Resident A is the only resident at the facility that wears compression socks and staff required education to assist Resident A to don correctly.

On 11/21/2022, I interviewed Employee C at the facility whose statements are consistent with Employee A's statements and Employee B's statements.

On 11/21/2022, I interviewed Resident A who reported falling four times since being admitted to the facility on 10/27/2022. Resident A reported the issues with care arise primarily on third shift due to needing help to get into bed and to and from the toilet. Resident A reported [their] compression socks were recently put on incorrectly causing constriction to both lower extremities. Resident A pointed out the posted compression socks instructions on the wall and reported [they] are to wear them regularly each day. Resident A reported an increase in anxiety since being admitted to the facility due to the number of falls and due to staff not assisting appropriately. Resident A reported [they] are receiving hospice services and "believe I will get the help I need now".

During the interview, I observed Resident A to be clean and groomed. Resident A's room was clean as well. Resident A was observed sitting in the wheelchair without compression socks on.

On 11/22/2022, I interviewed facility administrator, DaleTron Thompson, by telephone who reported Resident A fell four times at the facility, but the only fall that was reported to her by staff was reported late on 11/72022, five days after the initial fall occurred on 11/2/2022. This staff member failed to report Resident A's fall in a timely manner and was eventually terminated. Ms. Thompson reported three other falls were not reported to her until 11/4/2022 by the home health therapist that was recently attending to Resident A. The home health therapist reported to Ms. Thompson the falls occurred on occurred on 10/29 and the other two falls occurred on 11/1/2022. Ms. Thompson reported the falls were investigated but there was insufficient evidence to support the falls, but staff were re-educated on the importance of reporting and on fall prevention. Ms. Thompson confirmed Resident A is the only resident to wear compression socks in the facility and staff recently placed them on backwards. Ms. Thompson reported staff were educated on correctly assisting Resident A with the compression socks and instructions were also posted in Resident A's room. Ms. Thompson reported the facility has conferenced with Resident A's authorized representative to address the concerns about Resident A's care. Ms. Thompson provided me a copy of Resident A's incident report for my review.

On 11/22/2022, I interviewed the complainant by telephone who reported Resident A has fallen four times and it was not appropriately addressed by the facility. Resident A's compression socks were not placed on correctly causing restriction to both lower extremities and that staff do not regularly assist Resident A with donning them. The complainant reported conferencing with staff and management about Resident A's care but does not feel concerns are being addressed. Resident A has increased anxiety since being admitted to the facility and falling multiple times. Resident A was recently assigned hospice services to assist with care.

On 11/23/2022, I received evidence from the complainant pertaining to compression socks/TED hose placement on Resident A.

On 12/1/2022, I reviewed Resident A's service plan which revealed the following:

- Resident A is unable to transfer self without staff assist and Resident A uses a wheelchair for long distances.
- Resident A requires assistance with toileting, grooming, bathing, and dressing.
- Per the service plan, the donning of Resident A's compression socks is "*dependent upon trained staff with the application and/or removal of AFO's. Easier to apply if done while he is in still in bed. Requires assistance with putting on and removing ted hose. Will not dress/undress self if not assisted."*

I also reviewed the incident report from Resident A's fall on 11/2/2022 which revealed Resident A fell at 7am while attempting to get off the toilet. Resident A's legs were reported to "give out", and Resident A fell to floor. Staff performed range of motion without difficulty and assisted Resident A into chair. Staff noted no bruises at the time but documented a skin tear to the left arm. It is noted on the incident report that staff did not report the initial fall to facility management until 11/7/2022; however, the facility, Resident A's authorized representative, and physician were notified on 11/4/2022 of the three other alleged falls by the home health company.

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:	It was alleged staff do not follow Resident A's service plan resulting in multiple falls and incorrect placement of compression socks resulting in lower extremity restriction. Interviews, onsite inspection, and review of documentation reveal care provided by staff is inconsistent with Resident A's service plan. There is evidence Resident A has incurred falls at the facility due to staff not assisting during transfers appropriately. There is also evidence of incorrect placement of compression socks to Resident A's lower extremities resulting in significant restriction. The service plan review revealed that donning of Resident A's compression socks is "*dependent upon trained staff with the application and/or removal of AFO's."* Resident A is to wear the compression socks daily and during the on-site interview on 11/21/2022, it was observed Resident A did not have the compression socks on. Staff are not providing Resident A care in accordance with the service plan or ensuring the safety of Resident A during care routines and therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings

INVESTIGATION:

On 11/21/2022, Employee B also reported knowledge that on 11/19/2022 Resident A was left on the toilet by a staff member for an hour on third shift. Employee B reported Resident A reported using [their] call light to summon staff to assist getting off of the toilet, but staff left Resident A on the toilet for an hour.

On 11/21/2022, Employee C's statements were consistent with Employee B's statements.

On 11/21/2022, Resident A reported [they] were left on the toilet for about an hour on Saturday, 11/19/2022, despite pressing the call light for assistance.

On 11/23/2022, I received Resident A's call light log for 11/19/2022 which revealed the following:

- Call light was activated at 5:44am and cleared at 7:55am, totaling 130 minutes. There is handwritten documentation on this call light log which

reads: *Assisted to toilet @5:48am. Pendant wasn't cleared. Wanted to sit awhile to have a BM.*

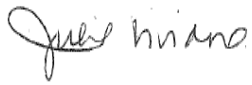
- Call light was activated at 6:15am and cleared 7:40am, totaling 85 minutes. There is handwritten documentation on this call light log which reads: *Med tech responded at 6:55 am. Gave meds and escorted to dining room by 0700. Pendant wasn't cleared.*

On 11/30/2022, I received staff documentation for pendant and pager training that occurred on 11/16/2022 from Ms. Thompson.

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: **b. Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Interviews revealed Resident A was allegedly left on the toilet for over an hour on 11/19/2022, despite Resident A using the call light to request staff assistance. Review of the call light log from 11/19/2022 reveals two significant call light times of 85 minutes and 130 minutes. There is handwritten documentation on Resident A's call light log from 11/19/2022 that the call light pendant may not have been cleared by staff. However, there is evidence that on 11/16/2022 staff were trained on use of call light pendants and the new call light system, which occurred prior Resident A's incident. Violation found.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



12/6/2022

Julie Viviano Date
Licensing Staff

Approved By:

12/21/2022

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