GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 10, 2023

Lisa Sikes
Care Cardinal Cascade
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410410352
Investigation #: 2023A1010023
Care Cardinal Cascade

Dear Ms. Sikes:

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

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 #:	AH410410352
Investigation #:	2023A1010023
Complaint Receipt Date:	01/19/2023
Investigation Initiation Date:	01/19/2023
Report Due Date:	03/18/2023
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:	Lisa Sikes
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:	REGULAR
Effective Date:	11/24/2022
Expiration Date:	11/23/2023
Capacity:	77
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident G went several days without her prescribed insulin.	Yes

III. METHODOLOGY

01/19/2023	Special Investigation Intake 2023A1010023
01/19/2023	Special Investigation Initiated - Letter Emailed assigned Kent Co. APS worker Kevin Souser
01/19/2023	Contact - Document Received Email received from Mr. Souser
01/24/2023	Inspection Completed On-site
01/24/2023	Contact - Document Received Received resident MAR
04/10/2023	Exit Conference

ALLEGATION:

Resident G went several days without her prescribed insulin.

INVESTIGATION:

On 1/19/23, the Bureau received the allegations from Adult Protective Services (APS). The complaint read, “[Resident G] was picked up by [Relative G1] on Sunday for a home visit. [Relative G1] reports that it was late morning and [Resident G] was still in bed and had not eaten. [Resident G] did not have any insulin packed so [Relative G1] spoke with the medical tech who reported that she has been covering all 3 wings of the facility. [Resident G] had not been given insulin in 3 days. [Relative G1] took [Resident G] home and while there she found [Resident G] unresponsive. [Resident G] was transported to the hospital and may have suffered a stroke. The medical results are still pending. [Resident G] is still in the hospital.”

I emailed assigned Kent County APS worker, Kevin Souser. Mr. Souser reported he had contact with Resident G and Relative G1 yesterday. Mr. Souser stated Resident G is still in the hospital and she will not return to the facility per Relative G1. Mr. Souser said he attempted to interview Resident G, however “her cognition was not

good, and did not provide too much info. She did say she wasn't given insulin on a regular basis but didn't know she has diabetes or what insulin really was."

On 1/20/23, I received an incident report regarding Resident G via email from the facility's administrator, DaleTron Thompson via email. The *date* section of the report read, "1/11, 1/12, 1/13, 1/14." The *Explain What Happened/Describe Inury (if any)* section of the report read, "It was reported to me on 1/19/23 that this resident missed at least 2 doses of Levemir." The *Action taken by Staff/Treatment Given* section of the report read, "No action could be taken for the resident as she had moved out already." The *Corrective Measures Taken to Remedy and/or Prevent Recurrence* section of the report read, "1. Med techs that did not follow protocol are being disciplined. 2. All meds [sic] techs are being re-educated 3. Count audit done to make sure all insulins were available."

On 1/24/23, Mr. Souser and I interviewed Ms. Thompson at the facility. Ms. Thompson's statements were consistent with the incident report she submitted regarding Resident G's missed insulin doses. Ms. Thompson reported the staff persons involved in the incident did not follow the corrective action plan that was recently put in place after Resident E went several days without his psychotropic medications. Ms. Thompson stated after she was informed Resident G missed doses of her prescribed insulin, she investigated the incident.

Ms. Thompson stated she interviewed Staff Person 1 (SP1), SP2, and SP3 regarding Resident G's missed insulin doses. Ms. Thompson reported SP1 stated after it was discovered Resident G was out of her prescribed Levemir insulin pens in the medication cart, she looked in the refrigerator in the secured medication room for them. Ms. Thompson explained SP1 said she did not locate any more of Resident G's Levemir insulin pens in the refrigerator, therefore it was not administered. Ms. Thompson said SP1 did not complete the required *Medication Incident* form or inform her or the facility's wellness director, Starlin Williams, that the insulin was not located or available.

Ms. Thompson reported SP2 and SP3 said they did not look for Resident G's prescribed Levemir insulin pens after they discovered there were no pens left in the medication care. Ms. Thompson stated SP2 and SP3 were supposed to look in the refrigerator in the secured medication room and other areas of the facility for Resident G's additional prescribed Levemir insulin pens. Ms. Thompson said SP2 and SP3 also did not complete the required *Medication Incident* form or inform herself and Ms. Williams that they did not administer Resident G's prescribed Levemir insulin because they did not locate it.

Ms. Thompson stated after she and Ms. Williams learned Resident G's prescribed Levemir insulin was not administered because staff could not locate it, Ms. Williams looked and located Resident G's additional prescribed Levemir insulin pens in the refrigerator in the secured medication room. Resident G's additional Levemir insulin pens were available, staff did not adequately search the refrigerator in the

medication room. Ms. Thompson reported SP1, SP2, and SP3 were formally disciplined and were re-educated after this incident.

Ms. Thompson provided me with a copy of Resident G's January medication administration record (MAR) for my review. The MAR was consistent with the incident report Ms. Thompson submitted and her statements. The MAR read Resident G did not get her prescribed "LEVEMIR FLEXTOUCH 100 UNITS Inject 8 unit subcutaneously at bedtime for diabetes" on 1/11/23, 1/12/23, 1/13/23, and 1/14/23.

On 1/24/23, I was unable to interview Resident G as she no longer resides in the facility.

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 interview with Ms. Thompson, along with review of Resident D's medication error incident report and her January MAR revealed she did not receive her prescribed Levemir insulin on 1/11/23, 1/12/23, 1/13/23, and 1/14/23. The interview with Ms. Thompson revealed SP1, SP2, and SP3 did not follow the facility's protocol regarding resident medication that is not available in the medication cart.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** Special Investigation Report (SIR) 2022A1010052 and Licensing Study Report (LSR)

I shared the findings of this report with licensee authorized representative Lisa Sikes and Ms. Thompson by telephone on 4/10/23.

IV. RECOMMENDATION

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

02/06/2023

Lauren Wohlfert Date
Licensing Staff

Approved By:

03/24/2023

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