GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 20, 2023

Lisa Sikes
Care Cardinal Kentwood
4352 Breton Rd. SE
Kentwood, MI 49512

RE: License #: AH410413166
Investigation #: 2023A1010047
Care Cardinal Kentwood

Dear Ms. Sikes:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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
Unit 13, 7th Floor
350 Ottawa, N.W.
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 #:	AH410413166
Investigation #:	2023A1010047
Complaint Receipt Date:	02/15/2023
Investigation Initiation Date:	02/16/2023
Report Due Date:	04/17/2023
Licensee Name:	CSM Kentwood LLC
Licensee Address:	4352 Breton Road SE Kentwood, MI 49512
Licensee Telephone #:	(312) 837-0704
Administrator:	Chelsea Lindsey
Authorized Representative:	Lisa Sikes
Name of Facility:	Care Cardinal Kentwood
Facility Address:	4352 Breton Rd. SE Kentwood, MI 49512
Facility Telephone #:	(616) 281-5170
Original Issuance Date:	05/11/2018
License Status:	REGULAR
Effective Date:	11/11/2022
Expiration Date:	11/10/2023
Capacity:	103
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff administered another Resident's medications to Resident I on 2/11/23.	Yes

III. METHODOLOGY

02/15/2023	Special Investigation Intake 2023A1010031
02/16/2023	Special Investigation Initiated - On Site
02/16/2023	Inspection Completed On-site
02/16/2023	Contact - Document Received Received resident MARs and medication lists

Allegations regarding residents being left soiled and unattended to were investigated under Special Investigation Report (SIR) 2023A1010022.

ALLEGATION:

Staff administered another Resident's medications to Resident I on 2/11/23.

INVESTIGATION:

On 2/15/23, the Bureau received the allegations from Adult Protective Services (APS). The complaint was not assigned for APS investigation. The complaint read, "One time, a staff member tried to give [Resident I] insulin, even though she is not diabetic; [Resident I] questioned staff and they realized the insulin was for another resident. However, there have been times where [Resident I] did ingest medications that were not hers due to staff error, including at least one incident where she was mistakenly given an opioid."

On 2/15/23, I reviewed the facility file. I received an incident report that was dated 2/11/23 via email from the facility's administrator Chelsea Lindsey on 2/15/23. The *Explain What Happened/Describe Injury (if any)* section of the report read, "Resident self-reported staff gave her the wrong medication and attempted to give her insulin on Saturday Feb. 11, 2023 at bedtime. Resident reported to Wellness Director on Monday 2/13/2023 around 1:30pm. Resident stated she took the meds but refused the insulin. The *Action Taken by Staff/Treatment Given* section of the report read,

“Spoke with resident dtrs about incident. Spoke with staff member from that night about medication error. Notify provider.” The *Corrective Measures Taken to Remedy and/or Prevent Recurrence* section of the report read, “Staff member removed from medication passing position and received written warning for resident safety.”

Witness Statement Forms were also included with the incident report. Resident I’s *Witness Statement Form* read, “[Resident I] stated at night time on Saturday, staff came in with my HS meds. I told her they weren’t my meds. It was a golden pill and two other little pills. She also came in a little while later and poked my finger took take [sic] my blood sugar. She left and came back with a needle (insulin). I refused and told her I’ve never used that before. She then said your [Resident B], I responded no I’m not [Resident B]. I had to tell her three times that I’m not [Resident B]. She stated ‘you have to be [Resident B].’ I stated ‘I don’t have to be [Resident B].’ Then she put the needle in her apron pocket and left my room.” The form was signed by Resident I and dated 2/13/23.

Staff Person 1 (SP1) also completed a *Witness Statement Form* that read, “I went into room 50 to do her blood glucose. Resident allow [sic] me to check her glucose blood. I came back with the insulin for bedtime and resident refused insulin, as I was allowed to find placement in her arm. I explain to resident that she gets insulin resident repeated I don’t get that. I said yes you do [Resident B]. Resident stated I’m not [Resident B]. I apologized and took the insulin away with me.” The form was signed by SP1 and dated 2/14/23.

On 2/16/23, I interviewed the facility’s wellness director Katrina Christian at the facility. Ms. Christian reported Resident B is prescribed Gabapentin, Oxycodone, and Melatonin at nighttime. Ms. Christian stated these were likely the medications that Resident I ingested after SP1 gave them to her. Ms. Christian explained Resident I’s physician was notified of the medication error and Resident I did not suffer any harm because of the incident.

On 2/16/23, I interviewed Ms. Lindsey at the facility. Ms. Lindsey’s statements were consistent with the incident report regarding Resident I that she submitted. Ms. Lindsey reported that upon investigation, it was discovered Resident I ingested some of Resident B’s medications. Ms. Lindsey did not know the names of Resident B’s medications that Resident I ingested when SP1 incorrectly administered them. Ms. Lindsey reported SP1 received medication administration re-education and written formal discipline after the incident.

On 2/16/23, I interviewed SP1 at the facility. SP1 reported she primarily worked in the secured memory care unit in the facility. SP1 stated she recently began working in the facility’s general assisted living area where Resident B and Resident I reside. SP1 said she is still getting to know and becoming familiar with the residents in the general assisted living area. SP1 reported she got Resident B and Resident I confused and did administer some of Resident B’s medications to Resident I.

SP1 said she did not know the names of the medications Resident I ingested that were Resident B's medications. SP1 reported when she attempted to administered Resident B's insulin to Resident I, Resident I informed her she is not prescribed insulin. SP1 said as a result, she did not administer the insulin. SP1 reported she did not report the incident to management staff because she was unaware, she gave Resident I the wrong medications, despite being told by Resident I that she was not Resident B.

On 2/26/23, I was unable to interview Resident I as she was signed out of the facility while I was there.

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. Lindsey, Ms. Christian, and SP1, along with review of Resident I's incident report and Resident I and SP1's *Witness Statement Forms,* revealed SP1 administered Resident B's evening medications to Resident I on 2/11/23. SP1 also attempted to administer Resident B's prescribed insulin to Resident I, however Resident I told SP1 she is not prescribed insulin, nor is she Resident B.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the issuance of a corrective notice order.

2/21/2023

Lauren Wohlfert Date
Licensing Staff

Approved By:

04/19/2023

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