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 #: 2023A1010049
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 #:	2023A1010049
Complaint Receipt Date:	02/02/2023
Investigation Initiation Date:	02/02/2023
Report Due Date:	04/04/2023
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?
Resident H was sent to the hospital with an incorrect “face sheet” and medication list.	Yes

III. METHODOLOGY

02/02/2023	Special Investigation Intake 2023A1010028
02/02/2023	Special Investigation Initiated - On Site
02/02/2023	Inspection Completed On-site
02/10/2023	APS Referral APS referral emailed to Centralized Intake

ALLEGATION:

Resident H was sent to the hospital with an incorrect “facesheet” and medication list.

INVESTIGATION:

On 2/2/23, the Bureau received the allegations from the online complaint system. The complaint read, “Resident was brought to emergency department by EMS for weakness and confusion on 1/8/23. Patient was brought with a face sheet and contact information from a former residence facility that had discharged her in November 2021. She was also sent with two different medication lists, each from a former facility with differing dates in 2022. No current medication or allergy list was sent with the patient. No paperwork indicated that the patient resided at Care Cardinal Kentwood. No paperwork provided contact information for patient care givers. Patient;s active MDPOA paperwork was not sent with the patient.”

On 2/2/23, I interviewed the facility’s administrator Chelsea Lindsey at the facility. Ms. Lindsey reported Resident H was recently sent to the hospital and staff did provide emergency medical services (EMS) staff with an incorrect “face sheet” and medication list for Resident H. Ms. Lindsey reported Resident H’s “face sheet” and medication list from her previous facility was incorrectly placed in the front of Resident H’s resident record binder. Ms. Lindsey stated staff did not check the “face sheet” and medication list to ensure it was current. Ms. Lindsey said Resident H’s

current “face sheet” and medication list should have been in Resident H’s resident record binder, however her previous documents from her previous facility were in her resident record.

Ms. Lindsey reported Resident H’s responsible person did not answer when staff contacted her to notify her Resident H was being transported to the hospital. Ms. Lindsey stated EMS staff asked Resident H what hospital she wanted to go to when staff were not present, therefore it was unknown what hospital Resident H was transported to. Ms. Lindsey said Resident H’s responsible person was upset because she was not informed what hospital Resident H was transported to.

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:	The interview with Ms. Lindsey revealed staff did not review Resident H’s “face sheet” or medication list to ensure the information was correct when EMS responded to the facility to transport Resident H to the hospital. EMS and hospital staff received incorrect medical and contact information for Resident H as a result. Resident H’s “face sheet” contains information such as Resident H’s address, health provider information, and responsible person information. EMS and hospital staff did not receive correct information or a correct medication list; therefore, Resident H’s medical treatment could have been adversely affected. This is not consistent with an organized program of protection.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **SPECIAL INVESTIGATION REPORT (SIR) NUMBER 2022A1028020 DATED 01/20/2022 AND SIR NUMBER 2022A1028006 DATED 11/08/2021**

IV. RECOMMENDATION

I recommend the issuance of a corrective notice order.

02/10/2023

Lauren Wohlfert Date
Licensing Staff

Approved By:

04/19/2023

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