GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 21, 2023

Allison Freed
Cascade Trails Senior Living
1225 Spaulding Road
Grand Rapids, MI 49546

RE: License #: AH410394304
Investigation #: 2023A1028034
Cascade Trails Senior Living

Dear Ms. Freed:

Attached is the Special Investigation Report for the above referenced facility. 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 #:	AH410394304
Investigation #:	2023A1028034
Complaint Receipt Date:	02/17/2023
Investigation Initiation Date:	02/22/2023
Report Due Date:	04/19/2023
Licensee Name:	Cascade Trails Senior Living, LLC
Licensee Address:	Suite 200 3196 Kraft Ave Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Administrator:	Matthew Fellows
Authorized Representative:	Allison Freed
Name of Facility:	Cascade Trails Senior Living
Facility Address:	1225 Spaulding Road Grand Rapids, MI 49546
Facility Telephone #:	(616) 328-6440
Original Issuance Date:	05/06/2020
License Status:	REGULAR
Effective Date:	11/06/2022
Expiration Date:	11/05/2023
Capacity:	71
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility staff did not follow physician medication administration orders.	Yes
Additional Findings	No

III. METHODOLOGY

02/17/2023	Special Investigation Intake 2023A1028034
02/22/2023	Special Investigation Initiated - Letter
02/22/2023	APS Referral APS referral sent to Centralized Intake.
03/01/2023	Contact - Face to Face Interviewed Admin/Matthew Fellows at the facility.
03/01/2023	Contact - Face to Face Interviewed Employee A at the facility.
03/01/2023	Contact - Document Received Received Resident A's service plan and MAR from Admin/Matthew Fellows.
03/01/2023	Contact - Telephone call made. Interviewed Employee B by telephone.
06/07/2023	Contact – Email Received Complainant requested via email that investigation be re-evaluated.

This investigation will only address allegations pertaining to the rules and regulations of Homes for the Aged (HFA).

ALLEGATION:

Facility staff did not follow physician medication administration orders.

INVESTIGATION:

On 2/17/2023, the Bureau received the allegations from the online complaint system.

On 2/22/2023, a referral was made to Adult Protective Services (APS) through Centralized Intake.

On 3/1/2023, I interviewed the facility administrator, Matthew Fellows at the facility who reported Resident A never missed any medication while at the facility. Mr. Fellows reported the facility conferenced with Resident A's authorized representative multiple times concerning medication administration to ensure appropriate care. The facility also consulted with Resident A's physician and hospice services as well. Mr. Fellows reported the facility followed Resident A's physician orders while Resident A resided at the facility. Mr. Fellows provided me Resident A's service plan and medication administration record from December 2022 to February 2023 for my review.

On 3/1/2023, I interviewed Employee A at the facility who reported there were no issues with Resident A's morphine administration; and Resident A did not miss any medication administration despite Resident A's multiple medication changes. Employee A reported a third staff member disposed of Resident A's short acting morphine medication due to a new cycle of medication beginning. The staff member was educated on the correct process of medication disposal due to this error, but it did not affect Resident A's medication administration. The facility picked up the new prescription with Resident A missing no medication administration. Employee A reported the facility consistently communicated with Resident A's authorized representative, physician, and hospice to ensure appropriate care and medication administration. Employee A reported the facility followed Resident A's physician orders.

On 3/1/2023, I interviewed Employee B by telephone. Employee B reported Resident A had multiple medication changes while at the facility, but Resident A never missed any medication administration. Employee B confirmed Resident A's short acting morphine was disposed of in error by a third shirt staff member due to a new cycle of medication beginning. However, this disposal did not affect Resident A's medication administration, as a new prescription was obtained. Employee B reported Resident A never missed any medication administration while at the facility and that Resident A's physician, authorized representative, and hospice team were conferenced with regularly. Employee B reported staff followed all physician orders for Resident A.

On 3/1/2023, I reviewed Resident A's service plan which revealed the following:

- Resident A has occasional confusion, requiring prompting.
- Wanders but is not intrusive.
- Does not exhibit any behaviors or verbal disruptions.
- Requires set-up to assistance with grooming, oral care, dressing, bathing, and toileting.

- The facility managed medication administration.

I also reviewed Resident A's medication administration record from December 2022 to February 2023 which revealed multiple prescription changes while Resident A resided at the facility but Resident A did not miss medication administration.

ADDENDUM:

On 6/7/2023, I received a request from the complainant to re-open the investigation pertaining to medication administration.

On 6/8/2023, the investigation was re-opened, and further review of Resident A's medication administration record (MAR) revealed the following:

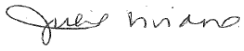
- Resident A was prescribed 1 tablet taken by mouth every 12 hours for chronic pain syndrome of Morphine Sul Tab 30mg ER beginning 1/24/2023. It was stopped on 2/20/2023.
- Resident A was prescribed 1 tablet taken by mouth every 4 hours as needed for pain of Morphine Sul Tab 15mg beginning 1/28/2023. It was stopped on 2/3/2023.
- Resident A was prescribed 2 tablets taken by mouth every 4 hours as needed for pain of Morphine Sul Tab 15mg beginning 2/1/2023. It was stopped on 2/8/2023.
- Resident A was prescribed 1 tablet taken by mouth every 4 hours as needed for pain of Morphine Sul Tab 15mg beginning 1/28/2023. It was stopped on 2/2/2023.
- Resident A was prescribed 2 tablets taken by mouth every 4 hours as needed for pain of Morphine Sul Tab 15mg beginning 2/14/2023. It was stopped on 2/20/2023.
- Resident A was prescribed 2 tablets taken by mouth every 4 hours as needed for pain of Morphine Sul Tab 15mg beginning 2/7/2023. It was stopped on 2/14/2023.
- The prescription for Morphine Sul Tab was prescribed by two different physicians during January 2023 to February 2023 with varying administration times and doses.

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:	It was alleged staff did not follow Resident A's physician or medication administration orders. Interviews, on-site inspection, and review of documentation reveal the facility followed physician medication administration orders. There is no evidence to support this allegation. **ADDENDUM:** On 6/8/2023, the investigation record was re-opened per complainant request and further review of the medication administration record revealed Resident A did not miss any administration of Morphine Sul Tab. However, there are six varying physician orders within the MAR with conflicting administration times and doses. Prescription dates between the six varying physician orders overlap resulting in complication of the administration timeline as well. It cannot be determined which physician order was being followed by staff and if the correct dosage was provided to Resident A during medication administration. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



3/8/2023
Addendum 6/27/2023

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Julie Viviano Date
Licensing Staff

Approved By:

06/05/2023
Addendum 08/21/2023

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