GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 1, 2023

Heather Rosenbrock
Cascade Senior Living II, Inc.
PO Box 3
Auburn, MI 48611

RE: License #: AL560274370
Investigation #: 2023A1033068
Cascade Senior Living II

Dear Mrs. Rosenbrock:

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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AL560274370
Investigation #:	2023A1033068
Complaint Receipt Date:	09/05/2023
Investigation Initiation Date:	09/07/2023
Report Due Date:	11/04/2023
Licensee Name:	Cascade Senior Living II, Inc.
Licensee Address:	4617 Eastman Rd. Midland, MI 48640
Licensee Telephone #:	(989) 631-7299
Administrator:	Heather Rosenbrock
Licensee Designee:	Heather Rosenbrock
Name of Facility:	Cascade Senior Living II
Facility Address:	4617 Eastman Road Midland, MI 48640
Facility Telephone #:	(989) 631-7299
Original Issuance Date:	10/06/2005
License Status:	REGULAR
Effective Date:	03/23/2022
Expiration Date:	03/22/2024
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The direct care staff are not providing correct management of Resident A's noninvasive ventilator.	Yes
Resident A was administered a medication that was not prescribed to him by direct care staff.	No
Resident A's bedroom is filthy and there is debris on the floors, including a soiled glove that has been there for months.	No

III. METHODOLOGY

09/05/2023	Special Investigation Intake 2023A1033068
09/07/2023	APS Referral- Denied APS referral.
09/07/2023	Special Investigation Initiated – Telephone- Interview with Resident A, via telephone.
09/07/2023	Contact - Telephone call made- Interview with Citizen 1, via telephone.
09/14/2023	Inspection Completed On-site- Interview with licensee designee, Heather Rosenbrock, direct care staff, Bethany Chlupac, Resident A, and direct care staff, Lydia Lewis. Review of Resident A's resident record initiated.
10/19/2023	Contact - Telephone call made- Interview with RN Supports Coordinator, Tracee Reddo, from A&D Home Health.
10/19/2023	Contact - Telephone call made- Interview with Alicia Mathews with Aria Healthcare.
10/23/2023	Exit Conference- Conducted via telephone with licensee designee, Heather Rosenbrock.

ALLEGATION: The direct care staff are not providing correct management of Resident A's noninvasive ventilator.

INVESTIGATION:

On 9/6/23 I received an online complaint regarding the Cascade Senior Living II adult foster care facility (the facility). The complaint alleged direct care staff are not properly managing and caring for Resident A's noninvasive ventilator machine. The complaint further alleged direct care staff will either overfill or underfill the machine with water, causing negative consequences for Resident A's physical health. On 9/7/23 I interviewed Citizen 1, via telephone. Citizen 1 reported that on 8/31/23 Resident A had reported to her that the week prior direct care staff had added too much water to his noninvasive ventilator machine. Citizen 1 reported that she is not aware of what this machine does for Resident A but reported that Resident A stated that too much water in the machine could cause him to drown as this machine is used for respiratory purposes. Citizen 1 reported that Resident A further claimed direct care staff have gone days without adding water to the noninvasive ventilator which can also cause difficulties with the machine functioning correctly.

On 9/14/23 I completed an unannounced on-site investigation at the facility. I interviewed licensee designee, Heather Rosenbrock, at this time. Ms. Rosenbrock confirmed Resident A does have a noninvasive ventilator, which direct care staff also refer to as a Bypap machine. Ms. Rosenbrock reported Resident A admitted to the facility with this machine. Ms. Rosenbrock reported Resident A uses this machine while he is napping or at night while he is sleeping. She reported direct care staff assist Resident A in turning on the noninvasive ventilator and filling the machine with water each night. Ms. Rosenbrock reported that there had been some issues with direct care staff not filling the noninvasive ventilator with water at night and they have since made this a task on Resident A's Medication Administration Record (MAR) for the staff to complete this task, each night at 12:30am. She reported that this change to the MAR occurred about a month ago as Resident A had made a telephone call to Ms. Rosenbrock when he became aware that the machine had not been filled with water as required. Ms. Rosenbrock reported Resident A has provided all the direct care staff education on how to use the noninvasive ventilator since he moved to the facility. Ms. Rosenbrock reported that they do not have any written orders regarding the use of this machine and no outside party has come to the facility to provide education to the direct care staff on the use of the machine. She reported Resident A understands how the noninvasive ventilator works and teaches all staff, including incoming new hires on how to manage the settings and the care of the machine. Ms. Rosenbrock reported that an outside Medicaid Waiver agency works with Resident A and provided the care plan for this agency for my review. She reported that the nurse with this agency is Tracee Reddo.

During on-site investigation on 9/14/23, I interviewed direct care staff, Bethany Chlupac. Ms. Chlupac reported that Resident A did admit to the facility with the

noninvasive ventilator machine. She reported that Resident A has provided the training to the direct care staff on how to manage the noninvasive ventilator and care for the machine as the equipment did not come with written orders for care and the direct care staff had not used one of these machines prior to Resident A's admission.

During on-site investigation on 9/14/23, I interviewed Resident A. Resident A reported that he has a noninvasive ventilator that has been ordered for his respiratory issues. He reported that the machine has three settings, and he prefers for the machine to be set to the lowest setting. He reported he has given direct care staff education on how to operate the equipment but reported that some of the direct care staff have put the machine on the wrong setting, overfilled the water required, or forgotten to add water to the machine. Resident A reported that when he first moved to the facility he was the only one who knew how to use the machine. He reported, "I had to train them", referring to direct care staff. Resident A reported that the management of the noninvasive ventilator has improved, but also noted that as early as a couple weeks prior there was an issue with a direct care staff putting too much water into the machine. He reported that adding too much water to the machine causes too much moisture build up and he feels as though he is suffocating.

During the on-site investigation on 9/14/23 I reviewed Resident A's resident record. I reviewed the document, *Assessment Plan for AFC Residents*, dated 5/27/23. On page 2 of this document, under section, *III. Health Care Assessment*, subsection, *D. Special Equipment Used (Wheelchair, Walker, Cane, Etc.)*, it reads, "amigo, Hoyer, Bypap". I also reviewed the document, *Vendor View for MICIS Assessment Report*, dated 6/28/23, completed by RN Supports Coordinator, Tracee Reddo, from A&D Home Health. On page 16 of this report, under *Section Q*, it reads, "[Resident A] uses a Non invasive ventilator with oxygen hook u at night while sleeping and also daily from 1p-3p." Also, I reviewed the document, *Person-Centered Service Plan for [Resident A]*, completed by Ms. Reddo and Julie Alarie, LLBSW, dated 9/14/23. On page 7, under section, *The following people and services will assist me in achieving my goals*, it reads, "Arranged services of durable medical equipment: Non invasive ventilator with oxygen". On page 4, it notes, "Durable Medical equipment: Non invasive ventilator with oxygen, Use when sleeps, Apria Healthcare LLC – Saginaw, MI"

On 10/19/23 I interviewed Ms. Reddo via telephone. Ms. Reddo reported that she is the nurse with the Medicaid Waiver Program who makes regular visits to Resident A at the facility. Ms. Reddo reported that she is aware of the noninvasive ventilator that Resident A uses but noted she does not manage this machine. She reported that she creates a care plan for Resident A based off his physical support needs and does include any assistive devices/medical equipment he may be using on this care plan but does not manage the order or the settings required to operate this machine. Ms. Reddo reported that a noninvasive ventilator would be managed through a local

durable medical equipment (DME) company. Ms. Reddo reported she did not provide any direct care staff training on how to use this machine.

On 10/19/23 I interviewed Alicia Mathews with Aria Healthcare. Ms. Mathews reported that Aria Healthcare is the DME provider who currently manages Resident A's noninvasive ventilator. Ms. Mathews reported that all noninvasive ventilators require an order, and the order will list the specific settings that are ordered by the medical provider. Ms. Mathews could not provide me with Resident A's specific noninvasive ventilator order due to confidentiality purposes.

On 10/23/23 I interviewed Ms. Rosenbrock, via telephone. Ms. Rosenbrock reported that she had found the order for Resident A's noninvasive ventilator machine and would email the order to this consultant.

On 10/24/23 I received an email correspondence from Ms. Rosenbrock with an attachment of the order for Resident A's noninvasive ventilator.

APPLICABLE RULE	
R 400.15310	**Resident health care**.
	Rule 310. (1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Based upon interviews with Resident A, Citizen 1, Ms. Rosenbrock, Ms. Chlupac, Ms. Reddo, and Ms. Mathews, as well as review of Resident A's resident record, it can be determined that Resident A had been prescribed a noninvasive ventilator, prior to admission to the facility, and the licensee designee and direct care staff did not obtain instructions from a medical provider on the appropriate usage of this durable medical equipment and instead relied on Resident A to provide instructions and training to the direct care staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before

	performing assigned tasks, which shall include being competent in all of the following areas:
ANALYSIS:	Based upon interviews with Resident A, Citizen 1, Ms. Rosenbrock, Ms. Chlupac, & Ms. Reddo, it can be determined that Resident A had been prescribed a noninvasive ventilator prior to admission to the facility and the licensee designee & direct care staff had no prior knowledge of how to operate this assistive device or knowledge of the written order for the device. The licensee and direct care staff relied on Resident A to provide training to the direct care staff on how to use, manage, and maintain this device based on his stated knowledge of the device. Although, Ms. Rosenbrock was able to find the order for the noninvasive ventilator, proper training from a medical provider or DME company was not sought to provide the education required for the direct care staff to manage this equipment for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A was administered a medication that was not prescribed to him by direct care staff.

INVESTIGATION:

On 9/6/23 I received an online complaint alleging that a direct care staff member at the facility had administered the wrong medication to Resident A. On 9/7/23 I interviewed Citizen 1 via telephone. Citizen 1 reported that Resident A had reported to her that on 8/28/23 a direct care staff member at the facility had tried to administer another resident's medication to him. Citizen 1 did not have any additional information regarding this allegation.

On 9/14/23, during on-site investigation, I interviewed Resident A. Resident A reported that on 8/28/23 direct care staff, Lydia Lewis, was administering his morning medications and she provided him with an extra pill that he noted was not his. Resident A reported he told Ms. Lewis that this was not his medication, and she took the pill away and reported Resident A was correct, this was not his medication. Resident A reported Ms. Lewis then took the pill back and left the room.

On 9/14/23, during on-site investigation, I interviewed Ms. Lewis. Ms. Lewis reported she has never given Resident A another resident's medication. She reported she never agreed with him that a pill being offered was not meant for him and taken the pill back. She reported that she can only administer one resident's medications at a time and is not able to set up more than one resident's medications due to the computer system that is used at the facility.

On 9/14/23, during on-site investigation, I interviewed Ms. Rosenbrock. Ms. Rosenbrock reported that Resident A has not made any complaints to her regarding a direct care staff accidentally trying to administer another resident's pills to him. She reported that all direct care staff who administer medications go through a thorough training and they are not able to administer more than one resident's medications at a time.

On 9/14/23, during on-site investigation, I interviewed Ms. Chlupac. Ms. Chlupac reported that Resident A has not made any complaints to her regarding Ms. Lewis attempting to administer another resident's medication to him on 8/28/23. She reported that the direct care staff who administer medications are taught to administer to one resident at a time and the computer system requires that you only set up one resident medication at a time.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	Based upon interviews with Citizen 1, Resident A, Ms. Rosenbrock, Ms. Lewis, and Ms. Chlupac, there is not sufficient evidence to determine that Ms. Lewis attempted to administer another resident's medication to Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident A's bedroom is filthy and there is debris on the floors, including a soiled glove that has been there for months.

INVESTIGATION:

On 9/6/23 I received an online complaint alleging that Resident A's bedroom has not been cleaned and is filthy. The complaint further alleged that there is a used latex glove on the floor of his bedroom that has been there for over a one month period. On 9/7/23 I interviewed Citizen 1. Citizen 1 reported Resident A reported these concerns to her on 8/31/23. Citizen 1 reported that she has never been to the facility and has not seen Resident A's bedroom.

On 9/14/23, during the on-site investigation I interviewed Resident A. Resident A reported that his room has not been kept clean and pointed out the latex glove on the floor. Resident A reported that this glove had been on the floor for over one month. I made observations of Resident A's bedroom during this interview. There was a latex glove found on the floor underneath the bedside table near Resident A's bed. The glove was picked up by Ms. Chlupac during this on-site investigation and

disposed of. It was determined that this glove had fallen from the box of gloves on the bedside table during personal care provided to Resident A as this glove showed signs of not being used. The bedroom was neat and fairly clean, no visible debris on the floor, some light dust in the windowsills. My observations of the remaining areas of the facility determined the same conclusions, the facility appeared clean and orderly.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Based upon interviews with Citizen 1 & Resident A as well as observations made during the on-site investigation it can be determined that there is not substantial evidence to determine that the direct care staff are not providing Resident A with housekeeping standards that present a comfortable, clean, and orderly appearance. There was a latex glove found on the floor but this glove could have easily been overlooked by direct care staff due to the location of the glove landing underneath the bedside table.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

10/26/2023

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Jana Lipps Date
Licensing Consultant

Approved By:

10/31/2023

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Dawn N. Timm Date
Area Manager