GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 14, 2024

Selma Alesevic
MS Cascade SH, LLC
Suite T-900
7900 Westpark Drive
McLean, VA 22102

RE: License #: AH410322787
Investigation #: 2024A1027033
Sunrise of Cascade

Dear Licensee:

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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410322787
Investigation #:	2024A1027033
Complaint Receipt Date:	02/08/2024
Investigation Initiation Date:	02/08/2024
Report Due Date:	04/07/2024
Licensee Name:	MS Cascade SH, LLC
Licensee Address:	300 10350 Ormsby Park Place Louisville, KY 40223
Licensee Telephone #:	(616) 942-7200
Authorized Representative/ Administrator:	Selma Alesevic
Name of Facility:	Sunrise of Cascade
Facility Address:	3041 Charlevoix Drive, SE Grand Rapids, MI 49546
Facility Telephone #:	(616) 942-7200
Original Issuance Date:	08/03/2012
License Status:	REGULAR
Effective Date:	04/30/2023
Expiration Date:	04/29/2024
Capacity:	125
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A lacked medication management.	Yes
Resident A lacked a bowel program resulting in the resident being diagnosed with a hemorrhoid.	Yes
Resident A's service plan was not prepared with her and her authorized representative's participation.	Yes
The facility was understaffed with no weekend help.	No
Additional Findings	No

In Special Investigation Report (SIR) 2024A1010013, the following allegations were investigated: Resident A was left soiled for long periods of time, Resident A was dropped when being transferred in a Hoyer lift, and Resident A had missing medications that were not administered as a result.

III. METHODOLOGY

02/08/2024	Special Investigation Intake 2024A1027033
02/08/2024	Special Investigation Initiated - Telephone Telephone interview conducted with Selma Alesevic and documentation requested
02/09/2024	Contact - Document Received Email received from Selma Alesevic with documentation
02/28/2024	Contact - Telephone call made Voicemail left with complainant.
02/28/2024	Contact - Document Received Telephone interview conducted with the complainant
02/28/2024	Contact - Document Sent Email sent to Ms. Alesevic requesting additional information and documentation
03/04/2024	Contact – Document Received

	Email received from Selma Alesevic with requested information and documentation
03/06/2024	Inspection Completed - BCAL Sub. Compliance
03/14/2024	Exit Conference Conducted by email with Selma Alesevic

ALLEGATION:

Resident A lacked medication management.

INVESTIGATION:

On 2/8/2024, the Department received allegations which read:

-Resident A's medications were not administered on time including Gabapentin.

-Resident A's Gabapentin was to be administered as follows: two capsules in the morning and at noon, and three capsules at 8:00 PM; however, the Gabapentin order was changed by the facility to include two capsules at 3:00 PM. The allegations read the prescription was not changed by Resident A's physician.

-A medication technician tried to administer a fourth dose of Gabapentin (three capsules); however, her physician prescribed "*2-2-2.*"

-Hydrocortisone 2.5% was to be applied into rectum for a hemorrhoid in which there was confusion on who could administer it and one staff member inserted the end of the tube into Resident A's rectum. The allegations read the medication was prescribed for two weeks, but only administered 2-3 times.

-Resident A's Nystatin was applied to the wrong side of her neck.

-It was uncertain if Resident A was supposed to receive one or two Tylenol every six hours.

I reviewed Resident A's October 2023 Medication Administration Record (MAR) which read in part she admitted to the facility on 10/6/2023 and discharged on 11/3/2023. The MAR read in part:

The MAR read Gabapentin 300 mg, give two capsules by mouth two times a day from 0700- 0900 [7:00 AM – 9:00 AM] and 1300 [1:00 PM], then three capsules from 1900-2100 [7:00 PM – 9:00 PM], which were initialed as administered per the order except on 10/6/2023 which was left blank. The MAR read the orders were started 10/6/2023 and discontinued on 10/19/2023.

The MAR read Gabapentin 300 mg give two capsules by mouth two times a day at 0800 [8:00 AM] and 1700 [5:00 PM] in which a dose was administered on 10/19/2023 at 5:00 PM and on 10/20/2023 at 8:00 AM, then was discontinued on 10/20/2023.

The MAR read Gabapentin 300 mg give three capsules by mouth at bedtime from 1900-2100 [7:00 PM – 9:00 PM] was initialed as administered on 10/19/2023 per the order, then discontinued on 10/20/2023.

The MAR read Gabapentin 300 mg give two capsules by mouth at 0800 [8:00 AM] and 1300 [1:00 PM] which started on 10/21/2023 and 10/20/2023 consecutively and was initialed as administered per the order, then was discontinued on 11/4/2023.

The MAR read Gabapentin 300 mg give three capsules by mouth at bedtime from 1900-2100 [7:00 PM – 9:00 PM] which started on 10/20/2023 and was initialed as administered per the order, then discontinued on 11/4/2023.

The MAR read Hydrocortisone External Cream 2.5% (Hydrocortisone topical), apply by inserting into the rectum topically two times a day for redness until 10/26/2023 (start date 10/17/2023) at 0700-0900 [7:00 AM – 9:00 AM] and 1300 [1:00 PM]. The MAR read the medication was administered at 1300 [1:00 PM] on 10/17/2023, then pending delivery for both doses on 10/18/2023, and initialed as administered per the order from 10/19/2023 through 10/26/2023.

Additionally, the MAR read Hydrocortisone External Cream 2.5% was administered within prescribed medication administration times of 7:00 AM to 9:00 AM and 1:00 PM. The MAR read staff documented the locations for administration were “*buttock-both*,” “*breast-both*,” “*other*,” or “*groin*.”

The MAR read Nystatin External Cream 100000 unit/GM, apply to affected areas topically two times a day for rash or irritation at 0700- 0900 [7:00 AM – 9:00 AM] and 1900-2100 [7:00 PM – 9:00 PM] which started on 10/6/2023 and was discontinued on 11/4/2023. The MAR read Nystatin was left blank for the 7:00 AM – 9:00 AM dose on 10/6/2023, then pending delivery on 10/6/2023 for the 7:00 PM – 9:00 PM dose, as well as pending delivery from 10/7/2023 to 10/8/2023, then was initialed as administered going forward.

The MAR read Nystatin was administered within the prescribed medication administration times of 7:00 AM to 9:00 AM and 7:00 PM to 9:00 PM. The MAR read staff documented the locations for administration were “*groin*,” “*breast-both*,” and “*neck*.”

The MAR read Acetaminophen 500 mg, give one tablet by mouth every six hours as needed for pain or fever which started on 10/12/2023 and was discontinued

on 10/17/2023. The MAR read Resident A received one dose of Acetaminophen on 10/12/2023, two doses on 10/13/2023, 10/15/2023, and 10/16/2023, and three doses on 10/14/2023.

The MAR read Acetaminophen 500 mg, give two tablets by mouth every six hours as needed for pain or fever which started on 10/17/2023 and discontinued on 11/4/2023. The MAR read Resident A received one dose on 10/17/2023, and 10/21/2023, two doses from 10/18/2023 through 10/20/2023, as well as two doses from 10/23/2023 through 10/25/2023, 10/29/2023, and 10/30/2023 and three doses on 10/22/2023, 10/26/2023 through 10/28/2023 and 10/31/2023.

Additionally, the MAR read Diphenhydramine was waiting for medication delivery from 10/7/2023 to 10/10/2023, then documented as administered on 10/11/2023 and pending delivery on 10/12/2023.

Furthermore, some prescribed medications were left blank on 10/6/2023 which was also the date they were ordered to start.

I reviewed Resident A's November 2023 MAR which read in part staff initialed her medications as administered and she moved out of the facility on 11/3/2023.

I reviewed Resident A's physician orders on the *Order Listing Report* which read consistent with the October and November 2023 MARs.

I reviewed the facility's *Medication Admin Audit Report* for Resident A's prescribed Gabapentin which read it was administered within prescribed medication administration times.

I reviewed Resident A's progress notes for October and November 2023 which read in part:

Note dated 10/24/2023 at 1837 [6:37 PM] written by Employee #2 read: "*Skin condition on neck and abdomen. Resident notes history of yeast rashes in skin folds. Resident has an order for Nystatin cream. RCD reminded MCM about the importance of applying Nystatin cream to resident's neck and abdomen due to concerns of a yeast rash*."

I reviewed Resident A's service plan updated on 10/23/2023 which read in part staff were to assist Resident A with administration of her medications. The plan read in part she was at risk for skin integrity impairment in which staff were to encourage/assist her with turning and repositioning frequently throughout each shift at least 2-4 times per shift and as needed while in bed. The plan read in part to observe for and report any changes in her skin, as well as keep it clean and dry. The plan read in part to hydrate her skin with lotion if indicated and report any alterations.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

ANALYSIS:	Review of Resident A's October and November 2023 MARs and medical records revealed the following: Resident A's medication Gabapentin was administered as prescribed and consistent with the physician orders, as well as within the time frames ordered by the physician. Resident A's physician orders for Gabapentin read consistent with the changes on the MARs. Additionally, there was an order which read for Gabapentin to be administered at 5:00 PM then it was discontinued. Resident A's prescribed Hydrocortisone 2.5% was ordered to be applied into rectum for a hemorrhoid. The MAR read staff initialed the medication administered then documented it was pending delivery in which it could not be confirmed if it was administered or not. Additionally, staff did not always document the location of administration of the medication consistent with the order on the MAR. Although the physician order for Nystatin External Cream lacked a specific location, chart notes read it was to applied Resident A's neck and abdomen in which was not consistent with staff's documentation on the October 2023 MAR. Resident A's physician order for Tylenol read consistent with the MAR in which the order was changed from one tablet to two tablets every six hours on 10/17/2023. The MARs lacked consistent documentation of whether a medication was available or not available for administration. For example, Diphenhydramine was held waiting for medication delivery, then documented as administered, and held again waiting for medication delivery. The MARs read some of Resident A's medications were prescribed to start 10/6/2023, in which one or more medications were left blank on that date. Although it could be concluded the medications were not delivered to the facility yet, the MAR would have reflected the medication was held for this reason. Furthermore, the MARs read Resident A was prescribed creams in which staff documented the administration of the cream inconsistent with the progress notes.

	Therefore, based on the aforementioned information Resident A's medications were not always administered consistent with the licensed healthcare professional's orders and this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A lacked a bowel program resulting in the resident being diagnosed with a hemorrhoid.

INVESTIGATION:

On 2/8/2024, the Department received allegations which read the facility never set up a bowel program for Resident A and she developed a hemorrhoid. The allegations read Resident A became dehydrated, constipated and was in pain so she was admitted to hospital. The allegations read Resident A's physician prescribed medication which was used twice; however, it was to be used for seven days.

I reviewed Resident A's service plan updated on 10/23/2023 which read in part Resident A had bowel incontinence and required bedpan assistance. The plan read in part staff would assist with incontinence care, observe her skin, and report any redness, rash, blisters, or open areas. The plan read in part staff were to cleanse and dry her skin thoroughly before applying any product.

I reviewed Resident A's October and November 2023 MARs which read in part:

> Magnesium Hydroxide Oral Suspension 400 mg/5 mL, give 15 mL by mouth every 12 hours as needed for constipation until 10/30/2023 which started on 10/12/2023. The MARs read no doses were documented as administered.
>
> Polyethylene Glycol 3350 oral packet 17 GM, give one packet by mouth every 24 hours as needed for constipation in which the start date was 10/15/2023 and was discontinued on 11/4/2023. The MAR read staff initialed the medication as administered on 10/15/2023 at 1334 [1:34 PM], 10/18/2023 at 1657 [4:57 PM], and 10/25/2023 at 1107 [11:07 AM]. The MAR read there were no doses of Polyethylene Glycol administered in November 2023.

I reviewed Resident A's physician orders on the *Order Listing Report* which read consistent with the MARs.

I reviewed Resident A's progress notes for October and November 2023.

Note dated 10/14/2023 at 12:50 [12:50 PM] written by Employee #1 read in part she would ask the Resident A's physician for a stool softener since Resident A had not had a bowel movement since admission.

Note dated 10/15/2023 at 14:45 [2:45 PM] written by Employee #1 read in part Resident A was thankful Employee #1 received an order for MiraLAX.

Note dated 10/16/2023 at 09:27 [9:27 AM] written by Employee #1 read: "[*Employee #1] got a call from [Relative A1] asking me to come to her room because she wants to be sent to the hospital. When I went in her room she was tearful and stated she wants to go to the hospital because she is only having tiny BM and is dehydrated. Shefeels [sp] it in her mouth being dry and she doesn't feel good overall. VS are stable. EMS was called and is on their way. Will continue to monitor her*."

Note dated 10/16/2023 at 12:40 [12:40 PM] written by Employee #1 read: *"[Employee #1] called [Relative A1] and he stated she's doing okay at St. Mary's hospital. She is getting a cocktail to help her have a BM and is receiving blood work and they are getting her hydrated. She will be coming back this afternoon he stated. I asked that he bring the after visit summary back with him and I can make a copy of it tomorrow. Will follow up*."

Note dated 10/17/2023 at 07:54 [7:54 AM] written by Employee #1 read in part: *"[Employee #1] was called by [Relative A1] to go to see her. I went in and she told me about her hospital visit and how miserable it was. She stated her bottom hurts really bad and I looked at it and there's no sign of a pressure ulcer. I explained we have cream we will be applying to her bottom 2 times a day that will help with the rawness. She stated she was very crampy, but refused miralax when I suggested it because her bottom hurts so bad*."

Note dated 10/17/2023 at 09:36 [9:36 AM] written by Employe #1 read: "*Note Text: Her rear end is sore with occasional bleeding.*
[Employee #1] checked on [Resident A] and she has a hemorrhoid from her rectum. She went to the hospital for this yesterday and they prescribed hydrocortisone rectal cream to help treat."

Note dated 10/17/2023 at 11:19 [11:19 AM] written by Employee #1 read: "*LATE ENTRY*
Note Text: Skin condition on buttock
[Employee #1] checked on [Resident A] and her bottom has no redness but she has the hemorrhoid that is from her rectum that the hospital gave us cream for that is applied 2x daily."

Note dated 10/18/2023 at 09:24 [9:24 AM] written by Employee #1 read: *"[Employee #1] called PCP office and spoke to Jamie explaining everything going on with [Resident A] with her stomach pain and no [sp] having a BM but refusing*

miralax. I answered several questions she had to try to give Dr. Burmeister all the answers he would need to come up with a plan. She took my name and call back number. Will follow up and keep [Resident A and Relative A1] in the loop."

Note dated 10/18/2023 at 15:54 [3:54 PM] written by Employee #2 read in part: *"[Relative A1 and Resident A] noted that resident had been dealing with ongoing issues with constipation and felt that when resident was sent to the hospital that the hospital did not help alleviate resident's abdominal cramping. Resident notes that she was given Mira Lax which did help alleviate her constipation but resident states she would like a stool softener or medication to help facilitate a BM regularly. Resident was advised that Sunrise is unable to administer medications without a physician's order but [Employee #2] offered to reach out to resident's PCP about getting orders to help facilitate a BM and [Relative A1 and Resident A] noted that they would appreciate this*."

Note dated 10/19/2023 at 14:48 [2:48 PM] written by Employee #1 read in part she contacted Resident A's physician office who reported they received her notes but had not reviewed them for the request for Ambien and milk of magnesium prescriptions.

Note dated 10/20/2023 at 15:31 [3:31 PM] written by Employee #1 read: "*[Employee #1] checked on [Resident A] and she has a hemorrhoid from her rectum. PCP is aware and she has cream for it to be placed on twice a day. We also have barrier cream for her bottom that can be applied every brief change*."

Note dated 10/20/2023 at 15:46 [3:46 PM] written by Employee #1 read: *"[Employee #1] talked with Jamie today and she reported PCP stating he wants to give [Resident A] and [sp] controlled bowel regimen. He prescribed her to start Milk of Magnesium for the next 10 days. He also prescribed her Ambien to be scheduled instead of prn per [Resident A's] request*."

Note dated 10/25/2023 at 15:12 [3:15 PM] written by Employee #1 read in part: "*She is still struggling with constipation which we encouraged lots of fluids to help with that. She received a prn dose of miralax today and I let her know she can ask for that every day whenever she wants it. RCD stated she reached out to PCP about receiving a script or electrolyte tablets she would like to help her stay hydrated. RCD stated she will follow up*."

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:	Review of Resident A's progress notes revealed an order was obtained for Magnesium Hydroxide Oral Suspension in which was transcribed onto the MAR; however, the order was entered "as needed" and not scheduled to ensure she received the medication as ordered. Therefore, the facility lacked an organized program to ensure Resident A's bowel medication were transcribed and implemented accordingly, thus a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's service plan was not prepared with her and her authorized representative's participation.

INVESTIGATION:

On 2/8/2024, the Department received allegations which read in part staff did not review Resident A's Care Plan. The allegations read Employee #3 was supposed to review it, but never did.

On 2/28/2024, I conducted a telephone interview with the complainant who stated Resident A nor Relative A1 were apprised of her service plan. The complainant stated Resident A's service plan was not reviewed nor communicated with Resident A or Relative A1.

On 3/4/2024, email correspondence with Ms. Alesevic read in part:

> "*We sign the service plan with responsible party/ resident at move-in and again at 6-month seha [sp] if necessary. If we make changes in between that time frame we have a verbal conversation with the resident/ RP and document via progress note."*

I reviewed Resident A's admission contract dated 10/6/2023 and digitally signed by Relative A1 on 10/7/2023 which read in part:

> "*Resident Service Plan. A service plan will be developed based on the Physician's Report, the Psychiatric Examination (if applicable) and the Assessment. The Resident's service plan will be developed with the Resident and/or any individual the Resident designates, including any Responsible Party.*

The service plan will outline the services the Resident is to receive. The Community shall provide room, board, protection, supervision, assistance, and supervised personal care consistent with the Resident's service and in accordance with this Agreement."

I reviewed Resident A's service plan which read in part it was initiated on 10/5/2023, and updated on 10/6/2023, 10/16/2023, 10/18/2023, and 10/23/2023. The service plan lacked signatures from facility staff, Resident A and/or Resident A's authorized representative.

I reviewed Resident A's progress notes for October and November 2023 which lacked evidence of communication of the service plan.

On 3/20/2024, the Department received additional documentation from Ms. Alesevic which included a signature page for Resident A's service plan. The signature page read it was signed and dated on 10/6/2023 by Resident A's spouse and the facility's assisted living coordinator.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
For Reference: R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	The facility's admission contract read residents' service plans were to be developed with the resident and/or any individual the resident designates, including any responsible party. Although Resident A's initial service plan revealed it was reviewed with her spouse on 10/6/2023, there was lack of evidence in Resident A's progress notes regarding communication of the updated service plan after that time with Resident A or her authorized representative; therefore, a violation was substantiated for this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility was understaffed with no weekend help.

INVESTIGATION:

On 2/8/2024, the Department received allegations which read the facility was understaffed with no weekend help.

On 2/8/2024, I conducted a telephone interview with administrator and authorized representative Selma Alesevic. Ms. Alesevic stated staff entered a resident's assessment information and plan of care information into their system called *Point Click Care* to create a resident's service plan. Ms. Alesevic stated the system also created each resident's acuity level. Ms. Alesevic stated *Point Click Care* communicated with another program called *Group Assignment Tool* to calculate staffing for the facility based off the residents' acuity levels.

On 2/9/2024, email correspondence with Ms. Alesevic provided a screenshot of the *Group Assignment Tool* for the current group of residents which read there were 28 assisted living residents on the first floor. The screenshot read the assisted living residents were assigned to two groups in which there were 10 residents on the "AL Hall 1" and 18 residents on the "AL Hall 2."

On 3/4/2023, email correspondence with Ms. Alesevic read in part:
"*Our assisted living is broken up in two neighborhoods AL and Terrace club. [Resident A] was in our Terrace Club neighborhood which had 18 residents at the time broken in two assignment groups 1 caregiver per assignment. We also have a lead caregiver who does not get an assignment but floats and assists with each group. There is an acuity mix with some independent residents, 1 person assists and 2 person transfers and at the time 2 Hoyer's, no 3-person assist*.

Total we have 4 Caregivers and 1 lead for all of AL on 1st and 2nd shift. 3rd shift we have 2 leads and 2 care givers."

I reviewed Resident A's service plan updated on 10/23/2023 which read in part she required a Hoyer lift for transfers. The plan read she required 2-3 persons for assistance with bathing but would only require one staff member if a bed bath was completed.

I reviewed the facility's staff schedule from 10/6/2023 through 11/3/2023 which read in part there were 95.3 to 130.0 hours worked per day for all care staff in the assisted living. The schedule read in part there were 19 to 13 staff on duty per day in the assisted living.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Staff attestations revealed the facility implemented a method in which a system encompassed each resident's needs to determine the acuity level and number of staff on duty. Review of the staff schedule along with the resident census and acuity revealed there was insufficient evidence to support this allegation, therefore it was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

03/06/2024

Jessica Rogers Date
Licensing Staff

Approved By:

03/14/2024

_____

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