GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 27, 2024

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

RE: License #: AL560274370
Investigation #: 2025A0466003
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) 284-9727.

Sincerely,

Julie Elkins

Julie Elkins, 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 #:	2025A0466003
Complaint Receipt Date:	10/03/2024
Investigation Initiation Date:	10/08/2024
Report Due Date:	12/02/2024
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:	03/23/2024
Expiration Date:	03/22/2026
Capacity:	20
Program Type:	AGED

II. ALLEGATIONS:

	Violation Established?
Facility does not have sufficient staffing.	Yes
On 10/03/2024, Resident F was locked in his room.	No
Additional Findings	Yes

III. METHODOLOGY

10/03/2024	Special Investigation Intake 2025A0466003.
10/03/2024	APS Referral Denied.
10/08/2024	Special Investigation Initiated - Face to Face On-site.
11/21/2024	Contact- document sent to admin/licensee designee Heather Rosenbrock.
11/25/2024	Contact- telephone call made to admin/licensee designee Heather Rosenbrock interviewed.
11/25/2024	Contact- documents received from admin/licensee designee Heather Rosenbrock.
11/27/224	Exit conference with admin/licensee designee Heather Rosenbrock.

**Please note: Resident coding is out of order due to coding created in SI#2023A133072 and this SIR follows that already established code.*

ALLEGATION: **Facility does not have sufficient staffing.**

INVESTIGATION:
On 10/03/2024, Complainant reported Resident F is 55 years old, lives in an assisted living facility, is disabled, and has a pacemaker, sleep apnea, claustrophobia, and high blood pressure. Complainant reported that Resident F is watching out for the other residents in the facility as two residents are "flight risks" and should not be at the facility because they require specialized care and very little staff at the facility. Complainant stated the owner or licensee designee has put the responsibility on residents, as well as direct care staff members, to monitor residents that need specialized care.

On 10/08/2024, I conducted an unannounced onsite investigation and I interviewed Resident F. When I entered his bedroom the bedroom door was open and his urinal

was completely empty. Resident F reported that the facility is too big for the number of direct care workers on shift. Resident F reported Resident B and Resident D are always trying to elope and take a lot of the time from direct care staff members.

I interviewed direct care worker (DCW) Bethany Chlupac who reported there are two direct care staff members in the building including the kitchen staff during day shift. DCW Chlupac reported that there is one direct care staff member assigned to pass medications in both this adult foster building and another separately licensed adult foster care building on the same property. DCW Chlupac reported DCWs use walkie talkies to communicate. DCW Chlupac reported that for the safety of residents and DCWs it is best to use two DCWs for all Hoyer transfers if the Hoyer is mechanical or not. DCW Chlupac reported Resident A, Resident E and Resident G all require the use of a mechanical Hoyer to assist with transfers. DCW Chlupac reported that Resident F requires the use of two DCWs due to his large size however he does have an electric Hoyer. DCW Chlupac reported that Resident B and Resident D wear wander guards and she denied that other residents are told that it is their responsibility to re-direct/supervise these two residents. DCW Chlupac reported that all residents are on two-hour checks. DCW Chlupac reported that Resident F is bossy and tells other residents what to do but no one has told him to watch or to oversee any other residents.

I interviewed DCW Paige McRoberts who reported there is always a direct care worker and a shared DCW trained in medication administration between this building and another licensed building on the property. DCW McRoberts reported that Resident C, Resident E, Resident F and Resident G all require the assistance of two care givers for personal care/transfers and they also utilize the use of a Hoyer. DCW McRoberts reported that Resident F is the only resident that has an electric Hoyer which can be used by one DCW although for safety it is better to have two DCWs since Resident F is a large individual. DCW McRoberts reported that Resident C, Resident E and Resident F use a manual Hoyer lift which require two DCWs to use the device. DCW McRoberts reported that Resident D has wandered out of the facility before (no date was provided) and she was found about a mile away in an Urgent Care parking lot by DCWs wearing her wander guard. Please note Resident D's elopement is being investigated under a different special investigation. DCW McRoberts reported that Resident D has taught Resident B how to get out of the building. DCW McRoberts reported that many of the residents redirect Resident B and Resident D but they do it on their own without being instructed to do so. DCW McRoberts reported that Resident F is upset when he wants something and he needs to wait.

I interviewed DCW Norm Rosenbrock and DCW Logan Rosenbrock who reported that the facility currently has 13 residents and has been struggling with direct care staff turnover. Both denied that residents are told to watch or redirect other residents. DCWs Norm Rosenbrock and Logan Rosenbrock reported residents that have a behavior of elopement wear wander guards including Resident B and Resident D. DCWs Norm Rosenbrock and Logan Rosenbrock reported that

Resident B and Resident D were both admitted in August 2024 and are still adjusting. DCWs Norm Rosenbrock and Logan Rosenbrock reported that if Resident B and Resident D get within 15 feet of the exit the wander guard goes off to alert staff. DCWs Norm Rosenbrock and Logan Rosenbrock both reported there is one DCW for each shift for each licensed building along with one DCW who floats between the two licensed facilities on the property. DCWs Norm Rosenbrock and Logan Rosenbrock both reported Resident A and Resident E require the assistance of two DCWs for transfers as they use a Hoyer and for some personal care needs. DCWs Norm Rosenbrock and Logan Rosenbrock reported that any resident who uses the mechanical Hoyer also requires the care of two DCWs for transfers.

I reviewed the *Staff Schedule* dated 09/15/2024-10/12/2024 with DCWs Norm Rosenbrock and Logan Rosenbrock who both reported this schedule was not up to date. DCWs Norm Rosenbrock and Logan Rosenbrock both reported that when staff call in or schedule changes are made, they communicate with the staff via phone or text message ensuring that shifts are filled. DCWs Norm Rosenbrock and Logan Rosenbrock reported that it is not a priority to make changes/update the staff schedule once they know the staffing need is met. I verified that there was one DCW scheduled per shift from 09/15/2024-10/12/2024. Additionally, except on 9/22/2024 and 10/06/2024, according to the *Staff Schedule* there was a “kitchen” staff scheduled from 10am-6pm.

On 11/25/2024, I interviewed licensee designee Heather Rosenbrock who reported Resident A, Resident C, Resident E and Resident F all require two DCWs at various times to assist with transfers and/or personal care needs. Licensee designee Heather Rosenbrock reported that Resident A, Resident C and Resident F are “young “and can help with transfers and changing therefore they do not always require the continual assistance of two DCWs for transfers and/or personal care needs. Licensee designee Heather Rosenbrock reported that Resident A and Resident D utilize a Hoyer. Licensee designee Heather Rosenbrock reported that Resident E and Resident G are older and if they are not feeling well or if they are having a bad day, they may require the assistance of two DCWs which is preferred. Licensee designee Heather Rosenbrock reported that only one “kitchen staff” works at a time from 10am-6pm. Licensee designee Heather Rosenbrock reported that she has hired two kitchen staff members however they do not work together. Licensee designee Heather Rosenbrock reported that one of the two kitchen staff members is trained as a direct care worker while the other is not trained as a direct care worker. Licensee designee Heather Rosenbrock reported that she would train the second kitchen staff as a direct care worker to meet the staffing needs of the residents. Licensee designee Heather Rosenbrock reported that some of the residents who require two-person assistance “at times” that it is documented in their assessment plans as “two-person assistance if necessary.” Licensee designee Heather Rosenbrock reported that based on assessment plans, staffing patterns were developed according to the staffing ratio requirement of 1 staff to 15 residents. Licensee designee Heather Rosenbrock reported the number of admitted residents under this license is 14 residents. Licensee designee Heather Rosenbrock reported

there are two DCWs on shift at all times for two separate adult foster care licenses, one DCW per building, with an eight-hour period when there are three DCWs for both adult foster care licenses to share.

I reviewed Resident F's *Health Care Appraisal* that documented his weight at 395 pounds. I reviewed *Health Care Appraisals* for Resident E and Resident F's and Resident E weighs 240 pounds and Resident F weighs 260 pounds which affects the ability of one DCW to transfer, change and provide personal care these three residents.

I reviewed Resident C's written *Assessment Plan for AFC Residents* which documented "2x assist if possible" for toileting and "2x assist to get into shower, 1x assist in shower if possible."

Special Investigation Report (SIR) #2023A133072 dated 11/14/2023 documented violation of Rule 400.15206(2). At the time of the investigation, direct care staff were not able to provide the supervision, protection, and personal care as identified in Resident A, D, & F's assessment plans, due to inadequate staffing. Each of these residents' assessment plans documented the need for two-person direct care staff member assistance with mobility, transfers, and personal care needs and having periods of time with only one direct care staff member working is not providing for this need, therefore a violation was established. Resident A, Resident C and Resident F documented in this investigation were also part of investigation #2023A133072. Licensee designee Heather Rosenbrock submitted a corrective action plan (CAP) dated 11/29/2023 that stated "Due to an unforeseen difficulty in trying to obtain documentation regarding the safety of a one person Hoyer transfer from outside doctors we have chosen to take an alternative corrective action plan. Therefore, going forward our policy will be when residents residing in the facility use a Hoyer and are a two assist, there will be two staff members on at all times. The CAP documented a date of achievement as 11/28/2023."

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.

ANALYSIS:	All those interviewed including licensee designee Heather Rosenbrock reported that Resident A and Resident E require the assistance of two DCWs. Additionally Resident A and Resident E's *Health Care Appraisals* noted that both weigh over 200 pounds which may impact resident safety when using only one DCW to change, transfer and/or provide personal care. All those interviewed, including licensee designee Heather Rosenbrock, reported any resident who utilizes a mechanical Hoyer (Resident A, Resident E and Resident G) requires the care of two DCWs. Based on my review of staff schedules, not all shifts have two direct care workers working at the facility at the same time. Licensee designee Heather Rosenbrock reported that some of the residents who require two-person assistance that it is documented in their assessment plans as "two-person assistance if necessary." Resident C's written *Assessment Plan for AFC Residents* documented "2x assist if possible" for toileting and "2x assist to get into shower, 1x assist in shower if possible." Based on the cumulative information and records reviewed, two direct care staff members are needed during each shift to provide personal care, transfer assistance for at least Resident A and Resident E.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [SEE SIR # 2023A1033072 dated 11/14/2023 and CAP 11/29/2023.]**

ALLEGATION: On 10/03/2024, Resident F was locked in his room.

INVESTIGATION:
On 10/03/2024 Complainant reported that Resident F had to pull the call light last night because he had a full urinal and the residents in the other rooms were making noise. Complainant reported that as a result Resident F was "locked in his room."

On 10/08/2024, I conducted an unannounced onsite investigation and I interviewed Resident F. When I entered his bedroom the bedroom door was open and his urinal was completely empty. Resident F reported that on 10/03/2024, DCW Skylar Herber was on duty and about 9:30pm/10pm Resident E had her television so loud he pulled the call light for the DCW Herber to intervene. Resident F reported that when the DCW Herber intervened, she shut his door. Resident F denied that the door was locked, however the door was shut. Resident F reported being claustrophobic and he wanted the door opened. Resident F reported that he is physically unable to get out of bed and open his bedroom door, so he called the police and his bedroom door was opened and the television across the hall was turned down.

I reviewed Resident F's record which contained a written *Assessment Plan for Adult Foster Care (AFC) Residents* which was dated 06/28/2024 and documented in the "walking" section of the report, "not ambulatory Hoyer lift for transfers."

I interviewed DCW McRoberts, Norm Rosenbrock and Logan Rosenbrock who all denied that Resident A was locked in his bedroom on 10/03/2024. DCW McRoberts, Norm Rosenbrock and Logan Rosenbrock all reported that DCW Herber shut Resident A's door and he was upset and called the police. Norm Rosenbrock and Logan Rosenbrock both reported police did not come to the facility rather they contacted licensee designee Heather Rosenbrock to inform her. Norm Rosenbrock reported meeting with Resident F about this situation. Norm Rosenbrock reported that Resident A does not want to wait when he needs assistance.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.**
ANALYSIS:	Resident F reported that on 10/03/2024 his bedroom door was not locked but closed by DCW Herber therefore there is not enough evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 10/08/2024, I conducted an unannounced investigation and I interviewed DCWs Norm Rosenbrock and Logan Rosenbrock who both reported that the *Staff Schedule* provided was not up to date. DCWs Norm Rosenbrock and Logan Rosenbrock both reported that when staff call in or schedule changes are made, they communicate with the staff via phone or text message ensuring that shifts are filled. DCWs Norm Rosenbrock and Logan Rosenbrock reported that it is not a practice to make changes/update the staff schedule once they know the staffing need is met. I had to go through the *Staff Schedule* day by day with DCWs Norm Rosenbrock and Logan Rosenbrock as not all the shifts were documented with a DCW assigned. DCWs Norm Rosenbrock and Logan Rosenbrock reported that this was because of staff that had been on the schedule but then left the position. Between 9/15/2024-10/12/2024, there were 10 days that were accurately documented according to the *Staff Schedule.*

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: (a) Names of all staff on duty and those volunteers who are under the direction of the licensee. (b) Job titles. (c) Hours or shifts worked. (d) Date of schedule. (e) Any scheduling changes.
ANALYSIS:	At the time of unannounced investigation, the *Staff Schedule* was not being updated with the name of the staff on duty. Therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:
On 10/08/2024, I conducted an unannounced investigation and I interviewed Resident F who reported that he was 55 years old. I reviewed Resident F's record which contained documentation verifying that he is 55 years old.

Based on my review of the Cascade Senior Living II facility record, I found the facility's is licensed for "aged" population and the definition of "aged" is 60 years and over.

On 11/21/2024, I did a review of the facilities file and a review of the Bureau Information Tracking System (BITS) and I found no documentation that Cascade Senior Living II had any variance approvals for the admission of any residents under 60 years.

On 11/25/2024, licensee designee Heather Rosenbrock reported that Cascade Senior Living II provides care to those that are "aged" and that is documented in her admission policy and her program statement. Licensee designee Heather Rosenbrock reported that Resident A, Resident C and Resident F are all "young," with their ages in the mid-50's. Licensee designee Heather Rosenbrock reported that after carefully looking through their files, it appears that no variances have been applied for Resident A, Resident C and Resident F.

APPLICABLE RULE	
R 400.15209	**Home records generally.**
	(1) A licensee shall keep, maintain, and make available for department review, all the following home records: **(a) Admission policy.** **(b) Program statement.**
ANALYSIS:	Resident A, Resident C and Resident F are younger than 60 years and therefore do not meet the definition of aged which is the program type that the facility is licensed. Therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend no change in license status.

Julie Elkins

11/27/2024

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Julie Elkins Date
Licensing Consultant

Approved By:

Dawn Timm

11/27/2024

_____

Dawn N. Timm Date
Area Manager