GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 3, 2025

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

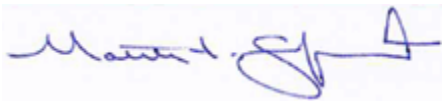
RE: License #: AL560274370
Investigation #: 2025A0360005
Cascade Senior Living II

Dear Mrs. Rosenbrock:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0100.

Sincerely,



Matthew Soderquist, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa Ave NW Unit #13
Grand Rapids, MI 49503
(989) 370-8320

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL560274370
Investigation #:	2025A0360005
Complaint Receipt Date:	11/06/2024
Investigation Initiation Date:	11/06/2024
Report Due Date:	01/05/2025
Licensee Name:	Cascade Senior Living II, Inc.
Licensee Address:	4617 Eastman Rd. Midland, MI 48640
Licensee Telephone #:	(989) 631-7299
Administrator/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. ALLEGATION(S)

	Violation Established?
Facility did not seek immediate medical attention for Resident A	No

III. METHODOLOGY

11/06/2024	Special Investigation Intake 2025A0360005
11/06/2024	APS Referral Jill Schmidt
11/06/2024	Special Investigation Initiated - Telephone APS
11/15/2024	Inspection Completed On-site Heather Rosenbrock administrator, Logan Rosenbrock home manager, DCS Bethany Chlupac
11/18/2024	Contact - Telephone call made Jen Seymour Mymichigan health
11/18/2024	Contact - Telephone call received APS Jill Schmidt
11/27/2024	Inspection Completed On-site DCS Bethany Chlupac
12/27/2024	Contact - Telephone call made Relative A
01/03/2025	Exit Conference

ALLEGATION:

Facility did not seek immediate medical attention for Resident A

INVESTIGATION:

On 11/6/24, I contacted adult protective services (APS) worker Jill Schmidt by telephone. Ms. Schmidt stated she was assigned an APS investigation due to Resident A developing pressure ulcers that went unaddressed. Ms. Schmidt stated Resident A is no longer at the facility.

On 11/15/24, I conducted an unannounced onsite inspection at the facility. The licensee designee Heather Rosenbrock stated Resident A was admitted to the facility on 8/8/24 and had numerous visits to the hospital throughout her stay. Ms. Rosenbrock stated they first noticed a small red mark on Resident A on 10/20/24. Ms. Rosenbrock stated direct care staff Bethany Chlupac noticed it while changing Resident A's brief. Ms. Rosenbrock stated Ms. Chlupac immediately notified Resident A's designated representative, Relative A, and they requested a wound assessment from MyMichigan Health. Ms. Rosenbrock stated they were notified on 10/23/24 that a wound nurse would be out on 10/25/24 to conduct a wound assessment. She stated on 10/25/24 a wound nurse from MyMichigan Health came to the facility and conducted a wound assessment. Ms. Rosenbrock stated they recommended turning and repositioning every hour. Ms. Rosenbrock stated Ms. Chlupac then started a repositioning log and provided me a copy of the log. The log documented that Resident A was repositioned every hour between 8 a.m. on 10/25/24 and 3 p.m. on 10/28/24. Ms. Rosenbrock also provided me with a timeline of major events for Resident A since her admission. The timeline documented that Relative A was notified of the sore on 10/20/24, the wound care nurse visit on 10/25/24, another wound care nurse visit on 10/28/24 and that Resident A was transported to the hospital on 10/29/24. Ms. Rosenbrock stated that they were notified that Resident A had tested positive for MRSA which she stated may have contributed to the rapid development of the pressure ulcers. Ms. Rosenbrock stated they did not hesitate to seek medical attention for Resident A.

On 11/15/24, while at the facility, I interviewed direct care staff Bethany Chlupac. Ms. Chlupac stated Resident A had been in and out of the hospital for various medical issues since she was admitted in August. She stated she first noticed some little red marks on Resident A's bottom about the size of a quarter on 10/20/24. She stated Resident A wears briefs and was checked routinely every two hours. Ms. Chlupac stated she contacted Relative A immediately on 10/20/24 and made a referral to My Michigan Health to do a wound assessment. She stated by the time the wound assessment was conducted on 10/25/24 the sores had opened despite regular monitoring and repositioning. Ms. Chlupac stated on 10/25/24 she started a repositioning log at the recommendation of the wound care nurse. She stated that they then started repositioning Resident A every hour. Ms. Chlupac stated a wound care nurse came out again on 10/28/24 and noticed no improvement in the pressure ulcers. She stated Resident A was transported to the hospital on 10/29/24 and has not returned to the facility.

On 11/18/24, I contacted Jen Seymour, wound care nurse with MyMichigan Health by telephone. Ms. Seymour stated the wounds seemed advanced from what was described to her on 10/20/24 and what she assessed on 10/25/24. She stated she

recommended turning and repositioning every hour. Ms. Seymour stated Resident A was clean and dry when she did her assessment. Ms. Seymour stated if the facility started a turning and reposition log that they must have taken her recommendations seriously. She stated she provided the facility education on changing briefs and checking for incontinence. She stated the pressure ulcers continued to advance rapidly between 10/25/24 and 10/29/24. Ms. Seymour stated she was not aware of any other residents who have had similar issues. She stated Resident A was very susceptible to pressure ulcers because of her incontinence, skin condition and dementia and not reporting pain.

On 11/18/24, I was contacted by telephone by APS worker Jill Schmidt. Ms. Schmidt stated Resident A had surgery for the pressure ulcers after being hospitalized and will not be returning to the facility. She stated Resident A did test positive for MRSA.

On 11/27/24, I conducted another unannounced onsite inspection at the facility. I observed the bathroom used for toileting Resident A to be clean. I interviewed DCS Ms. Chlupac. Ms. Chlupac confirmed that Resident A had not returned to the facility.

On 12/27/24, I contacted Relative A by telephone. Relative A stated they are still doctoring the pressure ulcers for Resident A, but she will not be returning to the facility. Relative A stated Resident A had surgery and was referred to physical therapy and is now living in another facility. She stated Resident A is getting once a week wound care. Relative A confirmed that she was contacted on 10/20/24 by Ms. Chlupac and made aware of the red sores developing on Resident A. She stated that she called the doctor and had an appointment on 10/22/24. Relative A stated the wounds seemed to advance quickly. Relative A stated Resident A had numerous medical evaluations and hospitalization while living at Cascades. She stated she was in and out of the hospital and had numerous agencies including MyMichigan Health providing care in the facility. She stated she visited the facility on at least a weekly basis and they had very good communication to try and meet Resident A’s medical needs.

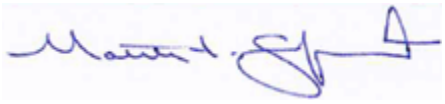
APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Interviews with Ms. Rosenbrock, Ms. Chlupac, Ms. Schmidt, Ms. Seymour, and Relative A revealed that care was obtained immediately for Resident A's sudden adverse change in physical condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 1/3/25 I conducted an exit conference with licensee designee Heather Rosenbrock. Ms. Rosenbrock concurred with the findings of the investigation.

IV. RECOMMENDATION

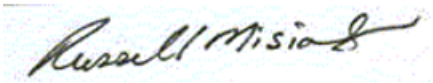
I recommend no change in the status of the license.



1/3/25

Matthew Soderquist Date
Licensing Consultant

Approved By:



1/3/25

Russell B. Misiak Date
Area Manager