GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 10th, 2025

Lisa Sikes
Valley Pines Senior Living
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410410352
Investigation #: 2025A1021029
Valley Pines Senior Living

Dear Lisa Sikes:

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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410410352
Investigation #:	2025A1021029
Complaint Receipt Date:	01/16/2025
Investigation Initiation Date:	01/17/2025
Report Due Date:	03/15/2025
Licensee Name:	Cascade Care Operations LLC
Licensee Address:	1435 Coit Ave NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 308-6915
Administrator:	DaleTron Thompson
Authorized Representative:	Lisa Sikes
Name of Facility:	Valley Pines Senior Living
Facility Address:	6117 Charlevoix Woods Ct. Grand Rapids, MI 49546-8505
Facility Telephone #:	(616) 954-2366
Original Issuance Date:	05/24/2022
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	71
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff are not following transfer requirements for Resident A.	Yes
Translator devices are not used.	No
Additional Findings	No

III. METHODOLOGY

01/16/2025	Special Investigation Intake 2025A1021029
01/17/2025	Special Investigation Initiated - Letter message sent to APS worker on allegations
01/17/2025	APS Referral referral came from APS
01/24/2025	Inspection Completed On-site
01/27/2025	Contact-Documents Received Received Resident A's documents
02/10/2025	Exit Conference

ALLEGATION:

Staff are not following transfer requirements for Resident A.

INVESTIGATION:

On 01/16/2025, the licensing department received a complaint from Adult Protective Services (APS) regarding Resident A. APS reporting source alleged Resident A is to be transferred using a gait belt and 1-2 people. APS reporting source alleged caregivers do not always transfer Resident A correctly and on 01/14/2025, Resident A suffered a skin tear due to being transferred incorrectly.

On 01/17/2025, I reached out to APS worker for additional information on the injuries of Resident A.

On 01/27/2025, I interviewed administrator DaleTron Thompson at the facility. Administrator reported Resident A is very fearful of falling and will try to grab staff

during transfers. Administrator reported Resident A is a stand pivot transfer using one person. Administrator reported on 01/24/2025, Resident A was transferred using the gait belt, Resident A tried to grab staff during the transfer, Resident A became unsteady, and staff grabbed Resident A's arm which resulted in a small skin tear. Administrator reported Resident A's family and physician were immediately notified. Administrator reported the following day, Resident A's physician came to the facility and advised no treatment on the skin tear. Administrator reported care staff are to always use the gait belt.

On 01/24/2025, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A is always transferred using the gait belt.

On 01/24/2025, I interviewed SP2 at the facility. SP2 reported Resident A requires assistance with transfers. SP2 reported care staff are to transfer Resident A using a gait belt.

On 01/24/2025, I interviewed Relative A1 at the facility. Relative A1 reported it is not certain if the gait belt was used on 01/14/2025 as Resident A has changed her story many times. Relative A1 reported she has visited Resident A at the facility and has observed staff members not using the gait belt with Resident A. Relative A1 reported since this incident, staff members are now using the gait belt.

On 01/28/2025, I obtained a written statement from SP3. The statement read,

"On 01/14/2025, I (SP3) was walking down the hall doing my rounds and I saw (Resident A) moving to her wheelchair by herself. I came into the room and she was able to fall so I grabbed her and put gait belt around her to stop the fall. While trying to put her back in her chair she hit her arm on the container that's in the window with her candy inside and received a skin tear on her left arm. She never fell to the floor because I got her into her chair."

I reviewed Resident A's service plan. The service plan read,

"(Resident A) is a 2 person transfer. Staff is to use gait belt at all times. (Resident A) will try and transfer herself to her wheelchair. Staff is to move wheelchair away from her when she is in her recliner."

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	While it is not certain if Resident A was transferred correctly on 01/14/2025, Resident A has been transferred incorrectly as

	evidenced by multiple interviews with staff members revealed no mention that Resident A was a two person assist transfer, even though Resident A's service plan indicates that she requires two person assist.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Translator devices are not used.

INVESTIGATION:

APS reporting source alleged the facility has multiple Spanish speaking employees that are to use a translator device to communicate with the residents. APS reporting source alleged the device is not always used and Resident A is unable to communicate her needs to the staff member.

Administrator reported there are staff members that speak Spanish at the facility. Administrator reported they have a translator device on them and are to use the device when interacting with the residents. Administrator reported she has not received any recent complaints on staff members not using the device.

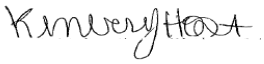
Relative A1 reported at times the staff do not initially use the device, but Resident A will prompt the caregiver to use the device to communicate. Relative A1 reported Resident A can communicate her needs and receives good care at the facility.

On 01/24/2025, I observed Spanish speaking caregivers interacting with the residents in common areas and in their rooms. I observed the caregivers using the device and resident needs were met.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level.
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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



01/28/2025

Kimberly Horst — Date
Licensing Staff

Approved By:

02/10/2025

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