GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 18, 2025

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

RE: License #: AL560274370
Investigation #: 2025A0360024
Cascade Senior Living II

Dear Heather Rosenbrock:

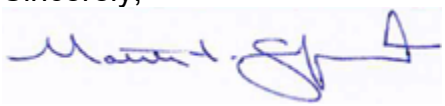
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (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 #:	2025A0360024
Complaint Receipt Date:	04/10/2025
Investigation Initiation Date:	04/14/2025
Report Due Date:	06/09/2025
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?
Resident A missed two dialysis appointments in a row and died.	Yes

III. METHODOLOGY

04/10/2025	Special Investigation Intake 2025A0360024
04/14/2025	APS Referral online
04/14/2025	Special Investigation Initiated - Letter APS compliant
04/30/2025	Inspection Completed On-site Manager Marc Capp, DCSM Regina Westley, DCSM Beth Chlupac
05/09/2025	Contact - Telephone call made Licensee Designee Heather Rosenbrock
06/16/2025	Exit Conference

ALLEGATION:

Resident A missed two dialysis appointments in a row and died.

INVESTIGATION:

On 4/30/25, I conducted an unannounced onsite inspection at the facility. The home manager Marc Capp stated Resident A was scheduled for dialysis three days a week on Monday, Wednesday, and Fridays but had refused to go. Mr. Capp stated Resident A did not have a legal guardianship and made all her own medical decisions. Mr. Capp stated that Resident A took the bus to dialysis appointments and that the staff would get her ready to go and she refused to get on the bus on 3/23, 3/24, and 3/26. Mr. Capp stated Resident A was found deceased on 3/27/25. Mr. Capp provided me with Resident A's written assessment plan, health care appraisal, resident care agreement and an incident report dated 3/27/25. The written

assessment plan and health care appraisal documented that Resident A had dialysis on Monday, Wednesday and Fridays. The incident report documented that Resident A was checked on at 8:30 a.m. on 3/27/25 then again at 10:45 a.m. to ask about lunch and she was found to be deceased on the floor and that the facility contacted 911.

While at the facility, I interviewed direct care staff member (DCSM) Bethany Chlupac by telephone. Ms. Chlupac stated Resident A had refused to go to dialysis several days because she stated she did not feel well. Ms. Chlupac stated that they would get Resident A up and ready to get on the bus but when the bus arrived Resident A refused to go. Ms. Chlupac stated Resident A did not have a legal guardianship and made all her own decisions regarding medical appointments. Ms. Chlupac stated she was working on 3/27/25 when Resident A was found deceased. She stated DCSM Regina Westley had checked on Resident A in the morning and another DCSM Jessica Westley found Resident A deceased at about 10:45 a.m.

While at the facility, I interviewed DCSM Regina Westley. Ms. Westley stated Resident A had refused to go to dialysis on 3/24/25 and so she contacted dialysis and had an appointment rescheduled for 3/25/25. Ms. Westley stated Resident A refused to go to that appointment as well. Ms. Westley stated her next shift was on 3/27/25 and had checked on Resident A at about 7:30 a.m. and recommended Resident A to go to dialysis that morning but Resident A was still refusing to go. Ms. Westley stated it looked like Resident A was suffering from the flu. Ms. Westley stated she left the facility at about 9:50 a.m. that morning before staff found Resident A deceased.

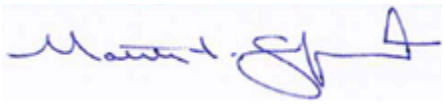
APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Interviews with Mr. Capp, Ms. Chlupac, and Ms. Westley revealed that Resident A refused to attend several dialysis appointments in a row and when her physical health declined, they did not obtain needed care immediately.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/16/25 I conducted an exit conference with licensee designee Heather Rosenbrock. Ms. Rosenbrock concurred with the findings of the investigation and stated she would submit a corrective action plan for approval. Ms. Rosenbrock also stated that Mr. Capp

is in the process of applying for his own license and has taken over daily operations of the facility.

IV. RECOMMENDATION

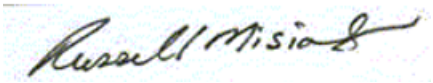
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



6/9/25

Matthew Soderquist — Date
Licensing Consultant

Approved By:



6/11/25

Russell B. Misiak — Date
Area Manager