

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Cascade Senior Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 Robinson Road Jackson, MI 49203	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2698300 Based on observation, interview, and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. Findings Include: Review of the medical record reflected R10 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease. The Minimum Data Set (MDS) reflected R10 scored 5 out of 15 (severe impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the medical record reflected R30 was admitted to the facility on [DATE], with diagnoses that included Unspecified dementia. The Minimum Data Set (MDS) reflected R30 scored 9 out of 15 (moderately impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). According to the Facility Reported Incident Report, R30 was observed grabbing R10's foot. R30 was redirected and provided bathroom assistance. During care, R30 began shouting that a staff member was attempting to rape her. Care was immediately stopped following the allegation. R30 remained fully clothed during the allegation. Both residents were assessed for injury, no injury noted. Law enforcement responded, however, was unable to obtain a statement due to residents being unable to recall the event. Review of the Facility Reported Incident Report revealed that the incident occurred on 12/4/25 at 11:00AM, and was discovered on 12/4/25 at 12:30 PM, however, the incident wasn't reported to the State Agency until 12/4/25 at 5:02 PM, past the 2-hour reporting guideline. In an interview on 12/30/25 at 11:54 am covering Nursing Home Administrator A stated that abuse allegations needed to be reported to the State Agency immediately but no longer than two hours.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Cascade Senior Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 Robinson Road Jackson, MI 49203	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Cascade Senior Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 Robinson Road Jackson, MI 49203	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2682852Based on observation, interview, and record review the facility failed to 1) ensure proper medication management, 2) accurate documentation, 3) recognize a change in condition and 4) adherence to physician orders for two (Resident #20, Resident #40) in three reviewed for quality of care. Findings include: Resident #20Review of the medical record reflected Resident #20 (R20) was admitted to the facility on [DATE] with diagnoses that included end-stage renal disease dependent on dialysis and disorder of phosphorus metabolism. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/28/25, reflected R20 scored 13 out of 15, indicating cognitive intactness, on the Brief Interview for Mental Status (BIMS), a cognitive screening tool. R20 no longer resided in the facility. Review of R20's physician orders revealed an active order for transport to dialysis on Tuesday, Thursday, and Saturday. An additional order instructed staff to notify the physician of missed dialysis appointments and obtain R20's weight. According to the dialysis center, Dialysis Employee (DE) F confirmed R20 attended dialysis on Tuesday, November 25th, and Wednesday, November 26th. No dialysis communication forms were located in the medical record, and no staff were able to explain or justify why R20's dialysis days were altered from the ordered schedule. DE F further confirmed the dialysis center was open on Thursday, November 27th. No documentation of physician notification or weights related to missed or altered dialysis appointments was located in R20's medical record. Review of the Discharge summary dated [DATE] documented R20's weight as 229 pounds. Review of the Speech Therapy evaluation dated 11/17/25 noted R20 had poor oral intake and included instructions to monitor intake. R20 was recommended a general renal diet with thin liquids, with a goal to consume 75% (percent) or greater of meals. Review of the Food Acceptance Record revealed 20 documented meal opportunities, all of which indicated R20 consumed less than 75% of meals, with the majority reflecting 0-25% consumption. No documentation was found indicating snacks or meal alternatives were offered. Review of R20's medical record revealed no Registered Dietician consultation or progress notes during the admission. Further review of weight documentation revealed only one weight was obtained during the admission, recorded on 11/26/25 at 214 pounds, reflecting a 15-pound weight loss. There was no documentation addressing the cause of the weight loss or interventions implemented to prevent further decline. Review of physician orders revealed Sevelamer HCl Oral Tablet 800 milligrams, three tablets by mouth three times daily with meals for chronic kidney disease. Sevelamer is used to treat hyperphosphatemia in patients with chronic kidney disease on dialysis. The order was active from 11/22/25 through discharge on [DATE]. Review of the November Medication Administration Record (MAR) revealed the following: on 11/22/25 and 11/23/25, two of three doses were marked as OS (see nurses' note), with the 5:00 PM dose marked as administered. On 11/24/25, all three doses were marked as OS. On 11/25/25, two of three doses were marked as OS, with the 5:00 PM dose marked as administered. On 11/26/25, all three doses were marked as OS. On 11/27/25, one of three doses was marked as OS, with the 8:00 AM and 12:00 PM doses marked as administered, and on 11/28/25, two doses were marked as administered. Nurses' notes for the above dates consistently stated, Medication not available. During an interview on 12/29/25 at 1:33 PM, Family Member (FM) I stated R20 was supposed to receive Sevelamer HCl three times daily. FM I reported being informed by the facility on 11/27/25 that R20 had not received a single dose of the medication since admission. FM I stated the former Director of Nursing reported the medication could not be delivered by the pharmacy however, after a phone call, the medication was located at a local pharmacy and available for pickup the same day. FM I further stated R20 experienced chewing and swallowing difficulties, increased confusion, and changes in mood, including depressive symptoms. FM I observed pocketed food in R20's mouth on more than one occasion and reported these concerns to the facility. FM I stated no actions were taken in response to these concerns. Review of hospital documentation dated 11/28/25-12/4/25 revealed R20 reported difficulty eating and described a clogged feeling in his throat. Hospital records also indicated R20 was admitted with skin breakdown on his buttocks, which was not present in any facility skin assessments. During an interview on 12/20/25 at 11:27 AM, the Director of Nursing (DON) B stated the facility had difficulty obtaining Sevelamer. DON B confirmed the medication was never in-house during R20's admission and acknowledged the MAR entries indicating administration were not accurate. DON B stated an investigation was initiated regarding falsification of the MAR, and staff received education. DON B further stated dialysis communication forms for R20 could not be located and acknowledged the facility was working to improve the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Cascade Senior Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 Robinson Road Jackson, MI 49203	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2682852Based on observation, interview, and record review the facility failed to maintain required dialysis coordination and communication documentation for two (Resident #20 and Resident #40) out of three reviewed for dialysis. Findings include:Resident #20Review of the medical record reflected Resident #20 (R20) was admitted to the facility on [DATE] with diagnoses that included end-stage renal disease dependent on dialysis and disorder of phosphorus metabolism. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/28/25, reflected R20 scored 13 out of 15, indicating cognitive intactness, on the Brief Interview for Mental Status (BIMS), a cognitive screening tool. R20 no longer resided in the facility.Review of R20's physician orders revealed an active order for transport to dialysis on Tuesday, Thursday, and Saturday. An additional order instructed staff to notify the physician of missed dialysis appointments and obtain R20's weight.According to the dialysis center, Dialysis Employee (DE) F confirmed R20 attended dialysis on Tuesday, November 25th, and Wednesday, November 26th. No dialysis communication forms were located in the medical record, and no staff were able to explain or justify why R20's dialysis days were altered from the ordered schedule. DE F further confirmed the dialysis center was open on Thursday, November 27th. No documentation of physician notification or weights related to missed or altered dialysis appointments was located in R20's medical record. Resident #40Review of the medical record reflected R40 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included end stage renal disease and dependance on renal dialysis. On 12/29/25 at 10:48 PM, R40 was observed in his room seated in his recliner. R40 was interview able and answered questions appropriately. R40 stated that he had been transferred to dialysis, but his schedule had been altered recently and was unsure why. Review of R20's physician orders revealed an active order for transport to dialysis on Tuesday, Thursday, and Saturday. An additional order instructed staff to notify the physician of missed dialysis appointments and obtain R40's weight.Review of R40's medical record revealed that R40 attended dialysis on Saturday, November 22nd however, was not able to complete the dialysis because the facility neglected to send R40 with the Hoyer sling, which is required to transfer the resident with the mechanical lift at the dialysis center.Review of the medical record revealed no documentation that the Physician was notified and no documentation that a weight was obtained. According to the Dialysis employee, DE F, R40 attended dialysis on Tuesday, November 25th and Friday November 28th. R40 did not attend dialysis on his dialysis day of Saturday, November 29th. No dialysis communication forms were located in the medical record, and no staff were able to explain or justify why R40's dialysis days were altered from the ordered schedule. DE F further confirmed the dialysis center was open on Thursday, November 27th. No documentation of physician notification or weights related to missed or altered dialysis appointments was located in R40's medical record. During an interview on 12/20/25 at 11:27 AM, the Director of Nursing (DON) B stated dialysis communication forms for R20 and R40 could not be located and acknowledged the facility was working to improve the dialysis communication process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Cascade Senior Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 Robinson Road Jackson, MI 49203	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2682852 Based on interview and record review, the facility failed to ensure accurate documentation for one (Resident #20) of three reviewed for accurate medical records. Findings include:Review of the medical record reflected Resident (R20) was admitted to the facility on [DATE] with diagnoses that included end-stage renal disease dependent on dialysis and disorder of phosphorus metabolism. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/28/25, reflected R20 scored 13 out of 15, indicating cognitive intactness, on the Brief Interview for Mental Status (BIMS), a cognitive screening tool. R20 no longer resided in the facility.Review of the physician's orders revealed Sevelamer HCl Oral Tablet 800 milligrams, three tablets by mouth three times daily with meals for chronic kidney disease. Sevelamer is used to treat hyperphosphatemia (excess phosphate in the blood) in patients with chronic kidney disease who are on dialysis. The order was active from the time of admission on [DATE] through discharge on [DATE].Review of the November Medication Administration Record (MAR) revealed the Sevelamer HCl Oral Tablet 800 milligrams was marked as OS (see nurses' note) for two of the three doses on 11/22/25 and 11/23/25. The 5:00 PM dose was marked as administered on both dates. Further review of the MAR reflected all three doses of Sevelamer HCl Oral Tablet 800 milligrams were marked as OS on 11/24/25.Review of the MAR revealed Sevelamer HCl Oral Tablet 800 milligrams was marked as OS for two of the three doses on 11/25/25, with the 5:00 PM dose marked as administered. Review of the MAR reflected all three doses were marked as OS on 11/26/25.Review of the MAR revealed Sevelamer HCl Oral Tablet 800 milligrams was marked as OS for one of the three doses on 11/27/25, with the 8:00 AM and 12:00 PM doses marked as administered.Review of the MAR reflected two doses of Sevelamer HCl Oral Tablet 800 milligrams were marked as administered on 11/28/25.Review of the nurses' notes for the aforementioned dates consistently stated Medication not available.During an interview on 12/29/25 at 1:33 PM, Family Member (FM) I stated that R20 was supposed to receive Sevelamer HCl three times daily. FM I stated it was brought to her attention by the facility on 11/27/25 that R20 had not received a single dose of the ordered Sevelamer since admission. FM I reported being told by the former Director of Nursing that the medication could not be delivered by the pharmacy. FM I further stated that after a phone call, the medication was located at a local pharmacy and was available for pickup the same day.During an interview on 12/30/25 at 11:27 AM, the Director of Nursing (DON) B stated the facility experienced difficulty obtaining Sevelamer. DON B stated the family raised concerns regarding the medication's availability, after which the Nursing Home Administrator contacted a local pharmacy and was able to obtain the medication that day. DON B stated he reviewed the medication cart on 11/28/25 and verified the medication was not in the facility and had not been in-house at any point during R20's admission. R20 was transferred to the local hospital on the afternoon of 11/28/25 due to a change in condition. DON B confirmed the doses of Sevelamer marked as administered on the MAR were not accurate, as the medication was never available in the facility. DON B stated an investigation was initiated regarding falsification of the MAR, and the staff involved received education.According to the National Center for Biotechnology Information (NCBI), missing doses of Sevelamer, particularly when combined with poor nutritional intake, is likely to worsen metabolic balance, which may contribute to increased confusion and lethargy.</p>		