GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 25, 2023

Darcy Quisenberry
CSM Alger Heights, LLC
1019 28th St.
Grand Rapids, MI 49507

RE: License #: AL410398969
Investigation #: 2023A0340040
Willow Creek - West

Dear Ms. Quisenberry:

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 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) 356-0183.

Sincerely,

Rebecca Piccard, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 446-5764

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410398969
Investigation #:	2023A0340040
Complaint Receipt Date:	09/08/2023
Investigation Initiation Date:	09/08/2023
Report Due Date:	11/07/2023
Licensee Name:	CSM Alger Heights, LLC
Licensee Address:	1019 28th St., Grand Rapids, MI 49507
Licensee Telephone #:	(616) 258-0268
Administrator:	Darcy Quisenberry
Licensee Designee:	Darcy Quisenberry
Name of Facility:	Willow Creek - West
Facility Address:	1011 28th St. SE, Grand Rapids, MI 49507
Facility Telephone #:	(616) 432-3074
Original Issuance Date:	11/02/2020
License Status:	REGULAR
Effective Date:	05/02/2023
Expiration Date:	05/01/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her Klonopin on 9/6/23.	**Yes**
Additional Finding	**Yes**

III. METHODOLOGY

09/08/2023	Special Investigation Intake 2023A0340040
09/08/2023	APS Referral
09/08/2023	Special Investigation Initiated - Telephone Area Agency on Aging
09/12/2023	Inspection Completed On-site
09/12/2023	Inspection Completed-BCAL Sub. Compliance
09/12/2023	Exit Conference Designee Darcy Quisenberry
09/25/2023	2nd Exit Conference Designee Darcy Quisenberry

ALLEGATION: Resident A did not receive her Klonopin on 9/6/23.

INVESTIGATION: On September 8, 2023, I received a complaint through the BCAL Online Complaints which stated that Resident A was not given her Klonopin on 9/6/23.

On September 8, 2023, I spoke with Andrea Putt from the Area Agency on Aging. She works with Resident A and informed me that there has been a "medication issue" with the pharmacy. Ms. Putt stated she was told by Resident A that there were other incidents when Resident A has gone without her medications.

On September 12, 2023, I conducted an unannounced home inspection. I spoke with Mechelle Holt who is the home nurse. She explained that Resident A's Klonopin prescription is a 30-day order and toward the end of the month when the next supply was supposed to be delivered, it wasn't. Ms. Holt stated that Resident A missed receiving her Klonopin only that one day. The pharmacy was contacted and

the Klonopin was delivered the next day. Ms. Holt stated that a meeting with the pharmacy was held in an attempt to prevent this from happening again. The home had only recently switched to Hometown Pharmacy. New owners are taking over the home and they will be switching to another pharmacy, but Ms. Holt did not know which one yet.

Ms. Holt showed me Resident A's Medication Administration Record (MAR) for September 2023. It did show that Resident A was not given her Klonopin on 9/6/23 as it was coded "11", which Ms. Holt stated meant that the prescription was not available due to the pharmacy not sending it. The MAR did not show any other missed medications for the month of September.

I then interviewed Resident A privately in her room. I identified myself and the reason for my visit. Resident A presented of sound cognitive ability. Resident A confirmed that she did not receive her Klonopin on 9/6/23 but added that there were many other days she has not received her medications. Resident A stated she believes there have been at least seven times she has not received her Klonopin but it is unknown how many times other medications have been missed.

I left Resident A's room and asked Ms. Holt to show me additional months of Resident A's MAR. I reviewed the MARs going backward from September. I counted 28 missed medications, not just Klonopin, going back to June 2023. Ms. Holt blamed the pharmacy for these missed medication administrations stating the pharmacy did not send the refills timely. I explained this was unacceptable and should have been addressed immediately with the pharmacy and not allowed to continue repeatedly for months.

On September 20, 2023, I reviewed the MAR for the month of August for all of the residents in the home. I found a total of 529 medication passes in the MAR that were coded "11", which Ms. Holt stated means the medication was unavailable due to the pharmacy not sending refills, and therefore were not passed.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	The allegation was made that Resident A was not given her Klonopin on 9/6/23. Ms. Holt stated there have been issues with the pharmacy delivering prescription refills in a timely manner and acknowledged that as a result, Resident A's Klonopin was not always administered as prescribed.

	Resident A confirmed she did not recieve her Klonopin on 9/6/23, and added there have been multiple additional occasions when medication was not passed to her. Resident A's MAR indicated multiple missed medication passes (28 dating back to June 2023), including Klonpin on 9/6/23, that were coded as being missed due to pharmacy issue. On September 20, 2023, I counted 529 medication errors for the entire home in the month of August, coded "11", being due to no medication due to pharmacy.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION: While conducting an investigation regarding medication errors, I discovered that staff did not inform Resident A's doctor of the medication errors that occurred.

On September 20, 2023, I asked nurse Me'Chelle Holt if anyone had called Resident A's doctor. She acknowledged that she did not inform Resident A's PCP regarding the issues with the pharmacy or Resident A's missed doses of medications. She stated the pharmacy was made aware and took their word that they would contact the PCP for Resident A.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	While conducting an investigation regarding medication errors, I discovered that staff did not inform Resident A's doctor of the medication errors made. On September 20, 2023, nurse Me'Chelle Holt stated that no one spoke with Resident A's PCP regarding the issues with the pharmacy or the missed doses.

CONCLUSION:	VIOLATION ESTABLISHED

On September 25, 2023, I conducted an additional exit conference to inform Ms. Quisenberry of the additional findings. I discussed with the requirements of the AFC home and how they were not being met. She understood and had no further questions.

IV. RECOMMENDATION

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

September 25, 2023

Rebecca Piccard — Date
Licensing Consultant

Approved By:

September 25, 2023

Jerry Hendrick — Date
Area Manager