GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 15, 2023

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

RE: License #: AL410398971
Investigation #: 2023A0350032
Willow Creek - East

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) 356-0100.

Sincerely,

Ian Tschirhart, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 644-9526

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410398971
Investigation #:	2023A0350032
Complaint Receipt Date:	09/07/2023
Investigation Initiation Date:	09/07/2023
Report Due Date:	10/07/2023
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 - East
Facility Address:	1019 28th St. SE, Grand Rapids, MI 49508
Facility Telephone #:	(616) 745-4675
Original Issuance Date:	08/05/2020
License Status:	REGULAR
Effective Date:	02/05/2023
Expiration Date:	02/04/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct Care Worker Elizabeth Curbelo used excessive force while transferring Resident A into his bed, causing him to hit his head against the wall.	Yes

III. METHODOLOGY

09/07/2023	Special Investigation Intake 2023A0350032
09/07/2023	Special Investigation Initiated - On Site I met with Darcy Quisenberry, Licensee Designee and Mechell Holt, Director of Wellness; I also observed Resident A
09/07/2023	Contact - Telephone call made I attempted to interview Elizabeth Curbelo but couldn't due to language barrier
09/07/2023	Contact - Telephone call made I interviewed Heather Taylor, DCW
09/07/2023	Contact - Telephone call made I spoke further with Ms. Quisenberry
09/08/2023	Contact - Document Received I received and email from Ms. Holt
09/12/2023	Contact - Telephone call made I spoke with Ms. Quisenberry and interviewed Antoinette Nyiramahirwe, DCW, with their using an interpretation app
09/13/2023	Contact - Telephone call made I spoke with Detective Rick Hebden
09/14/2023	Exit conference – Held with Darcy Quisenberry, Licensee Designee

ALLEGATION: Direct Care Worker Elizabeth Curbelo used excessive force while transferring Resident A into his bed, causing him to hit his head against the wall.

INVESTIGATION: On 09/07/2023, I made an onsite inspection and spoke with Darcy Quisenberry, Licensee Designee, and Me'chelle Holt, Director of Wellness. Ms. Quisenberry explained that Heather Taylor, Direct Care Worker (DCW) informed her that she observed Elizabeth Curbelo, DCW, being "rough" with Resident A while transferring him from his wheelchair to his bed. Because of this, Resident A hit his head against the wall. After hearing about this, Ms. Quisenberry called the police and terminated Ms. Curbelo and added that this will be reported to Adult Protective Services. Ms. Quisenberry stated that Resident A is nonverbal due to having a Traumatic Brain Injury and that he is "heavy" and "tough to handle" when transferring him. Ms. Quisenberry also informed me that Resident A will be transferred to another facility as he has become "a lot of work" for the staff. Ms. Holt reported that Antoinette Nyiramahirwe, DCW, also witnessed Ms. Curbelo transferring Resident A in a rough manner. Ms. Holt told me that she checked Resident A for injuries the same day of this incident and didn't find any. She also said that Andrea Sylvester, Nurse Practitioner from Home MD, examined Resident A for injuries and didn't note any. I requested to review Resident A's Assessment Plan, and Ms. Holt produced it. I observed that it stated that Resident A requires two-person assistant for transfers, including getting in and out of bed, chairs, cars, etc. I also asked for a copy of Ms. Sylvester's notes regarding her examination of Resident A, and Ms. Holt said that she would email them to me. I requested the telephone numbers for Ms. Curbelo, Ms. Taylor, and Ms. Nyiramahirwe, and Ms. Quisenberry provided them to me. However, I was informed that Ms. Nyiramahirwe doesn't speak English; she speaks Kinyarwandan as she is from Rwanda. They explained that staff communicate with her by using a translator app on a phone.

On 09/07/2023, I asked to see Resident A and was taken to him. Due to the severity of his cognitive impairment from his Traumatic Brain Injury and resultant verbal impairment, I was unable to interview Resident A. However, I did look at his head, which had no hair, and did not observe any bumps, bruises, or red marks.

On 09/07/2023, I called Ms. Curbelo, who answered the phone, but then a male came on the phone and said that they don't speak English and asked if I speak Spanish. I answered, "No Espanol," and the call was ended.

On 09/07/2023, I called and spoke with Ms. Taylor and asked her to describe what happened during the incident in which Resident A hit his head. Ms. Taylor reported that she walked into the sitting room and saw Resident A on the floor and Ms. Curbelo changing his adult briefs in front of other residents. She asked Ms. Curbelo how Resident A got on the floor, and she told her that he "scooched out of his (wheel)chair." Ms. Taylor also told me that another resident was helping Ms. Curbelo by holding Resident A's wheelchair while she was trying to get him back into it. Ms. Taylor stated that she went to get Ms. Nyiramahirwe and all three of them got Resident A back into his wheelchair and took him to his room to put him in his bed. Ms. Taylor said that she and Ms. Nyiramahirwe were holding Resident A's feet while Ms. Curbelo held his upper body. Ms. Taylor told me that while they were putting Resident A in his bed, Ms. Curbelo kept pushing him, causing his head to hit the wall

about three times, even though he was already far enough in his bed. Ms. Taylor stated that after this, she called Monique Jackson, Home Manager, and told her about this incident. Ms. Taylor informed me that it confused her why Ms. Curbelo was trying to change and transfer Resident A by herself when both of these activities require two-staff assistance.

On 09/07/2023, I called and spoke with Ms. Quisenberry further. I asked her when Ms. Nyiramahirwe worked next so that I could ask questions to a staff member who could then use the translator app to ask the questions to Ms. Nyiramahirwe. Ms. Quisenberry said that she worked next Tuesday (09/12) and that she would be the one who will ask Ms. Nyiramahirwe my questions through the translator app.

On 09/08/2023, I received an email from Ms. Holt with Ms. Sylvester's House Call Services notes pertaining to this incident. Ms. Sylvester wrote in her report: "There are no acute abnormalities that can be visualized on exam and director of facility reports a full assessment was completed as well after assult accusation and no abnormalities were noted either. Vital signs checked. Blood pressure is 102/62 mmHg and heart rate is 46 bpm. Amlodipine discontinued and patient continues to be monitored [sic]."

On 09/12/2023, I called and spoke with Ms. Quisenberry, who had Ms. Nyiramahirwe in her office so that I could ask questions and Ms. Quisenberry would repeat my questions into an interpretation app on a phone for Ms. Nyiramahirwe to read. Then Ms. Nyiramahirwe would speak her answers using the same app, which interpreted them into English. I first introduced myself to Ms. Nyiramahirwe and then asked her to tell me about the incident on 09/05 when she, Ms. Curbelo and Ms. Taylor transferred Resident A into his bed. Ms. Nyiramahirwe stated that she witnessed Ms. Curbelo punch Resident A in his ribs. She reported that Ms. Curbelo called out to other staff (her and Ms. Taylor) to come assist her with Resident A. Ms. Nyiramahirwe said that when she got to them, she observed Resident A on the floor and Ms. Curbelo changing his briefs. She informed me that all the while Ms. Curbelo was changing Resident A, she was speaking harshly to him, yelling at him to "Stand up, stand up," and Resident A was crying. Ms. Nyiramahirwe said that changing Resident A's briefs requires two staff, but Ms. Curbelo was doing it by herself. Ms. Nyiramahirwe reported that Ms. Curbelo told her that Resident A had slid out of his wheelchair. Ms. Nyiramahirwe stated that she had Ms. Taylor help Ms. Curbelo get Resident A back into his wheelchair and then take him to his room to put him in his bed. Ms. Nyiramahirwe then said that while they were putting Resident A in his bed, Ms. Curbelo shoved him such that he hit his head against the wall three times and that it was not accidental. Ms. Nyiramahirwe stated that she told Ms. Curbelo that she needed to take better care of Resident A, but Ms. Curbelo just shrugged her shoulders in response. Ms. Nyiramahirwe reported that immediately after this incident, she and Ms. Taylor spoke in private about it and it was decided that Ms. Taylor would call the Home Manager and tell her about it, which she did, and the Home Manager came there to find out what happened. After I was finished interviewing Ms. Nyiramahirwe, I asked Ms. Quisenberry for the detective's name

and phone number who was investigating this complaint, and she provided the information to me.

On 09/13/2023, I called and spoke with Detective Rick Hebden, who was assigned to investigate this complaint. I told him I interviewed Ms. Nyiramahirwe and Ms. Taylor, but when I called Ms. Curbelo I was informed that she did not speak English. As I do not speak Spanish, which is the language she speaks, I could not proceed with the interview. Detective Hebden informed me that when someone from his department who speaks Spanish called to speak with Ms. Curbelo, the number was disconnected. I verified that it was the same number I called. Detective Hebden told me that he obtained written statements from Ms. Taylor and Ms. Nyiramahirwe, whose was written in a Rwandan language. He said that someone from his office was working on translating Ms. Nyiramahirwe's written statement.

On 09/14/2023, I conducted an exit conference with Darcy Quisenberry, Licensee Designee. I informed Ms. Quisenberry that I was citing a violation of this rule. Ms. Quisenberry accepted this finding and had no further comment other that to say that it was "unfortunate" that this occurred.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Two Direct Care Workers, Heather Taylor and Antoinette Nyiramahirwe, observed their co-worker, Elizabeth Curbelo use excessive force on Resident A when transferring him into his bed, causing him to hit his head against the wall three times. There were no injuries; however, Ms. Curbelo's employment was terminated. Due to the severity of his cognitive impairment from his Traumatic Brain Injury, and resultant verbal impairment, I was unable to interview Resident A. I attempted to interview Ms. Curbelo by telephone, but a male took the phone from her and said they do not speak English, and asked if I spoke Spanish. I told him I didn't and the call was ended. I spoke with Detective Hebden who informed me that someone from his office who speaks Spanish attempted to speak with Ms. Curbelo on the phone, but the number was disconnected.

	My findings support that this rule had been violated.
CONCLUSION:	**VIOLATION ESTABLISHED**

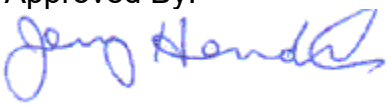
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend that the status of this home's license remain unchanged, and that this special investigation be closed.

September 14, 2023

Ian Tschirhart — Date
Licensing Consultant

Approved By:



September 15, 2023

Jerry Hendrick — Date
Area Manager