GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 30, 2024

Marcia Curtiss
CSM Alger Heights, LLC
1019 28th St.
Grand Rapids, MI 49507

RE: License #: AL410398969
Investigation #: 2024A0583036
Willow Creek - West

Dear Mrs. Curtiss:

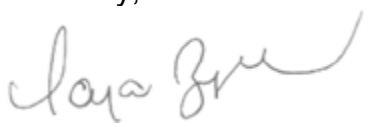
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410398969
Investigation #:	2024A0583036
Complaint Receipt Date:	05/21/2024
Investigation Initiation Date:	05/22/2024
Report Due Date:	06/20/2024
Licensee Name:	CSM Alger Heights, LLC
Licensee Address:	1019 28th St. Grand Rapids, MI 49507
Licensee Telephone #:	(616) 258-0268
Administrator:	Marcia Curtiss
Licensee Designee:	Marcia Curtiss
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, AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility staff administered the wrong medication to Resident A.	No
Additional Findings	Yes

III. METHODOLOGY

05/21/2024	Special Investigation Intake 2024A0583036
05/22/2024	APS Referral APS Marques McLemore
05/22/2024	Special Investigation Initiated - Letter APS Marques McLemore
05/24/2024	Inspection Completed On-site
05/29/2024	Exit Conference Licensee Designee Marcia Curtiss

ALLEGATION: Facility staff administered the wrong medication to Resident A.

INVESTIGATION: On 05/21/2024 I received a complaint allegation from the BCAL online reporting system which alleged that on 05/21/2024 facility staff “gave more than double dose of long-acting insulin and then took blood sugar after”.

On 05/22/2024 I emailed the complaint allegation to Adult Protective Services (APS) staff Marques McLemore who confirmed that he has an open investigation with Resident A.

On 05/23/2024 I interviewed staff Mario Abney via telephone. Mr. Abney stated that on 05/21/2024 at approximately 8:00 AM he checked Resident A’s blood sugar and then provided Resident A with his “Humalog”. Mr. Abney stated that Resident A injected the medication into his stomach. Mr. Abney stated that he did not administer the wrong medication and did not administer an incorrect amount.

On 05/23/2024 I spoke with Kristina Bagley via telephone. Ms. Bagley stated that she is Resident A’s guardian. Ms. Bagley stated that Resident A has been diagnosed with a developmental disability and displays a low Intellectual Quotient. Ms. Bagley stated that Resident A often gets his medications mixed up and doesn’t understand which medication is which.

On 05/24/2024 I completed a scheduled onsite investigation at the facility and interviewed staff Ericka Zoerhof and Resident A.

Staff Ericka Zoerhof stated that Resident A is prescribed a Humalog injection daily at 8:00 AM. Ms. Zoerhof stated that on 05/21/2024 at approximately 8:00 AM staff Mario Abney was assigned the task of administering Resident A's Humalog. Ms. Zoerhof stated that she directly observed the Humalog injection pen that staff Mario Abney provided to Resident A right after the injection. Ms. Zoerhof stated that Resident A did not receive "Lantis" and was provided the correct medication and dosage. Ms. Zoerhof stated that she observed Resident A after the injection, and he presented with no ill effects.

Resident A stated that on 05/21/2024 staff Mario Abney provided Resident A with an injection pen of Lantis and Resident A administered the injection himself. Resident A stated that Mr. Abney took Resident A's diabetic sugar reading after the administration of Lantis. Resident A stated that he should not have received Lantis but instead should have received Humalog. Resident A was adamant that he received the wrong medication. Resident A stated that staff Ericka Zoerhof was present during the incident and informed Resident A that he did receive the correct medication and dosage.

While onsite I observed Resident A's Medication Administration Record. I observed that Resident A is prescribed "HumaLOG 100 UNIT/ML KWIKPEN 100UNIT/ML INJECT 10 UNITS SUBCUTANEOUSLY THREE TIMES DAILY WITH MEALS (HOLD IF BLOOD GLUCOSE LESS THAN 100)". This document indicated that Resident A received Humalog on 05/21/2024 at 8:00 AM administered by staff Mario Abney. This document indicated that Mr. Abney measured Resident A's glucose as 143 at 8:00 AM.

On 05/29/2024 I completed an Exit Conference with Licensee Designee Marcia Curtiss via telephone. Ms. Curtiss stated that she had nothing to add to the Special Investigation report until after she read the report.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Staff Mario Abney stated that on 05/21/2024 at approximately 8:00 AM he checked Resident A's blood sugar and then provided Resident A with his Humalog injection pen. Mr. Abney stated that Resident A injected the medication into his stomach. Staff Ericka Zoerhof stated that Resident A is prescribed a Humalog injection daily at 8:00 AM. Ms. Zoerhof stated that on 05/21/2024 at approximately 8:00 AM she observed the Humalog injection pen that staff Mario Abney provided to Resident A right after the injection.

	Resident A's Medication Administration Record indicates that Resident A is prescribed "HumaLOG 100UNIT/ML KWIKPEN 100 UNIT/ML INJECT 10 UNITS SUBCUTANEOUSLY THREE TIMES DAILY WITH MEALS (HOLD IF BLOOD GLUCOSE LESS THAN 100)". This document indicated that Resident A received Humalog on 05/21/2024 at 8:00 AM administered by staff Mario Abney and that Mr. Abney measured Resident A's glucose as 143 at 8:00 AM. A preponderance of evidence was not discovered during the course of the Special Investigation to substantiate violation of the applicable rule
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Resident A administers his own prescribed injections.

INVESTIGATION: On 05/23/2024 I interviewed staff Mario Abney via telephone. Mr. Abney stated that on 05/21/2024 at approximately 8:00 AM he checked Resident A's blood sugar and then provided Resident A with his Humalog injection pen. Mr. Abney stated that Resident A injected the medication into his stomach which is Resident A's usual practice.

On 05/24/2024 I completed a scheduled onsite investigation at the facility and interviewed staff Ericka Zoerhof and Resident A.

Staff Ericka Zoerhof stated that Resident A is prescribed Humalog injections and administers the medication himself. Ms. Zoerhof stated that she was unaware that residents may not administer their own prescription injections without the approval of a physician in writing. Ms. Zoerhof confirmed that the facility has not obtained a physician's approval in writing to allow Resident A to administer his own prescription injections.

Resident A stated that he routinely administers his own prescription injections.

On 05/29/2024 I completed an Exit Conference with Licensee Designee Marcia Curtiss via telephone. Ms. Curtiss stated that she had nothing to add to the Special Investigation report until after she read the report but she would submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.15312	**Resident medications.**

	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.
ANALYSIS:	Staff Ericka Zoerhof stated that Resident A is prescribed Humalog injections and administers this medication himself. Ms. Zoerhof stated that she was unaware that residents may not administer their own prescription injections without the approval of a physician in writing and confirmed that the facility has not obtained a physician's approval in writing to allow Resident A to administer his own prescription injections. Resident A stated that he routinely administers his own prescription injections. A preponderance of evidence was discovered during the course of the Special Investigation to substantiate violation of the applicable rule; Resident A administers his own prescription injections without the written approval of his physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend that the license remain unchanged.

05/29/2024

Toya Zylstra — Date
Licensing Consultant

Approved By:

05/30/2024

Jerry Hendrick — Date
Area Manager