GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 7, 2024

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

RE: License #: AL410384527
Investigation #: 2025A0583003
Alger Heights - North

Dear Mrs. Curtiss:

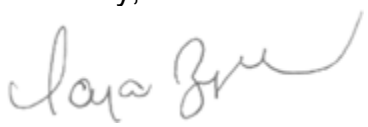
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL410384527
Investigation #:	2025A0583003
Complaint Receipt Date:	10/25/2024
Investigation Initiation Date:	10/25/2024
Report Due Date:	11/24/2024
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:	Alger Heights - North
Facility Address:	1015 28th St. SE Grand Rapids, MI 49548
Facility Telephone #:	(616) 229-0427
Original Issuance Date:	10/25/2016
License Status:	REGULAR
Effective Date:	04/25/2023
Expiration Date:	04/24/2025
Capacity:	17
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff do not administer Resident A's insulin as prescribed.	Yes
On 10/24/2024, facility staff sent Resident A's unknown prescription medications in an unlabeled baggie to Resident A's day program.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/25/2024	Special Investigation Intake 2025A0583003
10/25/2024	Special Investigation Initiated - Letter
10/29/2024	Inspection Completed On-site
10/30/2024	APS Referral
11/07/2024	Exit Conference Licensee Designee Marcia Curtiss

ALLEGATION: Facility staff do not administer Resident A's insulin as prescribed.

INVESTIGATION: On 10/25/2024 complaint allegations were received from Adult Protective Services via LARA-BCHS-Complaints. The complaint alleged that "(Resident A) made the statements that she feels neglected because the AFC is not checking her blood sugars like they should" and (Resident A) is "without her insulin all together".

On 10/29/2024 I completed an unannounced onsite investigation at the facility and privately interviewed Regional Clinical Director Jeannine Hayes, staff Iesha Cummings, and Resident A.

Regional Clinical Director Jeannine Hayes stated that Resident A was admitted to the facility on 10/18/2024 and Resident A's current physician's order for insulin is written as an "as needed order". Ms. Hayes stated that the current insulin order does not alert staff to check Resident A's insulin and administer the medication because it is not a regularly scheduled medication based on the wording of the order. Ms. Hayes stated that Resident A's current nurse practitioner is Andrea Sylvester of Home MD health care services. Ms. Hayes stated that Ms. Sylvester writes medication orders and sends the order directly to the pharmacy and the pharmacy adds the order to the Medication Administrator Record exactly as written.

Staff Iesha Cummings stated that Resident A's NovoLOG FLEXPEN 100 UNIT/ML (insulin) is currently written as an "as needed" order. Ms. Cummings stated that staff are not alerted to check Resident A' blood sugar regularly because Resident A's Medication Administration Record does not alert staff to as needed medications.

Resident A stated that she is prescribed insulin. Resident A stated that facility staff report that Resident A's Medication Administration Record does not direct staff to administer Resident A's inulin because the medication is an as needed medication. Resident A stated that she has asked that facility staff to check her blood sugar levels on multiple occasions last week, and administer her insulin, however staff have refused to do so stating that the "MAR" doesn't direct them to do so.

While onsite I reviewed Resident A's Medication Administration Record, which indicates that Resident A is prescribed NovoLOG FLEXPEN 100 UNIT/ML "inject 3 units subcutaneously three times daily with meals as need if blood sugar is greater than 250" starting 10/11/2024. I observed that Resident A has not received this medication since being admitted to the facility on 10/18/2024.

On 10/30/2024 I received an email from licensee designee Marcia Curtiss. The email contained an attachment of Resident A's Medication Administration Record. I observed that the MAR stated that on 10/29/2024 Resident A's NovoLOG FLEXPEN 100UNIT/ML was changed to a regularly scheduled dosage rather than as needed. I observed that the email stated the following: *"There is a new order that was written yesterday (10/29/2024) and it is on the MAR. The other Novolog that was there has now been dc'd as it was a prn order. There was no order to check the blood sugar prior until yesterday".*

On 10/31/2024 I interviewed staff Iesha Cummings via telephone. Ms. Cummings stated that Resident A's NovoLOG FLEXPEN 100 UNIT/ML "inject 3 units subcutaneously three times daily with meals as needed if blood sugar is greater than 250" started on 10/11/2024 and Resident A moved to the facility on 10/18/2024. Ms. Cummings stated that this medication was ordered on an as needed basis. Ms. Cummings stated that "last week Tuesday or Thursday," Resident A did request to have her blood sugar checked and asked that she be administered her NovoLOG based on her blood sugar levels. Ms. Cummings stated that she did not check Resident A's blood sugar level and did not administer Resident A's NovoLOG because Resident A "had only been here for a week" and Resident A's MAR indicated the medication was as needed.

On 10/30/2024 I completed a LARA file review for facility AL410384527. I observed that Special Investigation 2024A035606 (completed 11/30/2023) indicated that this facility was found to be in violation of R 400.15312 (1) because a preponderance of evidence indicated that a resident's medication, Carbidopa/Levodopa, was not being administered as prescribed.

On 11/07/20214 I completed an exit conference with licensee designee Marcia Curtiss via telephone. Ms. Curtiss stated that she had no information to add to the report but would read the report and contact me if she had additional information or questions.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Resident A's Medication Administration Record indicates that Resident A was prescribed NovoLOG FLEXPEN 100 UNIT/ML "inject 3 units subcutaneously three times daily with meals as needed if blood sugar is greater than 250" from 10/11/2024 until 10/28/2024. Resident A's MAR indicates that Resident A did not receive this medication from her admission date of 10/18/2024 until 10/28/2024. Staff Iesha Cummings stated that Resident A's NovoLOG FLEXPEN 100 UNIT/ML "inject 3 units subcutaneously three times daily with meals as need if blood sugar is greater than 250" started on 10/11/2024 and Resident A moved to the facility on 10/18/2024. Ms. Cummings stated that the medication was ordered on an as needed basis. Ms. Cummings stated that "last week Tuesday or Thursday" Resident A did request to have her blood sugar checked and asked that she be administered her NovoLOG based on her blood sugar levels. Ms. Cummings stated that she did not check Resident A's blood sugar level and did not administer Resident A's NovoLOG because Resident A "had only been here for a week" and Resident A's MAR indicated the medication was as needed. Resident A stated that she is prescribed insulin and that facility staff report that Resident A's Medication Administration Record does not direct staff to administer Resident A's inulin because the medication is an as needed medication. Resident A stated that she has asked facility staff to check her blood sugar levels

	on multiple occasions last week, and administer her insulin, however staff have refused to do so. A preponderance of evidence supports that a violation of the applicable rule occurred. Resident A was prescribed NovoLOG (insulin) as needed from 10/11/2024 until 10/28/2024. Resident A requested this medication but was denied administration by facility staff. Staff Iesha Cummings stated that Resident A requested the medication "last week Tuesday or Thursday" however Ms. Cummings acknowledged she did not administer the medication.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **2024A035606 11/30/2023**

ALLEGATION: On 10/24/2024, facility staff sent Resident A's unknown prescription medications in an unlabeled baggie to Resident A's day program.

INVESTIGATION: On 10/25/2024 complaint allegations were received from Adult Protective Services via LARA-BCHS-Complaints. The complaint alleged that "on 10/24/24, Resident A went to Sara Care with three pills in a baggie" and "Sara Care won't take them if they aren't labeled properly".

On 10/29/2024 I completed an unannounced onsite investigation at the facility and privately interviewed Regional Director of Clinical Services Jeanine Hayes, staff Iesha Cummings, and Resident A.

Regional Director of Clinical Services Jeanine Hayes stated that after residents are out of the facility, staff are required to pack residents' medications with the medications' name and instructions for administration. Ms. Hayes stated that staff are not permitted to send residents' medications out of the facility in unlabeled baggies. Ms. Hayes stated that staff Jeanpierre Mfitumukiza worked at the facility and passed medications on 10/24/2024. Ms. Hayes stated that she had no direct information regarding the 10/24/2024 complaint allegation.

Staff Iesha Cummings stated that Resident A was admitted to the facility on 10/18/2024. Ms. Cummings stated that she did not work at the facility on 10/24/2024 and has no knowledge of the alleged incident. Ms. Cummings stated that she is trained to administer residents' medications while they are at the facility however, she has not been trained regarding the proper protocol to pack residents' medications when they leave the facility.

Resident A stated that on 10/24/2024 she attended her day program called Sara Care. Resident A stated that she attends her day program in the morning and returns after lunch in the afternoons. Resident A stated that on 10/24/2024 a staff whose name she could not recall, packed her medications in a baggie, and sent the

medications with Resident A to her day program. Resident A stated that the proper manner for packing Resident A's medications while she out of the facility consists of packing the medications in their original pharmacy blister pack placed in a manilla envelope.

While onsite I observed Resident A's Medication Administration Record, which indicated that on 10/24/2024 staff Jeanpierre Mfitumukiza passed all of Resident A's medications during his scheduled first shift from 7:00 AM until 3:00 PM. The document indicated that Resident A is prescribed Magnesium TAB 250 1 tablet at noon and the document indicated that this medication was administered by Mr. Mfitumukiza on 10/24/2024. The document does not indicate that Resident A was out of the facility on 10/24/2024 and her prescription medications were packed.

On 10/30/2024 I received an email from Regional Director of Clinical Services Jeannine Hayes. The email stated, "(Resident A) goes to Sarah Care on Tuesdays and Thursdays, she leaves between 9:00am – 9:30am, and returns around 3:00pm".

On 10/30/2024 I interviewed Heather Gauger via telephone. Ms. Gauger stated that she is the Executive Director of Sara Care Day Program. Ms. Gauger stated that on 10/24/2024 Resident A arrived at the facility with a baggie containing three unlabeled pills. Ms. Gauger stated that day program staff will not administer medications that are not labeled. Ms. Gauger stated that she did not know what the pills contained. Ms. Gauger stated that facility staff must send Resident A's prescribed medications in the pharmacy blister package that is labeled with the name of the medication, dosage, and instructions. Ms. Gauger stated that Sara Care staff have informed facility staff in the past of the requirement to label and properly contain the medications Resident A transports for Sara Care staff to administer.

On 11/04/2024 I interviewed staff Jeanpierre Mfitumukiza via telephone. Mr. Mfitumukiza stated that he administered Resident A's medications while he worked on 10/24/2024 from 7:00 AM until 3:00 PM. Mr. Mfitumukiza stated that on 10/24/2024 Resident A attended her day program which resulted in Resident A being off sight during her scheduled "noon" medication administration. Mr. Mfitumukiza stated that he packed "three pills" into a small bag typically used to crush unused medications and wrote the "date and time" the medications should be administered to Resident A on the top of the bag. Mr. Mfitumukiza stated that he sent the bag with Resident A to her day program. Mr. Mfitumukiza stated that he did not write the names of the medications he placed in the bag, and he could not recall the names of the pills placed in the bag.

On 11/07/20214 I completed an exit conference with licensee designee Marcia Curtiss via telephone. Ms. Curtiss stated that she had no information to add to the report but would read the report and contact me if she had additional information or questions.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(5) When a resident requires medication while out of the home, a licensee shall assure that the resident or, in the alternative, the person who assumes responsibility for the resident has all of the appropriate information, medication, and instructions.
ANALYSIS:	Resident A stated that on 10/24/2024 a staff whose name she could not recall, packed her medications in a baggie, and sent the medications with Resident A to her day program. Heather Gauger, Executive Director of Sara Care Day Program, stated that on 10/24/2024 Resident A arrived at the facility with a baggie containing three unlabeled pills. Ms. Gauger stated that she did not know what the pills contained and they were not passed. Staff Jeanpierre Mfitumukiza stated that on 10/24/2024 Resident A attended her day program which resulted in Resident A being off sight during her scheduled “noon” medication administration. Mr. Mfitumukiza stated that he packed “three pills” into a small bag and wrote the “date and time” the medications should be administered to Resident A on the top of the bag. Mr. Mfitumukiza stated that he sent the bag with Resident A to her day program. Mr. Mfitumukiza stated that he did not write the names of the medications he placed in the bag, and he could not recall the names of the pills placed in the bag. A preponderance of evidence supports that a violation of the applicable rule occurred. Staff Jeanpierre Mfitumukiza placed Resident A’s unknown prescribed medications into an unlabeled bag and sent the medication to her day program. Facility staff failed to assure that Resident A’s medications were secured with the appropriate information, medication, and instructions while Resident A was out of the facility on 10/24/2024.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING: Resident A was admitted to the facility on 10/18/2024 and facility staff failed to complete an assessment plan.

INVESTIGATION: On 10/29/2024 I completed an unannounced onsite investigation at the facility. I interviewed Kelly McCann who identified her title to be “Regional

Operations Director". Ms. McCann stated that Resident A previously resided at AM410384528 / Alger Heights – South until Resident A was admitted to the current facility on 10/18/2024. Ms. McCann stated that the facility has not completed a new assessment plan for Resident A since she was admitted to the current facility on 10/18/2024.

On 11/07/20214 I completed an exit conference with licensee designee Marcia Curtiss via telephone. Ms. Curtiss stated that she had no information to add to the report but would read the report and contact me if she had additional information or questions.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Kelly McCann, Regional Operations Director, stated that Resident A previously resided at AM410384528 / Alger Heights – South until being admitted to the current facility on 10/18/2024. Ms. McCann stated that the move to the current facility was a planned move. Ms. McCann stated that the facility has not completed a new assessment plan for Resident A since her admittance to the current facility on 10/18/2024. A preponderance of evidence supports that a violation of the applicable rule occurred. Resident A was admitted to the facility on 10/18/2024 for a planned move and since that time facility staff have failed to complete a Resident Assessment Plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING Resident A was admitted to the facility on 10/18/2024 and facility staff failed to complete a Resident Care Agreement.

INVESTIGATION: On 10/29/2024 I completed an unannounced onsite investigation at the facility. I interviewed Kelly McCann who identified her title to be "Regional

Operations Director". Ms. McCann stated that Resident A previously resided at AM410384528 / Alger Heights – South until Resident A was admitted to the current facility on 10/18/2024. Ms. McCann stated that the move to the current facility was a planned move. Ms. McCann stated that the facility has not completed a new Resident Care Agreement for Resident A since her admittance to the current facility on 10/18/2024.

On 11/07/20214 I completed an exit conference with licensee designee Marcia Curtiss via telephone. Ms. Curtiss stated that she had no information to add to the report but would read the report and contact me if she had additional information or questions.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(6) At the time of a resident's admission, a licensee shall complete a written resident care agreement. A resident care agreement is the document which is established between the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee and which specifies the responsibilities of each party. A resident care agreement shall include all of the following: (a) An agreement to provide care, supervision, and protection, and to assure transportation services to the resident as indicated in the resident's written assessment plan and health care appraisal. (b) A description of services to be provided and the fee for the service. (c) A description of additional costs in addition to the basic fee that is charged. (d) A description of the transportation services that are provided for the basic fee that is charged and the transportation services that are provided at an extra cost. (e) An agreement by the resident or the resident's designated representative or responsible agency to provide necessary intake information to the licensee, including health-related information at the time of admission. (f) An agreement by the resident or the resident's designated representative to provide a current health care appraisal as required by subrule (10) of this rule. (g) An agreement by the resident to follow the house rules that are provided to him or her.

	(h) An agreement by the licensee to respect and safeguard the resident's rights and to provide a written copy of these rights to the resident. (i) An agreement between the licensee and the resident or the resident's designated representative to follow the home's discharge policy and procedures. (j) A statement of the home's refund policy. The home's refund policy shall meet the requirements of R 400.15315. (k) A description of how a resident's funds and valuables will be handled and how the incidental needs of the resident will be met. (l) A statement by the licensee that the home is licensed by the department to provide foster care to adults.
ANALYSIS:	Kelly McCann, Regional Operations Director, stated that Resident A previously resided at AM410384528 / Alger Heights – South until Resident A was admitted to the current facility on 10/18/2024. Ms. McCann stated that the move to the current facility was a planned move. Ms. McCann stated that the facility has not completed a new Resident Care Agreement for Resident A since her admit to the current facility on 10/18/2024. A preponderance of evidence supports that a violation of the applicable rule occurred. Resident A was admitted to the facility on 10/18/2024 for a planned move and since that time facility staff have failed to complete a Resident Care Agreement.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

11/07/2024

Toya Zylstra, Licensing Consultant Date

Approved By:

11/07/2024

Jerry Hendrick, Area Manager Date