STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

November 7, 2024

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

RE: License #: AL410398971
Investigation #: 2025A0583004
Willow Creek - East

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 #:	AL410398971
Investigation #:	2025A0583004
Complaint Receipt Date:	10/31/2024
Investigation Initiation Date:	10/31/2024
Report Due Date:	11/30/2024
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 - 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, AGED, ALZHEIMERS, MENTALLY ILL, DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Facility staff failed to notify Resident A’s legal guardian of Resident A’s leg fracture which required hospitalization.	No
Additional Findings	Yes

III. METHODOLOGY

10/31/2024	Special Investigation Intake 2025A0583004
10/31/2024	APS Referral
10/31/2024	Special Investigation Initiated - Letter Regional Director of Clinical Services
11/06/2024	Onsite Resident Care Manager Aimee Nelson
11/07/2024	Exit Conference Licensee Designee Marcia Curtiss

ALLEGATION: Facility staff failed to notify Resident A’s legal guardian of Resident A’s leg fracture which required hospitalization.

INVESTIGATION: On 10/31/2024 complaint allegations were received from Adult Protective Services Centralized Intake. Complaint allegations were screened out for formal Adult Protective Services investigation. The complaint stated the following: *“(Resident A) (67) resides at Care Cardinal Alger Heights. (Resident A) has been diagnosed with a cerebral palsy. (Relative 1) is (Resident A's) legal guardian. On 10/31/2024 at 1213a, (Resident A) presented to the hospital with a chief complaint of leg pain. (Resident A) was observed with a femur fracture, significant bruising/swelling to her right leg. The hospital contacted (Resident A's) legal guardian and she advised that she had not been made aware by the facility of any injuries or falls that (Resident A) sustained. There is a concern that (Resident A) sustained a fall that went unreported by the staff of Care Cardinal”.*

On 10/31/2024 I received an email from Jeannine Hayes, Regional Director of Clinical Services. The email contained an Incident Report signed 10/31/2024 and indicated that Relative 1 was notified of Resident A’s hospitalization on 10/31/2024 at 12:00 AM. The Incident Report stated that on 10/30/2024 at 11:30 PM staff observed “swelling of right leg and resident complained of pain in leg”. The document further stated that “PACE” staff were called to the facility to examine

Resident A's leg and after their evaluation Resident A was sent to the Emergency Department where Resident A was diagnosed with a right femur fracture.

On 11/01/2024 I received an email from Jeannine Hayes, Regional Director of Clinical Services. The email stated the following: *"Shauntrice contacted the guardian at 12am on 10/31/24 when she was sent out. A investigation was started immediately yesterday morning after being notified by the hospital of the fx and is ongoing as to how the injury occurred. I have attached the chart notes showing that a nurse from PACE saw her on 10/29/24, also on 10/29/24 it was noted that her knee was painful and swollen, PACE contacted. On 10/30/24 at 11pm leg noted to be swollen, PACE called, nurse came out to evaluate, instructed to send resident to hospital at 11:30pm. Resident was sent to ER and guardian notified at 12am".*

On 11/01/2024 I interviewed staff Sunantra Harris via telephone. Ms. Harris stated that she worked at the facility from 10/30/2024 11:00 PM until 10/31/2024 7:00 AM. Ms. Harris stated that when she arrived at the facility at 11:00 PM, second shift staff Benjila Green immediately asked Ms. Harris to observe Resident A's right leg. Ms. Harris stated that Resident A was in her bed and Resident A was "moaning and groaning" in pain. Ms. Harris observed that Resident A's right leg was "noticeably swollen" and "yellow" in color. Ms. Harris stated that Ms. Green reported that Ms. Green called Resident A's physician from the "PACE" program and had left a message requesting a call back. Ms. Harris stated that a staff member from the PACE program did call Ms. Green back and subsequently sent a medical provider to the facility. Ms. Harris stated that the PACE program's medical provider evaluated Resident A and sent her to the Emergency Department. Ms. Harris stated she telephoned Relative 1 before Ms. Harris finished her shift at 7:00 AM but could not recall the exact time. Ms. Harris stated that Relative 1 did not answer her telephone and therefore she left a voicemail message informing Relative 1 of Resident A's injury and emergency department visit.

On11/06/2024 I interviewed Relative 1 via telephone. Relative 1 confirmed that she is Resident A's mother and legal guardian. Relative 1 stated that on 10/31/2024 at approximately 12:30 AM, she received a telephone call from hospital staff indicating that Resident A was admitted to the hospital for a femur fracture which required surgery. Relative 1 stated that to her knowledge, facility staff hadn't contacted her regarding Resident A's hospitalization. Relative 1 stated that she had no concerns regarding Resident A's care at the facility and believed that the injury may have come from an unreported fall.

On 11/06/2024 I received a voicemail message from Relative 1. Relative 1 stated that she had checked her voicemail messages and located a message from facility staff relaying the details of Resident A's hospitalization. Relative 1 stated that the voicemail message was left on her cell phone on 10/31/2024 at approximately 12:30 AM.

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 400.15311	**Incident notification, incident records.**
	(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: **(b) Unexpected and preventable inpatient hospital admission.**
ANALYSIS:	Relative 1 stated that she checked her voicemail messages and located a message from facility staff relaying the details of Resident A’s hospitalization. Relative 1 stated that the voicemail message was left on her cell phone on 10/31/2024 at approximately 12:30 AM. A preponderance of evidence was not discovered during the Special Investigation to substantiate a violation of the applicable rule. Resident A’s legal guardian was provided appropriate notice of Resident A’s 10/31/2024 hospitalization.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Resident A’s Assessment Plan for AFC Residents is incomplete.

INVESTIGATION: On 10/31/2024 I received an email from licensee designee Marcia Curtiss. The email contained Resident A’s Assessment Plan for AFC Residents, but the document was incomplete. The Assessment Plan was not signed by the licensee designee, Marcia Curtiss.

On 10/31/2024 I received an email from licensee designee Marca Curtiss. Ms. Curtiss stated that her signature on Resident A’s Assessment Plan for AFC “was missed” and she “will ensure it is signed”.

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:	Resident A's Assessment Plan for AFC Residents is incomplete. The document was not signed by licensee designee, Marcia Curtiss. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Resident A's Assessment Plan for AFC Residents is incomplete.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS: Resident A's Resident Care Agreement is incomplete.

INVESTIGATION: On 10/31/2024 I received an email from licensee designee Marcia Curtiss. I observed that the email contained Resident A's Resident Care Agreement, but the document was incomplete. The Resident Care Agreement was not signed by Resident A's legal guardian, Relative 1.

On 10/31/2024 I received an email from licensee designee Marca Curtiss. Ms. Curtiss stated that the facility has experienced difficulty securing Relative 1's signatures on Resident A's Resident Care Agreement.

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:	Resident A’s Resident Care Agreement is incomplete. The document is not signed by Resident A or Resident A’s legal guardian Marianne Reber. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. Resident A’s Resident Care Agreement is incomplete.

CONCLUSION:	VIOLATION ESTABLISHED

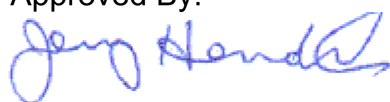
IV. RECOMMENDATION

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

11/07/2024

Toya Zylstra Date
Licensing Consultant

Approved By:



11/07/2024

Jerry Hendrick Date
Area Manager