GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 12, 2024

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

RE: License #: AL410398971
Investigation #: 2025A0583005
Willow Creek - East

Dear Mrs. Curtiss:

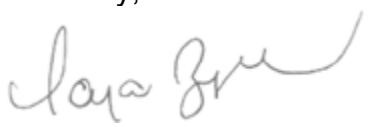
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
Report contains quoted profanity.

I. IDENTIFYING INFORMATION

License #:	AL410398971
Investigation #:	2025A0583005
Complaint Receipt Date:	11/05/2024
Investigation Initiation Date:	11/06/2024
Report Due Date:	12/05/2024
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, DEVELOPMENTALLY DISABLED, MENTALLY ILL, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff verbally mistreated Resident A	Yes

III. METHODOLOGY

11/05/2024	Special Investigation Intake 2025A0583005
11/06/2024	Special Investigation Initiated - On Site
11/08/2024	APS Referral
11/08/2024	Contact – Telephone call made Relative 1
11/12/2024	Contact – Telephone call made Relative 1
11/12/2024	Exit Conference Licensee designee Marcia Curtiss

ALLEGATION: Facility staff verbally mistreated Resident A.

INVESTIGATION: On 11/05/2024 I received a complaint directly via a voicemail message left from the complainant. The complainant stated that Resident A resides at the facility and is diagnosed with dementia. The complainant stated that on 11/03/2024 Resident A became verbally and physically aggressive towards staff Michael Madison. The complainant stated that Mr. Madison telephoned Resident A's wife, Relative 1, during the incident and Relative 1 did not answer the telephone call. The complainant alleged that Mr. Madison unintentionally left a voicemail on Relative 1's cell phone which recorded Mr. Madison yelling, "get the fuck away from me" to Resident A.

On 11/06/2024 I completed an unannounced onsite investigation at the facility and privately interviewed Regional Clinical Director Jeannine Hayes and Resident Care Manager Aimee Nelson.

Regional Clinical Director Jeannine Hayes stated that staff Michael Madison and staff Chynia Johnson worked at the facility on 11/03/2024 at 11:00 PM until 11/04/204 at 7:00 AM. Ms. Hayes stated that Resident A is diagnosed with dementia and was admitted to the facility for "respite care" for approximately one week but has since returned home to Relative 1's care. Ms. Hayes stated that due

to Resident A's advanced dementia he is unable to recount the events of the incident, and struggles with anger and aggression.

Resident Care Manager Aimee Nelson stated that on 11/04/2024 around 11:50 PM she received a telephone call from staff Michael Madison who stated that Resident A was displaying agitation and physical aggression. Ms. Nelson stated that she advised Mr. Madison to telephone "PACE" case management staff and call 911 for assistance. Ms. Nelson stated that she did not hear Mr. Madison verbally mistreat Resident A during her telephone conversation with Mr. Madison.

On 11/07/2024 I interviewed staff Chynia Johnson via telephone. Ms. Johnson stated that she worked at the facility with staff Michael Madison on 11/03/2024 at 11:00 PM until 11/04/2024 at 7:00 AM. Ms. Johnson stated that at approximately midnight, Resident A was observed taking food out of Mr. Madison's bag. Ms. Johnson stated that she and Mr. Madison attempted to verbally redirect Resident A however he continued to take food items out of Mr. Madison's bag. Ms. Johnson stated that Mr. Madison walked over to Resident A and took one of the food items away from Resident A which caused Resident A to begin punching the table. Ms. Johnson stated that Resident A subsequently punched Mr. Madison in the chest and attempted to choke Mr. Madison. Ms. Johnson stated that Mr. Madison removed himself from the kitchen area and walked into the office. Ms. Johnson stated that Mr. Madison telephoned Resident Care Manager Aimee Nelson, "PACE" staff, and 911. Ms. Johnson stated that Resident A was transported to the hospital for evaluation. Ms. Johnson stated that at no time did she hear Mr. Madison curse or verbally mistreat Resident A.

On 11/07/2024 I interviewed staff Michael Madison via telephone. Mr. Madison stated that he worked at the facility with staff Chynia Johnson on 11/03/2024 at 11:00 PM until 11/04/204 at 7:00 AM. Mr. Madison stated that at approximately 11:50 PM he was in the kitchen/dining area with Resident A and Ms. Johnson. Mr. Madison stated that Resident A began getting into Mr. Madison's bag and took out Mr. Madison's food items. Mr. Madison stated that he verbally redirected Resident A multiple times to stop taking Mr. Madison's items out of his bag however Resident A began to exhibit agitation and aggression. Mr. Madison stated that Resident A physically attacked Mr. Madison by punching him in the chest and attempted to choke Mr. Madison. Mr. Madison stated that Resident A also punched walls and hit the dining table. Mr. Madison stated that he left the area and moved to his office where he telephoned Relative 1 three times, however, Relative 1 did not answer the calls. Mr. Madison acknowledged that Relative 1's voicemail picked up and recorded him directly telling Resident A to "get the fuck away from me" because Resident A "was coming towards me again". Mr. Madison stated that he telephoned Resident Care Manager Aimee Nelson and requested guidance. Mr. Madison stated that Ms. Nelson directed Mr. Madison to telephone "PACE" staff and call 911. Mr. Madison stated that he did telephone "PACE" staff but no one answered and then he did telephone 911 around midnight. Mr. Madison reported that it took emergency personnel until approximately 2:00 AM to reach the facility and Resident A was

transported to the hospital for evaluation. Mr. Madison stated that he removed himself from Resident A's area while waiting almost two hours for emergency personnel to arrive.

On 11/08/2024 I telephoned Relative 1. Relative 1 did not answer her telephone and I left a voicemail message requesting a returned call back.

On 11/08/2024 I emailed the complaint allegation to Adult Protective Services Centralized Intake.

On 11/08/2024 I telephoned Relative 1. Relative 1 did not answer her telephone and I left another voicemail message requesting a return call back.

On 11/12/2024 I completed an Exit Conference with licensee designee Marcia Curtiss via telephone. Ms. Curtiss stated that she did hear the recording herself and heard staff Michael Madison curse at Resident A. Ms. Curtiss did not dispute the findings and stated that she agreed that a violation had occurred. Ms. Curtiss stated that she already has a corrective action plan drafted and will submit it after receiving a copy of the Special Investigation findings.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Staff Michael Madison stated that he worked at the facility on 11/03/2024 at 11:00 PM until 11/04/204 at 7:00 AM. Mr. Madison stated that he verbally redirected Resident A multiple times to stop taking Mr. Madison's items out of his bag however Resident A began to exhibit agitation and aggression. Mr. Madison stated that Resident A physically attacked him by punching him in the chest and attempted to choke him. Mr. Madison stated that Resident A also punched walls and hit the dining table. Mr. Madison stated that he left the area and moved to his office where he telephoned Relative 1 three times and she did not answer. Mr. Madison stated that Relative 1's voicemail picked up during one of the telephone calls and Mr. Madison was recorded as directing Resident A to "get the fuck away from me" because Resident A was coming towards Mr. Madison as he was in his office.

	A preponderance of evidence was established to substantiate violation of the applicable rule. Staff Michael Madison verbally mistreated Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

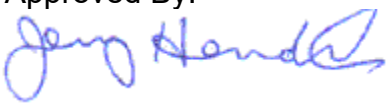
IV. RECOMMENDATION

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

11/12/2024

Toya Zylstra Date
Licensing Consultant

Approved By:



11/12/2024

Jerry Hendrick Date
Area Manager