GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 11, 2024

Amanda Brenner
CSM Serenity, LLC
61 Sheldon Ave., SE
Grand Rapids, MI 49503

RE: License #: AL030393311
Investigation #: 2025A0583006
Macatawa East

Dear Ms. Brenner:

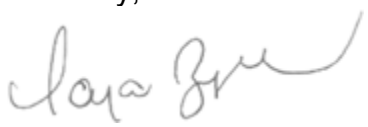
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL030393311
Investigation #:	2025A0583006
Complaint Receipt Date:	11/14/2024
Investigation Initiation Date:	11/14/2024
Report Due Date:	12/14/2024
Licensee Name:	CSM Serenity, LLC
Licensee Address:	61 Sheldon Ave., SE, Grand Rapids, MI 49503
Licensee Telephone #:	(616) 550-4653
Administrator:	Amanda Brenner
Licensee Designee:	Marcia Curtiss
Name of Facility:	Macatawa East
Facility Address:	1710 West 32nd St., Holland, MI 49423
Facility Telephone #:	(616) 550-4653
Original Issuance Date:	05/10/2018
License Status:	REGULAR
Effective Date:	11/07/2024
Expiration Date:	11/06/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, DEVELOPMENTALLY DISABLED, MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was inappropriately discharged.	Yes

III. METHODOLOGY

11/14/2024	Special Investigation Intake 2025A0583006
11/14/2024	Special Investigation Initiated - Telephone
11/18/2024	Inspection Completed On-site
11/22/2024	APS Referral
12/11/2024	Exit Conference Licensee designee Marcia Curtiss

ALLEGATION: Resident A was inappropriately discharged.

INVESTIGATION: On 11/14/2024 a complaint allegation was received from the LARA-BCHS-Complaints online reporting system. The complaint stated, "that on Oct 8th 2024 Amanda Brenner" emergently evicted Resident A after a 10/02/2024 suicide attempt which necessitated a hospital stay. The complaint stated that "once medically stable" staff "Amanda Brenner would not allow (Resident A) to return to the facility and would not allow her 30 days to find another facility to live".

On 11/14/2024 I interviewed Relative 1 via telephone. Relative 1 stated that she is Resident A's guardian. Relative 1 stated that on 10/02/2024 Resident A swallowed multiple Tylenol pills in a suicide attempt which necessitated an emergency room visit. Relative 1 stated that Resident A was admitted to the hospital due to the suicide attempt. Relative 1 stated that on 10/08/2024, Relative 1 received an email from administrator Amanda Brenner which stated that Resident A was emergently evicted and could not return to the facility. Relative 1 stated that she spoke to Ms. Brenner and informed her that Resident A had her medication adjusted which could alleviate her suicidal ideation however Ms. Benner refused to allow Resident A to return to the facility. Relative 1 stated that Resident A was forced to stay in the hospital until 10/24/2024 at which time a new placement was located.

On 11/18/2024 I completed an unannounced onsite investigation at the facility and interviewed administrator Amanda Brenner. Ms. Brenner stated that Resident A was admitted to the facility on "06/24/2024 or 06/25/2024". Ms. Brenner stated that Resident A was able to move freely within the community. Ms. Brenner stated that Resident A attempted suicide on 10/02/2024 by ingesting multiple over the counter

pain relivers. Ms. Brenner stated that the over-the-counter pain relievers did not belong to Resident A or any other resident of the facility. Ms. Brenner stated that facility staff did not know how Resident A obtained the medication but believe it to be from the community. Ms. Brenner stated that Resident A was immediately transported to the local emergency department for treatment. Ms. Brenner stated that while Resident A was at the hospital, Ms. Brenner located a “noose” in Resident A’s bedroom. Ms. Brenner stated that she felt that Resident A was a substantial risk to herself and therefore initiated a “24 hour” discharge notice. Ms. Brenner stated that she conferred with Resident A’s case manager, Amanda Put and Ms. Put agreed with the emergent discharge. Ms. Brenner stated that she sent Relative 1 the eviction notice via email on 10/08/2024 and faxed a copy of the document to licensing consultant Megan Aukerman on that same date. Ms. Brenner stated that she supplied a copy of the discharge notice to Ms. Put on 10/08/2024 via email. Ms. Brenner stated that she contacted multiple nursing homes in an attempt to find Resident A a new placement, but she was lodged at the hospital until 10/24/2024 at which time a new placement was secured.

On 11/19/2024 I interviewed licensing consultant Megan Aukerman via telephone. Licensing consultant, Megan Aukerman reported she had a phone conversation with administrator, Amanda Brenner, a few days after the discharge occurred. Mrs. Brenner informed Mrs. Aukerman of the 24-hour discharge. Mrs. Brenner stated she faxed licensing a copy of the notice; however, it may not have gone through as their internet was not working that day. Based on the information presented, Mrs. Aukerman felt the discharge was appropriate; however, she reminded Mrs. Brenner that the placing agency and guardian must agree with the discharge and a new placement. Mrs. Brenner indicated she was assisting with finding an alternative placement.

On 11/18/2024 I received an email from Licensee Designee Marcia Curtiss. I observed that the email contained an eviction document dated 10/08/2024 and signed by administrator Amanda Brenner. I observed that the document stated the following: *“I regret to inform you that we will be terminating (Resident A’s) placement in Care Cardinal -Macatawa. We are unable to continue to provide for her because she is a substantial risk to herself and others. Effective today, please consider this the twenty-four (24) Hour notice to move. If you have any questions, please feel free to call me at 616-550-4653”.*

On 11/19/2024 I interviewed case manager Amanda Put via telephone. Ms. Put stated that Resident A has a history of suicidal ideation. Ms. Put stated that administrator Amanda Brenner did confer with Ms. Put regarding the need to evict Resident A emergently because Resident A was a substantial risk to herself. Ms. Put stated that she agreed with the emergent discharge.

On 12/11/2024 I completed an exit conference via telephone with licensee designee Marcia Curtiss. Ms. Curtiss declined to offer further comment on the findings until

reading the Special Investigation Report. Ms. Curtiss stated that she would submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.** **(b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge.** **If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply:** **(i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.** **(ii) The resident shall have the right to file a complaint with the department.** **(iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.**

ANALYSIS:	Administrator Amanda Brenner stated that Resident A attempted suicide on 10/02/2024 by ingesting multiple over the counter pain relivers. Ms. Brenner stated that Resident A was immediately transported to the local emergency department for treatment. Ms. Brenner stated that while Resident A was at the hospital, Ms. Brenner located a "noose" in Resident A's bedroom. Ms. Brenner stated that she felt that Resident A was a substantial risk to herself and therefore initiated a "24 hour" discharge notice. Ms. Brenner stated that she conferred with Resident A's case manager, Amanda Put and Ms. Put agreed with the emergent discharge. Ms. Brenner stated that she sent Relative 1 an eviction notice via email on 10/08/2024 and faxed a copy of the document to licensing consultant Megan Aukerman on that same date. Ms. Brenner stated that she supplied a copy of the discharge notice to Ms. Put on 10/08/2024 via email. I observed an eviction document dated 10/08/2024 and signed by administrator Amanda Brenner. I observed that the document stated the following: *"I regret to inform you that we will be terminating Resident A placement in Care Cardinal - Macatawa. We are unable to continue to provide for her because she is a substantial risk to herself and others. Effective today, please consider this the twenty-four (24) Hour notice to move. If you have any questions, please feel free to call me at 616-550-4653."* A preponderance of evidence was discovered during the course of the Special Investigation to substantiate a violation of the applicable rule. Staff Amanda Brenner executed an emergency discharge of Resident A but failed to provide, in writing, the reason for the proposed discharge, including the specific nature of the substantial risk, the alternatives to discharge that had been attempted by the licensee, and the location to which the resident would be discharged, if known.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/11/2024

Toya Zylstra Date
Licensing Consultant

Approved By:

12/11/2024

Jerry Hendrick Date
Area Manager