GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 13, 2025

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

RE: License #: AL410398971
Investigation #: 2025A0583035
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) 356-0100.

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 #:	2025A0583035
Complaint Receipt Date:	04/30/2025
Investigation Initiation Date:	04/30/2025
Report Due Date:	05/30/2025
Licensee Name:	CSM Alger Heights, LLC
Licensee Address:	1019 28th St. Grand Rapids, MI 49507
Licensee Telephone #:	(616) 262-1792
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) 262-1792
Original Issuance Date:	08/05/2020
License Status:	REGULAR
Effective Date:	02/05/2025
Expiration Date:	02/04/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED,, ALZHEIMERS, DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Facility staff failed to provide Resident A with timely medical care.	No
Additional Findings	Yes

III. METHODOLOGY

04/30/2025	Special Investigation Intake 2025A0583035
04/30/2025	Special Investigation Initiated - Letter Licensee designee Marcia Curtiss
05/06/2025	Inspection Completed On-site
05/13/2025	Exit Conference Licensee designee Marcia Curtiss

ALLEGATION: Facility staff failed to provide Resident a with timely medical care.

INVESTIGATION: On 04/30/2025 the above complaint allegation was received from the LARA-BCHS-Complaint online system. The complaint stated that Resident A died October 22, 2024, due to what the complainant believes was “neglect on the part of” the facility. The complaint stated that Resident A died due to pneumonia and that Resident A was observed on 10/11/2025 by Relative 3 to be “having trouble breathing, he couldn’t drink anything, couldn’t eat”. The complaint stated that Relative 3 informed staff of Resident A’s health issues and was told that Resident A previously had an x-ray that ruled out pneumonia. The complaint stated that Relative 3 “insisted” that Resident A be transported to the emergency department and was ultimately diagnosed with pneumonia and died eleven days later.

On 05/05/2025 I interviewed Relative 1 via telephone. Relative 1 stated that she was Resident A’s wife. Relative 1 stated that Relative 2 is her stepdaughter and that Relative 2 was Resident A’s medical Power of Attorney. Relative 1 stated that there is a strained relationship between Relative 1 and Relative 2 and they did not agree upon Resident A’s care and placement preceding his death. Relative 1 stated that due to distance, she was unable to visit Resident A at the facility the month preceding his death. Relative 1 stated that Relative 3 is Resident A’s sister. Relative 1 stated that she spoke to Relative 3 after Resident A’s passing and Relative 3 stated that she visited Resident A at the facility on 10/11/2025. Relative 1 stated that Relative 3 observed Resident A coughing and unable to eat. Relative 1 stated that Resident 3 was informed by facility staff that Resident A had recently had an x-ray to evaluate the presence of possible pneumonia and those results were

pending. However Relative 3 requested that Resident A be seen immediately at a local emergency department. Relative 1 stated that on that same day Resident A was sent via ambulance to Corewell Health Butterworth and was diagnosed with pneumonia. Relative 1 stated that Resident A was transferred to Corewell Health Blodgett where he was admitted for eleven days before dying of complications of pneumonia. Relative 1 stated that she did not believe that Resident A was provided with an x-ray before 10/11/2025 and therefore did not receive adequate care.

On 05/06/2025 I completed an onsite investigation at the facility and interviewed Regional Executive Director Kelly McCann, staff Miranda Cockrell, and staff Darkesha Phillips.

Ms. McCann stated that Resident A was admitted to the facility on 08/15/2024 and suffered from dementia with agitation. Ms. McCann stated that Resident A's primary care services were provided through Careline Physician Services. Ms. McCann stated that per staff documentation, Resident A displayed a cough prior to his passing and an x-ray was completed by Careline Physician Services. Ms. McCann stated that she was unsure of the exact results of the last x-ray but stated that medical staff did not order Resident A to need inpatient care following his x-ray. Ms. McCann stated that staff documentation indicates that Resident A was transported to the local emergency department on 10/12/2024, rather than the date of 10/11/2025 reported by Relative 1. Ms. McCann stated that staff provided appropriate care and followed all doctor's orders prior to Resident A's 10/12/2025 hospitalization.

Staff Miranda Cockrell stated that she provided limited care to Resident A prior to his death because she was new to her position at the facility. She stated that she did not observe Resident A to be in respiratory distress prior to 10/12/2025 and stated that to the best of her knowledge, staff provided adequate personal care.

Staff Darkesha Phillips stated that Resident A had a history or dementia and agitation. She stated that Relative 1 and Relative 2 displayed a tumultuous relationship and it was sometimes difficult for staff to navigate his care while balancing the needs and wants of his family. Ms. Phillips stated that she did not work with Resident A on 10/12/2024, but did work with him the week before he left the facility. Ms. Phillips stated that the week preceding his leave from the facility; Resident A was eating and snacking normally. Ms. Phillips stated that Resident A did have a minor cough, but staff were "pushing fluids" and Resident A did not appear to be in respiratory distress. Ms. Phillips stated that to her knowledge, staff provided adequate care for Resident A prior to his hospitalization.

While onsite I reviewed an Incident Report drafted and signed by staff Michael Madison on 10/12/2025. The documentation stated that on 10/12/2025 Resident A "was visibly, not looking like his self" and exhibited "heavy breathing". The documentation stated that Resident A's vitals were taken but the "machine kept

saying error". The documentation stated that Resident A was "sent to the emergency".

While onsite I reviewed Resident A's Health Care Appraisal signed 07/25/2024 which stated that Resident A was diagnosed with "Alzheimer's" and "Dementia with agitation". I also reviewed the facility's "charting notes". I observed that on 10/10/2024, staff Aime Nelson observed that Resident A "has a cough" and "doctor is having a x-ray scheduled". The documentation stated that "family is aware".

While onsite I observed a university of Michigan Health West "After Visit Summary" dated 10/04/2024. The documentation indicated that Resident A was seen for a "fall injury" and was diagnosed with a "Urinary Tract infection" and was prescribed an "antibiotic". The documentation further stated that Resident A's condition at discharge was "good". The documentation stated that during the medical encounter, Resident A completed a basic metabolic panel, complete blood count, high-sensitivity troponin, POCT SARS-COV-2 & FLU A + B test, Urinalysis W/Cult, CT Chest ABD PEL W CONTRAST, CT HEAD WO CONTRAST, EKG, and Brittnay XR TIBIA FIBULA BILATERAL VW. Resident A's blood saturation was observed as 95%.

I observed a Careline Physician Services Order Form dated 10/09/2025. The documentation stated that Resident A was diagnosed with Respiratory tract congestion with cough and a Urinary Tract infection. The documentation stated that Resident A was prescribed Coricidin HBP Cough and Cold one tablet every six hours for ten days.

On 05/08/2025 I interviewed the regional manager of Optimal Care Hannah Rosema, formerly Careline Physician Services. Ms. Rosema stated that their medical practice provided care for Resident A. Ms. Rosema stated that on 10/09/2025 their medical practitioner observed Resident A at the facility and ordered a chest x-ray. Ms. Rosema stated that on 10/10/2025 a mobile diagnostic professional completed an x-ray of Resident A's chest at the facility. Ms. Rosema stated that on 10/11/2025 their practitioner received the results of the x-ray which indicated Resident A was diagnosed with pneumonia and at 10:15 AM an order was faxed to the pharmacy for Doxycycline administration. Ms. Rosema stated that the facility was notified of Resident A's x-ray results on 10/11/2025. Ms. Rosema stated that on 10/12/2025 facility staff contacted their practice and reported that Resident A displayed difficulty breathing, and their practitioner directed facility staff to send Resident A to the local emergency department. Ms. Rosema stated that the practitioner that observed Resident A on 10/09/2025 no longer works for their practice.

On 05/12/2025 I received an email from licensee designee Marcia Curtiss. The email stated the following: ***10/5/2024*** *– Returned from hospital with new order for Cephalexin (Keflex) 500mg, take one capsule by mouth three times daily for 7*

days. This started on 10/5/2024 with the first dose at 8pm and last dose given on 10/12/2024 at 2pm.
***10/10/2024** – Chart note by Aimee Nelson at 12:56pm, states resident had a cough, and the doctor was having an x-ray scheduled for him. Per chart note family was aware.*
***10/11/2024** – Order for Doxycycl HYC tab 100mg received with directions to give one tablet by mouth twice per day for 7 days. Order was received by pharmacy on 10/11/2024 at 10:30am per Nicole at Pharmascript. Nicole states in the chart notes of their system shows that a pharmacy tech called physician service to question the start of this antibiotic as the resident was still on the above antibiotic (Keflex). Per the notes of the pharmacy chat, the ordering provider stated the Keflex was for a UTI and the new antibiotic, Doxycycl HYC was for Pneumonia. The first dose of the Doxycycl was given on 10/11/2024 at 8pm after received from pharmacy.*
He received his 2nd dose of Doxycycl HYC on 10/12/2024 at 8am as ordered. He was then sent to the hospital before the next dose was scheduled. Per the chart notes he was sent to hospital at the beginning of 2nd shift (3pm).
Resident was on 2 antibiotics at the same time for approximately 14 hours, as the last prescribed dose of Keflex was given on 10/12/2024 prior to sending to hospital".

The email contained Resident A's Medication Administration Record, which indicated that Resident A was prescribed DOXYCYCL HYC 100 MG twice daily starting 10/11/2025 at 10:00 AM and received the medication as prescribed starting 10/11/2025 at 8:00PM and 10/12/2025 at 8:00 AM.

On 05/13/2025 I completed an exit conference via telephone with licensee designee, Marcia Curtis. She was informed of the investigation findings and stated that she agreed.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Regional manager of Optimal Care Hannah Rosema, formerly Careline Physician Services, stated that their medical practice provided care for Resident A. Ms. Rosema stated that on 10/09/2025 their medical practitioner observed Resident A at the facility and ordered a chest x-ray. Ms. Rosema stated that on 10/10/2025 a mobile diagnostic professional completed an x-ray of Resident A's chest at the facility. Ms. Rosema stated that on 10/11/2025 their practitioner received the results of the x-ray which indicated Resident A was diagnosed with pneumonia and at 10:15 AM an order was faxed to the pharmacy for Doxycycline administration. Ms. Rosema stated that the facility

	was notified of Resident A's x-ray results on 10/11/2025. Ms. Rosema stated that on 10/12/2025 facility staff contacted their practice and reported that Resident A displayed difficulty breathing, and their practitioner directed facility staff to send Resident A to the local emergency department. Ms. Rosema stated that the practitioner that observed Resident A on 10/09/2025 no longer works for their practice. Resident A's Medication Administration Record indicated that Resident A was prescribed DOXYCYCL HYC 100 MG twice daily starting 10/11/2025 at 10:00 AM and received said medication as prescribed starting 10/11/2025 at 8:00PM and 10/12/2025 at 8:00 AM. A preponderance of evidence was not discovered to substantiate violation of the applicable rule. Resident A received adequate medical care as evidenced by a 10/09/2025 physician's exam, 10/10/2025 x-ray, and the administration of subsequently prescribed Doxycycline on 10/11/2025 and 10/12/205.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS: Resident A's Assessment Plan is incomplete.

INVESTIGATION: On 05/09/2025 I received an email from staff Kelly McCann. The email contained Resident A's Assessment Plan for AFC Residents. I observed that the document was incomplete. The Assessment Plan was unsigned and lacked the date the document was completed.

On 05/12/2025 I interviewed licensee designee Marcia Curtiss via telephone. Ms. Curtiss stated that facility staff located Resident A's Assessment Plan for AFC Residents, however she could not locate a signature page, and it is unknown when the document was completed.

On 05/13/2025 I completed an exit conference with licensee designee Marcia Curtiss via telephone. Ms. Curtiss stated that she did not dispute the findings and would submit an acceptable Corrective Action Plan.

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 Resident A's designated representative or the licensee designee. 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:	**REPEAT VIOLATION ESTABLISHED** 2025A0583004 11/07/2024

IV. RECOMMENDATION

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

05/13/2025

Toya Zylstra Date
Licensing Consultant

Approved By:

05/13/2025

Jerry Hendrick Date
Area Manager